SPECIAL CARE DENTISTRY ADVISORY GROUP
SPECIAL CARE ORAL HEALTH SERVICES
A NORTH CAROLINA COMMITMENT

Session Law 2009-100

Presented to

NORTH CAROLINA STUDY COMMISSION ON AGING
&
NORTH CAROLINA PUBLIC HEALTH STUDY COMMISSION

March 1, 2010

Special Care Dentistry Advisory Group
Special Care Oral Health Services
A North Carolina Commitment

March 2010

Charge to the Advisory Group

Session Law 2009-100 directed the North Carolina Department of Health and Human Services, Division of Public Health, Oral Health Section in collaboration with the Division of Medical Assistance, the Division of Aging and Adult Services, the University of North Carolina at Chapel Hill and the East Carolina University Schools of Dentistry, the North Carolina Dental Society and current providers of special care dental services, to examine the current dental care options for populations requiring special care dentistry and provide suggestions for ways to improve the availability of services to those needing such dental services. The Department was directed to report findings and recommendations to the North Carolina Study Commission on Aging and the Public Health Study Commission.

The Oral Health Section of the Division of Public Health, was charged with identifying collaborative partners and coordinating preparation of this report. A Special Care Advisory Group of providers and consumers, individuals and agencies met twice and developed the sixteen (16) recommendations described in this report.

What Are the Oral Health Issues for Patients with Special Needs?

Optimal oral health is an integral component of health and well-being. Patients with special needs are at high risk for developing oral disease, and access to dental care has been recognized nationally as a major unmet health need for these groups. The US Surgeon General's Report on Oral Health (2000) discussed the inequalities that affect vulnerable populations, such as people with disabilities and those who are medically compromised and elderly, concerning untreated dental disease, access to dental care and the use of preventive services. Oral diseases and related problems are more common among these patients, who often require more extensive and complex dental care. Lack of care can have a direct and devastating effect on their health and well-being, leading to decreased systemic health and

resulting expensive treatment of preventable medical conditions. Many individuals are forced to live with gross oral infections that can lead to or complicate illnesses such as aspiration pneumonia, uncontrolled diabetes, wound healing, stroke, prosthetic joint failure and heart disease, resulting in additional expensive medical care. For those with chronic illnesses, lack of dental treatment can lead to oral infection which may then exacerbate their systemic conditions.

Who Are the Patients with Special Needs?

For purposes of this report, we are defining patients with special needs as those with intellectual and/or developmental disabilities, the frail elderly, those with multiple complex medical diagnoses, and the many other individuals with disabilities who do not fit into these categories but also encounter barriers when trying to access dental care in their community. Patients with special needs include all age groups. These individuals may have a variety of complicated intellectual, developmental and physical limitations, such as profound intellectual disability, autism, cerebral palsy, dementia, diabetes, cancer, multi-systems failure, cardiovascular disease, cerebral vascular disorders (stroke), brain injuries, multiple sclerosis and muscular dystrophy.

Quantifying the number of North Carolinians who can be accurately defined as having a disability and requiring special care dentistry services is difficult. Specific definitions of disability have been driven by government agencies to determine eligibility for benefits and services. As a result, disability has been measured in different ways across surveys and censuses, leading to conflicting estimates of the prevalence of disability. However, in North Carolina there are many who are disabled to the extent that they require special care dentistry services, and their numbers are increasing, in part due to the growing elderly population. The following data and table attempt to provide an estimate of those who may require special care dentistry services.

- It is estimated that more than 100,000 people in North Carolina have an intellectual and/or other developmental disabilities (I/DD) (Thompson, 2008). An I/DD manifests itself before age 22 and leads to substantial functional limitations in at least three of the following areas: self-care, receptive and expressive language, learning, mobility, self-direction, the capacity for independent living, or economic self-sufficiency.

- Approximately 180,000 people in North Carolina are living with long-term needs due to a traumatic brain injury (TBI) (Hooper, 2010).

- It is estimated that there are currently 170,000 older adults (age 65 +) in North Carolina living with Alzheimer's disease or other types of dementia (NC Division of Aging and Adult Services, 2010).

Population Definition	Potential numbers of North Carolinians who may require special care dentistry services
Those with intellectual and/or other developmental disabilities (I/DD);	100,000
Those living with long term needs due to a Traumatic Brain Injury (TBI)	180,000
Older adults living with Alzheimer's disease or other types of dementia	170,000
Total	450,000

Another way to gain some insight to the large numbers of adults who may be part of the special care category is to consider information from the North Carolina State Center for Health Statistics' 2008 Behavioral Risk Factor Surveillance System (BRFSS). BRFSS is a random telephone survey of state residents aged 18 and older. When informed that a disability can be physical, mental, emotional, or communication related, 5.3 percent of NC BRFSS surveyed adults (which translates to an estimated 370,000 persons) considered themselves to have a severe disability (BRFSS, NC State Center for Health Statistics, 2008). This is perhaps an underestimate since BRFSS does not reach those who are institutionalized.

What Are the Existing Dental Care Options Available to Patients with Special Needs?

Across the state, a small number of dental facilities and practices exist that employ providers with the knowledge base and skills to provide safe, comprehensive dental services to patients with special health care needs. However, the current capacity doesn't begin to address the need. The responsible parties, usually children or parents, who provide regular support for those patients often search statewide, finding no one, at any price, to treat the dental needs of loved ones.

- State Dental Clinics: State-funded dental clinics are housed in the four psychiatric hospitals, three developmental centers and three neuro-medical centers, with most serving only the patients of those facilities.
- Hospital Inpatient Services: Seven major hospital systems and three Veterans Administration hospitals provide at least some out-patient dental care on a non-emergency basis for their patients undergoing complex care, such as cardiac and cancer patients. Most major hospital systems and some smaller hospitals provide operating room time for dentistry.
- Mobile Programs: Two non-profit mobile programs provide on-site, comprehensive dental care to individuals in nursing homes, group homes, assisted living centers, adult day health care facilities and to individuals living in the community. Collectively these programs provide care to 69 facilities and 5,700 patients in Piedmont North Carolina.
- Local Practitioners/Pediatric Dentists: Pediatric dentists provide care to children and a limited number of adults with special health care needs. They are a natural fit to provide care because they are trained to deal with challenging behaviors and complex medical conditions. There are approximately 150 pediatric dentists in the state, but not all pediatric dentists accept Medicaid. This is an obstacle to care because many children with special needs are dependent upon Medicaid funding. As children with disabilities age out of a pediatric practice, there is often no place to go within the community.
- Local Practitioners/General Dentists: General dentists in private practice treat a limited number of patients with complex special health care needs. There are only a few who serve as a referral source for nursing and group homes, and a small number who visit nursing and group homes on an infrequent basis, providing primarily emergency care.
- Professional Education/Care Provider Institutions: The UNC School of Dentistry has historically been a primary source of referral for patients with special health care needs in North Carolina. This institution has a limited number of faculty who treat patients with special needs and who teach undergraduates, general residents and pediatric graduate students how to provide their care. The ECU School of Dentistry plans to have a suite dedicated to the care of patients with special needs when the school is completed in 2012, where several faculty and dental residents will provide training and exposure to all of its dental students. Residency training programs that provide care for patients with special needs include those located at Pitt Memorial Hospital, Greenville; UNC Health Care System, Chapel Hill; Carolinas HealthCare, Charlotte; Wake Forest Baptist Medical Center, Winston Salem; Mission

Health System, Asheville; Veterans Administration facilities plus three major medical centers also train dental residents.

Overview of the Problems

Challenges for patients with special health care needs receiving compassionate, comprehensive dental care are complex and involve issues related to consumers, providers, payers, and systems.

Consumer Issues

- Advocacy: Patients with limited mobility, medical impairments and complex medical issues are often unable to advocate for themselves. Caregivers and advocates for these patients frequently overlook the need for dental services or do not see dental care as a priority, given other health needs.
- Lack of Access to Care: Although general dentists in private practice provide limited services to some patients with special needs and most pediatric dentists see children and some adults with intellectual and developmental disabilities, many communities have no dental care services for these individuals. This is because general dentists have not been adequately trained to feel competent at managing challenging behaviors and complex medical conditions common to many patients with special needs.
- Physical Access: The traditional dental practice does not work for many patients with special needs; therefore, they have no access to routine dental services. Transportation issues to and from facilities and lack of wheelchair accessible operatory space and other physical barriers keep many out of the dental chair. Some cannot travel to a dental office without the aid of an ambulance or wheelchair transport.
- Deinstitutionalization: Deinstitutionalization from state hospitals and state regional DD centers has placed those with major mental illness and severe or profound intellectual disability in communities without accessible dental care services. These patients are among the most challenging dental patients to treat and often require hospital operating room support.
- Continuity of Care: Many patients who have become fully dependent and non-verbal have received quality preventive and restorative dental care throughout their life, but now live in a situation where their mouths are not cleaned on a daily basis. Many of these individuals must live in constant

pain and/or infection because they cannot communicate their needs and there is no consistent regimen for maintaining and monitoring their oral health.

- Inadequate Treatment: Individuals living in the community are often under-treated by local practitioners because the dentist and staff are not trained to deal with challenging patient behaviors or complex medical conditions. As a result, many individuals are not offered a full or typical array of services, such as root canals, crowns, etc.
- Financial Dependency: Many patients with special needs are totally dependent on strained family resources and public assistance. The lack of dentists accepting Medicaid who are adequately trained to provide care for patients with special needs is a barrier.

Provider/Payer Issues

- Limited State Dental Clinics: Many of the state dental clinics housed in the psychiatric hospitals, developmental and neuro-medical centers are limited to treating only the individuals who are residents in those facilities. Due to limited capacity, these clinics cannot treat patients living in the community. As an example of capacity limitations, there are currently only two full-time hospital dentists currently serving the approximately 1,300 mentally ill in-patients who are being treated within two state psychiatric hospitals and contract dental services are used at the other two state psychiatric hospitals to meet the dental needs of individuals in these facilities.
- Hospital Service Reduction: Many hospital systems are reducing out-patient services. Hospital operating room times for dental procedures are limited, and becoming more so, as administrators divert more operating room time to high revenue generators, none of whom are dentists.
- Limited Mobile Program Capacity: The two existing non-profit mobile programs providing on-site, comprehensive dental care to individuals in nursing homes and related facilities have the capacity to provide services to only a very small percentage of North Carolina's special care population.
- Limited Professional Training: Most communities have no dental care services for patients with special needs because dentists and their staff have not been trained to manage challenging behaviors or complicating medical conditions common to these individuals. The practice of special care dentistry requires expertise beyond that now taught to general dentists or dental hygienists at most dental schools or in dental hygiene programs. Continuing education for interested community practitioners is limited and has not produced a broad population of special care dental providers.

- Limited Financial Compensation: Low Medicaid reimbursement rates, coupled with the additional time it takes to provide dental services for some patients with special needs, serve as barriers to expanding the number of dentists willing to treat patients with special needs. As a result, there are only a limited number of dentists accepting Medicaid who feel competent to treat patients with special needs.

Systems Issues

No infrastructure exists for addressing or coordinating issues surrounding special care dentistry. Special care dentistry needs a home within a state agency or council to create/monitor/facilitate programs that:

- Provide early interception and referral to the appropriate care source.
- Advocate for expanding the capacity of existing state hospital and developmental center dental clinics to serve as regional referral sources.
- Advocate for reasonable compensation for those doing the extraordinary work of special care dentistry.
- Provide consumers a central point of communication to discuss special care dentistry issues.
- Advocate for training the dental and medical team.
- Implement preventive interventions for this rapidly growing population.
- Advocate for a research agenda and data collection for future policy decisions.

A Vision to Address the Gaps

North Carolina needs a coordinated systems approach to provide optimum and accessible dental services to populations requiring special care dentistry. Special care dentistry demands practice flexibility, specific training, multiple delivery systems, consistent case management, care coordination, adequate reimbursement and health systems research. Each program component is interdependent on the other to provide quality, accessible services.

To provide the framework for this coordinated systems approach, the Special Care Advisory Group has produced a comprehensive set of recommendations. These recommendations are divided into the categories of advocacy, professional development, reimbursement, clinical program expansion and health services research. If implemented, these recommendations will make a significant difference for patients with special needs and their families. The Special Care

Advisory Group recognizes the unprecedented budget crisis currently affecting North Carolina. Some of the recommendations could be implemented fairly quickly and would require no additional funding sources. However, many of the recommendations will require additional state funding and hopefully they will receive considerable attention once the current fiscal climate improves.

Conclusion:

As the 1999 report from the NC Institute of Medicine Task Force on Dental Care Access recognized, the issues and problems addressed in this report are multifaceted and complex, requiring multiple strategies and actions by both the public and private sectors. Increasing Medicaid reimbursement rates is a necessary, but not sufficient, response to the problems patients with special health care needs encounter accessing dental services. North Carolina needs to increase the supply of providers trained to treat patients with special needs, build facility capacity for treatment, and educate patients and their caregivers about the importance of oral health and ongoing comprehensive care. In addition, more emphasis must be placed on dental education and prevention strategies to prevent costly and painful dental disease. The sixteen recommendations in this report, if implemented, would go far toward the goal of assuring adequate dental health care for those vulnerable groups in our state who presently suffer the consequences of inadequate access to dental care.

RECOMMENDATIONS

ADVOCACY

Recommendation #1:

A State agency or council create and maintain a dental program position that is responsible for implementing the recommendations in this report.

Special care dentistry needs a central programming focus to implement the recommendations in this report. A person with dental expertise, working through the Division of Public Health, Division of Aging or Council on Developmental Disabilities would provide long term programming leadership. The person hired for this position would improve the oral health of North Carolinians with special health care needs by working to create/monitor/facilitate programs that:

- Provide early interception and referral for patients with special health care needs to the appropriate care source.
- Advocate for expanding the capacity of existing state hospital and developmental center dental clinics to serve as regional referral sources.
- Advocate for reasonable compensation for those doing the extraordinary work of special care dentistry.
- Provide patients with special health care needs and their care-givers a central point of communication to discuss special care dentistry issues.
- Advocate for training the dental and medical team.
- Investigate preventive interventions for this rapidly growing population.
- Advocate for a research agenda and data collection for future policy decisions.

This recommendation would require a new appropriation from the General Assembly.

Recommendation #2:

Partner with the Department of Health and Human Services, Division of Health Service Regulation to identify ways to ensure that oral health service standards in nursing homes and other residential facilities are carried out. Explore ways to encourage facilities to enhance dental care services to residents by such means as increasing staff devoted to daily oral care and expanding training of direct care personnel.

A successful model for minimal oral health service standards already exists, as there are strict Intermediate Care Facility Mental Retardation (ICFMR) guidelines in place for group home dental services. These guidelines are strictly enforced by state surveyors and are taken seriously by both administrators and staff.

The position established through Recommendation #1 should work with interested parties to develop a work group composed of dental care advocates, long-term care facility representatives and representatives of the North Carolina Division of Health Service Regulation to explore ways to encourage facilities to enhance oral health services to residents.

No appropriation is required for this recommendation, assuming the position in Recommendation #1 is funded.

Recommendation #3:

Request that a dentist be appointed to the Commission on Children with Special Health Care Needs.

The North Carolina Commission on Children with Special Health Care Needs is an eight member Governor appointed Commission. The purpose of the Commission is to monitor and evaluate the availability and provision of health services to children with special health care needs in this state, and to monitor and evaluate services provided to children with special health care needs under the Health Insurance Program for Children established under Part 8 of Article 2 of Chapter 108A of the General Statutes.

Because dental care has been cited as the most prevalent unmet health need for children with special health care needs (Lewis, Robertson and Phelps, 2005), the group felt that it was necessary for a dentist to be appointed to the Commission.

The potential appointee should be a North Carolina licensed dentist who serves children with special health care needs, accepts public health insurance, and is identified and recommended by the North Carolina Dental Society.

No appropriation is required for this recommendation.

Recommendation #4:

Develop and implement educational, media and social marketing campaigns that target optimal oral health for individuals with special health care needs. Outreach efforts should focus on individuals, families, care providers and service agencies.

Currently, the North Carolina Commission on Children with Special Health Care Needs' Oral Health Work Group is exploring the possibility of partnering with North Carolina's Family Council for Children and Youth with Special Health Care Needs, Family Voices, and Office on Disability and Health to develop an oral health outreach campaign for individuals and families. These groups should be encouraged to continue identifying and promoting existing resources and supporting educational opportunities among stakeholders and target populations.

This recommendation would require a new appropriation from the General Assembly.

Recommendation #5:

Expand the successful existing care coordination services provided by the Community Care of North Carolina/Carolina ACCESS (CCNC/CA) network to ensure oral health services for Medicaid patients with special needs.

Persons with special health care needs and their caregivers often cite frustration with the inability to locate providers who have the necessary expertise and training to provide comprehensive oral health care. Linking patients to a 'dental home' helps ensure that oral health care is delivered in a comprehensive, continually accessible, coordinated and family centered way. The Special Care Advisory Group felt that additional care coordination to augment the existing services provided by CCNA/CA is needed to provide valuable assistance for persons/patients with special needs and their families, to help them navigate the health care system and to provide guidance and reinforcement on personal oral health issues.

Pediatric dentists are the appropriate dental home for many of the children and some adults identified with special health care needs. The American Academy of Pediatric Dentists (AAPD) recommends the establishment of a dental home as early as 6 months of age, depending on the patient's risk for developing dental disease. Linking infants with pediatric dentists as soon as possible will maximize early intervention strategies to reduce morbidity.

Patients with special needs who receive treatment in the operating room must have care coordination and preventive guidance to avoid future deterioration of their oral health, requiring repeat expensive operating room visits.

This recommendation would require a new appropriation from the General Assembly.

PROFESSIONAL DEVELOPMENT

Recommendation #6:

To expand the dental workforce of providers who are comfortable treating patients with special needs, the UNC-CH School of Dentistry, the ECU School of Dentistry, once established, and the NC Community Colleges that offer educational programs for dental students, dental hygiene students and dental assisting students should require didactic and clinical training on the provision of oral health care for patients with special needs. Topics should include accessible and universally designed dental practices, behavior management skills, management of medically complex conditions and provision of quality oral health services to residents in group homes, long term care facilities, home health, and hospice settings.

With the opening of the East Carolina University School of Dentistry and scheduled increase in the number of dentist graduates at UNC-CH the dental workforce within the state of North Carolina will expand. This expansion alone, however, will not guarantee an increase in the workforce that provides dental care to patients with special health care needs. To accomplish this, the graduates of both North Carolina dental schools must have enough experience and exposure in working with this population to feel confident in providing care. (Wolff, Waldman, Milano and Perlman, 2004) demonstrated that 50% of dental students sampled nationally had no clinical experience and nearly 75% had little to no preparation in providing care to individuals with intellectual disabilities, a subgroup of patients with special needs. In addition, the authors reported that students who gained experience providing care for these patients with special needs while in dental school possessed greater self reported capability working with these patients after graduating from dental school.

With the aging and subsequent retirement of dental school faculty members nationally, along with fewer dental health professionals opting for an academic career, fewer faculty members will be available to provide instruction in special

care dentistry. However, additional faculty will be needed in order to meet the demands of this expanded curriculum. Attempting to increase the numbers of appropriately trained faculty will be a significant challenge in light of shrinking state financial resources. Obtaining a consistent source of funding to support this recommendation must be identified in order to put this recommendation into action.

This recommendation would require a new appropriation from the General Assembly.

Recommendation #7:

The UNC-CH School of Dentistry, the ECU School of Dentistry, once established, the NC AHEC system and the NC Community Colleges that offer educational programs for dentists, dental hygienists and dental assistants should intensify continuing education efforts for those providers who have an interest in providing oral health services to patients with special needs, but lack the necessary training. Included in this training should be information on how practices must, at a minimum, meet the Americans with Disabilities Act Standards for Accessible Design and how to utilize principles of Universal Design.

The North Carolina AHEC system, collaborating with community partners, should develop continuing education programs for dental health professionals and staff and investigate the most appropriate ways to expand delivery of these programs. Community partners would include private practices, hospitals, dental schools, disability service and advocacy organizations, and state agencies. Delivery methods to be considered would include live in-person sessions, webinars and online materials.

This recommendation would require a new appropriation from the General Assembly.

Recommendation #8:

Request that the North Carolina State Board of Dental Examiners investigate changing the state dental practice act to allow dental, dental hygiene and assisting students to receive training in private nursing homes and other facilities.

In the past, student rotation sites have been limited to state/federal institutions, teaching institutions and local health departments. Non-profit special care

dentistry programs are currently restricted from training students in private nursing facilities. All students (dental, dental hygiene and dental assisting) need the onsite experience that these non-profits can provide. Students trained in this setting may provide a valuable manpower pipeline for future practitioners.

This recommendation may require a change in regulations.

REIMBURSEMENT

Recommendation #9:

Request that the North Carolina General Assembly consider an increase in Medicaid dental reimbursement rates to 80% of the 2008 National Dental Advisory Service (NDAS) 50th percentile rate for each service covered under the Division of Medical Assistance (DMA) dental and orthodontic clinical coverage policies.

Licensed dentists in North Carolina often cite low Medicaid dental reimbursement rates that do not cover the cost of providing care as a barrier to more active participation in the Medicaid dental program. Access to care for many Medicaid recipients is affected by the lack of actively participating dental providers. This is particularly true in rural areas. Many Medicaid recipients with special care medical diagnoses are disproportionately affected by a lack of dentists to treat them, as their care is often time consuming and challenging. The Special Care Advisory Group believes that one step that could be taken by the North Carolina General Assembly which would help alleviate the oral health access problem for patients with special needs is to mandate an increase in Medicaid dental reimbursement rates to 80% of the 2008 National Dental Advisory Service (NDAS) 50th percentile rate for each service covered under the Division of Medical Assistance (DMA) dental and orthodontic clinical coverage policies.

The NDAS 50th percentile rate is the benchmark that DMA uses for dental rate setting and is based on a comprehensive national survey of dental fees. An individual rate at the 50th percentile means that 50% of the dentists in the nation charge above that rate and 50% charge below that rate. Raising rates to 80% of the 50th percentile of the 2008 NDAS will require approximately $50 million in State appropriations, or about $140 million in total funding requirements, including both State appropriations and federal matching funds. The requirements do not factor in any funds needed to cover additional expenditures that commonly occur each state fiscal year due to program growth and increased utilization. The section of the NC Medicaid State Plan that details the methodology for determining dental rates

currently allows rates for all covered services to be no higher than 75% of the 50th percentile of the NDAS in current use by DMA. Thus, an increase to 80% of the 50th percentile of the 2008 NDAS will require the Division to develop a State Plan Amendment which must be approved by the Centers for Medicare and Medicaid Services (CMS).

Both the North Carolina Public Health Task Force in its Public Health Improvement Plan 2008 Final Report (recommendation #21) and the North Carolina Institute of Medicine Task Force on Dental Care Access of 1999 (recommendation #1) made this recommendation.

This recommendation would require a new appropriation from the General Assembly.

Recommendation #10:

Request that the General Assembly consider providing funding to DMA to implement an inflationary rate increase for dental services on an annual basis.

The large funding requirements needed to raise Medicaid dental rates to more competitive levels serve notice of how quickly dental costs in the marketplace increase in a short period of time. The Dental Consumer Price Index (CPI) has increased more than 5% a year since 2004. Each year that NC Medicaid dental reimbursement rates are not addressed with at least an inflationary increase of 5% or more is a year when inflation continues to erode away at rates in comparison to other market based benchmarks like the NDAS 50th percentile.

The North Carolina Public Health Task Force in its Public Health Improvement Plan 2008 Final Report made this recommendation (recommendation #21).

This recommendation would require a new appropriation from the General Assembly.

Recommendation #11:

The Division of Medical Assistance should explore the benefits and risks of revising the policy limits on the facility code (CDT code D9410) to allow for providers to bill for each patient seen on a date of service in a nursing home, group home or other long term care facility.

The Special Care Advisory Group recognizes that established mobile dental providers who render services in nursing homes, group homes and other long term care facilities have a unique mission which is difficult to complete without adequate levels of reimbursement that will sustain their viability. The resources needed to bring dental services to patients with special needs who encounter tremendous barriers to obtaining access to care in private practice settings goes well beyond what is required to treat special care patients in fixed dental offices. In addition to the challenges that face all providers who treat patients with special needs, mobile dental providers have additional concerns like travel expenses and labor and capital costs (e.g. – the expense of purchasing portable dental equipment) in excess of those expected in more traditional settings. Currently, NC Medicaid reimburses mobile dental providers for a house/extended care facility call code (D9410) and this is reimbursed <u>one time per visit to the facility per date of service</u>. The current reimbursement for this service is $74.68. Issues to be taken into consideration when examining whether a proposed change in the way the code is applied include the determination of equitable compensation of mobile dental providers for the services that they render in a non-traditional clinical setting and the possibility of over utilization of this code by providers who do not intend to provide comprehensive oral health care services to the residents of long term care facilities. DMA may want to consider limiting the use of the facility code (D9410) to procedures provided in conjunction with services other than diagnostic and preventive codes (i.e.—Current Dental Terminology codes D2000 – D9999).

This recommendation may require a new appropriation from the General Assembly.

Recommendation #12:

Ensure that Medicaid dental services for adults are preserved and that consideration be given to expanding the services to include reimbursement for evidenced-based chemotherapeutic agents (i.e. fluoride therapies, periodontal therapies, etc.) for "high risk" adults with special health care needs. Funds should be provided to identify or develop a simple risk assessment tool to determine the risk status of these adults.

There has been considerable effort through legislation and advocacy to ensure that children identified as patients with special needs have adequate coverage and access to care through Medicaid and Health Choice options. Medicaid dental services are required under the Early Periodic Screening, Diagnosis and Treatment (EPSDT) statutes for children but optional for adults. Children identified as

patients with special needs who are able to obtain dental coverage as children through Medicaid are not necessarily covered once they reach the age of 21.

North Carolina currently provides Medicaid dental coverage for adults. Adult patients with special care needs are at higher risk for dental disease. Some have developmental disabilities or other physical limitations which make routine oral hygiene difficult whereas others have multiple medical diagnoses and are on medications that increase the risk for dental diseases. As the payment source for many adult patients with special care needs, the advisory group felt strongly that adult Medicaid dental services be maintained and that consideration be given to reimburse for evidence-based preventive services to prevent dental disease for those at increased risk for dental disease within this vulnerable population.

A significant challenge is that to date, organizations representing dental professionals have not been able to agree upon a universal definition of a person with special health care needs. Thus, it is difficult to determine the number of Medicaid recipients with special care diagnoses who would be eligible for and would benefit from evidence based preventive services.

This recommendation would require a new appropriation from the General Assembly.

Recommendation #13:

Increase the base units used to calculate fees for Medicaid dental and oral surgery cases to levels that will ensure adequate reimbursement of anesthesiologists and certified nurse anesthetists for services rendered in the hospital operating room or the outpatient surgical center setting.

Dental treatment for the patient who is medically compromised and for the very young patient with early childhood tooth decay is often done under general anesthesia in the operating room of an outpatient surgical center or hospital. The Anesthesiologists and Certified Nurse Anesthetists who administer the anesthesia need to be assured of adequate reimbursement prior to increasing the number of cases that reasonably should be expected to be done in the operating room. Dental procedures tend to take far longer than most surgical cases. Medicaid reimbursement for dental cases is currently 86% of the Medicare physician services rate. Increasing the base units to levels that provide equitable reimbursement will help ensure access to necessary anesthesiology care for persons with special health care needs.

This recommendation would require a new appropriation from the General Assembly.

CLINICAL PROGRAM EXPANSION

Recommendation #14:

Request state funding for an additional four (4) mobile dental programs, to be phased in one per year, to provide onsite comprehensive dental care for residents in nursing homes, group homes, assisted living centers, adult day health care centers and to certain individuals with special health care needs in the community.

There are only two existing non-profit mobile dental programs that provide such care. The existing mobile programs are currently serving 5,700 patients in 69 facilities, which is only a small percentage of the individuals that need special care dental services. Each year, they deliver approximately $187,000 per dental program in uncompensated care.

It takes approximately $400,000 to start a new mobile dental program. These programs require initial funding of capital and operating costs. North Carolina will benefit from four new, geographically distributed programs.
This recommendation would require a new appropriation from the General Assembly.

Recommendation #15:

Maintain and expand existing dental departments housed in all the psychiatric hospitals and developmental and neuro-medical centers that provide care to North Carolina's most vulnerable populations. Provide competitive salaries to attract and maintain well-qualified dentists.

Dentists in the state psychiatric hospitals, developmental, and neuro-medical centers provide compassionate and comprehensive care to approximately 3,800 residents. Due to extensive disabilities and challenging behaviors, these are often the most difficult patients to treat; therefore, many have no opportunity to obtain dental care anywhere else.

The dental departments at some of the facilities are alarmingly understaffed. The J. Iverson Riddle Center in Morganton has been without a fulltime dentist for about a year, and there are currently only two full time hospital dentists serving the

approximately 1,300 patients within two state psychiatric hospitals and contract dental services are used at the other two state psychiatric hospitals to meet the dental needs of individuals in these facilities.

Due to limited capacity, many of the dental programs in the state institutions are limited to treating only the patients or residents in their facilities. If adequately funded and staffed, the dental programs can be expanded to serve as regional treatment centers, serving community residents in addition to their in-house residents.

Providing equitable and competitive salaries to attract and maintain well-qualified dentists is essential. A recent attempt to fill a vacant dental position at Broughton Hospital was unsuccessful due to the low salary that was offered. To ensure that North Carolina's most vulnerable citizens continue to receive quality dental care and to facilitate community expansion, the Advisory Group recommends that salaries approximate those in the private sector.

This recommendation would require a new appropriation from the General Assembly.

HEALTH SERVICES RESEARCH

Recommendation #16:

Provide a research agenda to the UNC Gillings School of Global Public Health, the Cecil G. Sheps Center for Health Services Research and the UNC School of Dentistry to create a health services research agenda for persons with disabilities.

Future policy development depends on good information. This advisory group discovered a noticeable lack of information about:

- Categories and location of persons with disabilities.
- Where those with disabilities seek dental care services and the specific problems they have obtaining services.
- The need for additional fixed site facilities and the location of those facilities.
- The effectiveness of care delivered to this population and how preventive intervention strategies can save public funds.
- The oral health status of residents in nursing and assisted living facilities.
- The standard of care practices for those with disabilities.

- What types of continuing education would allow health professionals to develop a comfort zone when treating those with disabilities.
- How an integrated case management system would support those seeking care.
- How changes in Medicaid funding will affect the oral health status of persons with disabilities.

This recommendation would require a new appropriation from the General Assembly.

References

Hooper S. The Carolina Institute for Developmental Disabilities. Personal communication. January 26, 2010.

Lewis C, Robertson AS, Phelps S. Unmet dental needs among children with special health care needs: implications for the medical home. Pediatrics. 2005 Sep;116(3):e426-31.

NC Division of Aging and Adult Services. Personal communication. January 27, 2010.

NC State Center for Health Statistics. 2008 Behavioral Risk Factor Surveillance System (BRFSS) Survey. NC Department of Health and Human Services, 2010. Retrieved January 28, 2010 from http://www.schs.state.nc.us/SCHS/brfss/2008/nc/risk/disabil.html

Thompson S. Data for assessing the developmental disability services and supports system of North Carolina. Presented to: the North Carolina Institute of Medicine Task Force on Transitions for People with Developmental Disabilities; October 1, 2008; Morrisville, NC.

Wolff AJ, Waldman HB, Milano M, Perlman SP. Dental students' experiences with and attitudes toward people with mental retardation. Journal of the American Dental Association. 2004; 135: 353-357.

Members of the Special Care Dentistry Advisory Group

Doranna F. Anderson, BSEd. RHEd
NC Division of Public Health, Oral Health Section

Judi Ashbaugh
NC Office of Rural Health and Community Care

Darlene Baker, RDH
NC Division of Medical Assistance

Pat Beasley, RDH
Parent Advocate

Heather Beil
UNC-CH Gillings School of Global Public Health

Mary Bethel
AARP

Kevin Buchholtz, DDS
NC Division of Public Health, Oral Health Section

Jennifer Caplain
National Foundation of Dentistry for the Handicapped

Mark Casey, DDS, MPH
NC Division of Medical Assistance

Toni Chatman, MHA
Wake Area Health Education Center

Bryan Cobb, DDS, MS
Private Practicing Pediatric Dentist

Madge Cohen, MA, MBA
NC Division of Public Health, Oral Health Section

Kim Dehler, DDS, MS
Cabarrus Health Alliance

Mary Edwards, MA
NC Division of Aging and Adult Services

Sam Bowman Fuhrmann
Parent Advocate

Ford Grant, DMD
Carolinas Mobile Dentistry

Gavin Harrell, DDS
Private Practicing Dentist

Robert Hollowell, DDS
WakeMed Faculty Physicians Dentistry

James R. Hupp, DMD, MD, JD, MBA
East Carolina University School of Dentistry

Linda Kaufman
Parent Advocate

Rebecca King, DDS, MPH
NC Division of Public Health, Oral Health Section

Karen Luken, MS
NC Office on Disability and Health

Chris Mackey
NC Office on Disability and Health

Mary Makhlouf, DMD, MS
Private Practicing Dentist

Danielle Matula
NC Division of Public Health, Children and Youth Branch

Sally M. Mauriello, RDH, EdD
UNC-CH School of Dentistry, Department of Dental Ecology

Frances McClure, DDS
O'Berry Neuro-Medical Treatment Center

Tom McIver, DDS, MS
UNC-CH School of Dentistry, Department of Pediatric Dentistry

Judith K. Messura, DMD
Wake Forest University Baptist Medical Center Department of Dentistry

Michael Milano, DMD
UNC-CH School of Dentistry, Department of Pediatric Dentistry

Bill Milner, DDS, MPH
Access Dental Care

Alec Parker, DMD
NC Dental Society

Tom Parks, MEd
NC Division of Public Health, Oral Health Section

John Pendill, DDS
NC Division of Public Health, Oral Health Section

R. Gary Rozier, DDS, MPH
UNC-CH Gillings School of Global Public Health

Allen Samuelson, DDS
UNC-CH School of Dentistry, Department of Dental Ecology

David Snyder, DDS
Broughton Hospital

Janet Southerland, DDS, MPH, PHD
UNC-CH School of Dentistry, Department of Dental Ecology

Jean Spratt, DDS, MPH
NC Division of Public Health, Oral Health Section

Martha S. Taylor, RDH, MBA, MHA
NC Division of Public Health, Oral Health Section

Monica Teutsch, MPH
Program Consultant

Jennifer Webster-Cyriaque, DDS, PHD
UNC-CH School of Dentistry, Department of Dental Ecology

Marlyn Wells
NC Division of Public Health, Children and Youth Branch

Betsy White, RDH
Access Dental Care

Tim Wright, DDS, MS
UNC-CH School of Dentistry, Department of Pediatric Dentistry