



Center *for* Rural Health

Dentists Providing Oral Health Care to Long Term Care Residents

Survey Chartbook & Four North Dakota Case Studies

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The Center for Rural Health

The Center for Rural Health (CRH), established in 1980, is one the nation's most experienced organizations committed to providing leadership in rural health. The CRH mission is to connect resources and knowledge to increase the health status of people in rural communities. The CRH serves as a resource to health care providers, health organizations, citizens, researchers, educators, and policymakers across North Dakota and the nation. Activities are targeted toward identifying and researching rural health issues, analyzing health policy, strengthening local capabilities, developing community-based alternatives, and advocating for rural concerns. Although many specific activities constitute the agenda of the Center, four core areas serve as the focus: (1) education and information dissemination; (2) program development and community assistance; (3) research and evaluation; and (4) policy analysis. The CRH is also home to six national programs.

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Executive Summary

In August 2016, research staff at the CRH were contracted by the North Dakota Department of Health (DoH) Oral Health Program to complete an assessment of oral health services among long term care facilities (LTC) in North Dakota. This research included an evaluation of LTC facilities participating in the LTC Oral Health Program, a survey of North Dakota LTC facilities and their respective oral health policies and care practices, and assessment of dental providers' perceptions of geriatric oral health. Data from a previous survey developed and disseminated by the North Dakota Dental Association (NDDA) in 2015 indicated that there were 37 dentists in the state providing care for LTC residents. CRH research faculty surveyed those dentists working with LTC residents to identify best practices. The survey also identified providers for case study. This report includes the findings of the survey, published in March 2016 and the analyses of four case studies completed in July 2016.

Key Findings

- Of the 37 eligible dentists, only 15 responded to the NDDA's request to complete the survey.
- Only two dentists had taken specific training or continuing education on geriatric dental care.
- The most significant barrier to providing oral health care services for LTC residents included availability of suitable dental treatment space and equipment in the LTC setting.
- Oral health services provided in LTC facilities rely heavily upon the volunteer work of the dental team and the tradition of serving the members of their rural communities
- Reimbursement and cost are the major barriers for the expansion of services.

Dental Survey

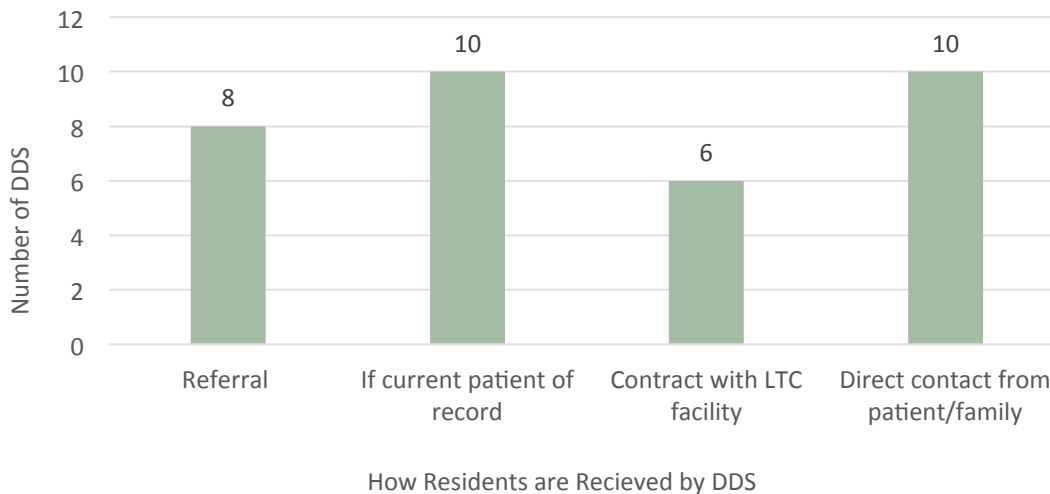
CRH research faculty and staff developed a survey to disseminate among 37 North Dakota dentists who had previously identified providing oral health care to LTC facilities in the state. The electronic survey was reviewed and approved by the University of North Dakota's Institution Review Board, and was developed in partner with the North Dakota Dental Association (NDDA), the North Dakota Long Term Care Association (NDLTCA) and the State DoH. The electronic survey and cover letter were emailed to the 37 eligible dentist by the NDDA. Two additional reminder emails were sent by the association as well.

Results

Of the 37 eligible dentists, 15 responded to the North Dakota Dental Association's (NDDA) request to complete the survey. Of the 15 dentists that responded, only 13 were providing oral health services or consultation among LTC residents. Care was most commonly provided in the dental clinic (12/13) while only 5 of the 13 providing care did so in a LTC facility. The five providing care will be invited to share more information for case study and identification of best practices that will then be disseminated among other dental providers in North Dakota.

Responding providers indicated that LTC residents gained access to their oral health care services in a variety of ways. Of the 13 providing care, 10 received patients through direct contact from the patient or the patient's family. Only six received patients through contract with LTC facilities. See Figure 1.

Figure 1. How Dentists Receive LTC Residents as Patients (n=13)

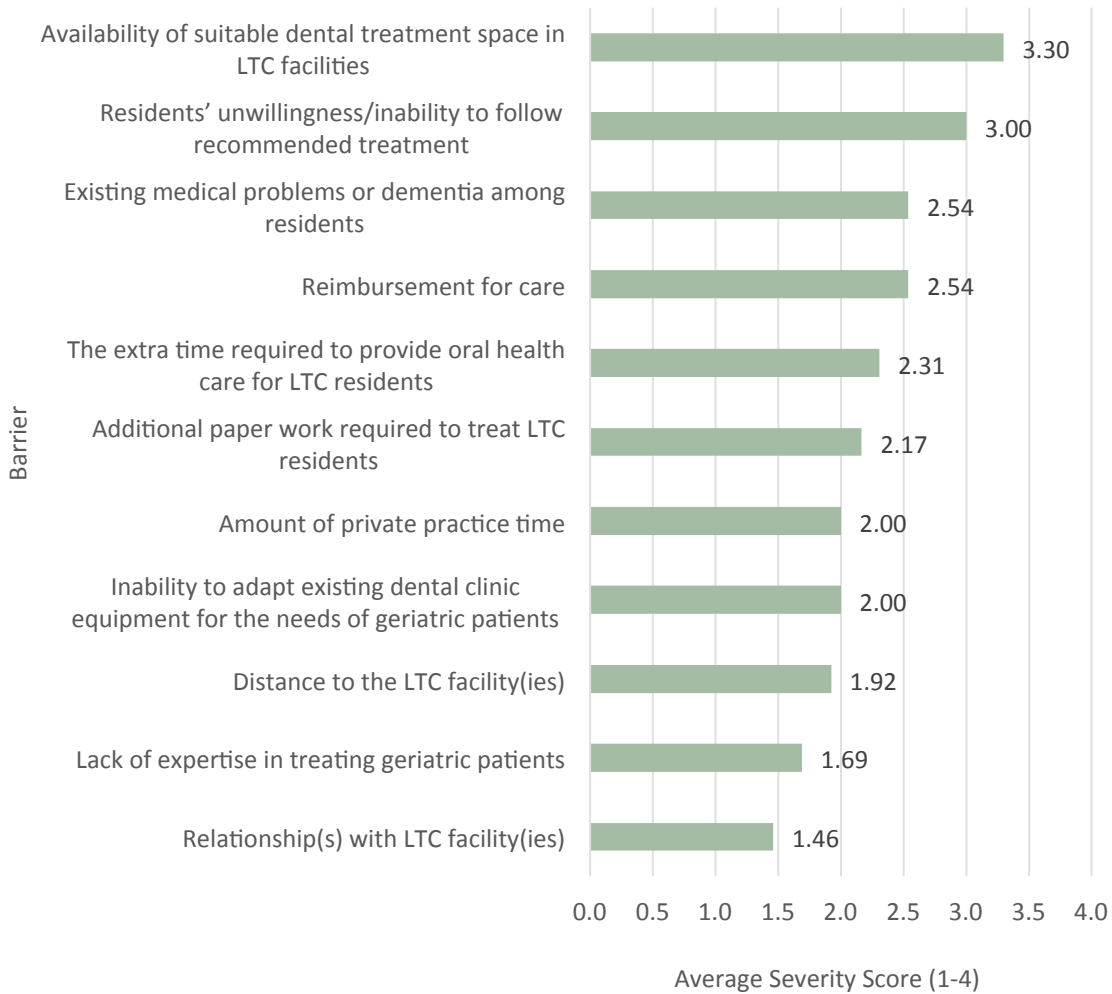


The care provided by the 13 responding dentists was most commonly (11 of 13) non-emergent, not consultation (1/13). Non-emergent care included routine visits, periodic exams, preventive services, basic restorative dental services without acute or chronic pain such as a filling, orthodontics, or periodontics. No dentist provided emergency oral health services to LTC residents; emergent care was defined as care required as result of acute or chronic pain.

Only two dentists had taken specific training or continuing education around geriatric dental care.

The most significant barrier to providing oral health care services for LTC residents among the 13 respondents included availability for suitable dental treatment space and equipment in the LTC setting. Barriers were rated on a scale of 1-4 (1 = not a problem; 2 = minor problem; 3 = moderate problem; 4 = serious problem). Figure 2 presents the average severity of each barrier in rank order.

Figure 2. Barriers to Providing Oral Health Care to LTC Residents: Average Severity



The remaining figures (Figures 3-13) present each of the above barriers with the number of respondents (n=13) that indicated if that particular barrier was: not a problem; a minor problem; a moderate problem; a serious problem; or, if the respondent did not know. The figures are presented in the rank order of problem severity as presented above.

Figure 3. Availability of Suitable Dental Treatment Space and Equipment in LTC Facility

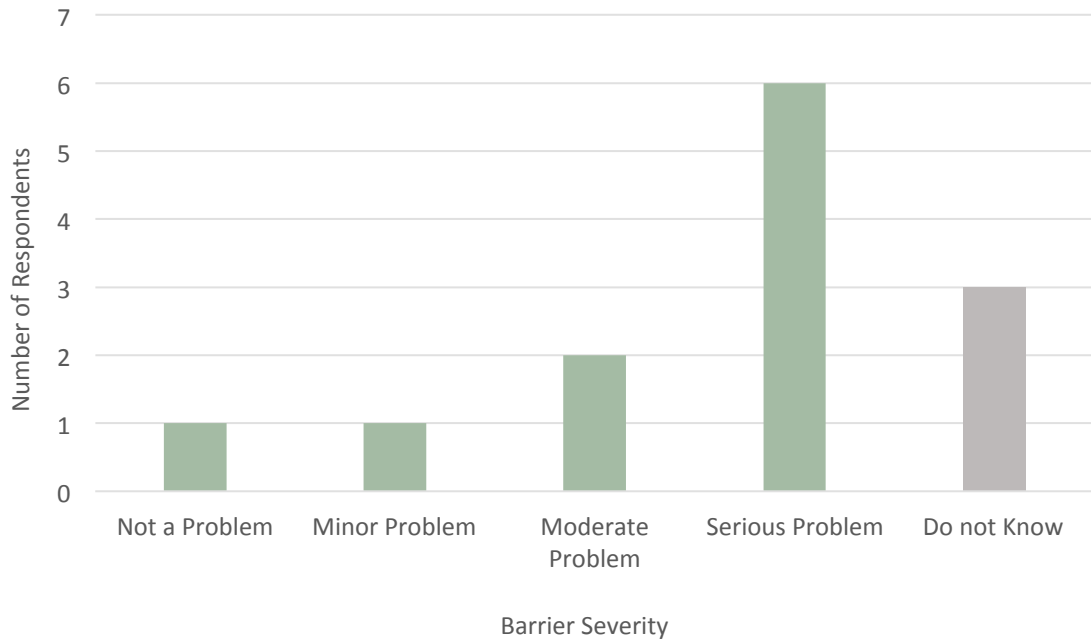


Figure 4. Residents Unwillingness/Inability to Follow Recommended Treatment

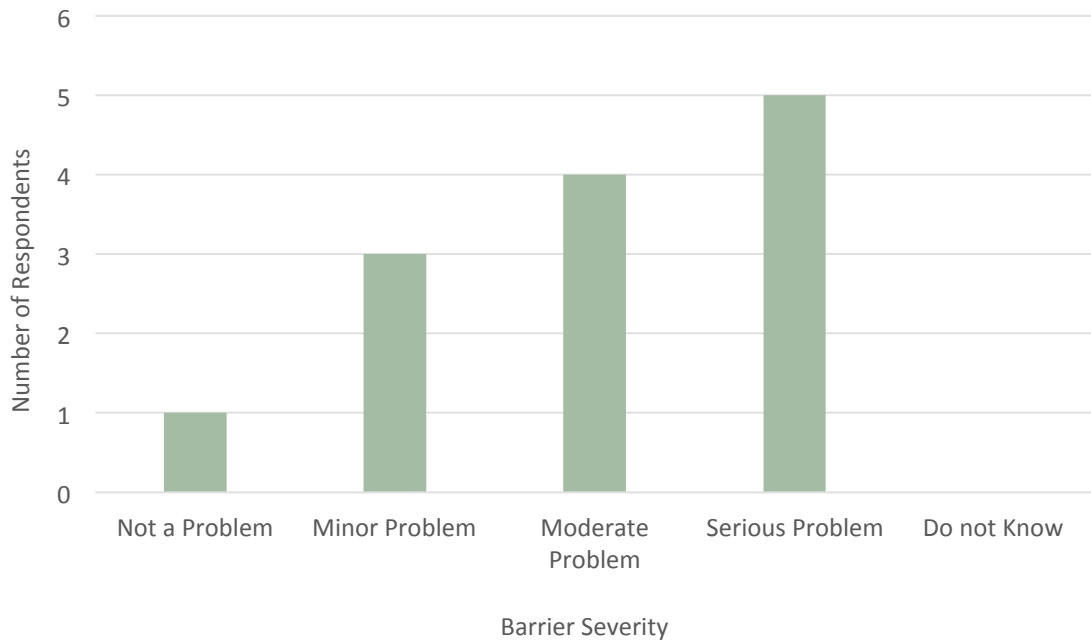


Figure 5. Existing Medical Problems or Dementia among Residents

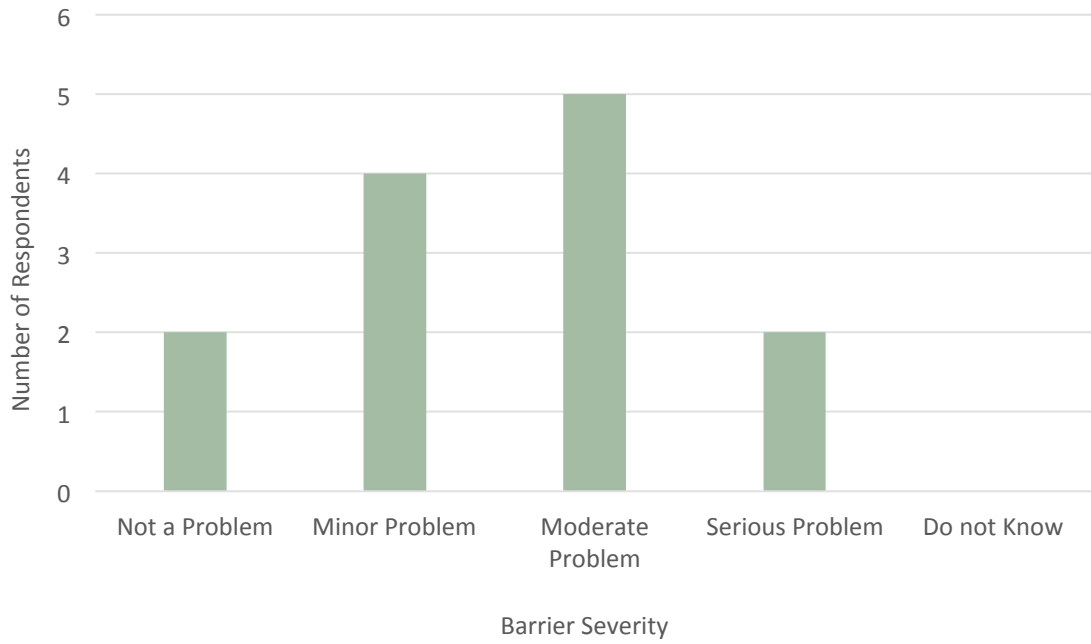


Figure 6. Reimbursement for Care

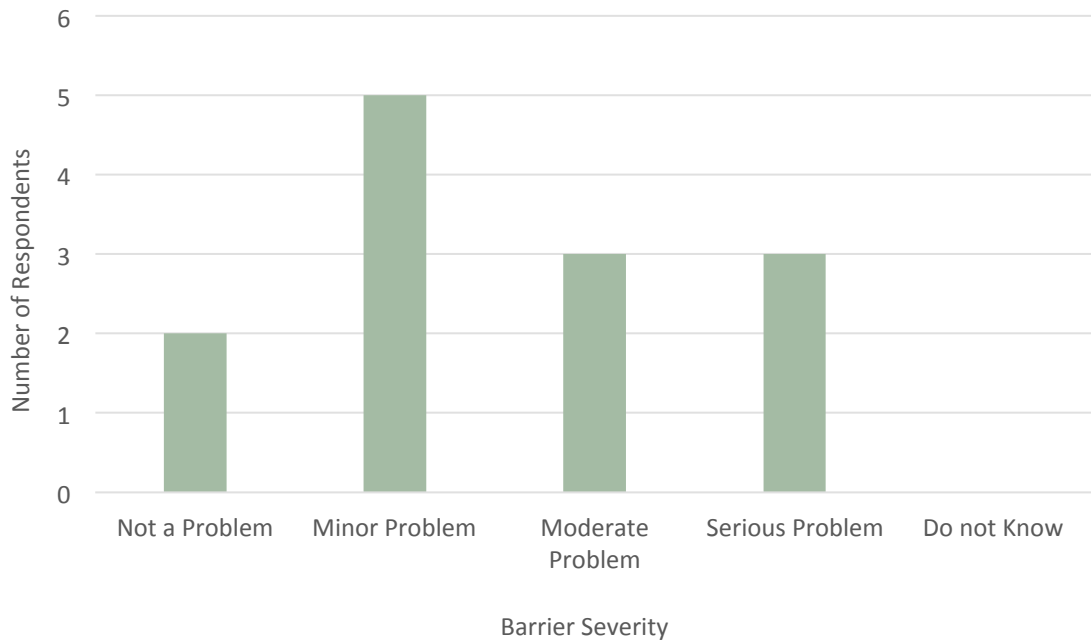


Figure 7. The Extra Time Required to Provide Oral Health Care to LTC Residents

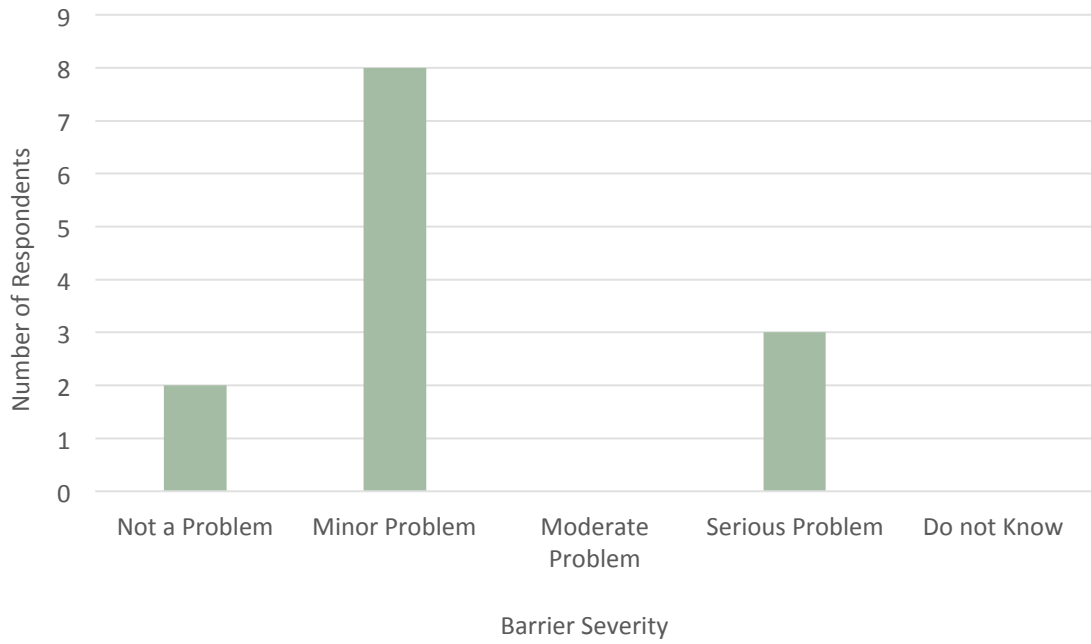


Figure 8. Additional Paperwork Required to Treat LTC Residents

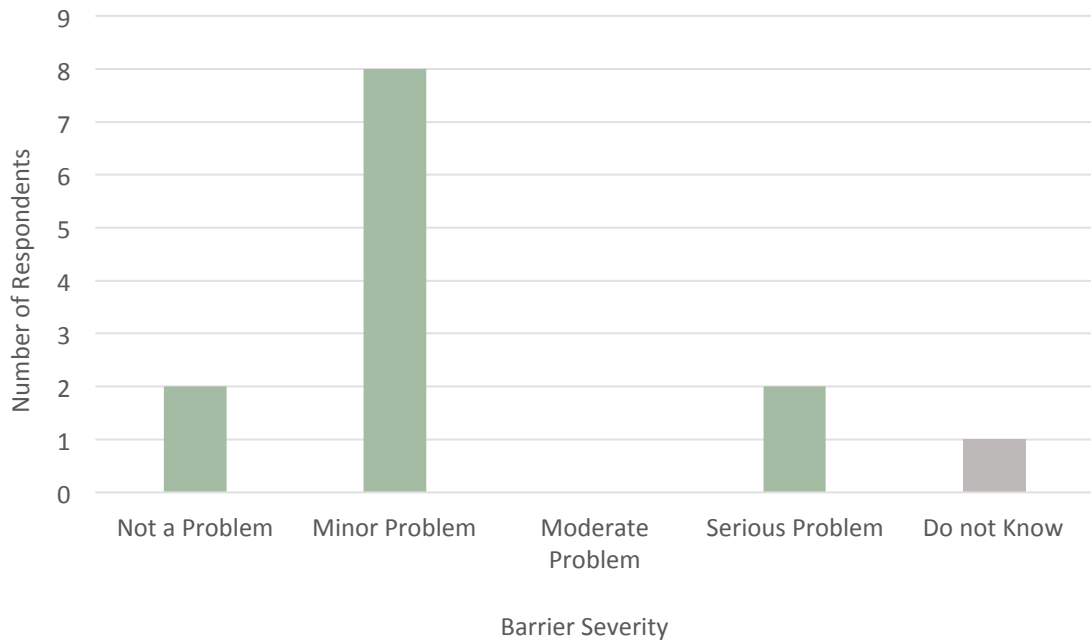


Figure 9. Amount of Private Practice Time

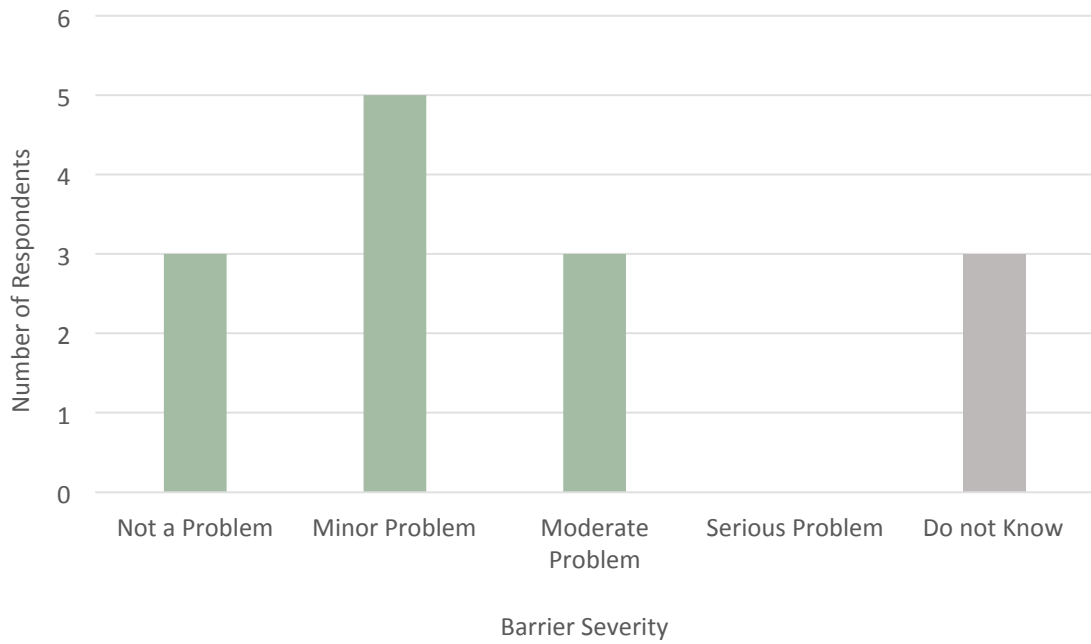


Figure 10. Inability to Adapt Existing Dental Clinic Equipment for the Needs of Geriatric Patients

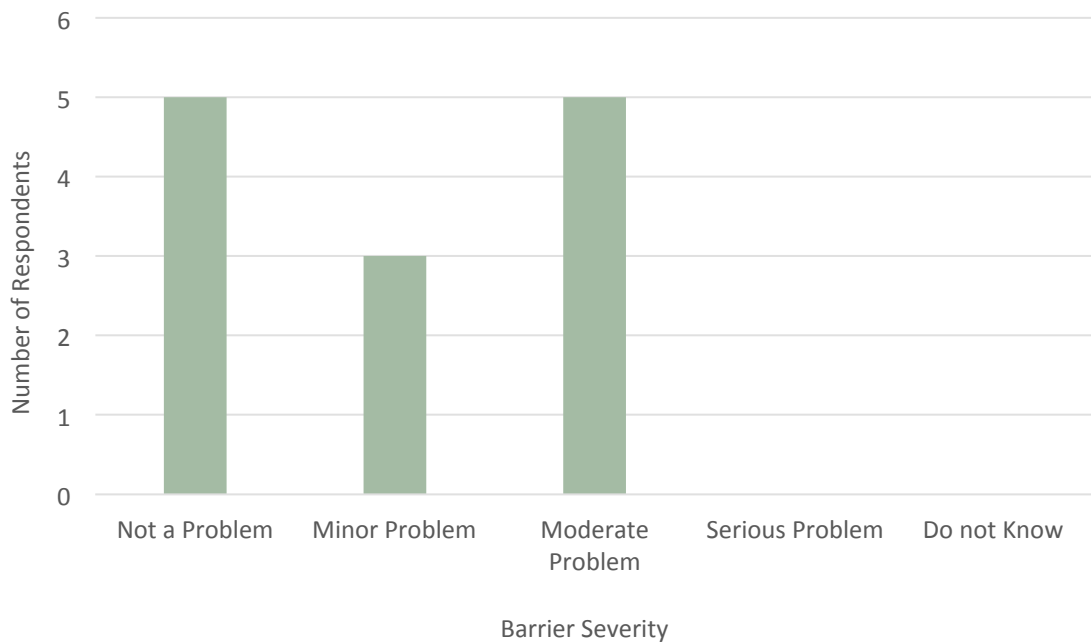


Figure 11. Distance to LTC Facilities

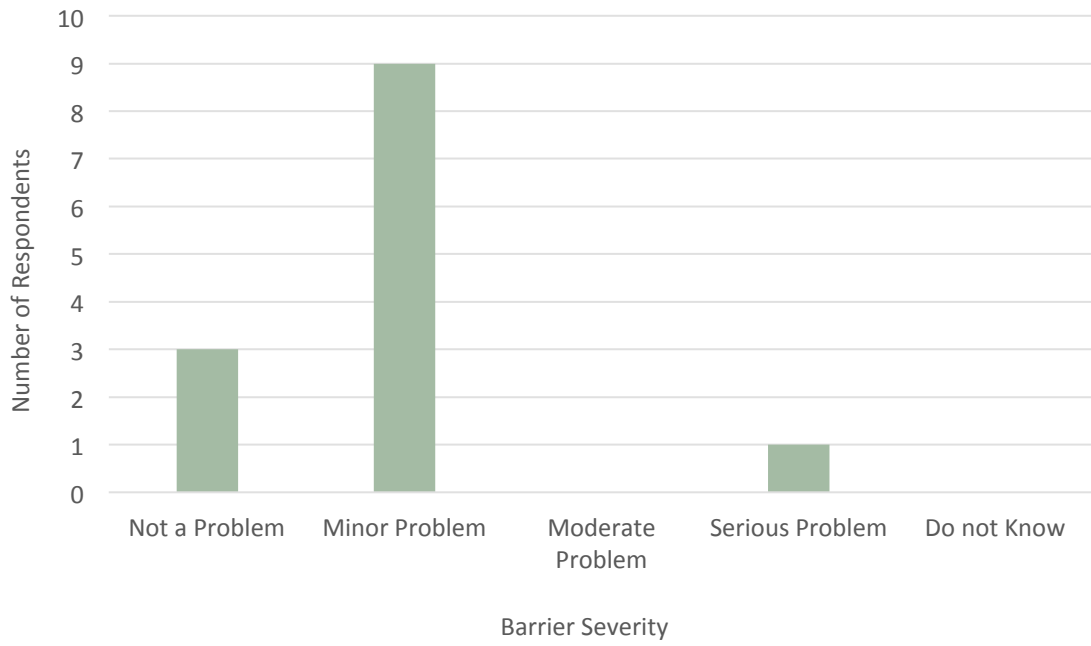


Figure 12. Lack of Expertise in Treating Geriatric Patients

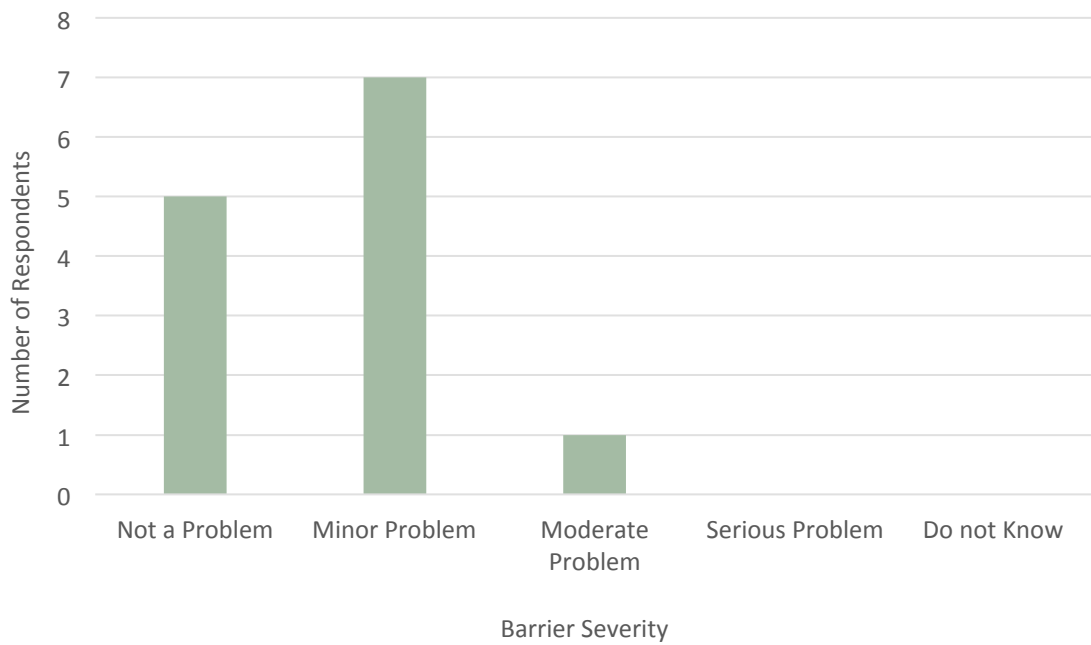
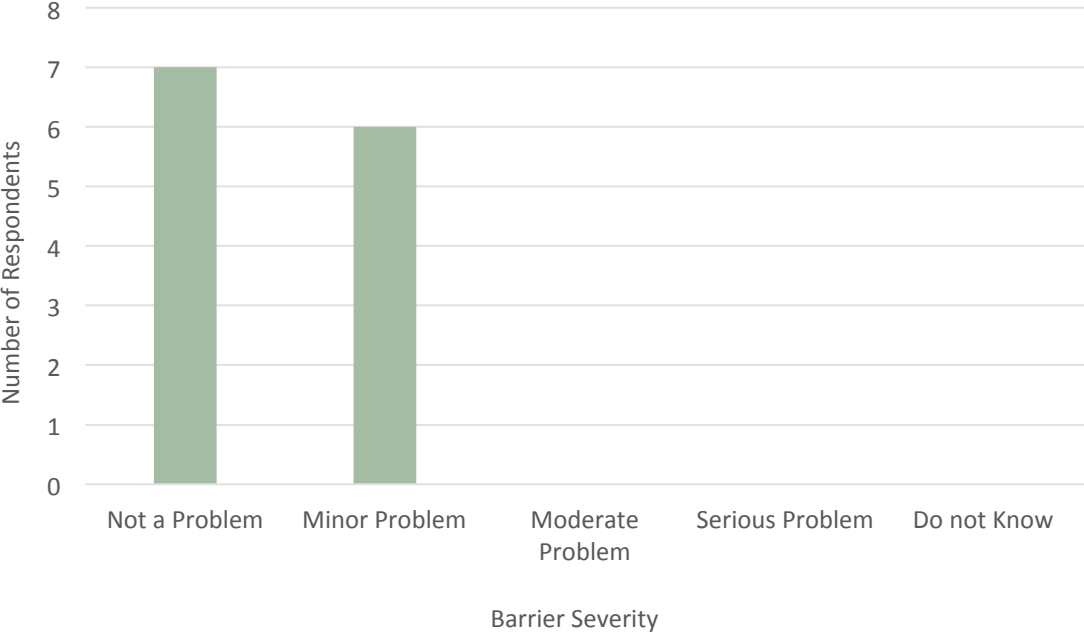


Figure 13. Relationship(s) With LTC Facilities



North Dakota Case Studies: Dentists Providing LTC Oral Health Services

As mentioned, two electronic surveys identified five dentists/dental practices in North Dakota that were providing oral health care for LTC residents. In April 2016, these five dental practices were invited to share the challenges and motivations behind their work in the LTC setting. Four dentists were willing to engage in discussion. Three of the four dentists were interviewed via phone in mid-April, and one dentist replied to questions presented via e-mail, per that particular dentist's request. The resulting case studies were compiled in June 2016 and provide further insight on what has, and has not, worked in providing oral health services to LTC residents in North Dakota.

Key Findings

- Oral health services provided in LTC facilities rely heavily upon the volunteer work of the dental team and the tradition of serving the members of their rural communities. Each of the four dentists offered oral health exams onsite at no cost to either residents, or the facility, regardless of a resident's insurance status.
- Oral health exams are the primary service provided in the LTC facilities.
- No advanced oral health care is performed in the LTC facilities.
- Reimbursement and cost are the major barriers for the expansion of services.
- Residents are generally grateful to access oral health care services within their LTC facility.
- Residents in hospice care receive oral health exams, but generally do not receive further treatment (ex: cavities).

Aggregate Assessment

All respondents cited several common reasons for providing oral health care to LTC residents in their rural communities. Respondents agreed it is partially due to feeling a sense of responsibility and a commitment to "give back." The four dental providers interviewed offer their services to the LTC residents and facilities at no cost. Each dentist performs a visual examination of the residents' soft and hard tissue of the mouth. No advanced dental work is performed in the LTC facilities. If advanced care is needed, the resident is transported to the dental clinic. The dentists reported financial loss when providing this advanced care to LTC residents in their dental clinics, and shared their frustration with the lack of reimbursement for these advanced care visits. Additionally, many who were surveyed identified complications with the new electronic system required for Medicare and Medicaid claims submissions as a source of frustration.

Common barriers that discourage more dentists from providing oral health care within LTC facilities include: school debt and time, especially for new and younger dentists; the lack of portable dental equipment which would allow for more efficient care, and subsequently, more time to provide additional services; and the lack of reimbursement for care provided.

All four dentists identify positive, collaborative relationships with LTC administrators. However, the direct care staff in the LTC facilities have a less positive perception of the dental team. The participating dentists perceived that LTC direct care staff were more sensitive to the dental care provided to their residents because they felt their care of residents was being brought into question. The dental team identified a lack of oral health knowledge and training among LTC direct care staff, reiterating that direct care staff play a pivotal role in the day to day care of residents' mouths.

All of the dentists who participated in the additional interviews were willing to be a resource for other dental professionals who wished to expand their oral health services into a LTC facility. The need to provide training for LTC nursing and nurse aide staff on how to examine a LTC resident's mouth and adequately provide daily oral health care is recognized among LTC facility staff in North Dakota as well as the dentists providing said care. Read more about LTC nursing and nurse aide staff knowledge of oral health care and the barriers to providing oral health care in *Oral Health Services and Barriers to Care in North Dakota Longer Term Care Facilities: Chartbook* at <https://ruralhealth.und.edu/pdf/2016-oral-health-ltc-chartbook.pdf>.

Dentist A

Dentist A is semi-retired and has not provided clinical care since January 2016. This provider had been in practice for 30 years and continues to do charity work on the side. The retiree had purchased their previous dental practice from another dentist in the community who had already begun collaboration with the local LTC facility. The dental practice is currently located in the same rural community as the LTC facility. The dentist and the dental team continue to visit the facility twice a year, performing general dental exams on all LTC residents. The dental team includes the dentist, one dental hygienist, and two dental assistants. The dentist did not indicate whether they intended to sell their practice to a new dentist.

Dentist A states that the LTC facility lacks a suitable dental treatment space. Oral health exams are performed in the room traditionally utilized by the facility's hairdresser. The LTC facility has remodeled the room in the years in which oral health care has been provided, but when remodeled, salon chairs were added into the space with no room for oral health equipment. The dental providers continue to provide oral health care services for residents in salon chairs. In some situations, the dental team will attend to residents' oral health needs bedside. Though the treatment space in the LTC facility is not efficient, the dentist has upgraded their own office to be accessible to those with physical disabilities or adaptive equipment such as wheelchairs and walkers. Better mobile dental equipment and new technology within the LTC facility would improve the efficiency of the oral health care provided and allow for expanded services. However, given the current treatment space, the dental provider has preferred to treat residents in the dental office.

The dental team visits the LTC facility twice a year to provide cleanings and oral exams to the residents. However, residents receive only one annual exam, with half of the residents receiving care at each dental team visit.

The dentist believed that seeing each resident only once a year in a less than favorable setting wasn't ideal, but at least "something was done." The most common procedures included cleaning of teeth and dentures, as well as oral exams. When asked if they supported allowing dental hygienists/assistants to conduct exams in the LTC facility in order to see more patients, the dentist responded in the negative, stating that hygienists and assistants are not trained to see certain ailments such as lesions, and that a dentist is more attuned to identifying oral health problems.

While the exams and cleanings provided to the LTC residents in the facility were offered as charity care, other restorative procedures and dental fittings required reimbursement from Medicaid, Medicare, or private insurance. The dentist stated their frustration with the reimbursement process. Dentists were often left to determine the funding situation of the patient. Dentist A perceived Medicaid reimbursement as tedious and that it was made more difficult in the last year with the new electronic

billing systems. When working with LTC residents, the dental provider was always working at a loss, but provided oral health care anyway, due to feeling a need to take care of the people.

There are several barriers preventing more dentists from providing care in their local LTC facilities. The dentist reiterated that many new dentists are usually deep in debt and not willing to volunteer their billable time. Most of the physical labor, such as packing and moving the dental equipment, must also be done by the dental team. LTC facility nursing and nurse aide staff's seemingly negative perceptions of dental care were also a barrier; however, Dentist A worked positively with LTC administration. The dentist identified that direct care staff at the LTC facility experienced frequent turnover, and were most commonly high school or college aged employees. The nurse aide staff appeared immature and lacked sensitivity to resident's situations. LTC staff's lack of knowledge and training around of oral health was a barrier, as was the direct care staff's fear of being bitten.

Dentist A is willing to work with other dentists in North Dakota to share their experience and encourage oral health care in LTC facilities. They emphasized how important it is to continue to provide oral health care for the elderly, including those in LTC, and that this was a need that is not being sufficiently met in North Dakota. Finally, all healthcare providers must work to maintain the dignity of the elderly and LTC residents while also striving to maintain good overall health for the LTC residents.

Dentist B

Dentist B provides oral health services to two LTC facilities in surrounding rural communities. While this provider has been providing oral health care services in LTC settings since 2009, they work with a larger group of six dentists in the area to provide this service. Case studies C and D are both dentists that work alongside dentist B as part of this collaborative effort. This dental group has been providing free oral health exams to LTC residents in their communities for over 35 years collectively.

When any one of these dentists visits the LTC facility, they are solely responsible for all care and management. There are no dental hygienists or dental assistants that work with Dentists B, C, and D. No reason was given for the lack of hygienists or assistants accompanying the dentists. They visit each of the two LTC facilities once a year and spend one afternoon providing general exams and cleanings. Exams are conducted in the residents' rooms. Residents also have the option to visit the dental clinic for the same oral health services. A resident's stage of life, as well as their cognitive abilities, determine the oral health care provided.

Dentists B, C, and D provide oral health care in LTC facilities voluntarily. The dental clinics are not reimbursed for care provided in the LTC facility. Outside of some supplies like gauze and decompressors, the dental clinic brings all needed equipment. There is no mobile dental chair or lighting. The dental team asks that the facilities contribute to a small fund (less than \$100) to support the purchase of toothbrushes and other supplies. Exams are noted to be easy in the facility; however, due to poor lighting, procedures such as fillings and extractions are not performed onsite.

General exams and cleanings are the primary focus of service. Dentist C was in support of sending in a dental hygienist to perform cleanings alone, which they believed would save time and money, and would allow oral health care to be performed more frequently and made available to more residents. The dental provider believed that exams and cleanings were necessary, and not too difficult to provide

in the LTC setting. However, mobile equipment would make it easier to provide care, and more effectively.

Because continually providing charity care is not financially sustainable, many dentists are deterred from participating. In general, the time spent volunteering takes away from potential revenue for a dentist. Additionally, dealing with Medicaid/Medicare coding and procedures for reimbursement is a barrier. Though there are barriers to growing the program, Dentist B would like to identify more dentists willing to participate in their program.

The dental practice has had a good relationship with the LTC administrators. Relationships with staff were not as strong. Much like dentist B this dentist also perceived that direct care staff were sensitive to the oral health care provided to residents.

Direct care staff at the LTC facilities have a bigger role in managing residents' oral health than do dental providers. Residents are "their responsibility" and "with them daily". Direct care staff, however, were perceived by dentists to lack training and knowledge on oral health care. Trying to educate staff on the importance of oral health was frustrating for the dentist. The provider stated that you "can tell when they care." There is need to educate direct care staff on the importance of oral health and how to provide geriatric oral health screens. Creating a culture of oral health and encouraging LTC staff to be proactive will result in fewer oral health concerns among residents.

Nearly all residents appreciated the oral health care provided by the dental team. The dentist is willing to be a contact for other dental providers and practices that may want to expand their services to LTC facilities. Additionally, the dentist would like to see more individuals volunteer to participate in similar programs, though they recognize how difficult it is to provide care without payment or appropriate equipment.

Dentist C

Dentist C has been providing oral health care to LTC residents in their community for 30 years. The oral health provider collaborates with other dentists in the community to provide consultations. Dentists two, three, and four work together with three other local dentists to provide these services. The collaborative group of providers identify a day that works with their schedules, meet at the LTC facility in the afternoon, and provide oral health exams and cleanings for the residents. Neither a dental hygienist nor a dental assistant accompanies the dental team during these visits. The services provided and charity care model follows the same description as detailed above.

Providing free oral health exams in the LTC facilities has been a long standing tradition. The provider shared they used to offer services in a basic care facility as well, but have ceased this activity due to the facility no longer asking for service. The dentist is currently semi-retired and would be open to providing more exams in general, excluding advanced care.

This provider observed that in their time providing this service, oral health has generally improved among the LTC residents. It was noted that 35 years ago most residents had dentures; today many still have their original teeth. An area of concern is the Alzheimer's unit, where the provider is unable to do much in terms of care because of the residents' cognitive and physical delays. The standard procedure is

to look for any signs of infection, and if found, refer the individual to an oral surgeon. Additionally, in this unit, if a tooth is found to be broken with no signs of infection or other ailments, it is left alone.

The provider is unsure of what prevents other dentists from providing the same service to LTC facilities. They describe the practice of providing service as “second nature” to them. Notably they observed that there is a collegial atmosphere among the dental providers in the community, and that this may be uncommon. The provider perceived debt as the primary barrier to expanding these services, especially for younger dentists who cannot afford to provide charity care.

The provider emphasized good working relationships with staff at the LTC facility, sharing that that they work primarily with the nurses, not the certified nurse aides. There is a “small town aspect” where everyone knows one another and works well together. However, it was noted that the LTC staff do not provide good oral care to residents, a result of inadequate training. Most often the only treatment the residents receive is a simple swabbing of the mouth. The dentist noted that they used to do in-service demonstrations and exams with facility staff, but were not asked to do so anymore. The dentist emphasized a lack of LTC staff training on how to address geriatric oral health, but also recognized that care staff have several other more pressing issues in their LTC facilities.

Most residents were thankful for the care provided. Residents do have the right to refuse treatment, however. Some residents are belligerent and defensive. In aggressive situations, the provider examines the individual from a distance noting that, “everything looks good from ten feet.” Residents in hospice are examined, but if an oral health concern is identified (cavity, for example) it is not treated if the resident has fewer than six months to live.

Dentist three expressed additional concern with the general public perception of dental providers. They shared that, “it’d be nice if politicians didn’t make dentists out to be bad guys.” Support for the dental team is critical.

Dentist D

Dentist D has been providing care and examining patients in the LTC setting for 37 years. The provider works in the same collaborative group as the one identified above.

Provider four reiterated much of what B and C had shared. The scope of the dentist’s visit is exams only. All of the residents of the facility are seen in one day. If a problem is found, the patient is referred to a dentist of their choice. If dental work is needed, that individual is then transported to a dental office. The exam itself is a visual exam of the hard and soft tissues of the mouth. In contrast to previous responses, the provider indicated that the facility provides dental supplies, although this was ambiguous, as the type of supplies were not stated.

When asked what they believe prevents other providers from offering a similar service, the provider believed that a lack of time and scheduling conflicts were the primary barriers.

The provider had good working relationships with LTC staff. The dentist noted that they received several calls from the LTC facilities hoping for them to see additional residents. The patients and the facility staff are grateful for the dentist’s work. The provider identified a lack of oral health knowledge among LTC

staff; they shared it would be nice if the facility provided aid in oral hygiene, but recognized that the facilities do not have the staff or time to provide such care.

The oral health care provided is largely dependent on the health, and stage of life, of the resident. Additionally, the family plays a significant role in allowing additional in-clinic care to happen. Families are more concerned with the ability to transport a resident, the cost Medicaid will not compensate, as well as having to be present for the treatment.

This provider is willing to be a resource for other dentists interested in providing similar services. When asked if there was anything else they wished to share with the public, the provider had several points. They recognized that finding staff to work in LTC facilities, as well as having money to hire additional staff, was a challenge. While everyone would like to see residents have the best of care, the key is finding the right people and being able to reimburse for the care provided. The provider is happy to see that residents have an annual exam, and that the facilities can maintain their goal of attending to residents' needs. They enjoy doing these exams and hope that it is a tradition passed down to a new generation of dentists.