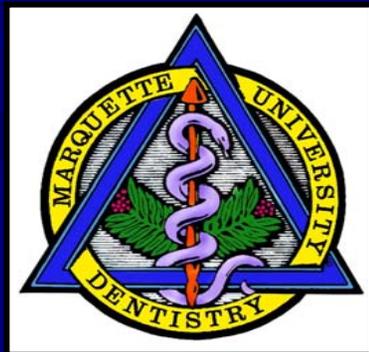


The Importance of Good Oral Care – Health and Legal Implications for LTC & AL Settings

DHFS Presentation/Webcast

Madison, WI

May 17, 2007



Presenters

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Marquette University School of Dentistry

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Shareholder
Reinhart Boerner Van Deuren, s.c.

Agenda

- Background – Issues affecting oral care and outcomes for the Elderly
- Federal & State Perspectives
 - Reimbursement and funding issues
 - Regulatory requirements
- Dental Care - For individuals in LTC and AL settings
- Possible Solutions – public & private
- Take Home Messages

Background

Issues affecting oral care and
outcomes for the Elderly

Aging Demographics: The “Senior Tsunami”

- **In 2006, 1 out of every 8 Americans is 65 or older**
- **The 2030 “doubling phenomena”**
 - **population over age 65 will double by 2030**
 - **population over age 85 will double by 2030**
 - **number of minority elders will double by 2030**
- **Most people over 65 have at least one chronic health condition (increasing burden on health care systems)**
- **Life expectancy continues to increase (additional 18 years after age 65)**

**United States Administration on Aging. Rockville, MD:
U.S. Department of Health and Human Services, 2000.**

Barriers to Oral Health for Older Adults

- **Finances**
- **Transportation**
- **Education/Awareness**
- **Systemic Health**
- **Social and Family Support Issues (Caregiving)**
- **Dietary and Lifestyle Factors**
- **Poor Oral Hygiene/Preventive Care Practices**
- **Shortage of Dentists**
- **Lack of Interpreter Services**

Current Status of Geriatric Oral Health: A National Crisis?

- **Oral Disease Burden in Older Adults:**
 - **Over 25% of 65-74 year-olds have severe periodontal disease**
 - **Over 50% of adults 65 years and older are edentulous**
 - **Oral/pharyngeal cancers are primarily diagnosed in the elderly (8,000 deaths annually, 5-year survival rate is only 35%).**
 - **Most elderly take many prescription and OTC drugs**
 - **individuals in long-term care facilities prescribed an average of 8 drugs**
 - **usually, at least one drug will have an oral side effect such as dry mouth**
 - **inhibition of salivary flow increases the risk for oral disease**
 - **5% of seniors 65 and older, 20% of those 85 and older, are living in long-term care facilities with inadequate dental care**

***Oral Health in America: a Report of the Surgeon General. Rockville, MD:
U.S. Department of Health and Human Services, 2000.***

Current Status of Geriatric Oral Health: A National Crisis?

- **Assessment of Current Environmental Conditions:**
 - oral health of older Americans in a state of decay (national report card reports an overall “D” grade and assigns failing or near failing grades to each state in all categories impacting on oral health, access to care, and quality of care; Wisconsin was given a “D” grade)
 - private dental insurance rates among older Americans are a national cavity (uninsured seniors have to pay out-of-pocket for all services other than those needed during life threatening or emergency situations)
 - many older Americans suffer in silence as their oral health and periodontal needs are neglected (oral disease is underestimated, ignored or not detected until far too late, resulting in increased morbidity/mortality)
 - elderly who receive oral care as part of their comprehensive healthcare are healthier and require fewer healthcare dollars as they continue to age
 - few dentists have any formal education/training in geriatrics/gerontology, few health professionals and paraprofessionals in other disciplines receive education/training regarding the importance of oral health to overall health

***A State of Decay: The Oral Health of Older Americans. Chicago, IL:
Oral Health America, 2003.***

Geriatric Dental Education: What is it?

- **Special knowledge, attitudes, technical skills required to care for older adults**
 - **classified by age (65 years or older) or functional categories (well, frail, disabled, functionally dependent, cognitively impaired, medically complex)**
 - **impact of social, psychological, interpersonal factors**
 - **polypharmacy and associated conditions**
 - **physical disabilities and cognitive dysfunction impact on compliance with instructions and care**
 - **technical procedures require modification due to medical conditions and age-related changes of oral tissues**
 - **older adults are retaining their natural teeth**
 - **transdisciplinary focus with emerging linkages between oral health and systemic health**

Workforce Issues

- **Few dental practitioners formally trained to meet the needs of elderly patients**
 - Approximately 100 faculty and 1,500 practitioners are currently needed
 - Approximately only 100 current trainees
 - By 2012, approximately 200 faculty and 5,000 practitioners with appropriate training will be needed
- **Current dental practice is “elective”**
 - Large graduation debt selects against geriatric practice
 - 25-45 year-old population dominates service profile
 - expensive elective and cosmetic procedures
 - procedures and patients are easy to manage
 - UCR fees covered by insurance/out-of-pocket supplementation
 - current incentive programs not effective for altering profile

Oral Health Services for Older Adults

- **Unlike children, few public health/policy interventions**
- **Unlike children, little data/effort regarding prevention**
- **Oral diseases have a disproportionate effect on the elderly**
 - **oral disease/systemic disease connections**
 - **cumulative nature of oral diseases**
 - **increased risk of the elderly for oral disease**
- **Medicare rarely provides coverage for dental services**
- **Medicaid is becoming increasingly limited**
 - **less than 35% of states provide any preventive and restorative coverage for adults**
 - **since programs are not mandated and states are facing budget exigencies, existing reimbursement rates are low**
- **Severity of access and disparities issues is far worse for disabled, homebound, and institutionalized elderly**
 - **most frequent cause of aspiration pneumonia is dental plaque around diseased teeth and poorly maintained dentures**

Lamster, Am J Pub Health 94: 699-704, 2004

Manski et. al., Am J Pub Health 94: 759-767, 2004

Service Utilization by Older Adults

- **Current oral health care delivery system for older adults predominantly accessed by dentate individuals with wealth or employer-sponsored insurance**
- **Edentulous and poor elderly are least likely to have dental coverage and dental visits**
 - 34% of all older adults had coverage in 1996, now less than 20%
 - only 43% had at least one dental visit in 1996, now less than 30%
 - average total expenditure per visit was \$428 in 1996, now over \$500
- **Retaining more teeth increasing their dental service needs while experiencing diminished capacity to access dental care due to loss of income and insurance coverage with upon retirement**
 - 75% increase in services and expenditures during the last 10 years
 - first wave of the “baby boom generation” comprising 77 million people will approach retirement age by 2010
 - middle-income elderly may be most affected by loss of coverage increasing risk for undetected oral disease including oral/pharyngeal cancer (35% five-year survival rate)

Manski et. al., Am J Pub Health 94: 759-767, 2004

Outcomes for Older Adults

- **Medicaid beneficiaries are more likely to access care than the uninsured (especially routine preventive care)**
- **Dental services adults receive in Medicaid are cost-effective**
- **Untreated oral disease complicates medical conditions like diabetes and heart disease and can jeopardize the health of Medicaid-eligible elderly and the disabled, disproportionately affecting health/well being of those living in LTC and AL**
- **Preventive and routine dental services save overall health care dollars by avoiding development and/or exacerbation of co-morbid conditions and costly visits to the emergency room (validated by CIGNA and Delta recent extension of preventive dental coverage for “high-risk” patients)**

Outcomes for Older Adults

GRAND ROUNDS in Oral-Systemic Medicine™

A Peer-Reviewed Journal



September 2006, Vol. 1, No. 3



**Alzheimer's Disease
and Periodontal Disease:
Mechanisms Underlying
A Potential Bi-directional
Relationship**

**Maintaining Oral Health
in the Aging Population:
The Importance of the
Periodontal-Systemic
Connection in the Elderly
(3 CEUs)**

**The Promise of
Transdisciplinary
Nurse-Dental Hygienist
Collaboration in Achieving
Health-Related Quality
of Life for Elderly
Nursing Home Residents**



Poor Access and Quality of Care



Federal and State Perspectives

- Reimbursement & Funding Issues
- Regulatory Requirements
- Risks

Dental Medicaid: Federal Perspective

- **Medicaid Coverage - for individuals age 21 and older:**
 - States may elect to provide dental services to their adult Medicaid-eligible population or elect not to provide dental services at all, there are no minimum requirements for adult dental coverage
 - Most states provide at least emergency dental services for adults, less than half of the states provide comprehensive dental care
 - Many state departments of health services find that fee-for-service benefits offer the most geographically expedient type of dental plan; states also frequently include various managed care provisions to ensure the maximum amount of program dollars are expended for appropriate services
 - Most elderly dental Medicaid enrollees are covered by fee-for-service programs, however, less than 8% received services last year

Dental Medicaid: Wisconsin Perspective

- **Joint federal and state program**
 - **Federal government provides approximately 60% of the funding and governs the basic structure of the program**
 - **Wisconsin required to provide 40% in matching funds and certain mandatory services, but has discretion regarding coverage of optional services and program administration**
 - **Adult dental coverage is optional**
 - **Dental exams and cleanings limited to one per year for adults, frequency of x-rays limited by type**
 - **Provider required to obtain prior authorization approval from the DHFS prior to the provision of many other dental services**

Dental Medicaid: Wisconsin Perspective

- **Fee for service provisions**
 - **All counties except for Milwaukee, Kenosha, Racine, Waukesha**
 - **Clients responsible for locating Medicaid-certified dentists and calling them to see whether they are accepting new patients**
 - **Current Medicaid reimbursement rates for dental services are approximately 46% of billed charges for adult dental services**
 - **Very few dentists accepting new patients**
 - **most that do place restrictions on admissions by patient age or place of residence and dismiss patients from their practice for missed appointments**
 - **Individual dentists submit claims to, and are paid by, the DHFS fiscal agent**

Dental Medicaid: Wisconsin Perspective

- **Managed care provisions**
 - **Milwaukee, Kenosha, Racine and Waukesha counties**
 - **Dental care for Medicaid recipients provided through health maintenance organizations (HMOs)**
 - **HMOs required to provide dental care within 90 days for a routine visit and within 24 hours for an emergency**
 - **HMOs have contracted with two dental managed care organizations that then negotiate with individual dentists**
 - **HMOs are paid a monthly amount per person for every Medicaid enrollee (capitation rate)**

Dental Medicaid: Wisconsin Perspective

- **Wisconsin received a “D” grade in overall elderly access to dental care from Oral Health America in 2003 (only 23% received any dental services)**
- **Only 40% of dentists participate, only 20% of dentists see any and all Medicaid patients**
- **Patients increasingly show up at Emergency Rooms for dental problems where no definitive treatment can be provided**
- **Low Medicaid fee reimbursement is major reason dentists limit participation (poor patient compliance, failed appointments, limitations in allowed treatment, and overwhelming paperwork burden are other reasons)**

Dental Medicaid: Wisconsin Dental Association Perspective

- **Represents 80% of all dentists in Wisconsin**
- **State has failed to prioritize oral health within growing list of entitlements of a large Medicaid program (dental services represent less than 1% of total budget)**
 - **Wisconsin spends more than most states on expensive medical services and nursing home medical care**
 - **If all proposed solutions were enacted, dental would be 5%**
- **Dentists are independent small businesses (would rather remain in control of charity care and free of contractual obligations, paperwork, and bureaucratic hassles)**

Federal Regulations

- Sec. 483.55 Dental Services: “The facility must assist residents in obtaining routine and 24-hour emergency dental care.”
- Sec. 483.55(a) Skilled Nursing Facilities:
 - A facility:
 - “Must provide or obtain from an outside resource, in accordance with sec. 483.75(h) of this part, routine and emergency dental services to meet the needs of each resident;
 - May charge a Medicare resident an additional amount for routine and emergency dental services;
 - Must if necessary assist the resident – in making appointments and by arranging for transportation to and from the dentist’s office; and
 - Promptly refer residents with lost or damaged dentures to a dentist.
- Makes the facility directly responsible for residents’ dental care needs

State Regulations - NHs

- **HFS 132.67 - Dental Services**
 - **HFS 132.67(1) - Advisory Dentist - The facility shall retain an advisory dentist to participate in the staff development program for nursing and other appropriate personnel and to recommend oral hygiene policies and practices for the care of residents**
 - **HFS 132.67(2) - Attending Dentists -**
 - (a) Arrangements for Dental Care - The facility shall make arrangements for dental care for residents who do not have a private dentist**
 - (b) Transportation - The facility shall assist the resident, if necessary, in arranging for transportation to and from the dentist's office**
 - **HFS 132.67(3) - Dental Examination of Residents - Every resident shall have a dental examination by a licensed dentist within 6 months after admission unless a dental examination has been performed within 6 months before admission; subsequent dental health care shall be provided or arranged for the resident as needed**
 - **HFS 132.67(4) - Emergency Dental Care - The facility shall arrange for emergency dental care when a resident's attending dentist is unavailable**

State Regulations – AL Settings

- No specific dental services requirements
- Requirements:
 - Monitoring health and making arrangements for needed health services (CBRF, RCAC, AFH)
 - Prompt and adequate treatment (CBRF, AFH)
 - Providing or arranging for transportation to appointments for medical appointments (CBRF, RCAC, AFH)
 - Assistance, as needed, with “grooming” or ADLs (CBRF, RCAC, AFH)

Legal Risks?

- Regulatory Risks: Out of compliance
 - Federal deficiencies and remedies
 - F411 Dental Services
 - F250 Social Services (“attain or maintain the highest practicable physical ... well-being of each resident”)
 - F500 Use of Outside Resources (adequate & timely)
 - State citations and enforcement actions for related deficiencies, e.g., prompt & adequate treatment, failure to arrange for or provide transportation to medical appointments

Liabilities for Lack of Access and Preventive Care?

PERIODONTAL DISEASE
HAS BEEN CONNECTED
SCIENTIFICALLY TO
THE FOLLOWING
SYSTEMIC DISEASES

+ Heart Disease

+ Diabetes

+ Premature Births

+ Stroke

+ Other Dental
Malpractice Issues

+ Other Medical
Malpractice Issues

+ Other Systemic
Diseases

LOCATION

Contact Mr. Smith at
800-990-7500
FAX Number is 480-990-7860

Smith Law Firm
4310 North 75th Street
Suite A
Scottsdale, AZ 85251

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Contact us today for a FREE
Case Evaluation!

FREE CASE EVALUATION

Contact David Burnell Smith,
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evaluation.

name	<input type="text"/>
address me as	<input type="text"/>
e-mail	<input type="text"/>
phone	<input type="text"/>
message	<input type="text"/>

Submit

EXPERIENCED ATTORNEYS

If you or someone you know had periodontal disease, diagnosed or undiagnosed, and either ignored or treated unsuccessfully, before or during the same time as any of the mentioned systemic diseases, you may be eligible for damages caused by these systemic diseases.

Please complete the contact information or phone my office for a free consultation. I am committed to providing you with the expertise necessary to meet your medical and dental malpractice needs.

At my law office, you, our client, comes first. We will do whatever is necessary to defend and uphold your legal rights.

PERIODONTAL DISEASE FACTS

- For Diabetics with severe periodontal disease, the mortality rate was 7.5 times risk over normal compared to diabetics with no periodontal disease.
- For Moms with severe periodontal disease, the pre-term, low birthweight, babies was 7.5 times risk over normal
- In a research group, the top 25% CRP participants had 2.5 times rate of colon cancer compared to the bottom 25% CRP group!
- In a research group, the top 1/3 in CRP values had twice the heart attack rate compared to the bottom 1/3 CRP group!

Legal Risks, cont'd

■ Civil Liability: Equal Access (> 20 States)

■ New Hampshire 2004: Class action lawsuit on behalf of 58,000 Medicaid recipients under age 21

- Consent decree – 5 yrs: State must spend \$1.2 million each year – may be matched by Federal dollars – to ensure children get dental care

■ Pennsylvania 2004: Class action lawsuit on behalf of disabled individuals who alleged that they were denied access to dental services by the policies and procedures of the state's Public Welfare Agency because the State:

- failed to provide them with medically necessary dental services;
- failed to provide dental services with reasonable promptness,
- failed to take necessary steps to ensure equal access to dental services for MA recipients;
- failed to ensure that children receive early and periodic screening, diagnostic and treatment services in the form of dental care.

Legal Risks, cont'd

- Dental Malpractice— *Judith Tice v. Steven Heald, DDS, Michigan 2006*
 - 60 yr old patient regularly seeing dentist
 - Increasing problems of bleeding gums and loose teeth
 - Dentist liable for failing to either diagnose or treat the progressing periodontal disease, resulting in extraction of all of patient's maxillary teeth
 - Patient awarded \$300,000 by arbitrator
- Wrongful Death – Patient swallowed partial denture; lodged above vocal cords. Not discovered for weeks, despite complaints, signs and symptoms (difficulty swallowing, infection in throat, congestion with cough). Died shortly after surgery. Case settled.

Popular Press: Mobilizing the Masses

INVESTORS	SAVINGS	SOCIAL SECURITY
Too Smart for Your Own Good P.23	The Magic of Autopilot P.20	Not Dead Yet? So Prove It P.3

AARP Bulletin

www.aarp.org/bulletin Vol. 47 No. 8 SEPTEMBER

OPERATION IDENTITY THEFT
'I Was Billed For a Stranger's Surgery' P.22

PART D UPDATE
Company Plan Winners & Losers P.26

Why Isn't This Man Smiling?
50+ America's growing dental epidemic P.14

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AARP Bulletin CRACKDOWN
Why the Feds Are Seizing Your Canadian Drugs...

Nothing To Smile About

Too few Americans get oral health care, spawning a silent epidemic of dental disease

By Carole Fleck

Marie Burton craves chilled watermelon and other cool fresh fruit, but she can't eat them. Carrot are a favorite, and she adores a cut of steak, but she can't eat either. Hard, chewy or crunchy cuisine is a pain for Burton because her teeth hurt so much—at least the ones she has left. They're wiggly, broken and sore.

"I have teeth missing, and the teeth I have left ache," says Burton, 59, of Westport, R.I. "I get this bad taste in my mouth all the time, and my stom-ach is upset. I can't eat sometimes because I feel nauseous."

Burton has consulted with local dentists, but the dental plan provided by her employer, R.L.I., a quality control inspector, is extremely limited. She says she can't afford the \$2,000 "up front" to fix her missing teeth. So she stays home and socializes by her appearance. "I don't like looking in the mirror or in the car unless I have to," says a soft-spoken mother of three.

She doesn't like to smile or open her mouth. "It's awful," she says.

Like Marie Burton, millions of Americans have little or no dental care. An estimated 108 million have no dental insurance, more than twice the 46 million without health insurance. About three-quarters of people 65 and older are not in a dental plan.

The lack of access to affordable oral health care has long been ignored in the United States. But the problem is likely to get more attention as boomers retire in droves and lose their employer-provided dental benefits—and as evidence mounts that poor oral health may cause or worsen serious medical problems such as diabetes and cardiovascular disease.

A growing number of studies indicate that bacteria from chronic gum infection can travel through the bloodstream to the heart and other organs. Researchers are also exploring the connection between gum disease and inflammation elsewhere in the body: If the lining of the arteries becomes inflamed, blood clots can form and cause a heart attack.

In one study, researchers from Columbia University's College of Dental Medicine and the Aetna insurance company tracked 145,000 Aetna subscribers with diabetes, coronary artery disease or stroke. They found that medical costs for those conditions were lower among subscribers who had sought early treatment for periodontal disease.

"The way the health care system functions, one might think the mouth isn't connected to the whole body," says William Maas, director of the division of oral health at the U.S. Centers for Disease Control and Prevention. "Dental care is just as important as medical care, hospital care and...

scription drugs," Maas says. "It is inconsistent for society to recognize that oral health is important yet treat dental care as if it were discretionary."

A National Toothache
 In May 2000, U.S. Surgeon General Davidatcher, in the first-ever report on oral health by the nation's top doctor, called dental disease "a silent epidemic" among older people and children. The report cited a lack of insurance or the inability to pay as barriers to care.

Since then, not much has changed in the private or public sector to improve access to affordable dental care. Older Americans are still disproportionately affected because retirees no longer have dental insurance provided by employers and often live on fixed incomes.

Medicare, which primarily benefits people age 65 and up, does not provide dental coverage except in rare circumstances—such as surgery to treat oral injuries sustained in a car wreck. Medicaid, the federal-state health program for low-income people, provides a...

Smoking may lead to more than half of all cases of gum disease among American adults.

SOURCE: CENTER FOR THE ADVANCEMENT OF MEDICINE

Dental Care for Residents

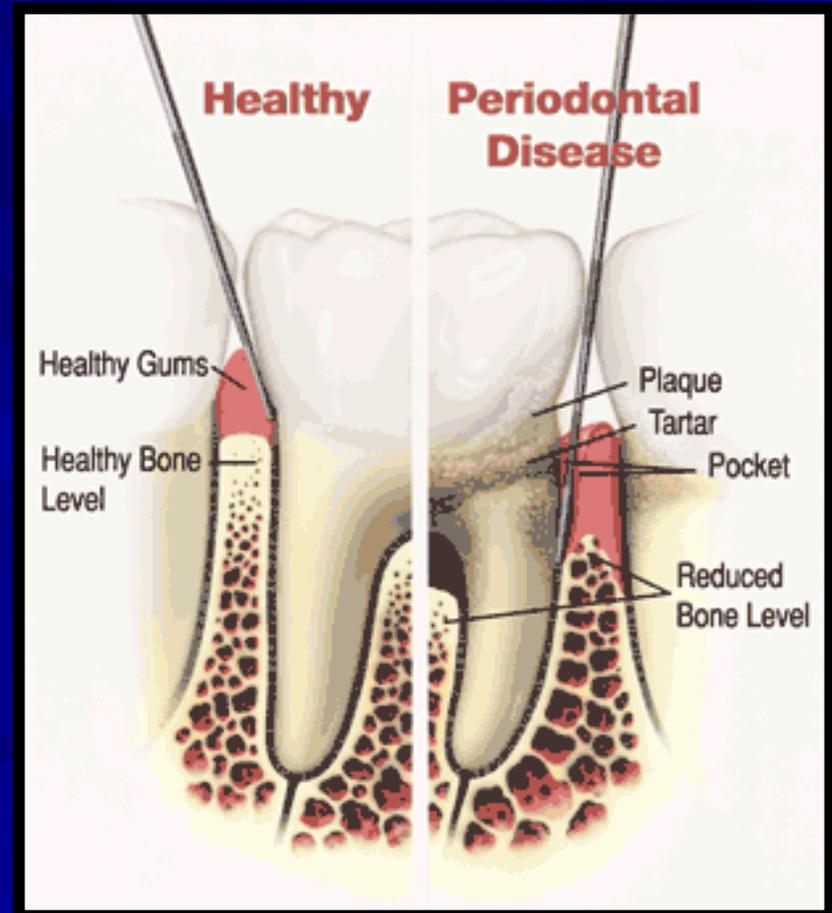
Nursing Homes and
Assisted Living Settings

LTC and AL Dental Concerns:

- 1. What is the ability of the patient to cooperate during a dental exam/treatment?**
- 2. How do you perform an effective evaluation of the dental condition?**
- 3. What type of dental problems are likely to be seen in patients with poor oral care?**
- 4. What is the most effective way to manage behavior if extensive treatment is needed?**
- 5. What should be the long-term prevention plan (oral hygiene program) given associated conditions and present living situation?**
- 6. Very important to teach caregivers (family and/or LTC and AL staff) about denture and oral health care. They can be the primary oral health providers in LTC and AL settings.**

The Holy Grail!

**All health professionals
and caregivers can be
trained to distinguish
between healthy and
diseased oral tissues
activating dental
referral networks**



Normal (Healthy)

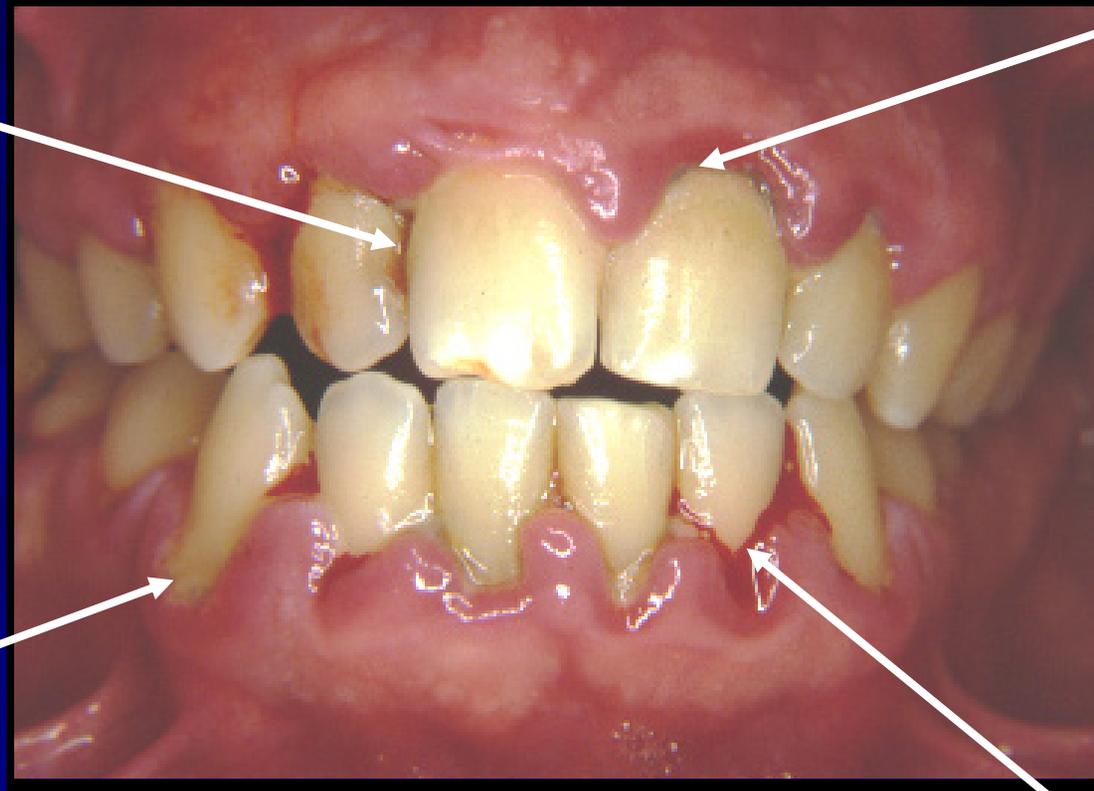


Normal Teeth and Gingiva (Age 63)

Mild Gum Disease (gingivitis)

bacterial
plaque

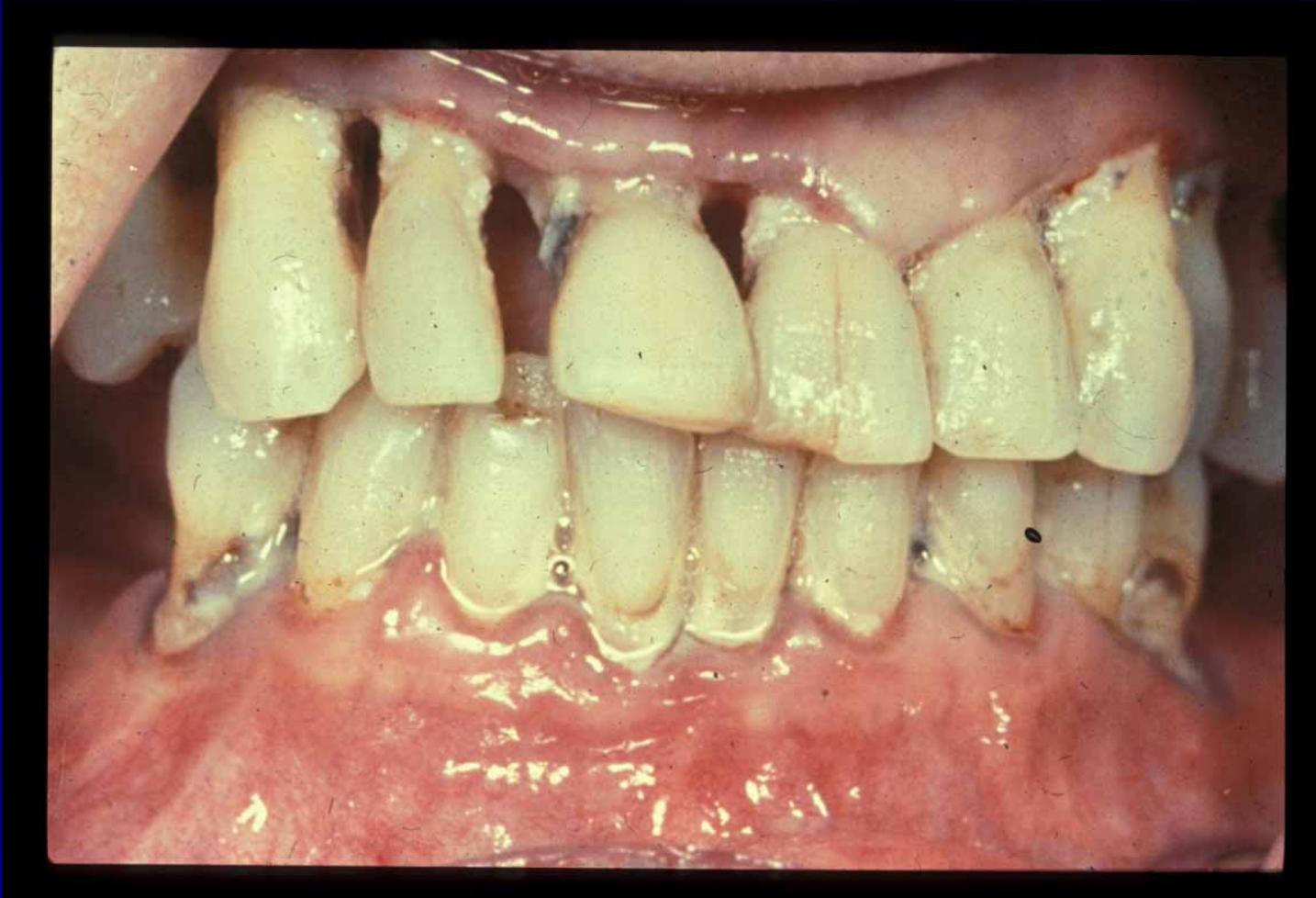
tartar



recessed
gums

bleeding gums

Severe Gum Disease (periodontitis)



Periodontal Changes



Gingival recession



Plaque, recession, and tooth loss



Gingivitis with poor oral hygiene

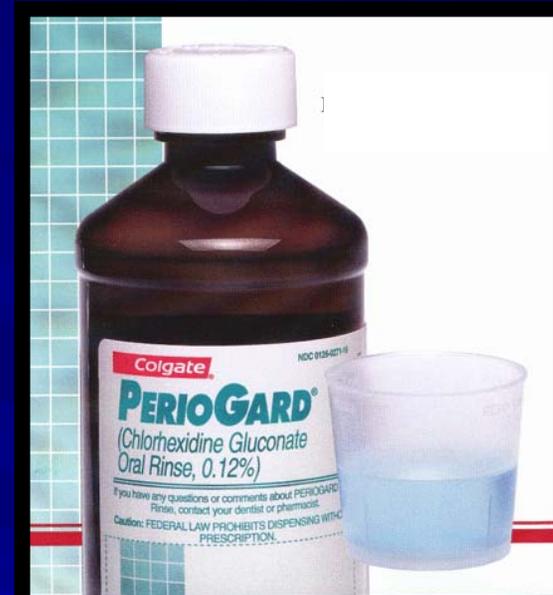
Risk Factors for Gum Disease

- **Inadequate plaque removal**
- **Diabetes mellitus**
- **Smoking**
- **Poor nutrition**
- **Genetics**
- **Immune status**

Preventing Gum Disease

- **Effective daily brushing/flossing and antimicrobial mouth rinses**
- **Smoking cessation**
- **Nutritional counseling**
- **Address systemic diseases/conditions**
- **Regular dental visits**

Antimicrobial Rinses



Alcohol-Free Antimicrobial Rinses



For those with dry mouth

Relationship Between Periodontitis and Systemic Diseases/Conditions

- **Respiratory disease**
- **Arthritis**
- **Stroke**
- **Heart disease**
- **Alzheimer's disease**
- **Diabetes**

Root Caries

- **Risk Factors**
 - **Gingival recession**
 - **Physical disabilities**
 - **Existing restorations or appliances**
 - **Decreased salivary flow**
 - **Medications**
 - **Cancer therapy**
 - **Low socioeconomic status**



Root Caries

- As gums recede, roots are more exposed and vulnerable to caries
- Desensitizing toothpaste or fluoride gel can reduce future caries and sensitivity
- Restoration or extraction is required



Factors Contributing to Root Surface Decay

- **Gum recession**
- **Poor oral hygiene due to physical and/or cognitive limitations**
- **Dry mouth (xerostomia)**
- **Frequent snacks between meals and beverages high in sugars**

Prevention of Tooth Decay

- **Plaque control**
 - brushing and flossing
 - mouth rinses (chlorhexidine)
- **Use of fluorides (rinses, gels, varnishes)**
- **Dietary education (avoid frequent snacks and beverages high in sugars)**
- **Consider salivary substitutes for dry mouth or if salivary flow is reduced**
- **More frequent dental examinations**

Topical Fluorides

- **Self-applied: toothpastes, mouth rinses**
- **Professionally applied: gels, varnishes, fluoride-releasing restorative materials**



Oral Care: Who is Responsible?



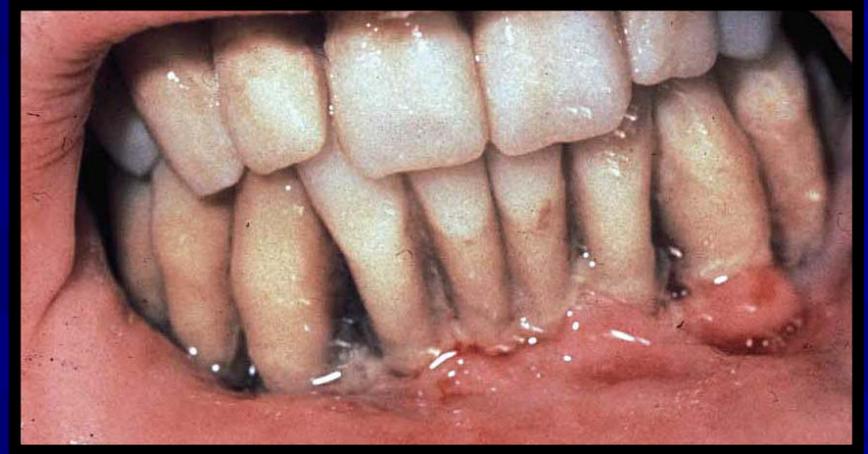
Systemic Conditions and Oral Health

- **Dementia**
 - oral hygiene often neglected
 - hard to localize oral pain
- **Arthritis**
 - impaired manual dexterity leads to poor oral hygiene
- **Osteoporosis**
 - accelerates tooth loss
 - increases frequency of denture replacement
- **Xerostomia**
 - accelerates decay and periodontal disease
 - higher risk for fungal infections
- **Cancer**
 - can occur in the mouth
 - treatments have oral complications

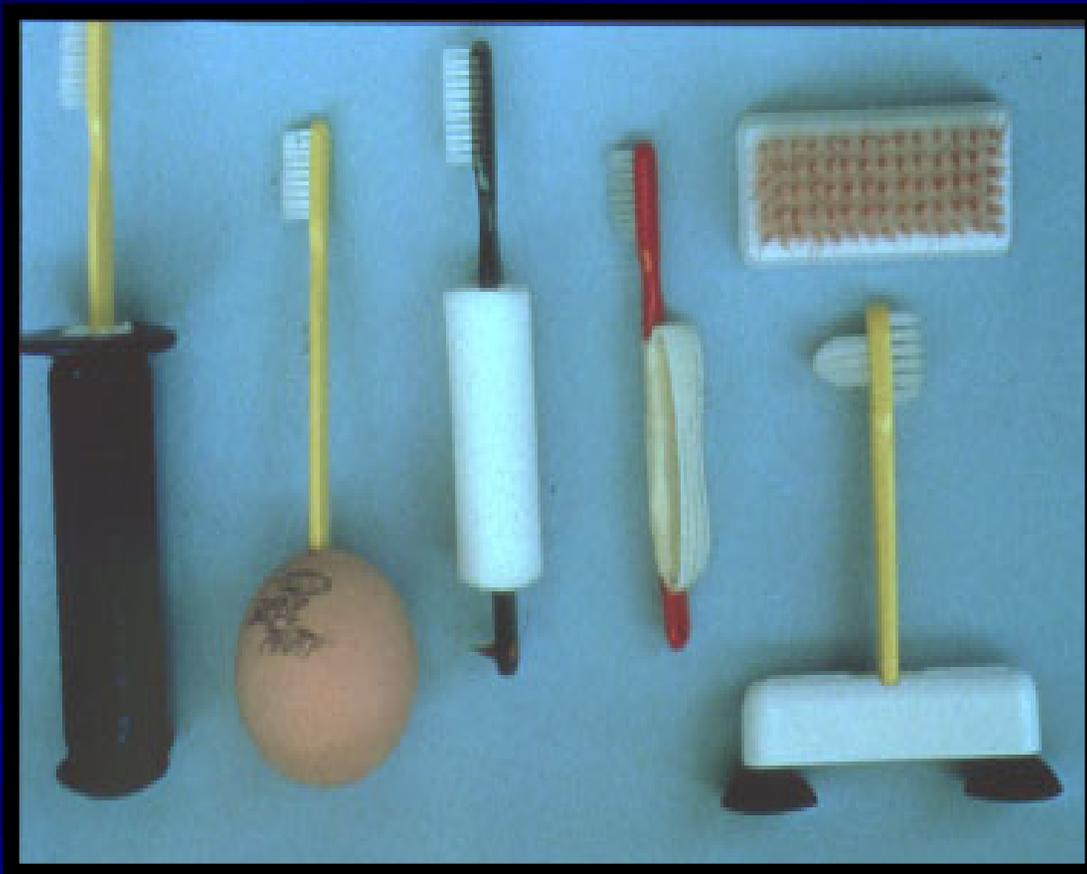


Systemic Conditions and Oral Health

- **Nutritional Status**
 - affects periodontal condition
 - oral signs/symptoms
- **Immunosuppression**
 - higher risk for fungal infections, viral infections, oral ulcerations
- **Diabetes**
 - accelerates periodontal disease
 - higher risk for fungal infections
 - periodontal disease impacts glycemic control



Modified Brushes

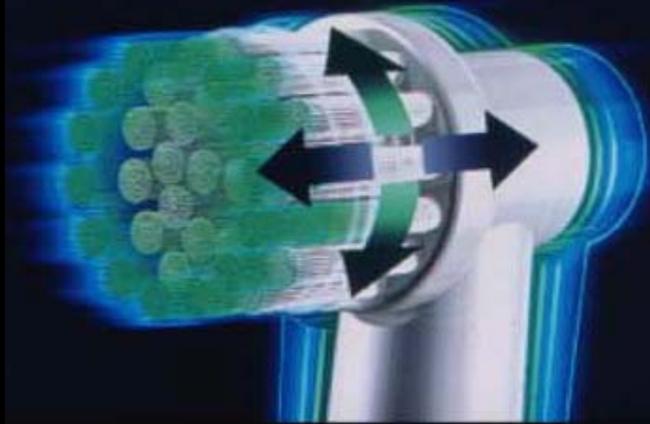


Electric Toothbrushes



FlexiSoft bristles

- Located in centre of brush head
- Crimped to give softer feel
- Move back under pressure
- Support penetration of Interdental Tips



Other Helpful Products



Special toothbrushes
for use by caregivers



Interproximal Cleaners

Dental Erosions

- Gastric acid erodes dentin and enamel
- Causes: GERD, bulimia, citrus products
- Teeth become smooth and glassy
- Pulp exposure causes hot and cold sensitivity
- Rinse with water after reflux or vomiting



Dry Mouth



Functions of Saliva

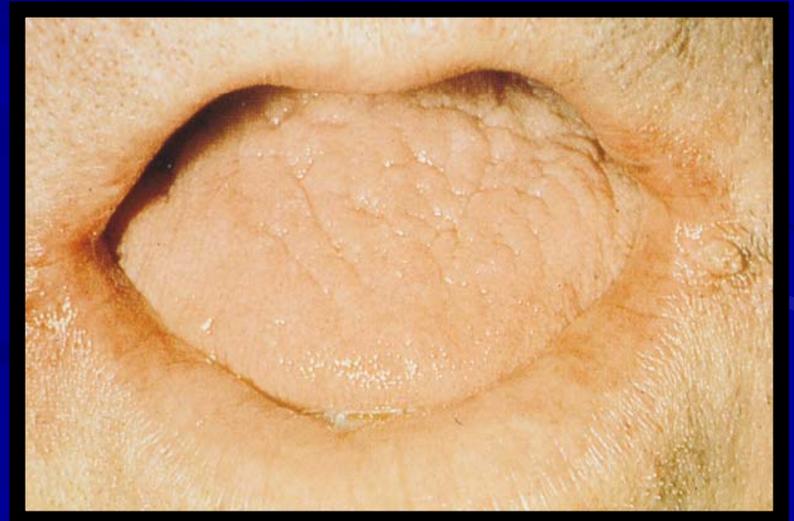
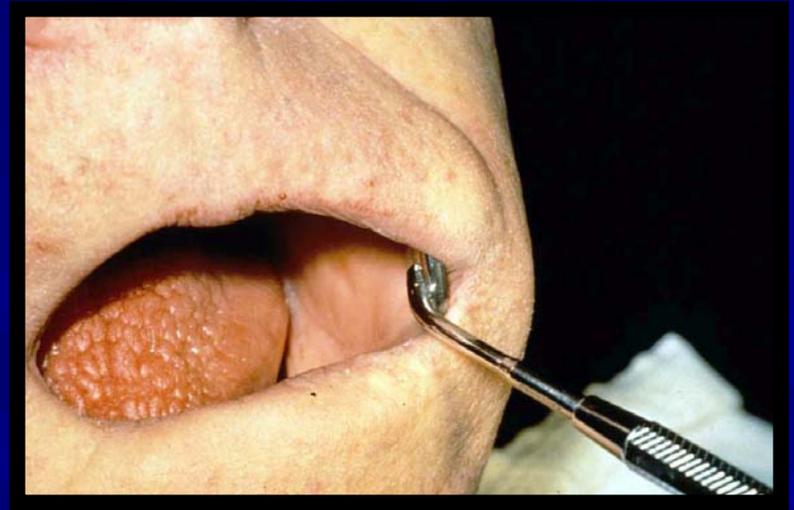
- **Lubrication**
- **Buffering microbial acids**
- **Cleansing**
- **Antimicrobial**
- **Swallowing**

Causes of Dry Mouth

- **Side-effect of medications**
- **Diseases and disorders (Sjögren's syndrome, diabetes mellitus, depression)**
- **Radiation therapy to the head and neck**
- **Menopause**
- **Local factors (infections of salivary glands, obstructions)**
- **Eating disorders and dehydration**

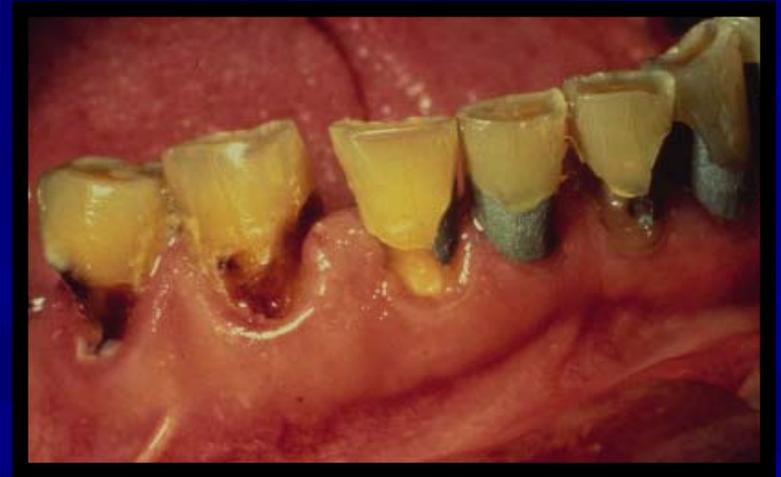
Dry Mouth: Signs and Symptoms

- Dryness of oral tissues
- Difficulties with speaking, eating dry foods, and swallowing
- Increased thirst
- Difficulty in wearing removable dentures
- Increase in fungal infections



Dry Mouth: Signs and Symptoms

- Rapidly increased dental decay rates
- Decay in places normally not susceptible
- Increased plaque accumulation
- Increased periodontal disease



How to Manage Dry Mouth

- **Change in medications or dosages**
- **Stimulation of salivary glands (sugar-free gums, lozenges)**
- **Salivary substitutes**
- **Meticulous oral hygiene**
- **Non-alcohol antimicrobial mouth rinses**
- **Fluoride therapy to prevent tooth decay**
- **Frequent dental examinations**

Salivary Substitutes

- Over the counter
- Lubrication of oral tissues
- No antibacterial properties
- Not all products contain fluoride
- Can be used as needed
- Provide antibacterial protection and long-lasting relief of dryness



Fungal Infections (Candidiasis)

- Common in immunocompromised or malnourished elderly
- Usually asymptomatic but may cause burning
- Angular chilitis at corners of mouth can be very painful
- Treatment is topical or systemic antifungal agents



Oral Ulcerations

- Aphthous
- Traumatic
- Viral
- Bacterial
- Drug reactions



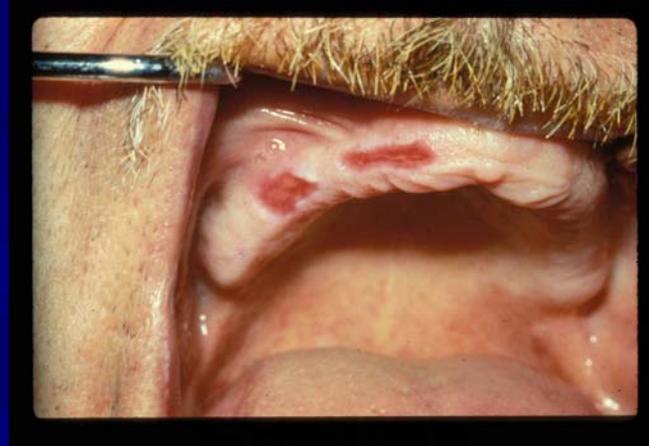
Oral Cancer: Common Locations



Denture Related Problems



Loose Denture



Denture Sores



Denture Stomatitis

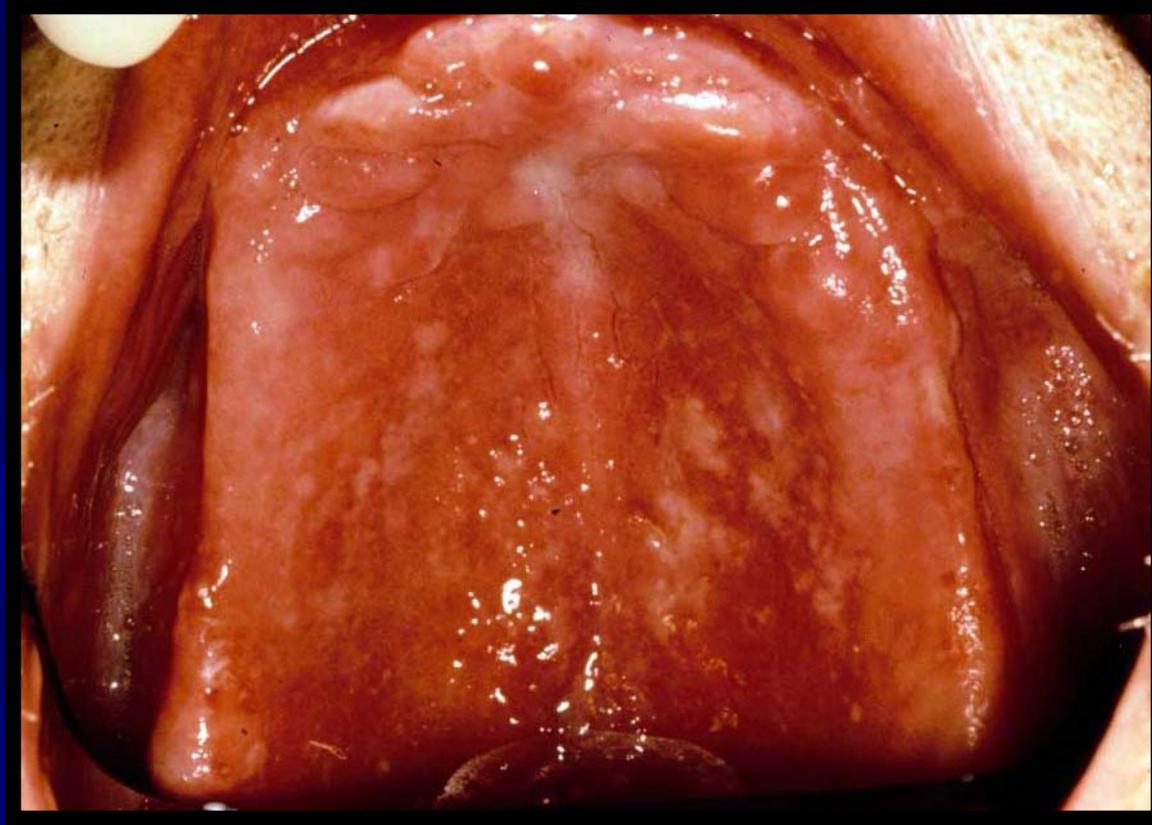


Papillary Hyperplasia



Epulis Fissuratum

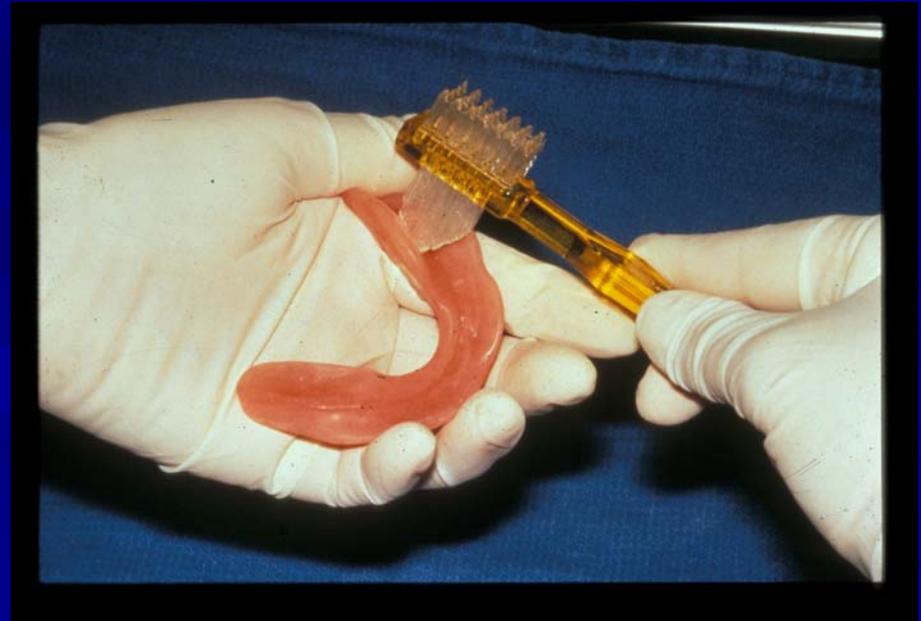
Denture Stomatitis: Causes



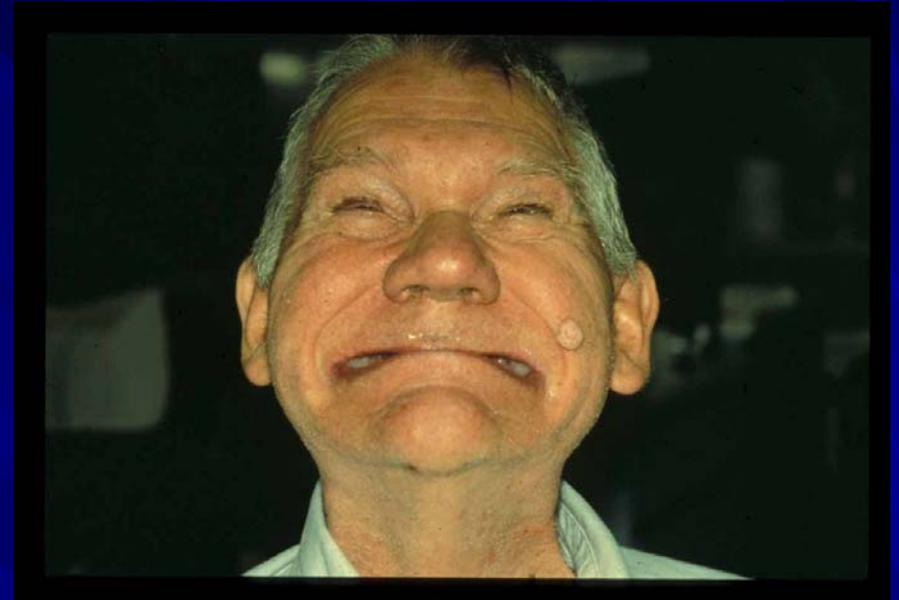
- Fungal infection (*C. albicans*)
- Poor denture hygiene, denture fit, nutrition
- Immunosuppression
- Wearing dentures continuously day and night

Denture Stomatitis: Treatment

- **Daily denture cleaning**
- **Wear dentures only during the day**
- **Rinse mouth with Nystatin**
- **Soak dentures in Nystatin mixed with water**
- **Address denture fit (reline) and systemic issues**



Waiting for Solutions



**The Issues
Have Faces**

Potential Solutions: Wisconsin Legislature

- **Legislative proposals**
 - **change licensure procedures to make it easier for dentists from other jurisdictions to obtain a license (increases number of dentists but assumes these dentists will behave differently)**
 - **allow dental hygienists to practice in a variety of settings without a dentist in the facility and without a prescription from a dentist if the dental hygienist meets additional experience and educational requirements**

Potential Solutions: Wisconsin Legislature

- **Legislative action (recently approved, *objection)**
 - Medicaid will pay for the following services provided by a hygienist without dentist diagnosis:
 - **preliminary exam and oral assessment**
 - prophylaxis
 - topical fluoride, sealants
 - **scaling and root planning**
 - **full mouth debridement and periodontal maintenance**
 - The hygienist must be employed by or independently contracted with:
 - public or private schools
 - dental or dental hygiene schools
 - city or county public health departments

Potential Solutions: Governor's Committee on Access

■ Proposals

- increase Medicaid reimbursement rate to 75th percentile of fees from American Dental Association fee schedule for the Midwest region (increased participation in other states)**
- provide reimbursement for two dental cleanings per year**
- provide coverage under the state's "Healthcheck" program for fluoride varnish treatment**
- require DHFS to reduce prior authorization requirements and to simplify the process for obtaining prior authorization**

Potential Solutions:

Governor's Committee on Access

■ Proposals

- increase funding for health care provider loan forgiveness programs with eligibility for loans linked to serving minimum number of unduplicated number of Medicaid recipients**
- provide funds for community health centers to expand provision of dental services for older adults**
- provide funding for one public health dental professional in each of the five DHFS regions, to provide dental care outreach activities and direct services to the Medicaid population**

Potential Solutions:

Governor's Committee on Access

■ Proposals

- Increase number of tuition subsidy for Wisconsin students from 40 to 50 in each future class at the Marquette University School of Dentistry
- \$20 million annual increase in state funding to increase the dental reimbursement rate (funded through soda tax)
- DHFS to contract with a specialized dental benefits administrator for claims processing, customer service, and maintenance of a dental provider network (include enforceable benchmarks regarding utilization/access targets and customer outreach/education)

Potential Solutions:

Governor's Committee on Access

■ Proposals

- develop a DHFS complaint form for use by current HMO dental system patients who are unable to access dental care in the contractually required timeframe**
- develop patient education materials/programs to encourage proper behavior and responsible use of Medicaid system**
- establish advanced practice dental hygienist education program in Wisconsin**
- activate retired dentists so they can participate in strategies to improve oral health in their communities**
- DHFS to be more proactive in informing family practitioners about integrating oral health into all health care practices**

Potential Solutions: Wisconsin Dental Association

- **Recently created a low cost dental care program called Donated Dental Services**
 - **to be eligible, an individual must be permanently disabled, critically ill, or elderly and the condition must be severe enough to prohibit or limit gainful employment**

Potential Solutions: Wisconsin DHFS

- **Added Recipient Ombudsman to assist patients seeking a dentists and to develop list of dentists who are accepting new patients**
- **Has made efforts to reduce paperwork burden by adopting the American Dental Association claim form**
- **Added specialized claims staff to reduce claims denials**
- **Rule change to reduce the number of services requiring prior authorization effective September 1, 2006**
- **Developed an “urgent care” form for non-certified dentists who provide emergency care to Medicaid clients**
- **Recently bid Medicaid fiscal agent contract will allow for several technical improvements including eligibility verification via the Internet**

Potential Solutions:

Marquette University School of Dentistry

- **Free screenings, referrals for low cost/free care**
 - **Milwaukee County Department on Aging**
 - **Greater Milwaukee Dental Association**
- **Annual consensus conference**
 - **national/international experts**
 - **interdisciplinary**
 - **professional and consumer brochures**
- **Geriatric Oral Health Website**
 - **interdisciplinary**
 - **professional and consumer sections**
 - **continuous expansion and improvement**

Potential Solutions:

Marquette University School of Dentistry

- **Comprehensive 4-year curriculum**
 - interdisciplinary
 - didactic and clinical components (grand rounds)
 - virtual aging patient CD-ROM
 - extramural rotations (**Village at Manor Park**)
- **Geriatric Dentistry Study Club**
 - interdisciplinary
 - statewide locations
- **Training programs for LTC and AL settings**
 - nurses and medical residents
 - screening examinations and preventive approaches

Potential Solutions:

Marquette University School of Dentistry

- **Caregiver Identification Program**
 - **trains dentists and office staff to identify caregivers**
 - **provides caregivers with oral health education and training**
 - **encourages dental office to become more engaged in aging issues and community-based programs**
 - **facilitates dental office/community partnerships**
 - **improves quality of life for caregivers and older persons**

Dental Medicaid: Wisconsin Contacts

- **Dr. Robert Dwyer, Program Administrator**
 - **608-264-6754**
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 - **snydea@dhfs.state.wi.us**

Take Home Messages

What Can You Do?

- **Examine gums, teeth, and surrounding soft tissues, including removing dentures**
- **Be alert for caries, periodontal disease, and common oral lesions**
- **Consider oral-systemic linkages, including oral effects of disease and medications**
- **Counsel appropriate oral preventive practices**
- **Collaboratively manage patients with family members, LTC/AL staff, and health professionals**
- **Transdisciplinary care with integrated preventive measures**

And remember...

Don't forget to **FLOSS!**

Comments, Questions, or Concerns?

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