Conference Paper

Systems Issues Workshop Report

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Panel members: Ms. Besty Anderson, Albuquerque, NM; Dr. M. Ann Drum, Bethesda, Md; Burton L. Edelstein, New York City, NY; Dr. Steven P. Perlman, Lynn, Mass

Abstract: *The Systems Issues Workshop held November 18, 2006 in Chicago, Illinois, as part of the AAPD Symposium on Lifetime Oral Health Care for Patients with Special Needs, focused on health care systems that influence access to and the quality of dental care for persons with special health care needs (PSHCN). This paper summarizes the workshop discussion and presents recommendations to the American Academy of Pediatric Dentistry (AAPD) regarding means of improving health care systems for PSHCN. (Pediatr Dent 2007;29:150-2)*

KEYWORDS: PERSONS WITH SPECIAL HEALTH CARE NEEDS, HEALTH CARE SYSTEMS, WORKFORCE, QUALITY OF CARE

Persons with special health care needs (PSHCN) suffer disparities in oral health. The Systems Workshop, held November 18, 2006 in Chicago, Illinois, as part of the AAPD Symposium on Lifetime Oral Health Care for Patients with Special Needs, focused on health care systems that influence access to and quality of dental care for PSHCN. The following topics from papers presented during the conference were identified as germane to the workshop discussion and recommendations: (1) characteristics of ideal systems; (2) problems with existing systems; and (3) best practices in current systems.

Recommendations for an optimal system for PSHCN presented to the American Academy of Pediatric Dentistry's (AAPD) 2003 Interfaces Conference included: (1) ease of use by families; (2) comprehensive care; (3) family satisfaction with quality; (4) sufficient funding; and (5) smooth transitions from pediatric to adult oral care.[1] Qualities of an ideal system, as envisioned by the Maternal and Child Health Bureau for care of PSHCN, were:

1. family satisfaction and partnerships;
2. family centeredness;
3. comprehensiveness;
4. adequate insurance for needed services;
5. early and continuous screening; and
6. organized community services easy for families to access and transitioning into adulthood.[2]

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Workshop participants identified 6 additional characteristics of an ideal system:

1. establishment of a dental home for infants with SHCN prior to tooth eruption;
2. PSHCN engagement with the dental system at the level needed (general vs specialist care);
3. lifetime care transitioned from pediatric to adult to elder care;
4. a full range of periodontal therapies to be included in comprehensive care;
5. oral care integrated into the patient's total health care plan; and
6. quality established using standard measures including but not limited to family satisfaction.

Problems with the current system were discussed concurrently with best practices where applicable and included issues related to: (1) financing; (2) workforce; (3) care integration/coordination; and (4) quality.

Financing

A major reason for PSHCN difficulties with access to the dental care is the high cost of providing care and low remuneration to the dentist by Medicaid and other third-party payers. PSHCN experience differential referral and treatment based upon financial support. Areas of concern included:

1. Medicaid coverage inadequacies;
2. PSHCN aging out of Medicaid at 21 years in most states[3];
3. inadequate coverage by private insurers as PSHCN exceed yearly maximum benefits;

4. undocumented PSHCN with no resources to support needed care; and
5. inequities in financial support for children with SHCN vs adults with SHCN.

It was emphasized that extending coverage without improving reimbursement will not improve access.

Workforce

As the overall dentist-to-population ratio declines, the workforce is shrinking for increasing numbers of PSHCN. Not every PSHCN requires specialty level services; the bulk of dental care for PSHCN is and must be provided by general dentists. Numerous opportunities exist for the AAPD to facilitate care of PSHCN by the existing dental workforce. Workshop participants suggested building on relationships with the American Dental Association (ADA), Academy of General Dentistry (AGD), Special Olympics, and local dental societies to:

1. remove the stigma of PSHCN;
2. emphasize that most PSHCN are treatable in the office setting;
3. provide continuing education on SHCN topics; and
4. socially reward those who treat PSHCN.

Additionally, dental schools could consider a demonstrated affinity for PSHCN as a desirable attribute of applicants to dental school.

Integration

As PSHCN are integrated into community life rather than living apart in institutions, coordination of services is critical. In most communities, parents/guardians are responsible for accessing the medical, dental, educational, and social services needed for their special-needs family member. Care coordination is currently the responsibility of parents/guardians who have varying amounts of time and expertise. Workshop participants identified the medical, family advocate, and education systems as areas where efforts by the AAPD could result in significant benefits to PSHCN.

Recent attention to the inter-relationship of oral health and systemic health may offer health policymakers an incentive to integrate dental care into a total health care plan for all patients, including PSHCN.[4] Preventive information could be disseminated via prenatal care systems and oral health screening mandated for all children, as is current practice for vision and hearing. Education of primary care providers (PCP) regarding the dental needs of PSHCN should lead them to view the dentist's role as analogous to other medical specialists. In addition to collaboration with medicine, the AAPD could partner with other health disciplines serving PSHCN, such as nutrition, speech, and occupational therapy to integrate oral health/hygiene practices into the daily lives of PSHCN. Current examples of care integration success cited by workshop participants were:

1. case management systems in Medicaid;
2. Title V; and
3. a California model where social service monies fund dental case managers for PSHCN.

Workshop participants noted that dentists practicing outside institutions have limited access to current medical records and often have difficulties communicating relevant oral health information to other care providers. The AAPD could facilitate communication between dentists and medical providers by creating a dental consultation template. Evolving electronic patient records offer the possibility for creating of virtual care teams where all providers caring for a PSHCN could exchange information and locate resources. Changes in the political landscape may offer the opportunity to create a demonstration project of centers of excellence for interdisciplinary care of PSHCN across the country.

Families of PSHCN are potentially powerful allies. The AAPD could partner with the family advocate system by:

1. identifying existing advocacy groups and informing them about oral/systemic health relationships;
2. getting oral health on the advocacy agenda at state and national levels; and
3. educating families using evidence-based information and contemporary standards of dental care regarding oral health for varying populations of PSHCN.

An individual education plan (IEP) is mandated for PSHCN. It was suggested that a portion of the proposed AAPD dental consultation report include specific recommendations for oral hygiene care at school to be included in the IEP for PSHCN when appropriate. This strategy would raise awareness of teachers, aides, and school nurses regarding the importance of oral health and assist families in meeting the daily challenge of providing good oral hygiene practices.

Quality

Patients and their families, caregivers, providers, educators, third-party payers, and policymakers have vested interest in the quality of care delivered to PSHCN. Systemic health, behavioral limitations, and challenges with activities of daily living/oral hygiene practices are among the factors which may modify treatment planning for PSHCN. As dentistry moves toward an evidence-based model, efficacy of therapeutic modalities and patient/care giver satisfaction are areas of interest. Outcomes research is lacking for oral care delivered to this population.

It was noted that PSHCN and their families are a subculture of a broader culture. Workshop attendees were challenged to become aware of how families of differing cultures view their own PSHCN and develop creative strategies for

oral health education outreach to PSHCN and their families. An oral health education program presented through a public housing association was cited as an example of a resourceful method of reaching a population groups whose cultures do not make oral health a priority.

Recommendations to the AAPD

The workshop participants recommended that the AAPD pursue the following to enhance the health care systems for PSHCN:

1. Support national efforts to declare PSHCN a medically underserved population.
2. Extend lifetime dental coverage to PSHCN with Medicaid.
3. Support state-level efforts to expand coverage for dental care under general anesthesia (GA) when necessary for PSHCN of all ages. Expansion could be sought through legislative and regulatory routes using contacts established during recent successes with similar efforts for pediatric patients.
4. Advocate for enhanced payment by third-party payers for care of PSHCN to practitioners who receive special education and training in the care of PSHCN.
5. Advocate for financial resources for populations with additional barriers to care such as immigrant populations.
6. Partner with the ADA, AGD, and local dental societies to increase involvement of all dentists in the care of PSHCN; replicate the AAPD infant oral health educational effort to facilitate training of primary care providers in the care of PSHCN.
7. Create an associate member student status in the AAPD for dentists in advanced education in general dentistry and general practice residency programs emphasizing the benefits of continuing education and resources related to PSHCN.
8. Charge the AAPD Council on Clinical Affairs to develop a prototype consultation form for dentists to facilitate communication with medical providers and others caring for PSHCN. This form should be:
    a. available electronically;
    b. user friendly to general dentists and specialists; and
    c. meet current standards of oral health literacy.
9. Explore existing case management systems related to dental care services and coordination with other health care. Examples include:
    a. Medicaid;
    b. Title V; and
    c. a California model of dental case managers for PSHCN.
10. Investigate models for creating electronic virtual team care that includes:
    a. medicine;
    b. dentistry, and
    c. other disciplines serving PSHCN.
11. Develop a model program for transitioning care of PSHCN from pediatric dentists to those practicing general dentistry.

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