

***ORAL HEALTH
TASK TEAM REPORT TO
THE CALIFORNIA
COMMISSION ON AGING***

Prepared for
**PLANNING FOR AN AGING
CALIFORNIA: AN
INVITATIONAL FORUM**
March 8, 2005

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The Purpose

The purpose of this document is to provide a status report of the work of a stakeholder task team on Oral Health organized around working on implementation of “Planning for an Aging California Population” (Health and Human Service Agency October 2003).

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I. Forward

A. Who is the California Commission on Aging?

The California Commission on Aging (CCoA) was established in 1973 by the Burton Act. It was confirmed in the original Older Californians Act of 1980 and reconfirmed in the Mello-Granlund Older Californians Act of 1996.

The Commission serves as "*the principal advocate in the state on behalf of older individuals, including, but not limited to, advisory participation in the consideration of all legislation and regulations made by state and federal departments and agencies relating to programs and services that affect older individuals.*" As such, the CCoA is the principal advisory body to the Governor, State Legislature, and State, Federal and local departments and agencies on issues affecting older Californians.

B. SB 910—Aging Planning Legislation

California is home to nearly four million people over age 65—the largest older adult population in the nation. This number is expected to more than double over the next several decades as the baby boomers begin reaching this milestone. To address this impending reality, Senator John Vasconcellos wrote Senate Bill 910 (Ch. 948/99, Vasconcellos). The bill mandated that the California Health and Human Services Agency develop a statewide strategic plan on aging for long term planning purposes. On October 14, 2003, the *Strategic Plan for an Aging California Population—Getting California Ready for the Baby Boomers*, was completed with the major support of the CCoA and a plan development task team representing 25 older adult stakeholder organizations supported by 15 state departments. The Governor signed the plan in November 2003. (The Strategic Plan can be reviewed at http://www.calaging.org/works/population_files/population.pdf.)

C. CCoA's Monitoring Role of the Strategic Plan

SB 910 calls for periodic updates so that it can be continuously improved and reflect new circumstances, new opportunities and the changing socio-political environment. The CCoA agreed to assume responsibility for the monitoring and updating the Strategic Plan. In this capacity, the CCoA is responsible for convening stakeholders, holding meetings, and monitoring the progress of priority action items outlined in the Plan. The CCoA will report to the Legislature the progress of the Plan's implementation, and update the Plan's contents to reflect changing priorities and actions. Reports to the Legislature will be on a biennial basis.

The CCoA's approach to monitoring the Strategic Plan's implementation during 2003-2005 includes:

- Encouraging/facilitating work on Strategic Plan implementation by convening nine new stakeholder task teams, facilitating initial meetings and establishing partnerships with two previously formed stakeholder teams.
- Dialoguing with state officials at the March 8, 2005 Forum on the top 15 priorities in the Strategic Plan.
- Distributing and compiling the results of a baseline questionnaire on the Strategic Plan's 15 Priorities. The questionnaire was distributed to private, public and non-profit providers and aging advocates.
- Reporting to the Legislature by May 2005, on the progress of the Strategic Plan.

D. Stakeholder Task Teams

Eleven Stakeholder Task Teams have been charged with identifying and focusing efforts on several of the top priority recommendations, developing action plans to support or achieve implementation of these priorities and identifying necessary amendments or additions to the original Plan. These volunteer Task Teams have been meeting for the period October 2003 through December 2004, though some Task Teams started their efforts later than others. Written reports have been received from all Task Teams—copies are available from the CCoA office. The focus areas for the 11 stakeholder task teams are: Housing, Economic Security, Elder/Financial Abuse, Transportation, Wellness/Prevention, Mental Health, Oral Health, Long Term Care, Palliative/End of Life Care, Assistive Technology, Provider Workforce.

The choices and actions taken by the Task Teams are solely their own and do not necessarily represent the position of the CCoA.

Strategic Plan for an Aging California Population
Report to the California Commission on Aging
March 8, 2005

Oral Health Task Team

II. Background on Oral Health¹

The number of people who are elderly and have special needs who need oral health services is rising dramatically. In this context people with special needs refers to those individuals who have barriers to achieving good oral health primarily because of a disability or medical condition. They include people who are elderly; have complex medical, physical and psychological problems; or who have social barriers to achieving optimal oral health including language, cultural and economic barriers.

The rise in numbers of people with special needs is due to many factors. The percent of people over age 65 is increasing at the same time that the rate of edentulism is decreasing dramatically. In California only 13 percent of people over 65 are edentulous now compared to close to 50 percent only a few decades ago. This new population of “Baby Boomers with Teeth” has invested heavily in maintaining oral health, has complex restorations that require maintenance and will present significant challenges to the dental profession as they become less able to maintain good oral health. Another group is people with complex developmental and mental disabilities who are being released from state institutions into the community living arrangements. Over 75 percent of those living in institutions 20 years ago, now live in community settings. Specialized services that were available in these institutions are typically not available in the community. In addition, the medical health care system has made dramatic strides, which have resulted in far more people with chronic diseases, taking multiple medications, and undergoing complex medical treatments, living and seeking dental services in community settings.

The current oral health care system is not working well for those populations described above. Increasing oral health workforce shortages, inadequate training of oral health professionals, a reimbursement system, which does not reward the kinds of services needed by these populations, and other factors all contribute to the failure of the current system for these groups. The result is significant oral health disparities with more dental disease, few preventive services, and significant access problems for people with special needs.

¹ Paul Glassman, DDS, MA, MBA, excerpts from *Oral Health for People with Special Needs – implications for the Dental Profession*, the report from the Pacific School of Dentistry Oral Health Conference, November 4, 2004.

III. Current Status of Oral Health Task Team

The University of the Center for Special Care at the Pacific School of Dentistry (Pacific) has been designated as the lead agency to form the Dental Task Team. Pacific established a Statewide Task Force on Oral Health and Aging several years ago. That Task Force is now serving as the California Commission on Aging (CCoA) Oral Health Task Team for the *Long Range Strategic Plan for an Aging California*.

The Task Force has been meeting two to three times per year. Approximately 30 to 40 individuals and agency representatives attend each meeting. Dr. Paul Glassman from Pacific has been serving as the Director of the Oral Health Task Team and representative to the CCoA. Task Team members are listed on page i of this document.

The most recent meeting of the Oral Health Task Team took place at a major conference put on by Pacific in conjunction with the Statewide Task Force on People with Special Needs and with support from the California Dental Association Foundation. The conference took place on November 4, 2004.

The purpose of this conference was to explore the changing population of people with special needs, analyze the implications for the dental profession and society, and describe systems and strategies that might lead to improved oral health for these populations. Seven nationally recognized speakers presented draft papers on various aspects of this topic. There was time for audience reaction and discussion with the speakers. The speakers and a designated group of reactors (known as the panel) then developed a draft consensus statement with recommendations for addressing these issues.

IV. Oral Health Implementation Priorities and Action Plan

In the coming year, the Oral Health Task Team will continue to meet and develop ways to implement the specific recommendations created in the November 4, 2004 conference and identify future action plans.

New priorities not included in the original October 2003 *Strategic Plan for an Aging California Population* are shown below in Italics.

Priority	Action Plan
<p><i>Develop a new model/system for delivering oral health services with the following characteristics:</i></p> <p>a) <i>A focus on prevention</i></p> <p>b) <i>A reward system that addresses services likely to improve oral health for these populations.</i></p> <p>c) <i>A system integrated with other community health and social service systems.</i></p> <p>d) <i>A triage and referral system where oral diseases can be identified and people referred to care settings that best match their situation and needs</i></p> <p>e) <i>A tiered delivery system with oral health professionals serving as coaches, mentors, and supporters of other health and social service professionals.</i></p> <p>f) <i>A system that engages those caregivers closest to the individual in playing a major role in maintaining oral health.</i></p>	<ul style="list-style-type: none">• The results of the conference described above are currently being reviewed and compiled. They will be circulated for feedback and published in the June 2005 issue of the Journal of the California Dental Association.• The Oral Health Section of the Long Range Strategic Plan for an Aging California should now be replaced with the above referenced conference report.

Priority	Action Plan
<p><i>Develop a new model/system for delivering oral health services with the following characteristics (continued):</i></p> <p><i>g) A tiered delivery system where increasingly complex care is performed by those with most extensive training to deliver such care and less complex care is delivered by those with less extensive training.</i></p>	
<p><i>Provide adequate reimbursement for oral health treatment services. Provide a mechanism in the California Denti-Cal program to reimburse for extra time spent with a patient with special needs with medical or behavioral challenges.</i></p>	
<p><i>Develop oral health goals and standards for residential facilities and use quality improvement systems to improve compliance with these standards. Tie this to licensure and certification inspections.</i></p>	
<p><i>Recognize that many people with special needs require professional care from dentists with a higher level of training than is provided in dental schools. Require year of “service and learning” for all dental graduates in an advanced education program accredited by the Commission on Dental Accreditation for dental licensure in California.</i></p>	

Priority	Action Plan
<p><i>Increase training for all dental professionals in providing care for people with special needs. This includes providing didactic instruction and clinical experience in this area for dental and dental hygiene students. Make this a part of the accreditation requirements for dental and dental hygiene programs. Also require continuing education in this area for all dental professionals.</i></p>	
<p><i>Coordinate data systems across state programs. Right now it is difficult to obtain good data about the oral health and other characteristics of people with special needs because information about them is tracked by differing state agencies using systems that do not allow cross-tabulation of data.</i></p>	
<p><i>Construct an index of dentally underserved populations which would include ways to identify underserved populations of people with special needs.</i></p>	
<p><i>Catalog and publicize successful models. Fund replication and expansion of models that have been shown to be cost-effective addition to the current delivery system.</i></p>	
<p><i>Fund research on oral health delivery and prevention models for people with special needs.</i></p>	

V. Barriers to Oral Health Priorities Implementation

In order to realize the above priorities, it will take one or more of the following:

- A change in law or regulation governing the practice of dentistry.
- A change in reimbursement mechanisms for oral health services.
- Integration of oral health services with general health and social service systems.
- Training of oral health, general health, and social service professionals about oral health and prevention of dental diseases in older individuals, especially those individuals with complicated social, physical, or medical conditions.

If we [use] the analogy of a world with heart disease and only heart surgeons to treat this disease, we can see the advantage of a world where there are heart surgeons, cardiologists, nurse practitioners, dieticians and physical fitness coaches. We also can see how these professionals might be supported by information about healthy diets, physical fitness programs, statin medications, and public awareness campaigns.

The challenge for the dental profession is to take the leadership role in finding the analogies to the heart disease world for dental disease. We have the opportunity now to design a new model for delivering oral health services that can better provide services for people with special needs and allow all of them to have a lifetime of oral health.

VI. Proposed Revisions to the *Strategic Plan for an Aging California Population*

The Task Team recommends that the new implementation priorities listed above in Section IV be added to the Oral Health Section II, F, 2 of the *Strategic Plan for an Aging California*. The full report of the November 4, 2004 conference is located in Attachment 1

Attachment 1

Oral Health Task Force Conference Report November 4, 2004

Issues to be Addressed

The panel considered the major issues that need to be addressed if people with special needs are to achieve optimum oral health. The following is a summary of those issues as determined by the Panel:

1. People with special needs including elderly individuals who have complex medical, physical and psychological problems; or who have social barriers to achieving optimal oral health including language, cultural and economic barriers, are having increasing difficulty finding oral health services and obtaining good oral health.
2. There is inadequate training for dental professionals in treatment of individuals with the complex situations described above. There are currently no accreditation requirements for dental schools to provide any treatment experiences for their graduates for these groups of people.
3. There are inadequate incentives for dental professionals to become involved in treatment of individuals with the complex situations described above who may take more time to treat and may produce less income for the dental professional.
4. The predominant funding mechanism for oral health care for people who are disabled and consequently have lowered incomes is Medicaid. In California as in most states, this reimbursement system does not recognize the issues in caring for people with special needs including the need for increased consultation and more time to complete procedures.
5. The current system of care relies predominantly on dental offices and clinics to provide all levels of oral health services including screening, oral health education, minor procedures and complex procedures. A dental office or clinic may not be the only place where some of these services can be provided and for some services it may not be the best place. In particular preventive services may be more effectively delivered in settings closer to where people live and spend the majority of their time.
6. The separation between the oral health care system and other health and social services systems leads to lack of integration of oral health issues into general health treatment and funding mechanisms.
7. Those caregivers who work with people with special needs on a daily basis are typically not educated, motivated or engaged in efforts to prevent dental disease in the people they are caring for.

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8. Quality improvement systems in place in residential facilities for people with special needs including nursing homes, licensed health care facilities, and community living facilities often do not consider the extent to which oral health services are being provided or not in these facilities.
 9. Policy makers who calculate current and future oral health workforce needs typically do not consider the needs of underserved populations such as people with special needs. Many workforce projections assume that people who are currently outside of the currently delivery system will continue to stay outside.

Characteristics of a New System

The panel then considered what a new system for delivering oral health care would look like. They agreed upon a series of characteristics of such a new system. These are:

1. A focus on prevention
The current and future oral health workforce will not be able to keep up with the burden of oral disease as special needs populations continue to grow unless there is a dramatic shift in the rate of development of oral diseases. This shift will require a focus on prevention of oral diseases by oral and other health professionals and by social service systems as well as by caregivers, families and people with special needs themselves.
2. A reward system that addresses services likely to improve oral health for these populations
The current system rewards surgical interventions and does not reward other activities that might be less costly overall and might be more likely to lead to better health outcomes. A new system should reward early promotion of preventive practices, early identification of potential and actual oral health problems, application of the least invasive solutions, and major surgical interventions as a last resort. In this context one could consider restorative dentistry procedures such as fillings and crowns as major interventions. They are certainly major compared to re-mineralization procedures applied early in the caries process.
3. A system integrated with other community health and social service systems
If we consider an emphasis on preventive education and early intervention to be important aspects of a new oral health system, then it can be argued that the dental office is not the best place for such activities to take place. They might be better applied in the context of other community health and social service systems. This would not only integrate these services with social and general health services, but it would allow dental practices to focus on those more complex procedures where surgical intervention is needed.

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4. A triage and referral system where oral diseases can be identified and people referred to care settings that best match their situation and needs
Currently many people with special needs have trouble finding sources of oral health care. It has been shown that a case management model can significantly decrease problems people have in finding sources of care. A community triage and referral system can identify people in need of oral health services and facilitate matching them with sources of care that best meet their needs.
 5. A tiered delivery system with oral health professionals serving as coaches, mentors, and supporters of other health and social service professionals
The current and future oral health workforce will never be able to provide all the preventive education, minor treatment procedures and surgical interventions that are needed to maintain oral health in populations of people with special needs. It is therefore critical that other people become involved in these oral health preventive and treatment activities. Oral health professionals can act as coaches, mentors, and supporters of other health and social service professionals, thereby multiplying their effectiveness.
 6. A system that engages those caregivers closest to the individual in playing a major role in maintaining oral health
If oral health professionals act as coaches, mentors, and supporters of other health and social service professionals, then it may be possible to support those individuals who provide care and are in contact with people with special needs on a daily basis in their application of oral health prevention practices.
 7. A tiered delivery system where increasingly complex care is performed by those with most extensive training to deliver such care and less complex care is delivered by those with less extensive training.

If the bulk of preventive activities and even less invasive oral health treatment procedures are integrated with activities of other community health and social service systems, then this will enable dental providers to concentrate on the most complex procedures that only they are trained to perform.

Figure 1 contains a diagram of a tiered oral health system. In this diagram, basic services are delivered in settings where people live, work, play, go to school, or receive social services. These basic services include screening, triage, preventive education, fluoride application including fluoride varnish, sealants, and minor dental procedures. When more complex services are required, traditional dental providers in dental offices, clinics and hospitals can be involved.

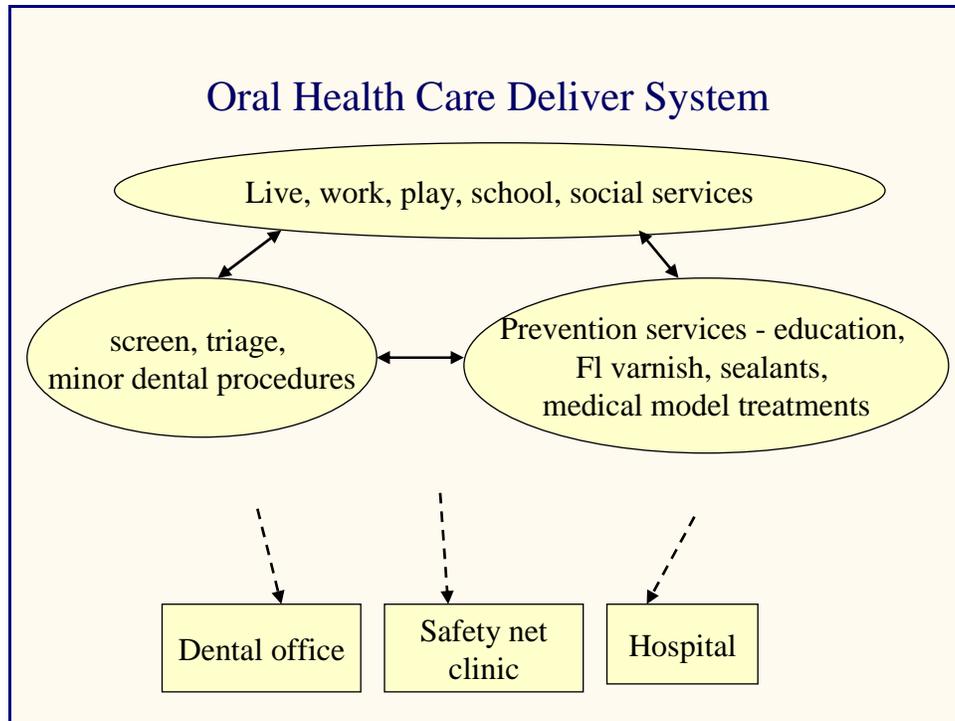


Figure 1 - A Tiered Oral Health Care Delivery System

Recommendations

The Panel then considered a series of ideas that could lead to specific solutions for the issues listed above and developed a list of recommendations to address these issues. These are:

1. Focus on prevention. Although the current population of people with special needs is carrying a large burden of current disease we are falling further behind in our ability to provide treatment. Therefore we must begin to focus more on preventing future disease.
2. Develop a reward system that addresses services likely to improve oral health for these populations. It is currently very difficult to find funding for case management services, health education programs, triage and referral systems, and other strategies that can limit the need for costly complicated dental procedures.
3. Provide adequate reimbursement for oral health treatment services. Provide a mechanism in the California Denti-Cal program to reimburse for extra time spent with a patient with special needs with medical or behavioral challenges.
4. Provide support systems for professionals working with people with special needs. These include the ability to consult with experts in person or using distance technology, web-based resources, on-line education programs.

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5. Integrate oral health services with other community health and social service systems. It is clear that oral health professionals cannot solve the oral health problems of people with special needs alone. Oral health identification, prevention, and treatment activities can be integrated with general health and social service systems and professionals in these fields trained and enlisted to carry out these activities in conjunction with other health and social interventions they are performing.
 6. Develop oral health goals and standards for residential facilities and use quality improvement systems to improve compliance with these standards. Tie this to licensure and certification inspections.
 7. Employ case management systems including triage and referral systems where oral diseases can be identified and people referred to care settings that best match their situation and needs
 8. Consider a new role for oral health professionals as coaches, mentors, and supporters of other health and social service professionals. Expand the scope of oral health activities that can be performed by allied dental professionals and general health and social service professionals when working with people with special needs.
 9. Develop incentives and systems for engaging those caregivers closest to the individual in playing a major role in maintaining oral health. Incentives can include providing performance rewards, and developing standards tied to licensing.
 10. Recognize that many people with special needs require professional care from dentists with a higher level of training than is provided in dental schools. Require year of “service and learning” for all dental graduates in an advanced education program accredited by the Commission on Dental Accreditation for dental licensure in California.
 11. Increase training for all dental professionals in providing care for people with special needs. This includes providing didactic instruction and clinical experience in this area for dental and dental hygiene students. Make this a part of the accreditation requirements for dental and dental hygiene programs. Also require continuing education in this area for all dental professionals.
 12. Coordinate data systems across state programs. Right now it is difficult to obtain good data about the oral health and other characteristics of people with special needs because information about them is tracked by differing state agencies using systems that do not allow cross-tabulation of data.
 13. Construct an index of dentally underserved populations which would include ways to identify underserved populations of people with special needs.

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14. Catalog and publicize successful models. Fund replication and expansion of models that have been shown to be cost-effective addition to the current delivery system.
 15. Fund research on oral health delivery and prevention models for people with special needs.