

Evolving Delivery Models for Dental Care Services in Long-Term Care Settings: Four State Case Studies

Elizabeth Mertz, PhD, MA and Cynthia Wides, MA

I. Introduction

Over 40 million people in the U.S. are ages 65 or older, and an estimated 40% of these seniors will enter a long-term care (LTC) facility at some point in their lives. Individuals living in LTC facilities or receiving in-home care (IHC) are more likely to have poorer oral health status compared to individuals living independently, yet provision of dental services in LTC settings is limited.¹ Numerous barriers to oral health care exist for the poor, elderly, and institutionalized population. There is little geriatric training in dental schools, and post-graduate geriatric training is sparse and highly variable.² Medicare provides no dental benefits. Although Medicaid covers approximately two-thirds of Skilled Nursing Facility (SNF) residents, many states still do not provide dental coverage for adults.³ In states that do provide dental coverage under Medicaid, reimbursement rates are very low and few dentists accept Medicaid patients.³

II. Methods

This mixed method study examines the models of delivery of dental care in LTC facilities under varying policy conditions in four U.S. states – California, Florida, Minnesota, and North Carolina. Researchers completed a comprehensive literature review and conducted qualitative interviews with dental providers, LTC administrators, and state and national policy experts.

III. Findings

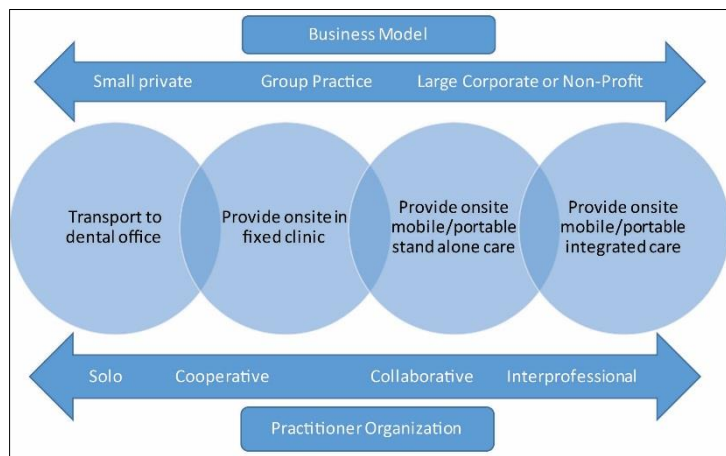
Currently, a continuum of models exists that extends the capacity for oral health services beyond the traditional dental office. These models range from a traditional transport-model; where accountability is primarily the responsibility of the nursing home staff and family, to fully mobile and tele-health enhanced models and large comprehensive care organizations (CCOs) that take on accountability for all aspects of oral health care provision. A trend was found towards larger, mobile providers who are better able to meet the needs of multi-site nursing homes, but cross-subsidies remain necessary as provision of oral health care to LTC residents is different and more difficult than provision of oral health care to other patients. Frail and cognitively impaired patients require greater resources and time allowances for care delivery. States largely ignore these differences in applying laws around scope of practice, nursing facility regulations, and funding.

Conclusions & Policy Implications

- 1) Evidence of the ongoing evolution of a continuum of care models can be found across States seeking to address gaps in access to care for LTC residents.
- 2) The federal mandate to provide oral care in LTC facilities lacks evidence-based standards. Therefore availability of care, as well as care delivery models, are largely determined by the state policy environment – in particular Medicaid coverage and reimbursement and scopes of practice for allied providers.
- 3) Core standards, adequate workforce, and dental benefit packages that support meeting LTC residents' needs, along with regulation of care to penalize neglect, are needed to shift away from idiosyncratic and opportunistic dental care models and toward patient centered, appropriate and affordable care.

Key informants agreed there are unique best practices for oral health care with this population yet there is no standard of care for provision of these services in LTC facilities. Lacking evidence-based guidance to the federal mandate to provide oral care in LTCs, the largest determinant of how care is delivered is the state policy environment -- specifically Medicaid reimbursement and scope of practice for dental hygienists. Further, low priority is given to oral health in regulations for nursing facilities resulting in a normalization of no or minimal mouth care for patients who are viewed as not cooperative. Given the complexities of oral care in LTCs, dental care delivery to LTC residents requires complex, collaborative, inter-professional team efforts spanning multiple health care domains that do not traditionally overlap. Oral health providers generally lack both geriatric and inter-professional training. Even though exemplary training models exist and some states require training for LTC staff around oral health care provision, LTC staff are challenged to provide daily mouth care that is safe for themselves and their patients. Unfortunately, a thorough examination of data sources found that traditional sources of workforce data do not adequately capture the size, scope, training, or capacity of the professional oral health workforce engaged in LTC settings, nor the volume or appropriateness of oral health services being provided to nursing home or other LTC residents.

Figure 1. Continuum of Long-term Care Dentistry Models



Oral health providers generally lack both geriatric and inter-professional training. Even though exemplary training models exist and some states require training for LTC staff around oral health care provision, LTC staff are challenged to provide daily mouth care that is safe for themselves and their patients. Unfortunately, a thorough examination of data sources found that traditional sources of workforce data do not adequately capture the size, scope, training, or capacity of the professional oral health workforce engaged in LTC settings, nor the volume or appropriateness of oral health services being provided to nursing home or other LTC residents.

IV. Conclusion

Oral health is critical to overall health and well-being, even at the end of life. Many tools are in place, but progress is needed to align supportive dental benefits, health care regulations, and workforce training to adequately address the oral health care needs of patients in LTC settings.

V. Policy Implications

Workforce policies that enable serving LTC residents include expanded workforce training in geriatric dentistry as well as hygienist autonomy, billing abilities, and expanded practice. Care configuration policies shown to support LTC dentistry include inter-professional practice, teledentistry and mobile dentistry. Payment policies to improve care for LTC residents include a Medicare dental benefit; adult dental benefits under Medicaid; and a reimbursement structure that encourages safe, effective, and evidence-based oral health care for this vulnerable population. Finally, federal and state regulations around the provision of oral health services in nursing facilities should be strengthened and consistently enforced.

References

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