Policy and Proposals That Will Help Improve Access to Oral Care Services for Individuals With Special Health Care Needs

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Historically, access to oral care for individuals with disabilities has been a challenge. This commentary provides an overview of this issue and discusses a recent policy and several proposals that will help improve outcomes and access to oral care for individuals who require special care dentistry services.

The US Surgeon General’s Report on Oral Health (2000) highlighted the relationship between oral health and overall health and the importance of optimal oral health for all ages [1]. The report acknowledged that while significant gains in oral health have been made, they have not been shared equally. Oral health disparities exist, and 2 groups particularly affected by these disparities are people with disabilities and the elderly.

Despite legislation enacted over the past decade in North Carolina to improve dental workforce capacity and access to care issues, oral health disparities continue to exist for some of our most vulnerable citizens who disproportionately suffer the consequences poor oral health has on quality of life.

Children and adults with disabilities exhibit a wide range of conditions and levels of impairment. Some have developmental disabilities or physical limitations that hinder their ability to provide effective oral hygiene to themselves, while others have multiple medical diagnoses requiring medications that adversely affect oral health. Although many children and adults with disabilities are able to receive routine oral care in traditional office settings without the need for special accommodations, others require an enhanced level of care—a practice referred to as special care dentistry. Special care dentistry provides oral health care services for people with physical, medical, developmental, or cognitive conditions that limit their ability to receive routine dental care [2]. Although the number of North Carolinians requiring these services is difficult to ascertain, it likely comprises a fairly large segment of the population. Currently an estimated 100,000 North Carolinians have an intellectual and/or other developmental disability (I/DD), [3] and more than 170,000 older adults (age 65+) in North Carolina are living with Alzheimer’s disease or other types of dementia, a number which is expected to increase to 210,000 by 2030 [4].

Children with Special Health Care Needs

It is estimated that 15.4% of North Carolina children have special health care needs (CSHCN), compared to 13.9% of children nationwide[5]. Recent studies of national survey data indicate that CSHCN visit the dentist with at least the same frequency as children without special health care needs and that total expenditures for dental care do not significantly differ [6, 7]. However, CSHCN who have more significant health issues have more unmet dental needs and are less likely to receive preventive services [7].

Adults with Special Health Care Needs

Adults with special health care needs face significant barriers accessing oral health care services in North Carolina. In 2010, it was reported that only 59% of disabled adults visited a dentist, dental hygienist, or dental clinic within the past year compared to 73% of adults with no disability [8]. Access to care is a particular concern for those who reside in assisted living facilities, nursing homes, and other long-term care facilities. It is well established in the literature that residents in nursing homes exhibit poor oral health, which can have serious systemic consequences, such as increased risk of stroke, cardiovascular disease, and pulmonary infection [9].

North Carolina Special Care Dentistry Advisory Group Report

In 2009, in response to established concerns about the oral health of individuals with special health care needs, the North Carolina General Assembly charged the North Carolina Department of Health and Human Services (NCDHHS), Oral Health Section (OHS) of the Division of Public Health, with examining the current dental care options for special care populations and releasing a report...
Divisions of Medical Assistance (DMA) and Public Health, North Carolina General Assembly directed the NCDHHS to initiate a study and released the report, Special Care Oral Health Services, A North Carolina Commitment, in March 2010 [10]. The report acknowledged the challenges in providing oral care for patients with special health care needs, as well as the many barriers that individuals with special needs face when trying to access care. The report observed that due to the committed efforts of caregivers and dental professionals, there are many individuals with disabilities in North Carolina who are receiving outstanding, comprehensive oral care. Nevertheless, the advisory group concluded that the current dental workforce capacity is insufficient to address the growing need to care for North Carolina’s special care population.

Two main reasons cited were the lack of dental providers trained in the complexities of treating patients with more severe special health care needs and inadequate compensation from third-party payers who don’t address the additional time and management often required for treatment [11]. The report included a comprehensive set of 16 recommendations, divided into categories of advocacy, professional development, reimbursement, clinic program expansion, and health service research that, if implemented, would improve access to care and oral health outcomes significantly for this population. Many of the recommendations require new appropriations from the North Carolina General Assembly. Due in large measure to the challenging economic climate, very few of the report’s recommendations have been addressed; however, incremental progress has been made, some of which is discussed below.

**A Recent Policy and Proposals**

Dental care has been cited as the most significant unmet health need for children with special health care needs [12]. Recommendation #3 in the report requested that a dentist be appointed to the North Carolina Commission on Children with Special Health Care Needs (CCSHCN). The CCSHCN is an 8-member Governor-appointed commission whose purpose is to monitor and evaluate the availability and provision of health services to children with special health care needs in the state. Dr. Donna Spears, endorsed by both the North Carolina Dental Society and the University of North Carolina-Chapel Hill (UNC-Chapel Hill) School of Dentistry, was appointed to serve on the CCSHCN in September 2010.

Dr. Spears brings a wealth of experience as a clinician, providing oral care to residents of the Murdoch Developmental Center, as well as an educator at the UNC-Chapel Hill School of Dentistry.

In response to recommendations specific to preventive dental services for Medicaid eligible adults (recommendation #11) and reimbursement models for those who provide care in long-term care facilities (recommendation #12), the North Carolina General Assembly directed the NCDHHS to initiate a study to address two issues: 1) the feasibility and anticipated impact of expanding Medicaid dental services to include reimbursement for evidenced based topical fluoride treatment and other chemotherapeutic agents used to prevent periodontal disease in high risk adults with special health care needs, and 2) the feasibility and anticipated impact of implementing facility code policies that would allow certified providers to bill for each patient seen in a long-term care facility or group home on the date of service.

In early 2012, a draft of the study was completed and will soon be submitted to the North Carolina General Assembly. The study plans to propose innovative new initiatives from DMA, which are described below.

**Fluoride Varnish Coverage Proposed for Older Adults**

After reviewing the evidence and conducting a financial analysis, DMA plans to propose covering fluoride varnish for adult Medicaid recipients over age 65 who are not dually eligible for both Medicaid and Medicare. Dually eligible beneficiaries do not qualify for North Carolina Medicaid dental benefits under the current eligibility rules.

Fluoride varnish has been proven to prevent dental caries (cavities) in children and adults, and as a result, leading national dental organizations support its use for all patients at high risk for dental caries. DMA’s proposed policy change will benefit older Medicaid recipients residing in long-term care facilities. These recipients are less likely to be able to access oral care in a traditional dental office.

A recent modification to the North Carolina Dental Hygiene Practice Act could also help increase access. North Carolina Administrative Code 16Z.0101-.0103 allows dental hygienists who have met the legal requirements of the code—following an exam and written treatment plan by a supervising dentist—to perform certain dental hygiene activities, such as fluoride varnish placement outside the direct supervision of that dentist in long-term care settings.

**Changes in Reimbursement for Dental Providers who Serve Residents in Long-Term Care Facilities**

After consulting with providers who deliver comprehensive dental services to residents in long-term care facilities, DMA believes that amending the current reimbursement model will help enable the expansion of existing dental practices that treat this population, as well as provide a financial incentive for new qualified dentists to deliver care in those settings.

DMA currently reimburses those who provide dental care to residents in long-term care facilities through what is commonly referred to as the facility code [13]. The current limitation for the service is that providers can be paid for only one facility code per date of service per facility, regardless of the number of recipients treated on that day. In other words, a dentist’s reimbursement for the facility code is the same regardless of whether 1 patient or 20 patients are treated. The service is currently reimbursed at $72.86 [14].
There are very few North Carolina dental practices that provide comprehensive care (ie, preventive, restorative, surgical, and partial or full dentures) to residents in long-term care facilities. They are typically able to serve up to 18 patients a day, but incur a financial loss for certain procedures such as partial- and full-denture appliances and appliance repairs (B. White, personal communication). DMA believes that a facility code reimbursement at a per-patient fee of $32.52 is feasible and will be more financially equitable to the providers. According to DMA, the proposal will need to be budget-neutral. To ensure this, DMA will consider implementing a policy that will prohibit use of the code by providers who render and bill Medicaid for diagnostic care only (eg, dental screenings) and restrict use of the code to providers who have met certain credentialing or continuing education requirements that have yet to be developed.

At the state level, there are several initiatives that are being coordinated by the North Carolina Office on Disability and Health. Educational programs targeting community college dental assistant and hygiene students, which focus on the importance of providing optimal oral care for patients with special health care needs, have begun. Site-specific training to dentists regarding how they can make their offices more accessible to patients with special needs has been provided and is currently available. Several different checklists for both professionals and families/consumers to assess the accessibility of dental practices are also being developed.

The East Carolina University (ECU) School of Dental Medicine, whose first class of 50 dental students began in the fall of 2011, intends to provide training to increase students’ abilities to provide care to patients with special health care needs. They are building a dedicated special care patient clinic in their facility in Greenville. After coursework in the management of patients with special needs, all students will rotate through that clinic during their third year. Students will then take that knowledge and experience with them to the Community Service Learning Centers currently being developed across the state. These students will provide care to patients with special needs alongside faculty and ECU School of Dental Medicine graduate students (J. Hupp, personal communication).

Conclusion

DMA’s proposals represent a concerted effort and commitment to improving the oral health of older adult Medicaid recipients, as well as a commitment to help the providers who deliver comprehensive oral care to residents of long-term care facilities. As highlighted in the 2010 Special Care Dentistry report, there are a number of practices and facilities that provide outstanding, comprehensive dental care to patients of all ages with disabilities [10]. However, with the dramatic population growth expected over the next 2 decades, and the 40% increase in the very old (age 85+) that occurred from 2000-2010 [15], the number of dentists qualified to provide special care dentistry services will need to increase significantly. Awareness at the federal and state level concerning these issues has never been greater. It is the hope that once the current economic situation improves, additional meaningful action addressing the care for patients with special health care needs will occur, which will help ensure that all North Carolinians achieve and maintain optimal oral health. NCMJ

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