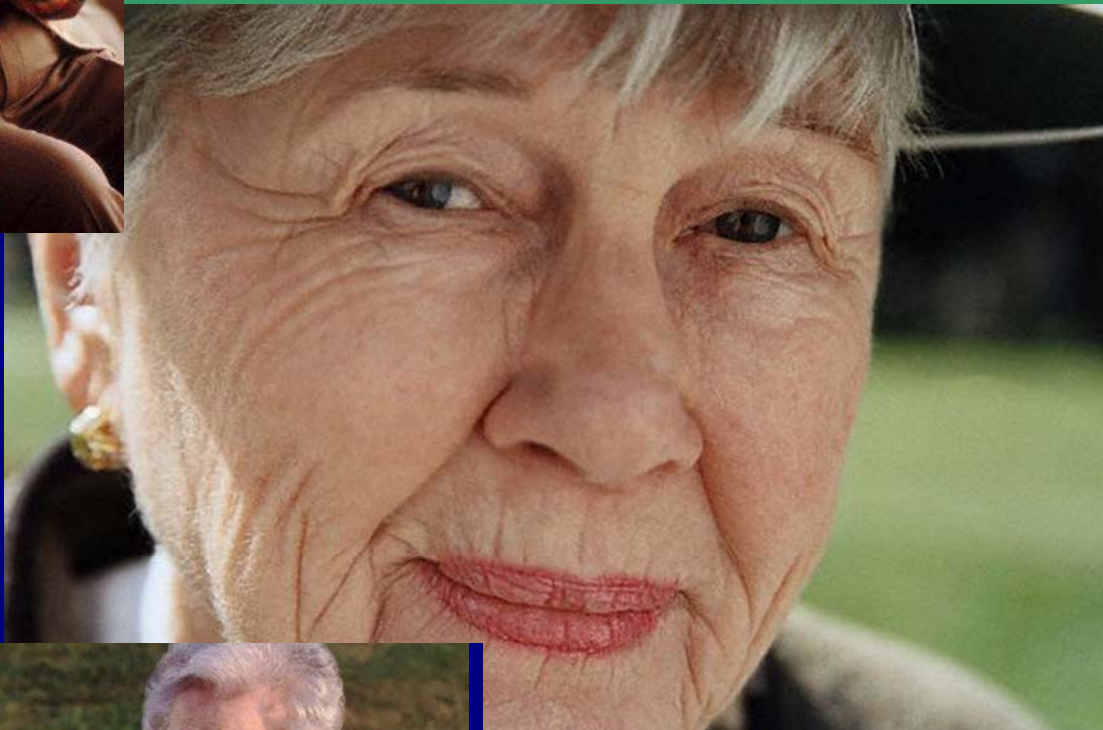




The TRECS Institute
Targeting Revolutionary Elder Care
Solutions



Improving Dental and Oral Care Services for Nursing Facility Residents



FINAL REPORT
January 20, 2006



The TRECS Institute

“Targeting Revolutionary Elder Care Solutions”

Improving Dental and Oral Care Services for Nursing Facility Residents

*Final Report
January 20, 2005*

The TRECS Institute is a non-profit 501©(3) organization dedicated to serving as a catalyst to bring about positive changes and improvements to the long term care industry. For more information on The TRECS Institute, please visit www.TheTRECSInstitute.org

The Board of Directors of The TRECS Institute identified dental and oral care for nursing home residents as a major area of concern and targeted this topic for research. The Board wishes to thank the State of Florida, Agency for Health Care Administration for their generous support of this initiative.

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Improving Dental and Oral Care Services for Nursing Facility Residents

Linda A. Whitman, PhD and John Whitman, MBA, LNHA

Abstract

Objective:

This paper discusses the findings of a recent study designed to understand how long-term care residents in nursing homes currently receive dental and oral care services and to identify improved methods of assuring better dental and oral care services in the future.

Methods:

A research team was assembled of qualified professionals, representing a variety of disciplines essential to assure the success of this research project and the credibility to the findings and recommendations developed.

A literature review was conducted in the following areas: oral health assessment, oral care of elderly in homes, institutionalized aged, nursing dental assistants, oral health in elder care, portable dentistry, aspiration pneumonia, periodontal disease, diabetes mellitus, mobile dentistry, and the Surgeon General's Call to Action. The search was conducted through Medline from 1998-2004 through the library at the University of Pennsylvania's School of Dentistry.

In June of 2005, six focus groups were conducted in the State of Florida. Three groups with residents of nursing homes and three groups with families of current residents. Focus group sizes ranged from six to ten participants and were conducted by a professional focus group leader.

Interviews with other industry experts, nursing facility staff, administrative staff, geriatric dentists, general practice dentists specializing in nursing home care, geriatricians, attorneys specializing in eldercare and healthcare issues, insurance experts, brokers and social workers were conducted by telephone and in person.

A legal and regulatory review, evaluating all applicable laws, regulations and reimbursement issues regarding the provision of oral and dental care services for nursing home residents was conducted by an attorney specializing in eldercare and dental services for the elderly.

A summit of the key members of the research team was held to review all data and develop findings and recommendations. The draft report was then circulated among the entire team as well as a select group of industry experts for review and comment.

The final report was submitted to the State of Florida, Agency for Health Care Administration. The educational programs being developed as a result of this study and targeted to nursing facility staff, families and residents, will be distributed to nursing facilities throughout the State of Florida.

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Findings:

The dental and oral health care needs of the elderly residing in nursing homes are not being adequately met due to several key factors:

- #1. A pervasive lack of knowledge of the importance of dental and oral health care on the part of residents, their families and the nursing facilities staff.
- #2. Difficulties faced by some residents in providing self care due to physical limitations despite the desire to maintain good oral health and the desire to remain independent.
- #3. Providing good daily oral care to residents with dementia and/or behavioral problems can be extremely difficult for staff despite good intentions and efforts.
- #4. Ageism prejudices are overtly evident among staff, families and even the residents themselves.
- #5. A lack of or severely limited reimbursement for professional dental services resulting in significant access problems.
- #6. Extremely poor dental and oral health care is currently being seen among the cohort of elderly between the time they retire and their admission to a nursing facility, resulting in new nursing home residents with tremendous dental and oral care needs upon admission.

Conclusions:

The following conclusions were generated from this study:

- #1. There is a profound and basic need to develop a program to educate all cohorts including residents, family and health care professionals on the importance of good dental and oral care for the elderly.
- #2. Long-term care professionals should implement a preventive oral screening program consisting, not only of entrance examinations but also routine (daily) preventive care, with special training of staff for challenging patient types.
- #3. A recently developed commercial dental insurance program designed specifically for nursing home residents, should be tested as a realistic approach to improving dental care services by increasing reimbursement for dental professionals thereby eliminating the access problem that dominates the industry today.

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#4. The use of dental hygienists should be expanded within the nursing home setting by allowing collaborative relationships with dentists similar to the relationship nurse practitioners share with their collaborating physician in many States.

#5. Taking the appropriate efforts to improve oral and dental care for nursing home residents could have a significant impact not only on quality of life for nursing facility residents, but also a meaningful impact on downstream medical costs for the health care system by preventing hospitalizations and death resulting from medical care needs arising out of poor oral and dental care.

#6. The need for better education and preventive dentistry also needs to be stressed for the senior population in general, especially those retiring from active employment long before nursing home placement possibilities. Data currently shows that this population's lack of good oral and dental care during the period after retirement and before entering a nursing facility is poor at best resulting in significant dental concerns upon admission.

The ultimate goal of this study was to establish an integrated approach to maintaining quality dental and oral care for institutionalized elderly, thereby improving overall health and quality of life for nursing facility residents while saving our health care system millions of dollars by avoiding downstream medical problems and their costs.

Key Terms: ageism, oral health care,

Background:

The TRECS Institute (**T**argeting **R**evolutionary **E**lder **C**are **S**olutions) is a non-profit 501©(3) organization dedicated to serving as a catalyst to bring about positive changes and improvements to the long term care industry.

The Board of The TRECS Institute identified dental and oral care for nursing home residents as a major area of concern and targeted this topic for a research effort. Through a generous grant from the State of Florida, Agency for Health Care Administration, this project was initiated.

For the purposes of this report, the terms “oral health care” or “oral dental care” will be used and includes not only traditional dental care services, but all medical and preventative services that deal with the resident's teeth, mouth and gums.

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The TRECS Institute and the research team associated with this project wish to thank the many organizations and professionals that contributed to the success of this effort. Special thanks and recognition are offered to:

Michael J. Helgeson, DDS
Chief Executive Officer
Apple Tree Dental
Minneapolis, Minnesota

James E. Udan
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Barbara Smith PH.D..
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Steve Moses
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The Center for Long-Term Care Reform, Inc
Seattle, Washington

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Improving Dental and Oral Care Services for Nursing Facility Residents

Introduction and History

The first ever Surgeon General's Report on Oral Health Care, published in May 2000, alerted Americans that oral health care is critical to general health and well-being, and can be achieved (U.S. Department of Health and Human Services, 2000). However, profound oral health disparities exist within the U.S. population. Those who suffer the worst oral health care and hygiene include older adults residing in nursing homes.¹

Oral health care for elders is under-funded, under-researched, and has been a low health care priority. The Surgeon General's recent report on "Oral Health Care in America" identified frail elders and nursing home residents among the populations most vulnerable to poor dental care.² Currently, there are approximately 34.5 million people age 65 and older living in America. This number is expected to increase to 70 million by 2030.³ Of this 65 age cohort, 5 percent reside in over 17,000 nursing homes in the United States. An additional 16 percent of those 85 and older also reside in nursing homes.⁴ It has been estimated that this increasing over 65 population will easily double the need for nursing home care in this nation in the foreseeable future. As the Secretary of Health and Human Services notes, "Ignoring oral health problems can lead to needless pain and suffering, causing devastating complications to an individual's well being, with financial and social costs that significantly diminish quality of life and burden American society."⁵

¹ Coleman, P. (2002). Improving oral health care for the frail elderly: A review of widespread problems and best practices. *Geriatric Nursing*, 23, 189-199.

² *Oral Health in America: A Report of the Surgeon General*, National Institute of Dental and Craniofacial Research, National Institutes of Health, Bethesda, MD. Online, Available at: www.nidr.nih.gov/sgr/execsumm.htm

³ Administration on Aging. Profile of Older Americans: 2000.

⁴ Strayer M. Consensus Conference on practical guidelines for institutionalized older dental patients. *Spec. Care Dent*, 16:141-2, 1996.

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Yet the changing needs of elders have not been recognized in the overall health care plan for this special cohort. In the 1960's, when most of our current health care policies were being developed, the majority of elders did not have natural teeth; dental care for elders was synonymous with denture care.⁶ Today, not only are people living longer, they are retaining the majority of their natural teeth. With the retention of natural teeth, dental care and maintenance becomes more complex and the neglect of dental care can lead to increased health risks.^{7 8}

Oral needs of institutionalized elderly represent a special challenge. The number of elderly and the amount of elder dental disease is increasing in the United States. The elderly population over 65 years old is expected to double over the next twenty-five years^{9 10} so that by 2030, twenty five percent of Americans (about 70 million) will be sixty five years of age or older. Between 1960 and 1994, the population of the "oldest-old," (those above age eighty-five) increased by two hundred and seventy-four percent.^{11 12}

Since elders are retaining their natural teeth, their risk of oral disease increases and it increases even more rapidly among elders unable to adequately perform their daily

⁵ *Aging America Poses Unprecedented Challenges, Says New Census, Aging Institute Report*, Available at www.nih.gov/nia/new/press/census.htm

⁶ Burt BA, *Influences for change in the dental health status of populations: an historical perspective*, *Journal of Public Health Dentistry*, 38(4):272-88(1978 Fall).

⁷ Ettinger RL, *The unique oral needs of an aging population*, *Dental Clinics of North America* 41(4):633-49 (1997 Oct).

⁸ Berkey D., Berg R, *Geriatric Oral Health Issues in the United States*, *International Dental Journal* 51(3 Suppl):254-64 (2001 Jun).

⁹ Slavkin, HC, *Maturity and oral health: live longer and better*, *Journal of American Dental Association*, 131(6):805-8 (2000 Jun).

¹⁰ NIA News Release, *Aging America Poses Unprecedented Challenge*, www.nia.nih.gov/news/pr/1996/05-20.htm(May, 1999).

¹¹ National Center for Health Statistics, US Department of Health and Human Services. *Changing Mortality Patterns. Health Services utilization and health care expenditures: US 1978-2003*, analytical and epidemiological studies series 3, 1993;23(PHS PUB):83-1407.

¹² See n. 11

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oral hygiene care. However, even for elders without teeth, the risk for oral disease is increased. The incidence of oral mucosal diseases increases with the presence of chronic diseases and use of multiple medications.¹³ Oral disease can complicate certain medical problems and many medical problems can increase risk of oral disease.¹⁴ Additionally, elders are prescribed an ever-expanding variety of medications; over 80 percent of which are known to have adverse oral tissue side effects.¹⁵ Oral soft tissue lesions are estimated to annually affect 10-38 percent of elders 65 and older, with the highest rate among frail and institutionalized elders.

Dental disease rates actually begin to increase after age 45 and nearly double by age 65. Since elders are retaining their teeth, their risk of dental disease continues throughout their life. Aging alters the immune system response which coupled with common chronic conditions and medications, results in a growing population with growing rates of disease and a growing level of need.

Exclusion of oral health from general health issues and from coverage in Medicare compounds the problem.^{16 17} Dental professionals suggest that dentistry's evolution from the focal infection theory and exodontias (extraction of teeth) to today's advanced restorative and preventative care has created a new need for oral care among the current and future elderly dental consumers.¹⁸

¹³ Beck, JD., Watkins, C., *Epidemiology of non-dental oral disease in the elderly*, [Review] Clinics in Geriatric Medicine 8(3):447-59 (1992 Aug).

¹⁴ Burt BA, *Epidemiology of dental diseases in the elderly*, [Review] Clinics in Geriatric Medicine, 8(3):447-59 (1992 Aug).

¹⁵ Lewis IK, Hanlon JT, Hobbins MJ, Beck JD, *Use of medications with potential oral adverse drug reactions in community-dwelling elderly*, Special Care in Dentistry. 13(4):171-6 (1993 Jul-Aug).

¹⁶ Meskin LH, Dillenberg J, Heft MW, Katz RV, Martens LV, *Economic impact of dental services utilization by older adults*, Journal of the American Dental Association 120(6):665-8(1990 Jun).

¹⁷ White BA., *An overview of oral health status, resources and care delivery*, [Review] Journal of Dental Education 58(4):285-90 (1994 Apr).

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The 2000 Surgeon General's report findings was the catalyst for the current call to action of policymakers, community leaders, industry, health professionals and the public. Under the leadership of the Office of the Surgeon General, a National Call to Action was established in the spring of 2005.

According to the data collected at the Call to Action, the following elderly facts were extrapolated.

- Twenty-three percent of 65 to 74 year old have severe periodontal disease.
- Thirty percent of adults 65 years and older are edentulous.
- Individuals in long-term care facilities are prescribed an average of eight drugs. Many of these drugs have side effects such as dry mouth. The decrease in saliva increases the risk of oral disease.
- Five percent of Americans aged 65+(approximately 1.65 million) are living in a long-term care facility where dental care is problematic.
- Many elderly lose dental insurance with retirement. Medicare does not reimburse for dental care and Medicaid funds only for low income and disabled in a few states and reimbursement amounts are low.
(U.S. Department of Health and Human Services. Oral Health in America: A Report of the Surgeon General. Rockville, MD)

Oral care in the United States is provided predominantly by dental professionals in private practice. People who are able to 1) recognize the need for care; 2) identify a provider; 3) obtain transportation to the provider or convince the provider to come to the facility, and 4) pay for needed care, can enjoy the highest level of oral health care in the world. According to dental access studies, inabilities by many elderly, especially nursing home residents, to meet these four factors are among the most prevalent reported barriers to dental care. Data from the U.S. Department of Health and Human Services states that a lack of dental insurance, private or public is one of several impediments to obtaining oral health care.

¹⁸ Ettinger, RL. Watkins, C. Cowen, H., *Reflections on changes in geriatric dentistry*, Journal of Dental Education 64(10):715-22 (2000 Oct.).

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This paper will focus on LTC residents in nursing homes because they are the ones who are the most incapacitated and for whom dental care is often only marginally available. Once an individual enters a nursing home, their access to adequate dental care drops markedly. Estimates of the percentage of these patients with unmet dental needs range from 80% to 96%.^{19 20} This problem is likely to worsen when the baby-boom generation reaches the age when a substantial number will require LTC in a nursing home. Studies during the past decade have identified specific statistics concerning nursing facility residents that are concerning in general but especially from a dental care perspective:

- Women outnumbered men by approximately 3:1²¹
- The typical resident needed help with four activities of daily living (ADLs), which are bathing, dressing, eating, toileting, and transferring-as from a bed to a chair.²²
- Two thirds relied on Medicaid to pay for their care²³
- 6% were confined to bed²⁴
- 80% took six or more medications daily²⁵
- Up to 78% had untreated caries²⁶
- More than 40% had periodontal disease²⁷
- Up to three quarters of those over 65 had lost some or all teeth²⁸
- More than half of those over age 75 were edentulous²⁹
- 80% of those who had lost all teeth had dentures, but 18% did not use them.³⁰

¹⁹ Kambhu PP, Warren JJ, Hand JS, et al. *Dental treatment outcomes among dentate nursing facility residents: an initial study*. Spec Care Dent. 1998;18:128-132.

²⁰ Warren JJ, Kambhu PP, Hand JS, . *Factors related to acceptance of dental treatment services in a nursing home population*. Spec Care Dent. 1994;14:15-20.

²¹ National Nursing Home Survey 1999. Selected characteristics of homes, beds and residents. Table 3. Division of Data Services, National Center for Health Statistics, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. ftp.cdc.gov/pub/Health_Statistics/NCHS/Datasets/nnhs/nnhs99/.

²² Facts and Trends: The Nursing Facility Sourcebook 2001. American Health Care Association. 2001. www.ahca.org/research/nfs/nfs2001.pdf.

²³ The looming crisis: 15 key questions about long term care. American Health Care Association. 1998. www.ahca.org/secure/top15.htm.

²⁴ see n. 20

²⁵ Council on Access, Prevention and Interprofessional Relations. *Providing Dental Care in Long-term Care Facilities: A Resource Manual*. Chicago, IL: American Dental Association; 1997.

²⁶ See n. 23

²⁷ Vargas CM, Kramarow EA, Yellowitz JA. *The Oral Health of Older Americans. Aging Trends*; No. 3. Hyattsville, MD: National Center for Health Statistics; 2001.

²⁸ see n. 23

²⁹ see n. 25

³⁰ see n. 23

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The oral health of the growing elder population in long-term care facilities is becoming an important social issue. Over the past several decades, the pattern of oral disease has been shifting. Older adults in the United States are retaining their teeth longer with a significant decline in the rate of edentulism.^{31 32} In the New England Elders Dental Study (NEEDS), Douglass et al³³ reported a significant decline in edentulism from 1962 to 1990 among elders age 70 and over. The number of retained teeth per person has increased. Consequently, increased tooth survival has resulted in an increase in teeth exposed to the risk of dental disease. The NEEDS findings reveal a high prevalence of root caries in New England elders, suggesting a greater need for dental care than for previous generations of elders. The increasing number of older people living in nursing homes at some point in their lives, combined with declining tooth loss among the elderly, will lead to increased need for dental services within long term care facilities.

The U.S. Surgeon General's report *Oral Health in America* emphasizes the importance of oral health care to overall general health. The report describes the existing disparities in access to dental services among different population groups, especially the very young and very old. Berkey et al.³⁴ reviewed the oral health status of elderly nursing home residents and reported that 70 percent of residents had unmet oral health needs. The residents exhibited high rates of dental caries, edentulism, poor oral hygiene, periodontal disease, and soft tissue lesions. Unfortunately, there are

³¹ Weintraub J, Burt B. *Oral health status in the United States: tooth loss and edentulism.* J Dent Educ 1985; 49:368-76.

³² Douglass CW, Jette AM, Fox CH, Tennstedt SL, Joshi A, Feldman HA, McGuire SM, McKinlay JB. *Oral health status of the elderly in New England.* J Geront 1993;48:M39-M46.

³³ See n. 32

³⁴ Berkey DB, Berg RG, Ettinger RL, Meskin LH. *Research review of oral health status and service use among institutionalized older adults in the United States and Canada.* Spec Care Dentist 1991;11:131-6.

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obstacles in improving and maintaining good oral health for those individuals.

Many elderly Americans lack the financial resources to access dental care. Upon retirement, few older adults retain dental insurance. Kington et al.³⁵ found that only 13 percent of elder Americans have private dental insurance. Findings from the 1989 National Health Interview Survey conducted by Bloom et al.³⁶ reports significantly higher utilization of dental services by those elders with private dental insurance than those without.

Barbara Smith, PhD completed her doctoral thesis in 2002 for the University of Michigan looking at “Stability of Oral Health Status in a Long-Term Care Population – A Longitudinal Analysis of Dental Treatment Needs.” Her study focused on records maintained for almost 20 years from Apple Tree Dental, a non profit organization located in Minneapolis, Minnesota and serving the residents of approximately 80 nursing homes in that area. What is unique about the population of nursing home residents served by Apple Tree Dental is that this organization, with its non-profit mission, has literally broken the reimbursement barrier and its residents receive regular dental screenings, cleanings and care, unlike other nursing home residents across the nation. By breaking the reimbursement barrier, this unique organization is able to hire and reimburse its professional staff in a manner that makes working with nursing home residents an economically sound business model. Apple Tree Dental is only able to do this because of the outside funding it is able to raise as a non profit organization that helps supplement the program’s basic

³⁵ Kington R, Rogowski J, Lillard L. *Dental Expenditures and insurance coverage among older adults*. *Gerodontol* 1995;35:463-43.

³⁶Bloom B, Gift HC, Jack SS. *Dental services and oral health care: United States, 1989*. National Center for Health Statistics Health Survey, Vital Health Statistics Series 10, No. 183. Hyattsville, MD: Public Health Service; 1992.

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operation. These findings strongly suggest that a private or commercial dental insurance program that would essentially eliminate the reimbursement barrier currently in place and effectively make the business of providing professional dental care to nursing home residents a financially sound model, could have a profound impact on the industry.

Another very interesting finding from Dr. Smith's work is the confirmation that a large percentage of elderly take very poor care of their oral health needs between the time they retire and the point at which nursing home placement becomes a reality. As a result, Dr. Smith found that the average nursing home resident, if seen by a dentist upon admission, requires an average of 13.2 initial dental treatments with a mean ranging from 2 to 66! Furthermore, after three visits and with regular and consistent oral care, the ongoing need for professional care stabilized and was dramatically reduced.

Oral health is integral to an older adult's general health and quality of life, and basic oral health services are an essential component of primary health care.³⁷ Though not usually life threatening or seriously impairing for the majority of people, unchecked oral diseases in an older person can have far greater systemic impact than in a younger individual. A common route of systemic infection by oral micro-organisms is through the aspiration of oropharyngeal fluids containing oral pathogenic micro-organisms, which can cause pneumonia in patients with diminished host defenses.³⁸ A link has been shown between dental disease and coronary heart disease.³⁹ Dental infections have also been shown to be a risk factor for

³⁷ Dolan T, Atchison K. *Implications of access, utilization and need for oral health care by the non-institutionalized and institutionalized elderly on the dental delivery system.* J Dent Educ 57:876-87, 1993.

³⁸ Limeback H. *Implications of oral infections on systemic diseases in the institutionalized elderly with a special focus on pneumonia.* Ann Periodontol 3:262-75,1998.

³⁹ Loesche WJ, Schork A, Terpenning MS, et al. *Assessing the relationship between dental disease and coronary heart disease in the elderly U.S. veterans.* J Am Dent Assoc 129:301-11,1998.

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arteriosclerosis.⁴⁰ Some other dire consequences reported for the elderly are nutritional compromise, empyema, bacteremia, and brain abscess.⁴¹ As well as placing residents at risk for life threatening conditions, oral health problems also affect self-esteem, the ability to maintain a favorable self-image, and the ability to masticate food comfortably and efficiently(which may adversely affect nutritional status).⁴² Oral health problems can hamper one's ability to live without pain or discomfort. Above all, oral health is crucial to an individual's quality of life.⁴³ It is tragic that people whose quality of life is already diminished due to cognitive and functional loss may also be suffering unnecessarily from untreated oral disease.⁴⁴ Nursing home elderly, perhaps more than any other nursing home population group, need complete, comprehensive, and routine dental services to maintain an adequate level of oral health.⁴⁵

The changing demographics, barriers to treatment including apathy/ignorance, lack of perceived need, access, staff knowledge, institutional constraints, reimbursement difficulties, dentists' lack of geriatric dental care knowledge and the difficulty of treating elderly with functional impairment make this a unique challenge. These aging Americans deserve the opportunity to age gracefully and with dignity. They should maintain their teeth for a lifetime with manageable oral health care, and minimal functional problems that allow for a positive appearance, articulation and functionality. Above all, the senior citizens should have the oral care they need to pursue

⁴⁰ Meurman JH. *Dental infections and general health*. Quintessence Int 28:807-11, 1997.

⁴¹ Shay K. *Dental management considerations for institutionalized geriatric patients*. J Prosthet Dent 72:510-6, 1994.

⁴² Kayser-Jones J, Bird W, Redford M, et al. *Strategies for conducting dental examinations among cognitively impaired nursing home residents*. Spec Care Dent 16:46-52, 1996.

⁴³ See n. 37

⁴⁴ See n. 42

⁴⁵ Henry R, Ceridan B. *Delivering dental care to nursing home and homebound patients*. Dent Clin North Am 38:537-51, 1994.

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the quality of life they deserve. To quote Senator John Breaux (D-LA)

“Poor oral health care causes millions of vulnerable seniors to suffer needlessly. Too often, dental problems in this population are underestimated, ignored or not detected until far too late, resulting in serious disease and even death!”

Quoted by Senator John Breaux (D-LA), ranking member of the Senate Aging Committee, In *Nothing to Smile About on Older American’s Oral Health Report Card*” Senate Aging Committee Examines Ageism in Dental Care, September 22, 2003.

Study:

Methodology:

Phase One: Research Team

To complete this project in the most effective way possible, a research team was established comprised of industry experts in a variety of areas essential to assure a meaningful project design and accurate and reliable results. These experts included the following:

Yolanda Ann Slaughter, DDS, MPH,
Geriatric Dentistry
University of Pennsylvania
School of Dental Medicine

John D. Cacciamani, MD, MBA
Geriatric Medicine
Medical Director Clinical Informatics
Temple University Health System

Dr. Erika Matulich, PhD, PCM
Focus Group Leader
The University of Tampa

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Charlotte Albano R.N.

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President, The TRECS Institute & Vice President of Clinical and Regulatory Compliance,
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Cynthia L. Pearse, LCSW, NHA, LHRM\

Education

Social Work Consultants of Florida
Tampa, Florida

John Whitman MBA, NHA

Project Coordinator

Executive Director
TRECS Institute
North Wales, PA.

Phase Two: Literature Review

A literature review was conducted of the following areas:

- oral health assessment
- oral care of elderly in homes
- institutionalized aged
- nursing dental assistants
- oral health in elder care
- portable dentistry
- aspiration pneumonia
- periodontal disease
- diabetes mellitus
- mobile dentistry
- Surgeon General's Call to Action.

The search was conducted through Medline from 1998-2004 through the library

At the University of Pennsylvania's School of Dentistry.

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Phase Three: Industry Experts:

In an effort to better understand the current situation, a variety of interviews with industry experts were conducted, including a site visit to Apple Tree Dental in Minneapolis, Minnesota. Apple Tree Dental is a non-profit group that has been providing mobile dental services to nursing home residents for almost 20 years. Established as a non profit, this unique group has been able to effectively remove the access to professional care barrier by removing the reimbursement issue. They provide dental care services based on the residents' needs and not reimbursement. Their 20 years of data was compiled and extrapolated for the PhD thesis topic for Dr. Barbara Smith at the University of Michigan.

Phase Four: Focus Groups

Six focus groups were conducted in the State of Florida in June of 2005. Three focus groups took place with the residents of nursing home facilities and three focus groups took place with family members responsible for care of a family member in the nursing home. Focus group sizes ranged from 6 to 10 participants and two focus group moderators were present at the focus group meeting.

To summarize the overall results of the resident focus groups, they indicated that dental care is a low priority in nursing homes. However, respondents indicate that dental care is not only necessary, but strongly desired. Many residents indicated frustration with lack of dental care and inability to properly enjoy food without adequate dental services. Access to dental care was found to be a major concern. Frustration was expressed at the lack of professional attention to dental issues. Most

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residents felt they had the responsibility of their own dental care. Again frustration abounded at the inability to provide better self-care. In addition, difficulty to access dental equipment and supplies was noted, as well as difficulty in correctly using current toothbrush designs.

Overall results from family members responsible for nursing home residents expressed similar sentiments. Dental care appears to be a low priority in nursing homes. There is an absolute need not only for daily oral care services by the staff of the facility, but also for regular professional services as well. Both were felt to be critical for meeting the dental and oral health care needs of their family members.

Currently, family members perceive they are largely responsible for providing regular oral care, and that daily oral hygiene practices are not a high priority for staff to provide. In terms of professional dental care, both residents and family members perceive little or no access to professional care. When dental insurance was discussed as a possible option, family members were excited and responded favorably to the possibility of an insurance product that could increase access to professional dentists within the nursing facility, as transportation of residents was considered difficult or impossible.

Specific Findings:

- I. Prevalence of Ageism across all cohorts**
- II. Education and Training badly needed across all levels**
- III. Legal Review and Reimbursement Implications**
- IV. Significant Timing Lag from identification of dental problem till resolution**
- V. Consumer Dissatisfaction widespread**
- VI. Downstream Medical Cost a real issue yet not fully understood or appreciated**

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I. Ageism

The term “ageism” was coined in 1969 by Robert Butler, the first director of the National Institute on Aging. He defined it as a process of systematic stereotyping and discrimination against people because they are old. Today, it is more broadly defined as any prejudice or discrimination against people because they are old.⁴⁶

Ageist attitudes are perpetuated in many ways. Examples are abundant in the popular culture such as negative birthday cards which belittle old age, the lack of positive images of the elderly in advertisements and on TV programs, and the widespread use of demeaning language about old age. Some illustrative examples of such language include such colloquialisms as “geezer,” “old fogey,” “old maid,” “dirty old man,” and “old goat.”

In addition, institutions perpetuate ageism. Businesses frequently reinforce ageist stereotypes by not hiring or promoting older workers. The American health care system focuses on acute care and cure rather than chronic care which most older adults need. Government policies which reinforce ageism include use of a higher federal poverty standard for the elderly and, job training targeted for younger age groups. Another example is the use of state welfare funds which are often targeted at children and adolescents, excluding equivalent services for older adults such as adult protective services and geriatric mental health services.

Underlying these attitudes are myths and stereotypes about old age which are deeply entrenched in American society. Even those who would not say that they are

⁴⁶ Palmore, E. (1990). *Ageism: Negative and positive*. New York: Springer.

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ageist probably have some ageist attitudes based on distorted or inaccurate information.

In general, the consequences of ageism are similar to those associated with all attempts to discriminate against other groups: persons subjected to prejudice and discrimination tend to adopt the dominant group's negative image and to behave in ways that conform to that negative image.⁴⁷ Furthermore, the dominant group's negative image typically includes a set of behavioral expectations or prescriptions which define what a person is to do and not to do. For example, the elderly are expected to be asexual, intellectually rigid, unproductive, forgetful, happy, enjoy their retirement, and also be invisible, passive, and uncomplaining. Unfortunately, a denial acceptance mentality is established which leads to self acceptance of the myths. For example, an elderly person who accepts the negative image may "act old" even though this may be out of keeping with their personality or previous habits. This may mean that they stop or reduce social activities, do not seek appropriate medical treatment, or accept poverty. In essence, this internalization of a negative image can result in the elderly person becoming prejudiced against him/herself, resulting in loss of self-esteem, self-hatred, shame and depression.

Ultimately, stereotypes are dehumanizing. Elders are not seen as human beings but as objects who, therefore, can be more easily denied opportunities and seen as "old" and, therefore, incurable. Such discrimination is also evident on the social policy level where the elderly are blamed for having medical problems and consuming public resources rather than seeing them as having human needs requiring appropriate social responses.

A final reality of ageism is that by devaluing this segment of the population, a vital human resource is lost. The elderly represent a vast amount of

⁴⁷ See n. 44

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experience, skill, and knowledge which this country needs to remain strong and true to its ideals. The ability to live with dignity should be a protected American value.

Unfortunately, based on the focus groups and interviews conducted, ageism, as it relates to dental care for the elderly, is rampant across residents, families and the staff, “I am old.... What do my teeth matter?” or “All my teeth are gone, I don’t need to do anything to care for my gums.” Of “What do you expect, Mom is 86 years old... of course her teeth are bad.”

The need to change these inaccurate perceptions and raise the level of knowledge and concern over the importance of good oral care among the elderly and especially nursing home residents needs to be an essential component of any plan to improve the current level of oral care services to this special population.

II. Education and Training:

Improving Dental Care Services for Nursing Facility Residents Through Resident, Staff and Family Education

Findings of focus groups, professional recommendations, research and current oral hygiene practice in nursing homes accentuate the need for oral health education. Current attitudes of staff, residents and family reflect an ageist perception of dental and oral care. Why does someone who is 90 years old need dental care? Why spend the money on new dentures if pureed food is available? If you don’t have any teeth why do you need dental care?

Current industry literature reveals that oral care is a low priority for nursing home staff. A series of focus groups conducted as part of this study, confirmed that fact. A pervasive lack of knowledge exists at all levels concerning the medical complications and consequences of poor oral hygiene such as aspiration pneumonia, chronic infection and cardiovascular

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disease. (1). Dry mouth and low levels of saliva, complications of many frequently utilized medications, create problems with eating and swallowing (2). Provision of dental care and good oral hygiene are preventive measures that result in better quality of life, saving of human suffering, reduced cost and improved disease management. Improvement in resident and family satisfaction is also a likely result of better oral care. As a component of this study, a series of educational programs will be developed. These educational programs will be tailored for three distinct groups: residents, family and staff and management. Each group represents an opportunity to improve day-to-day oral hygiene and dental care. Existing training materials will be evaluated for use with staff, resident and family. Materials will be developed to convey the intended message.

A) Resident Education: Resident education will be provided in a group setting with minimal use of technology due to hearing and visual deficits often encountered by this population. Direct teaching with residents will include the importance of oral care, consequences of lack of care, resident rights, care of dentures and availability of some adaptive equipment. Education can be provided by direct care staff and families, as well as formal educators. Individual follow up by the residents' primary direct care staff member and/or family will also be recommended.

B) Family Education: Family Education will be provided in a group setting with some technology and the opportunity to discuss issues pertinent to family members. Family education includes the importance of oral and dental care and the consequences of lack of care. As family members often provide care, improving family oral care giving skills will improve outcomes for residents. Training emphasis includes oral screening, oral care, use of dental implements and challenges experienced during the provision of oral care. Potential

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solutions to confront dental care access barriers and accessing oral care solutions include potential funding and payment for services. The goal is to increase information and practical skills to further empower family care givers. Video tape and hand out materials will be used in family care giver education. Family training sessions will be held in the nursing home. Facilities will be encouraged to repeat this training on a regular basis to recognize new residents and their family care givers.

C) Staff and Management Education: Direct care staff and management comprise two distinct groups requiring oral health education.

1) Direct Care Staff: The focus of direct care staff education is to provide an understanding of the importance of oral health, assessing oral health, the medical complications that result from poor hygiene, quality of life implications of poor oral health, methods to provide oral hygiene, available equipment, tools and their use and methods to deal with resistance during oral care. Quality of life and oral health are closely related. Staff education and training will be accomplished through the use of oral presentation, handouts, video tape and equipment suggestions.

2) Management Staff: Management staff requires a comprehensive understanding of the importance of oral and dental care as it relates to quality of life and quality of care, regulatory implications, risk management and fiscal implications. A power point presentation will be used that; frames the grant project, discusses focus group finding, defines the clinical risk of poor oral care, identifies barriers, makes practice change recommendations and identifies potential solutions for access and service provision. The power point presentation will be distributed to all nursing homes in the State of Florida.

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III. Legal and Reimbursement Review: Dental Service Reimbursement for Nursing Home Residents

Historically, dental coverage was viewed as a luxury and not a necessity. Public policy and coverage curtailed under the Medicare and Medicaid programs because the majority of dental services were viewed as not medically necessary. Traditionally, Medicare provides coverage for acute care only, which generally does not include dental coverage. In the rare instances where Medicare will provide dental coverage, the dental procedure must be linked to an underlying health condition that Medicare would cover. While more dental services are covered under Medicaid, the coverage varies from state to state. Dental services provided under Medicaid have focused on children, and not seniors residing in nursing homes. Dentists are deterred from taking on Medicaid patients due to the low reimbursement rates and limited covered services. As a result, reimbursement under the Medicare and Medicaid programs is severely limited and poorly funded. Since nursing home residents cannot rely on Medicare and Medicaid to consistently provide dental coverage, an alternative would be to private pay for dental services as needed. However, many nursing home residents and their families are unable or unwilling to exercise this option due to financial constraints. Dental insurance may be an appropriate solution because public policy permits the purchase and retention of a dental insurance policy. With the

1 Loesche WJ, Lopatin DE. Interactions between periodontal disease medical disease and immunity in the older individual. *Periodontology* 2000, Vol 16, 1998, 80-105.

2 Oral hygiene care for functionally dependent and cognitively impaired older adults. Iowa City (IA): University of Iowa Gerontological Nursing Interventions Research Center; 2002 Nov, 48.

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proper policy design suitable for nursing home residents, it would be possible to reimburse the dental providers fairly, resulting in a dramatic improvement in the quality of dental care available in nursing homes.

A) MEDICARE

Generally speaking, Medicare part A and B do not provide payment for Dental services. Medicare will cover dental procedures when, and only when those conditions are directly related to an underlying health issue already covered by Medicare. For instance: if a patient developed bone cancer of the jaw and subsequently teeth needed to be removed to eradicate the cancer, then Medicare may cover such a procedure. However, Medicare has very specific guidelines describing what constitutes “directly related” and in instances where ambiguity existed as to whether a condition was “directly related” the courts have traditionally found in favor of Medicare and caused the patient to bear the cost of the procedure. Also, Medicare will cover dental procedures in such instances where hospitalization is required because of the severity of the health issue. Find also (Appendix I), containing the applicable laws pursuant to Medicare coverage. These statutes identify what the courts have held when Medicare policies have been challenged in the court. Contained also in the appendix is information about codified laws, regulations, and findings from the applicable case law that sets a precedent with regards to challenging Medicare dental coverage. Legal authorities are listed in Appendix I.

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B) MEDICAID

Florida Medicaid will cover a greater number of dental services, although it is an optional coverage for the state and over the years has been severely limited in scope of service and reimbursement. It is complex and not commercially enticing to dental providers. With regard to Medicaid, traditionally dental coverage for children has been a priority and seniors have had limited coverage overall. Contained herein are the coverages that apply to persons over 21 years of age. When reading the document referenced in the Medicaid (appendix I), it is important to read every article individually to identify what age range (older than 21 years of age or under 21 years of age) the article covers. Legislative priorities have ebbed back and forth concerning coverage under Medicaid. Financial concerns forced the legislature to curtail dental coverage for nursing home residents resulting in the removal of denture coverage. Successful grassroots advocacy resulted in a temporary coverage that was to end July 1st 2005. The grassroots advocacy continued to successfully motivate the legislature to eliminate the July 1st 2005 sunset provisions. Currently, Medicaid will provide for reimbursement of full or partial dentures once in a recipients lifetime for persons older than 21 years of age. In general, Medicaid will cover extractions preceding construction of complete or partial dentures. Beginning January 1, 2005, Medicaid may pay for dentures, the procedures required to seat dentures, and the repair and relining of dentures, provided by or under the direction of a licensed dentist, for a recipient who is 21 years of age or older.

SOURCE: Florida Statute § 409.906. Optional Medicaid services

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In addition, Medicaid will reimburse for medically-necessary emergency dental procedures to alleviate pain and or infection for adult Medicaid recipients. The cost of extractions will generally be reimbursed provided that such extractions are caused by acute emergency services for the alleviation of pain or infection and are limited to extractions and the incision and drainage of an abscess. Source: 2-12 & 2-13.

C) PRIVATE PAY

Since nursing home residents cannot rely on Medicare and Medicaid to consistently provide dental coverage, an alternative would be to private pay for dental services as needed.

However, many nursing home residents and their families are unable or unwilling to exercise this option due to financial constraints. Certain incurred dental expenses not covered by Medicaid or another third party are deductible from a Medicaid residents income when calculating patient responsibility. Federal law and state implementation support the ability to pay for “medically necessary” dental services paid for out of pocket. This does not impact the net payment received by a Medicaid nursing home provider. Expenses for dental services must meet all of the following criteria:

- Be recognized under state law (use existing Medically Needy policy).
- Be medically necessary (use existing Medically Needy policy).
- Not be a Medicaid compensated expense
- Not be subject to payment by a third party
- Not be covered by the Medicaid nursing or other facility per diem

An area of concern with regard to dental services will revolve around the definition and verification of “medical necessity.” This author believes an expanded definition of “medical necessity” would include routine oral health care preventive procedures. The department of children and family services will accept verification of medical necessity, “a written statement from the individual’s health care provider or the provider’s designee.

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Recent training of department of children and family services caseworkers should ease the implementation of this reimbursement methodology. Source: Transmittal #p-04-06-0007

Florida Department of Children and Families. Date: June 8, 2004

D) Dental Insurance

Federal and state laws, regulations permit deductibility of dental insurance premiums from a resident's patient responsibility. Deductibles and co-pays are similarly permitted to be deducted. These procedures have been adopted by the Department of Children and Family Services. Patient responsibility is calculated by determining the actual amount incurred for health insurance payments (other than Medicare) for a nursing home resident's dental insurance coverage which would include premiums, deductibles, and co-pays.

But for dental insurance coverage, routine dental services that are not considered medically necessary would not be covered at all, and therefore would not be performed; leaving nursing home residents without a means of obtaining dental services. Source: Transmittal #p-04-06-0007 Florida Department of Children and Families. Date: June 8, 2004

IV. Treatment Time Lag

Focus groups and discussions with physicians, staff, family and patients confirmed the disturbing fact that our current system often incorporates extensive delays or lag time from the initial identification of a significant dental problem to the actual resolution of that problem by a dental professional. This time lag can be as long as six weeks! In the interim, the resident is often prescribed pain medications to minimize the discomfort until resolution is reached. Some of the current reasons leading to these delays are:

Initially, patients must be cognitive enough to identify a problem and to notify nursing staff, physicians or family of the problem. Secondly, nursing staff must be aware of signs and

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symptoms of dental issues in this age cohort, especially for those lacking the ability to communicate the problem themselves. Finally, the current reimbursement structure is a major cause for the lag time because few dentists are willing to come to see residents in the nursing homes due to the limited and often complicated reimbursement process.

Regardless of the cause, this kind of time lag is clearly inappropriate and certainly not in the best interest of the resident or the healthcare system as a whole.

V. Consumer Dissatisfaction

Respondents to focus groups revealed a high level of concern and dissatisfaction over current dental care in many homes. Comments included:

“Oral hygiene in nursing homes is really bad.”

“These CNAs need to be trained-it’s not just about pretty white teeth, it’s about health and quality of life.”

“It’s not that big of a chore to deal with daily mouth care-they can’t expect us to do it all the time. What about those people who don’t have visitors to take care of their mouths?”

“Prisoner’s get better dental care than the folks in nursing homes, and the prisoners are the ones who are supposed to be punished.”

“For God’s sake, the State pays to give Viagra to sex offenders, and they can’t pay for basic dental care in nursing homes? There’s something really wrong here.”

“Dental care is just a basic part of living needs. Quality of life is a real issue here, and it’s just not recognized.”

Many focus group participants also agreed that nursing staff has a difficult job providing oral care especially when residents are uncooperative or combative.

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VI. Downstream Medical Costs

Poor dentition in the elderly population clearly has significant quality of life impact upon patients with significant oral or periodontal disease, but it is also likely to have a significant impact upon other clinical conditions that may be either created by oral disease or possibly complicated by the presence of oral disease. The literature has not as of yet described the population impact of oral and periodontal disease on total downstream medical cost and therefore this is an area where better understanding of the relationship between oral and medical care may result in a significant change in national policy.

Clinical experience has shown that poor dentition and periodontal disease can lead to medical conditions. The first area of consideration in nursing home patients is the relationship of painful dentition to malnutrition. Patients with painful dentition eat less, and if the patient is demented at baseline, the communication of the painful condition is often missed by care providers. Dentition problems along with the normal loss of the sense of smell accompanied with aging can result in significantly reduced caloric intakes. Malnutrition frequently leads to immunocompromise and this puts individuals at risk for a whole host of opportunistic infections such as urinary tract infections and pneumonia, both of which are common primary diagnoses for nursing home patients admitted to acute care centers. In addition, poor nutrition also reduces a patient's ability to rebuild tissue. This in turn results in increased risk for bed sores that can and often lead to decubitus ulcers. These ulcers are clearly one of the major causes of mortality and morbidity in this population.

In addition to malnutrition related illness, there are several medical conditions that have a direct relationship to oral disease. One of the worst is bacteremia. When the oral mucosa lining is compromised there is an increased risk that bacteria will enter into the blood

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stream and seed heart valves and other locations such as joint spaces, urine and prosthetic devices. Physicians and dentists are acutely aware of this issue and whenever dentist do invasive oral procedures in patients with medical conditions that put them at risk, antibiotics are given for prophylaxis. One can easily reason that nursing home patients with oral conditions that result in the deterioration of the mucosal barrier may also be at increased risk of bacterimia.

There are many other possible medical conditions in addition to those listed above that may be caused or exacerbated by poor dental care. The opportunity to reduce patient morbidity, mortality and total medical costs is likely significant and therefore further investigation may lead to potential redesign of the medical benefits offered to our nursing home population.

Recommendations:

Based on all study data, the research team has accepted the following six major recommendations for improving oral and dental care services for nursing home residents:

#1. Develop a series of broad based educational programs to raise the awareness and understanding of the importance of oral healthcare, especially for the elderly residing in nursing homes. These educational programs should be developed for each specific cohort including residents, family and facility staff. These programs should:

- a) Review and update health professional educational guidelines including courses and in-service education to include oral health and dealing with special residents like those with dementia and those that may be combative or uncooperative.
- b) Train health care professionals to perform oral screenings as part of the admissions process and through routine follow-ups.
- c) Elevate the importance of daily oral care by incorporating it as a key component of the nurses daily flow sheet
- d) Develop specialized training programs for family and residents again emphasizing the importance of good oral care.

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#2. Incorporate into all training programs for all cohorts, the inappropriateness of ageism and the inaccuracy of that thinking.

#3. Encourage the testing of commercial dental insurance products that are now available on the market as a method for reducing or minimizing the reimbursement barrier for dental professionals that currently exists in the market. This could also result in a substantial savings to the health care system by reducing downstream medical costs.

#4. Encourage the use of adaptive tools and other resident friendly devices that will encourage and promote ongoing self care and independence.

#5. Encourage facilities to assure that all daily oral care supplies and tools are readily available and accessible to the resident, the family members participating in oral care and the staff.

#6. Encourage additional research activities as a follow up to this study to include such topics as the following:

- a) The Impact of Commercial Dental Insurance on Access and Quality of Oral Care for Nursing Home Residents.
- b) Evaluating the Impact on Downstream Medical Costs by Improving Oral Care for Nursing Home Residents.
- c) Utilizing Alternative Devices to Extend and Improve Self Care and Independence for Nursing Home Residents.
- d) The Impact of Focused Educational Programs for staff, families and residents on Improving Oral Care for Nursing Home Residents

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Appendix I & II of the Legal and Reimbursement Review:

Medicare Dental Coverage (Appendix I) VII.

Introduction

The following information is provided by the Centers for Medicare and Medicaid Services. It contains the information specific to Medicare; specifically, what Medicare will and will not cover with regards to dental services. All information provided in this appendix was taken from: "Oral Health...Medicare Dental Coverage." A web page. This information was retrieved from the World Wide Web at:

<http://www.cms.hhs.gov/oralhealth/2.asp>

Dental services are generally excluded from Medicare coverage; however, there are a few minor exceptions. Payment may be made under Part A for inpatient hospital services in connection with the provision of dental services if the individual, because of an underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services.

Currently, Medicare will pay for dental services that are an integral part either of a covered procedure (e.g., reconstruction of the jaw following accidental injury), or for extractions done in preparation for radiation treatment for neoplastic diseases involving the jaw. Medicare will also make payment for oral examinations, but not treatment, preceding kidney transplantation or heart valve replacement, under certain circumstances. Such examination would be covered under Part A if performed by a dentist on the hospital's staff or under Part B if performed by a physician.

Statutory Dental Exclusion

Section 1862 (a) (12) of the Social Security Act states, "Where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, except that payment may be made under part A in the case of inpatient hospital services in connection with the provision of such dental services if the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services."

Background

The dental exclusion was included as part of the initial Medicare program. In establishing the dental exclusion, Congress did not limit the exclusion to routine dental services, as it did for routine physical checkups or routine foot care, but instead it included a blanket exclusion of dental services.

The Congress has not amended the dental exclusion since 1980 when it made an exception for inpatient hospital services when the dental procedure itself made hospitalization necessary.

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Coverage Principle

Coverage is not determined by the value or the necessity of the dental care but by the type of service provided and the anatomical structure on which the procedure is performed.

Services Excluded under Part B

The following two categories of services are *excluded* from coverage:

A primary service (*regardless of cause or complexity*) provided for the care, treatment, removal, or replacement of teeth or structures directly supporting teeth, e.g., preparation of the mouth for dentures, removal of diseased teeth in an infected jaw.

A secondary service that is related to the teeth or structures directly supporting the teeth unless it is incident to and an integral part of a covered primary service that is necessary to treat a non-dental condition (e.g., tumor removal) and it is performed at the same time as the covered primary service and by the same physician/dentist. In those cases in which these requirements are met and the secondary services are covered, the Medicare payment amount should not include the cost of dental appliances, such as dentures, even though the covered service resulted in the need for the teeth to be replaced, the cost of preparing the mouth for dentures, or the cost of directly repairing teeth or structures directly supporting teeth (e.g., alveolar process).

Exceptions to Services Excluded

The extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease.

An oral or dental examination performed on an inpatient basis as part of comprehensive workup prior to renal transplant surgery or performed in a RHC/FQHC prior to a heart valve replacement.

Additional exceptions will make it more difficult to resist further erosion of the application of the dental exclusion. In a recent decision from an appeals court, the court seemed to be critical of the extent of the exceptions that have made over the years.

Definition

Structures directly supporting the teeth means the periodontium, which includes the gingivae, periodontal membrane, cementum of the teeth, and the alveolar bone (i.e. alveolar process and tooth sockets).

Osseous Implants

Medicare under the prosthetic device benefit could cover the cost of an osseous implant (obturator) for the purpose of sealing the opening in the roof of a patient's mouth. Medicare could also cover the cost of an anchor that is necessary to hold the obturator in place. However, because of the dental exclusion, it would not cover the total cost of furnishing the patient with an osseous implant device that would also serve as an implanted denture. We believe the part of the device that serves as a denture would fall within the dental exclusion regardless of the reason why it is needed by the patient. We would recommend that with these types of implants that Medicare limits its payment to the cost of sealing the opening in a patient's mouth (including the obturator and the anchor necessary for its support) but not include the cost of the implanted denture.

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APPLICABLE LAWS GOVERNING MEDICARE

(Appendix II)

Section 1862(a)(12) of the Social Security Act provides that:

"Notwithstanding any other provision of this subchapter, *no payment may be made under part A or part B* of this subchapter for any expenses incurred for items or services....

...where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, except that payment may be made under part A of this subchapter in the case of inpatient hospital services in connection with the provision of such dental services if the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services"

Further, 42 CFR 411.15, provides that

Dental services in connection with the care, treatment, filling, removal, or replacement of teeth, or structures directly supporting the teeth, except for inpatient hospital services in connection with such dental procedures when hospitalization is required because of-

- (1) The individual's underlying medical condition and clinical status; or
- (2) The severity of the dental procedures.

Section 2020.3 of the Medicare Carrier's Manual (MCM) states that

"payment for the services of dentists is also limited to those procedures which are not primarily provided for the care, treatment, removal, or replacement of teeth or structures directly supporting teeth."

Further, section 2136 of the Medicare Carrier's Manual provides that

"If an otherwise non-covered procedure or service is performed by a dentist as incident to and as an integral part of a covered



The TRECS Institute

“Targeting Revolutionary Elder Care Solutions”

The TRECS Institute is a non-profit organization dedicated to finding new and effective ways to better meet the needs of America’s elderly in the most cost effective manner possible.

“Targeting Revolutionary Elder Care Solutions” recognizes the need for new and creative thinking in the long-term care market. TRECS is designed to be a catalyst to bring about needed changes to this Industry with the goal of improving the overall quality of care in the most cost effective manner possible.

The dictionary defines a “TREK” as a journey, a pilgrimage towards a desired goal. Just as the spelling of TRECS falls outside the true dictionary spelling, so too will TRECS go “outside” the traditional boundaries that have historically defined and restricted this industry.

The Board of Director’s of The TRECS Institute is proud to offer this document as an example of our organizations commitment to making a positive change in the Long Term Care Industry and ultimately improve the quality of care received by one of our Nation’s most precious resources.... our seniors!

The Board also wishes to thank the State of Florida, Agency for Health Care Administration for their generous support of this initiative.

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