Dental Public Health Activity Descriptive Report

Practice Number: **36006**
Submitted By: **Access Dental Care**
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SECTION I: PRACTICE OVERVIEW

Name of the Dental Public Health Activity:
North Carolina Special Care Dentistry

Public Health Functions:
Assessment – Acquiring Data
Assessment – Use of Data
Policy Development - Collaboration and Partnership for Planning and Integration
Policy Development - Oral Health Program Policies
Policy Development - Use of State Oral Health Plan
Policy Development - Oral Health Program Organizational Structure and Resources
Assurance – Population-based Interventions
Assurance - Oral Health Communications
Assurance - Building Linkages and Partnerships for Interventions
Assurance – Building State and Community Capacity for Interventions
Assurance - Access to Care and Health System Interventions
Assurance - Program Evaluation for Outcomes and Quality Management

Healthy People 2020 Objectives:
OH-1 Reduce the proportion of children and adolescents who have dental caries experience in their primary or permanent teeth
OH-2 Reduce the proportion of children and adolescents with untreated dental decay
OH-3 Reduce the proportion of adults with untreated dental decay
OH-4 Reduce the proportion of adults who have ever had a permanent tooth extracted because of dental caries or periodontal disease
OH-5 Reduce the proportion of adults aged 45 to 74 years with moderate or severe periodontitis
OH-6 Increase the proportion of oral and pharyngeal cancers detected at the earliest stage
OH-7 Increase the proportion of children, adolescents, and adults who used the oral health care system in the past year
AHS-6.3 Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary dental care
DH -4 Reduce the proportion of people with disabilities who report delays in receiving primary or periodic preventive care due to specific barriers
OA-7.4 Increase the proportion of dentists with geriatric certification

State:	**Federal Region:**	**Key Words for Searches:**
NC		Special Care Dentistry, Intellectual/Developmental Disability, Mobile Dentistry, Community Dentistry, Geriatric Dentistry

Abstract:

Access Dental Care (ADC) is a non-profit organization whose mission is to provide on-site, quality comprehensive dental services, via mobile equipment and trained professionals, to the intellectually disabled/developmentally disabled (ID/DD) and frail elderly populations in long-term care facilities (nursing and group homes) and community-dwelling individuals with disabilities. Recent program expansion includes service to Program of All-Inclusive Care for the Elderly (PACE) centers and regional HIV clinics. Access Dental Care began as a sponsored North Carolina Dental Society and Area Agency on Aging program, with initial funding of $365,000 from the Cone Foundation of Greensboro, North Carolina. It has always had four missions: clinical care for special care patients, continuing education for medical professionals, advocacy for expansion of special care services and health services research. ADC has always maintained a large group of special care interest

organizations that push for our initiatives. (See attached list.)

Started in 2000, this organization currently serves 52 facilities in the North Carolina Piedmont Region. Five days a week, two teams (dentist, hygienist, 1-2 assistants) travel to a facility, serving an average of 18 patients. Three office support personnel manage initial exam/treatment plan permission, financial affairs and responsible party communication.
Program Stats: Totals from 8/2000-12/2014

Clinical

- 57 Active Facilities
- 12,965 Patients Served, 80% of whom are Medicaid
- 85,251 Patient Visits
- 134,595 Patient Services
  1. 70% Diagnostic/Preventive
     61,705 Diagnostic (exams, x-rays)
     33,016 Preventive (cleanings, fluoride treatment, sealants)
  2. 12% Restorative (16,525 fillings)
  3. 11% Oral Surgery (14,731 extractions and other surgery)
  4. 4% Removable Prosthetics (5,769 denture procedures - dentures, partials, relines, repairs)
  5. 1% Perio (2,199 treatments – scaling/root planing, surgery)
  6. <1% Fixed Prosthetics (498 crown and bridge units)
  7. <1% Endodontic (152 root canals)

  (No sealants completed on nursing home patients.)

Special Recognition

- 518 Operating Room Patients Completed - Most are persons with profound intellectual disabilities cared for at Moses Cone and Randolph Hospitals.
- 1,017 Patients with Intellectual/Developmental Disabilities cared for through group home day centers
- 233 Patients care for at The Arc of High Point Clinic
- 160 Patients care for in PACE programs
- 357 Patients care for at Central Carolina Health Network (all HIV+)

Financial

- 12.5 Million in Gross Production
- 3.65 Million in Uncompensated Care
- $1.5 million of Foundation/Grant funding for capital expenses

	2011	2012	2013
Gross Production	$1,037,886	$1,131,015	$1,299,284
Net Income (Including Retainers)	$915,388	$961,038	$1,086,428
Uncompensated Care	$122,497	$169,977	$212,856

- Average gross production per appointment was $170.00 in 2013
- 80% are Medicaid recipients

While providing the above daily care, Access Dental Care has:

- Received $1.5 million from private foundations, the NC Legislature, Area Agencies on Aging and the NC Council on Developmental Disabilities to create 5 community special care and regional community programs.
- Created a coalition of 34 aged/disability statewide organizations to deal with consumer advocacy issues.
- Educated medical professionals and consumers on special care dentistry issues. (See website, accessdentalcare.org, for articles and DVD.)
- Created a policy agenda – Special Care Oral Health Services, A North Carolina Commitment, March, 2010.
- Worked closely with NC Medicaid to improve the quality of dental services provided to long-term care residents.
- Manufactured a line of mobile equipment.

Contact Persons for Inquiries:

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SECTION II: PRACTICE DESCRIPTION

History of the Practice:

The North Carolina Dental Society (NCDS) appreciated back in the 1980's that a systems approach was necessary to providing services to special care populations. It partnered with, at that time, the state's public health Dental Division to provide dental provider education and related agency coalition building.

By the early 1990s, a clinical model (Apple Tree Dental, Minnesota) had been identified for replication. Carolinas Medical Center, Charlotte (Carolinas Mobile Dentistry) received funding from the Kate B. Reynolds Charitable Trust of Winston-Salem, NC for a pilot project in 1997. Access Dental Care (ADC), a sponsored program of the North Carolina Dental Society, was then started in 2000. Since then, ADC has created special care programs through-out the NC Piedmont and community programs for the North Country Health Consortium, New Hampshire (2005) and CareSouth Carolina, South Carolina (2010).

ADC continues to work closely with the NCDS and the newly formed NC Oral Health Collaborative to expand state services and improve the quality of care for special care patients.

** As this report is being written, ADC has assumed responsibility for Carolinas Mobile Dentistry, Charlotte. ADC now has responsibility for 90 facilities in the NC piedmont. New service numbers will not be available until October, 2016.

Justification of the Practice:

The elderly and disabled are one of the most often neglected community populations. Patient behaviors, on-site locations, complicated medical histories, responsible party issues, inadequate dental/medical team training, financial reimbursement, specific dental equipment and software purchases create barriers to service. All of these service delivery issues come at a time when states are deinstitutionalizing those with disabilities back into local communities and the aging growth rate is increasing rapidly.

Having special care expertise in the community at large benefits everyone. Medical/dental practitioners have a referral source. Responsible parties' search for routine dental services is less complicated and patients get compassionate care. Use of oral sedation and the operating room setting ensures that even the most difficult cases get the care they need. (fee-for-service funding)

North Carolina's coalition building efforts have been the ultimate key to our success. It has been a grass-roots effort - involving patients, care givers, special care interest organizations and legislators. As a result, North Carolina still has adult Medicaid funding and special care is a part of the oral health agenda.

Inputs, Activities, Outputs and Outcomes of the Practice:

August 2000 – December 2012
Clinical

- 64 Facilities Served
- 57 Active Facilities
- 12,965 Patients Served
- 1,017 Patients with Intellectual/Developmental Disabilities
- 429 Operating Room Patients (Most are persons with profound intellectual disabilities.)
- 69,810 Patient Visits
- 111,020 Patient Services

8. 74% Diagnostic/Preventive

51,483 Diagnostic (exams, x-rays)
26,698 Preventive (cleanings, fluoride treatment, sealants)

9. 11% Restorative (13,234 fillings)
10. 10% Oral Surgery (12,097 extractions)
11. 4% Removable Prosthetics (4,956 denture procedures - dentures, partials, relines, repairs)
12. 1% Perio (2,031 treatments – scaling/root planing, surgery)
13. <1% Fixed Prosthetics (402 crown and bridge units)
14. <1% Endodontic (119 root canals)

Care is provided with a "Truck Team." Each team is composed of a DDS, RDH, 2 CDAs and 1.5 office support personal.

Budget Estimates and Formulas of the Practice:

Financial

- $10,054,164 Gross Production over twelve and a half years.
- $1.5 million of Foundation/Grant funding for capital expenses

	2010	2011	2012
Gross Production	$964,676.12	$1,037,885.84	$1,131,015.37
Net Income (Including Retainers)	$909,502.11	$915,388.44	$961,037.63
Uncompensated Care	$55,174.01	$122,497.40	$169,977.74

- Average gross production per appointment was $157.00 in 2012
- 80% are Medicaid recipients
- Very little commercial insurance.

Lessons Learned and/or Plans for Improvement:

1. Creating a systems approach to special care dentistry involves a huge coordination effort taking place over many years.
2. It is difficult to create expertise in a "specialty' area of dentistry where financial incentives are limited.
3. The above mentioned barriers-to-care will continue to limit access to care.
4. This group of patients must depend on others to advocate for change.
5. Setting up new programs takes one committed organization and approximately $400,000 in initial capital and operation funding.
6. Never "reinvent the special care wheel." There is too much program expertise available.

Available Information Resources:

Contact Access Dental Care for your specific needs after visiting our website.

www.accessdentalcare.org

Available of the website:

- A description of our program and activities

- Pictures and descriptions of custom made dental equipment that Access Dental Care offers for sale to organizations wanting to provide mobile dental services.
- Ordering information for an educational DVD "A hands-on approach to daily oral care for people with intellectual and developmental disabilities"
- Previously published articles
- Contact information

SECTION III: PRACTICE EVALUATION INFORMATION

Impact/Effectiveness

How has the practice demonstrated impact, applicability, and benefits to the oral health care and well-being of certain populations or communities (i.e., reference scientific evidence, outcomes of the practice and/or evaluation results)?

1. Residents of over 57 skilled nursing/group home day centers and those in the community at-large receive care on a routine basis.
2. Administrators, directors of nursing and staff better understand the oral health needs of their residents.
3. Educated private dental providers provide better and more comprehensive care to special care patients.
   (No clinical outcome data available – only service numbers.)

Efficiency

How has the practice demonstrated cost and resource efficiency where expenses are appropriate to benefits? How has the practice demonstrated realistic and reasonable staffing and time requirements? Provide unit cost analysis or cost-benefit analysis if appropriate.

1. Mobile, on-site care saves facilities transportation and personnel cost. It also saves the construction of costly dental facilities used on an infrequent basis.
2. Serving an average of 18 patients per day is impressive. These patients need to be transferred, have complicated medical histories and can present difficult behaviors. Travel time to facilities also impacts the number of patients seen. (No best practices data available.)
3. Preventive care (0.12% Chlorhexidine, MI paste, high fluoride toothpaste) is delivered by staff on a daily basis or monthly by the dental staff.
4. Clinical care, paperwork processing and billing work in a seamless operation.
5. Everyone on staff has cross-over responsibilities.
   (No cost/appointment data.)

Demonstrated Sustainability

How has the practice showed sustainable benefits and/or how has the practice been sustainable within populations/communities and between states/territories? What mechanisms have been built into the practice to assure sustainability?

Few thought that a practice that concentrates its efforts on arguably the most difficult-to-treat population, using mobile equipment and has 80% of its patients funded by adult Medicaid could make it. While providing care for this typical long-term care population mix (80% Medicaid, 20% private pay) our actual revenue is 30% Medicaid, 30% private patient and 30% retainer fee ($6 per licensed bed per month) has kept Access Dental Care break-even for 15 years. Future reductions in Medicaid funding could jeopardize this sustainability. We do not depend on operational grant funding.

Collaboration/Integration

How has the practice built effective partnerships/collaborations among various organizations and integrated oral health with other health projects and issues? What are the traditional, non-traditional, public and private partnerships/collaborations established by the practice for integration, effectiveness, efficiency and sustainability?

A 34 member special care interest organization is maintained by Access Dental Care and the North Carolina Dental Society.

Organization	Name	Title	Email
Support Groups			
AARP	Mary Bethel	Associate State Director for Advocacy AARP-NC	mbethel@aarp.org
Access Dental Care	Jean Small	Board Member, Retired Executive Director Adult Day Health Care Center	jsmall14@triad.rr.com
Alzheimer's North Carolina	Alice Watkins	Executive Director, East Chapter	awatkins@alznc.org
Alzheimer's Association	Nicole Reiger Thomas	Western Region Representative	neek_kay@yahoo.com
Access Dental Care	Sarah Escue	Board Member, Retired Social Worker	sescue@yahoo.com
DHHS	Dave Richard	Deputy Secretary of Behavioral Health and Developmental Disabilities Services	dave.richard@dhhs.nc.gov
Arc of NC	Ellen Russell	Director Emeritus of Advocacy at The Arc of NC	erussell@arcnc.org
LeadingAge North Carolina	Tom Akins	President	tom.akins@leadingagenc.org
Autism Society	Jennifer Mahan	Director of Advocacy and Public Policy	jmahan@autismsociety-nc.org
CCCR of NC	Walton Boyer	President, Continuing Care Community Residents of NC	walton.boyer@charter.net
Participating Facility	Bill Wood	Director Health Care, Retirement	wwood@BRH.org
DHHS	Holly Riddle	Mental Health Division	holly.riddle@dhhs.nc.gov
NC Council on Developmental Disabilities	Position Vacant	Executive Director	
Dental Society	Dr. Alec Parker	Executive Director	aparker@ncdental.org
Dental Society	Lisa Ward	Director of Public Affairs	lward@ncdental.org
Friends of Residents in LTC	Sheyna Alterovitz	Friends of Residents in LTC Staff	friends@forltc.org
Friends of Residents in LTC	Doris Jacobs	Board Chair, Friends of Residents in LTC	
Friends of Residents in LTC	Bill Lamb		william.e.lamb@gmail.com
Healthcare Facilities Association	Kristi Huff	Director of Government Affairs	kristih@nchcfa.org
Hospital Dentists	Ronald Kulinski	Director of Dental Medicine, Moses Cone Hospital	ronald.kulinski@conehealth.com
ICF/MR	Robin Correll	RHA	rcorrell@rhanet.org
ICF/MR Providers Association	Janet Schenzenbach	Lobbyist for NCICFMR	larrye@blueridgehomes.org
ICF/MR Providers Association	Tonda Stillwell	President NC ICF/MR Providers	
Parent Advocate	Pat Beasley		pbeasley@email.unc.edu
Parent Advocate	Sam Bowman Fuhrmann		Vbowman@triad.rr.com
Private Nursing	Laura Lucas	Autumn Corporation	

Facilities			
Sr. Citizen Association	Ben Sutton	Executive Director	bsutton@ncseniorcitizens.org
Ombudsman Association		Ombudsman	
Keep Informed			
AHEC	Elizabeth Haile	Retired Educator	hailemartin@aol.com
Justice Center	Adam Searing		adam@ncjustice.org
School of Dentistry, UNC	Allen Samuelson	Director of Special Care Dentistry	allen_samuelson@dentistry.unc.edu
Wake Forest University Baptist Medical Center	Judith Messura	Dentist, Past President SCDA	jmessura@wfubmc.edu
Area Agency on Aging	Blair Barton-Percival	Piedmont Triad Director of Aging	bbpercival@ptrc.org
Area Agency on Aging (NC Assoc.)	Gayla Woody		gwoody@centralina.org
Area Agency on Aging (NC Assoc.)	Leslie Roseboro	Staff	lroseboro@ncanpha.org
The Corporation of Guardianship	Dorian Fredricksen	Executive Director	
NC Department of Health and Human Services	Chris Mackey	NC Office of Disability and Health, Disability and Health Specialist	chris.mackey@dhhs.nc.gov
NC Department of Health and Human Services	Danielle Matula	Director, NC Office of Disability and Health Children and Youth Branch	danielle.matula@dhhs.nc.gov
Frank Porter Graham Child Development Institute	Karen Luken	Principal Investigator	karenluken@gmail.com
Office of Rural Health & Community Care	Chris Collins, Director John Price		chris.collins@dhhs.nc.gov john.price@dhhs.nc.gov
Ombudsman	Carmelita Karhoff	Region J Long Term Care Ombudsman	ckarhoff@tjcog.org
Ombudsman	Debi Lee	Long Term Care Ombudsman	dlee@centralina.org
Ombudsman	Sharon Wilder	State LTC Ombudsman	sharon.wilder@dhhs.nc.gov

Oral Health Section	Rebecca King	Chief	rebecca.king@dhhs.nc.gov
Dentist	Mary Makhlouf	Private Practice General Dentist	dmd@docmary.com
Disability Rights of NC	Vicki Smith	Executive Director	info@disabilityrightsnc.org
Division of Aging	Mary Edwards	Consumer Affairs Program Manager	mary.edwards@ncmail.net
Division of Medical Assistance	Darlene Baker	DMA Dental Policy Analyst	darlene.p.baker@dhhs.nc.gov
Division of Medical Assistance	Mark Casey	Medicaid Dental Director	mark.casey@dhhs.nc.gov

Division of Mental Health, Developmental Disabilities and Substance Abuse	Bob Hollowell	Dentist, Murdoch Center	roberthollowell@dhhs.nc.gov
Carolinas Mobile Dentistry	Ford Grant	Dental Director	Ford.Grant@carolinashealthcare.org

We are currently reorganizing our board to reflect our recent expansion.

Objectives/Rationale

How has the practice addressed HP 2020 objectives, met the National Call to Action to Promote Oral Health, and/or built basic infrastructure and capacity for state/territorial/community oral health programs?

HP 2020 –

Access Dental Care's primary mission is providing comprehensive dental care using our mobile equipment. Access barriers are removed by our trained dental team bringing emergency and routine dental services to our patient's age one year to 112. Due to the complex medical needs of the individuals that we treat, most have not received routine past care. The majority have significant oral problems and require extensive treatment. We do comprehensive and recall exams on all of our patients at least every six months. These exams include oral and pharyngeal cancer screenings, allowing early interception of potential lesions.

Another part of the mission includes education of both providers and consumers. Dr. Bill Milner and Betsy White lecture at the regional and national level about special care dental issues. Informed individuals and organizations create proactive allies supporting the special care agenda. We also invite dental practitioners to spend time with our clinical team, learning the hands-on aspects of taking care of older adults with special health care conditions. These providers become more comfortable with the unique practice environment and treatment of those with disabilities.

We are able to provide preventive services and oral health education to patients and caregivers, helping reduce the amount of caries and periodontal disease. Our comprehensive treatment model provides a convenient avenue for early interception of dental disease and extensive rehabilitation for those who have not been able to access care.

One of our greatest successes has been treating HIV patients at a regional hospital infectious disease clinic. Reducing infection and maintaining periodontal health has helped control their HIV viral loads. These patients are motivated to improve their daily oral hygiene routines, making them healthier individuals.

National Call to Action to Promote Oral Health

Access Dental Care primarily provides dental services on-site to adults in the nursing home or group home. (Community children are seen at a once a month community clinic site or in the hospital OR.) The presence of a dental team inside the building increases the oral health awareness. We are also able to educate the caregivers about the importance of dental care and its relationship to overall systemic health.

Dr. Milner and Betsy White are frequent lecturers to physicians, nurses, and direct care staff. We are able to update these practitioners on the association between oral health and general health, help them to recognize potential oral health issues during screenings and physical exams and to establish an interdisciplinary relationship between the medical and dental providers.

Access Dental Care's treatments are developed using science-based interventions that are appropriate for a special care populations. We have 13 years of treatment data that is available for research agendas. We consult with the Medicaid Dental Director on a regular basis. His office maintains data on all State long-term care providers, helping us determine the number and type of

services provided. This information will later be used to create legislation that defines standard of care for special care populations in North Carolina.

Access Dental Care has been identified by both state and national groups for its effective model and has been replicated five times within the state. The model has been proven to be financially stable while being an effective delivery model that breaks access barriers and has been effective in treatment and prevention of dental disease.

Access Dental Care has established an advocacy group representing the above public and private organizations. These partnerships are invaluable for legislative action and helping both dental and non-dental groups understand the importance of oral health to overall health.

Action 1 – Change Perceptions of Oral Health

Action 2 – Overcome Barriers by Replicating Effective Programs and Proven Efforts

Action 5 – Increase Collaborations

Extent of Use Among States

Describe the extent of the practice or aspects of the practice used in other states?

North Country Health Consortium, New Hampshire (www.nchcnh.org)
CareSouth Carolina, South Carolina (www.caresouth-carolina.com)
(Both operate multi-county delivery programs.)

Other states have used our advocacy materials. (No tracking is done.)