

Proceedings of the November 18-19, 2010

National Coalition Consensus Conference on Oral Health of Vulnerable Older Adults and Persons with Disabilities

J.W. Marriott Hotel, Washington, D.C.

Council on Access, Prevention and Interprofessional Relations
American Dental Association

ADA American Dental Association®

America's leading advocate for oral health

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The National Elder Care Advisory Committee (NECAC) is a standing committee of the American Dental Association's Council on Access, Prevention and Interprofessional Relations (CAPIR). NECAC was instrumental in the conception, design and execution of this conference. The Council and Committee wish to acknowledge the contributions of Dr. Barbara Smith, Manager for Geriatric and Special Needs Populations for CAPIR in putting on the conference and preparing these proceedings.

This is a record of the proceedings and does not reflect ADA policy unless expressly stated.

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Executive Summary

Background

The American Dental Association (ADA) convened a National Coalition Consensus Conference on Oral Health of Vulnerable Older Adults and Persons with Disabilities on November 18 and 19, 2010 in Washington D.C. The conference drew over 150 representatives from professional dental associations, general health organizations, consumer advocacy groups and policy makers.

Unprecedented numbers of vulnerable older adults and people with functional limitations and complex medical conditions live in community settings and need oral health care. More than ever before, people keep their teeth as they age. The aging of disabled populations and the common complications of medical treatments for vulnerable and disabled persons point to increased numbers of more complex people needing more complex oral health care management and unparalleled challenges for our health care system. However, they also bring opportunities to develop systems and train personnel adequately equipped to face these challenges.

Organization

The conference took place over two days and was organized around a consensus development process. On the first day invited experts presented commissioned papers and made recommendations based on specific topic areas. These presentations were followed by short reactor comments. Input on the topics and recommendations was solicited from audience members. The recommendations were organized at a second day of the conference and further refined through post-conference communication.

The conference was structured as follows:

- Welcome and Opening Remarks
- The Expanding Population of Older Adults and Persons with Disabilities
- Medical Consideration in the Oral Health of Older Adults and Persons with Disabilities
- Oral Health Delivery Systems for Older Adults and Persons with Disabilities
- Keynote Address
- Professional Education for Oral Health for Older Adults and Persons with Disabilities
- Policy Implications for Improving Oral Health for Older Adults and Persons with Disabilities
- Meeting Summary and Call to Action

Recommendation Topics

A series of conference recommendations was developed that included the following areas:

- Oral Health Delivery Systems
 - Establish delivery systems that meet the needs of vulnerable adults.
 - Specifically address oral health needs in long-term care facilities.
- Finance

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- Education
 - Educate the general public about the importance of oral health for frail elders and adults with disabilities
 - Enhance education of oral health professionals on providing oral health care for frail elders and adults with disabilities
- Research
- Policy and Advocacy
- Development of a National Coalition to address the lack of oral health care for frail elders and adults with disabilities

The American Dental Association (ADA) convened a National Coalition Consensus Conference on Oral Health of Vulnerable Older Adults and Persons with Disabilities on November 18 and 19, 2010 in Washington D.C. The conference drew over 150 representatives from professional dental associations, general health organizations, consumer advocacy groups and policy makers.

This document contains a summary of the proceedings as well as a listing of the recommendations from the conference.

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Background

Unprecedented numbers of vulnerable older adults and people with functional limitations and complex medical conditions live in community settings and need oral health care. More than ever before, people keep their teeth as they age. The aging of disabled populations and the common complications of medical treatments for vulnerable and disabled persons point to increased numbers of more complex people needing more complex oral health care management and unparalleled challenges for our health care system. However, they also bring opportunities to develop systems and train personnel adequately equipped to face these challenges.

Among the many issues faced by the oral health profession and society at large is the need for a professional oral health workforce able to provide leadership, education, and research in this increasingly important field. In addition, these developments provide the opportunity to foster increased collaboration between oral health and general health and social service professionals. Finally, as systems for improving and maintaining oral health for vulnerable older adults and people with disabilities evolve there will be opportunities to advocate for reform of educational programs, public policy, and funding programs.

Purpose

The purpose of the Coalition Consensus Conference was to take the first step in building a broad coalition of groups aware of the challenges facing our nation in this area and committed to developing resources needed to address the issues articulated above. The rationale, implications, and steps needed to create solutions were addressed using an interactive consensus-building approach. The results of the conference are a set of recommendations for educational institutions, professional organizations, and policy makers.

Organization

The conference took place over two days and was organized around a consensus development process. On the first day invited experts presented commissioned papers and made recommendations based on select topic areas. These presentations were followed by invited reactor comments. Audience members then participated in small group discussions on the topics and offered recommendations.

On the second day, a small group consisting of the planning committee members, invited presenters, reactors and some organizational representatives considered the input from the previous day and refined the overall recommendations. These recommendations were further refined through post-conference communication.

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Program Schedule

The following is the schedule of presentations and events from the conference. Speaker biographies are located in Appendix 1.

Welcome and Opening Remarks

- Paul Glassman, DDS, MA, MBA
- Kevin T. Hendler, DDS, FASGD, DABSCD
- Raymond F. Gist, DDS

The Expanding Population of Older Adults and Persons with Disabilities

- Presenter: Chester W. Douglass, DMD, PhD
- Reactor: Jonathan Musher, MD, CMD

Medical Consideration in the Oral Health of Older Adults and Persons with Disabilities

- Presenter: Douglas B. Berkey, DMD, MPH, MS
- Reactor: Sarah Crane, MD

Oral Health Delivery Systems for Older Adults and Persons with Disabilities

- Presenter: Michael Helgeson, DDS
- Reactor: David Fray, DDS, MBA

Keynote Address

- Mary Wakefield, PhD, RN

Professional Education for Oral Health for Older Adults and Persons with Disabilities

- Presenter: Teresa A. Dolan, DDS, MPH
- Reactor: Paul Mulhausen, MD, MHS

Policy Implications for Improving Oral Health for Older Adults and Persons with Disabilities

- Presenter: Burton L. Edelstein, DDS, MPH
- Reactor: Robyn I. Stone, DrPH

Meeting Summary and Call to Action

- Linda C. Niessen, DMD, MPH
- Beth Truett

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Summary of Presentations

The following is a list of the presentations made at the conference and a summary of the content: Power Point presentations from the conference are available at <http://www.ada.org/nccc>.

Welcoming Remarks

Paul Glassman DDS, MA, MBA

I want to welcome everyone today. I will serve as conference moderator. This conference is an historic opportunity for people from diverse organizations to gather and begin to work together to improve the oral health and well being of vulnerable older adults and people with disabilities. The vision for the conference started with the Special Care Dentistry Association a number of years ago. Today, we start the journey to building a world where vulnerable older adults and people with disabilities will be able to count on being able to have healthy mouths and healthy smiles.

Raymond Gist DDS

Successfully expanding access to care for our most vulnerable citizens will require a broad collaborative effort, embracing the concerns of advocacy organizations, health professions, corporate sectors, foundations, other nonprofits, and the public sector. The ADA is committed to fostering a culture of engagement, and to reaching out to the broadest possible array of communities. We're reaching out to you, stakeholders with diverse values and beliefs, because this is a learning experience for all of us. By combining our shared commitments and understanding, we can turn our commitments into action.

Kevin Hendler DDS

I also remember a meeting a few years ago in Chicago when Dr. Glassman was discussing having a conference sponsored by the Special Care Dentistry Association similar to this one. The concept was to bring together experts to discuss and then publicize the unique issues associated with providing dental care for older adults and patients with special needs. It seemed like a great idea and I figured that if people only knew about the problems that were involved with this, that maybe something could be accomplished to address the concerns that we have. The Special Care Dentistry Association is excited to be part of this collaborative effort to bring increased focus to the complex issue of ensuring oral health for the increasing numbers of vulnerable older adults and people with disabilities.

The Expanding Population of Older Adults and Persons with Disabilities

Chester Douglass DMD, PhD

My presentation can be summed up by saying that there are going to be more older people, and more of them will have more teeth than ever before. They're going to have more dental care needs than ever before. They're going to have access problems. They're going to have financial problems paying for the care they need, and we ought to do something about it.

Almost 1 in 5 people in the U.S. has a significant disability and the number is growing. The number of people with certain disabling conditions is growing much faster than the population at large. The number of elderly people is expanding with 20% of the population expected to be over 65 years old by 2050 and 5% over 85. The number of teeth at risk in these groups will increase from about 140 million in 1972 to 933 million in 2030.

In addition to having more dental needs, more older people and people with disabilities will be living in long term care or assisted living arrangements and need more help with activities of daily living. So we have a situation where the need for oral health services for these populations is high and rising. The demand for services will increase dramatically and we currently have shortages in the supply of services. This gap will be expected to widen in the future unless we put steps in place to make a difference.

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Jonathan Musher, MD, CMD

I represent the American Medical Directors Association (AMDA). The Omnibus Budget Reconciliation Act enacted in 1987 (OBRA '87) mandated that all nursing homes have a physician medical director. AMDA is the professional organization of practitioners in long-term care. Its 8000 members are mostly physicians (80%) but we also represent the interdisciplinary care team, practicing in sites ranging from nursing homes to community based programs.

The role of the medical director is two-fold: 1) implementing resident care policies and 2) coordinating medical care within the facility. This includes assuring that all services, including oral care, are available. Getting dental care for residents can be very difficult and requires a shift in how that care is delivered.

The White House Conference on Aging in 2005 dealt with Baby Boomers and their impact on the economy, especially as they begin to reach age 80 and beyond. The number of disabled older Americans is projected to be 21 million in 2040. We must be prepared for substantial increases in the need for long-term care services. Testimony provided to the US Senate Special Committee on Aging in 2003 on behalf of AMDA and the American Health Care Association underscored the following: 1) oral health in the elderly is important to providers, 2) proper assessment and intervention is critical to quality care and the quality of life of our patients and 3) Lack of oral health can lead to numerous problems that affect overall health and quality of life

Medical Considerations in the Oral Health of Older Adults and Persons with Disabilities

Douglas B. Berkey, DMD, MPH, MS

My presentation emphasizes the profound disparities in oral health and access to care that exist for all ages – and especially for the vulnerable elderly and persons with disabilities. It is very important to effectively address prevalent oral health needs because they can severely impair quality of life and negatively affect systemic health. Healthy smiles lead to vital social engagement, self esteem and mental health. Biofilms (plaque) are responsible for most oral-related problems (e.g., dental caries and periodontal disease). Dental caries may contribute to malnutrition due to loss of teeth and concomitant poor chewing function. Dental infections may lead to extreme tooth pain, bacteremia, facial cellulitis, brain abscess, and airway compromise. Circulating inflammatory mediators associated with periodontal disease have been implicated in a large number of systemic diseases. Epidemiologic studies are demonstrating that dental prevention efforts may provide substantial medical cost savings associated with diabetes, pneumonia, coronary artery disease, stroke, dementia, and other conditions. The U.S. Surgeon General affirmed that "...too many people outside the oral health community are uninformed about, misinformed about, or simply not interested in oral health." Future efforts must: 1) build a broadly-based and energized coalition advocating for improved oral health for the most vulnerable; 2) improve epidemiological research on oral/general health links (risk factors) and operational public health research; 3) develop oral health systems capacities based on age and disability friendly primary health care; 4) better integrate effective health promotion/disease prevention efforts; and 5) enhance dental health insurance coverage.

Sarah Crane, MD

Mouth care, unfortunately, doesn't seem to be a medical concern. Some reasons include: 1) Despite extensive training, physicians learn little about teeth or the diseases that affect them. 2) Medicare doesn't pay for dental care. 3) Within long term care, there is no regulation that compels medical directors to send residents to the dentist. As a result, mouth disease is missed, sometimes with catastrophic outcomes at enormous cost. Medicare and Medicaid pay for almost every infected device, heart attack, aspiration pneumonia, and ventilator associated pneumonia caused by ignoring tooth problems and mouth health.

Data which would support changing the situation is absent. The dental care system and the medical care system exist in silos with independent diagnostic documentation and reimbursement mechanisms. This

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makes the science of demonstrating interconnections between the two extremely challenging as well as limiting our ability to draw cost benefit ratios.

Geriatric medicine employs the following guidelines: 1) identify and closely monitor high risk populations, 2) utilize allied health professionals to the top of their licensure, and 3) avoid catastrophic events that require expensive solutions. Integration of dentistry into medicine requires talking about regulation and addressing reimbursement.

Oral Health Delivery Systems for Older Adults and Persons with Disabilities

Michael J. Helgeson, DDS

Given the dramatic growth of the older adult population, the increasing survival of natural teeth into old age, and the mounting epidemiological evidence linking mouth infections and inflammatory mediators to complications of diabetes, heart disease and other conditions, the need for an improved oral health delivery system targeting frail elderly and adults with disabilities is clear. Several new oral health delivery system approaches have been designed to increase access to care by changing how, when and where care is provided. Two innovative models for geriatric and special care dentistry are described here. The Apple Tree Dental model is a nonprofit group practice approach called "Community Collaborative Practice" that builds working partnerships with community organizations including group homes for disabled adults and nursing facilities for frail elders. The "Virtual Dental Home Project" is another new model developed by the University of the Pacific in California that uses tele-health technologies and community based care coordination to create virtual dental homes. Both models have produced early successes by proactively delivering on-site oral health and dental care services in settings where vulnerable adults live, work, go to school or receive other health and social services. These new models were designed to deliver ongoing care that is proactive, prevention focused, geographically distributed, interdisciplinary, collaborative and tele-health enabled. New oral health team roles needed to build working relationships between dentists and hygienists, nurses and other caregivers were described.

David Fray, DDS, MBA

I am speaking to you as a member of the National Association of State Developmental Disabilities Directors, a government bureaucrat, and a former nursing home administrator who happens to also be a dentist. Oral health is a disgrace in vulnerable populations.

Although dentists are part of the health care team, we are not in control of what's going to be driving the system for the next ten to twenty years. State budgets are under enormous pressure.

Most state directors of developmental disabilities service agencies are under pressure to reduce their budgets by as much as 20%. In Hawaii, the expenditures for developmental disabilities services approach 120 million dollars; nearly \$40,000 was spent per disabled individual in the program. However, nothing from this budget is spent for dental care as all dental services are paid only through the Medicaid State Plan. In tight economic times, the first thing that many states eliminate from the Medicaid budget is adult dental benefits. In the past I suggested to my Medicaid agency that they eliminate services for toes rather than teeth. Dentistry needs to be seen as relevant by all health stakeholders. If physicians and dentists were trained together they would be better able to understand each other's world. We need to demonstrate relevance through documentation of mortality data. Deaths resulting from oral infections are under reported and are not easily verified thus fly under the radar. We can improve oral health outcomes within the existing fiscal structure. The solution is not always more funding but realignment of resources and the development of alternative models of practice.

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Keynote Presentation

Mary Wakefield, PhD, RN

As the Administrator of the Health Resources and Services Administration (HRSA) and also representing the U.S. Department of Health and Human Services (HHS), I am very pleased to be here. This topic is one that many of us from our different vantage points have an interest in addressing and at the end of the day, I think that we do it best, especially in times of economic constraints, when we're doing it together. This topic is perhaps especially important for us at the Health Resources and Services Administration because we focus on vulnerable populations.

HRSA has many areas of focus. Many of HRSA's activities impact our vulnerable aging and disabled populations. Our programs support health centers, health professional education, and health delivery for underserved populations. Oral health is present in virtually every one of our programs.

HHS has traditionally focused the bulk of its oral health efforts, as you probably are aware, on children. But today, we are working to reach all vulnerable populations in comprehensive, evidence based, and coordinated manner, including additional attention on our elderly population and those with disabilities.

So, let me just say a couple of words about the HHS Oral Health Initiative. The Initiative's overarching goal is really pretty straightforward. It is to promote the concept that good oral health is essential, is integral, to good physical health. And, the Initiative aims to create a systems based approach to oral healthcare through a solid foundation of coordination, collaboration, and integration of department wide efforts.

We have moved to reassess the nation's capacity to provide good oral healthcare, especially for those that are least able to help themselves, and for the 21 million people that reside in health professions and dental health professions shortage areas. And so, with those goals in mind at HRSA, we have commissioned the Institute of Medicine to do two studies for us. Those studies are currently underway. One, the Oral Health Initiative study and the second study focusing on oral health access to services.

Tele-health is another area that we use to facilitate access to health services. It holds great potential to provide cost effective services for people who reside in underserved areas or who have mobility problems because you can take services right into patient's homes, for example.

To maximize quality and cost effective care, we, from our vantage point, are looking for innovative approaches to expand services. So, with that, thank you to all of you for being here today and for extending to me the opportunity to be here with you, and rest assured, we have this commitment. We're looking for your best ideas, and when you don't think we're executing them well, I'm here to tell you, we are here to listen.

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Professional Education for Oral Health for Older Adults and Persons with Disabilities

Teresa A. Dolan, DDS, MPH

A well prepared dental workforce is critical to meeting the oral health needs of all children and adults, but is especially important for special needs populations including vulnerable older adults and persons with disabilities. Disability is increasingly common, and there is ample evidence that vulnerable elders and persons with disabilities have poorer oral health and greater difficulty accessing dental services as compared to individuals without these challenges. This challenge must be addressed by a combination of initiatives that would include attention to the professional education of the entire dental workforce. In this presentation I have reviewed opportunities to enhance the pre-doctoral dental and dental hygiene curricula, the curriculum in the Advanced Education in General Dentistry and General Practice Residency post-graduate programs, dental specialty programs, and the continuing education of the dental workforce. There is an ever increasing need for faculty trained in gerontology, geriatrics and special patient care, as well as opportunities for improved curriculum and team training both within the dental team and among the diverse group of health professional that often collaborate in the care of a special needs patient. These educational advancements require consideration of other initiatives including the creation of the specialty of Special Care Dentistry, the exploration of how new dental team members could be incorporated into the care of special needs patients, the establishment of a network of referral centers for special needs dentistry or other models of care delivery designed for this patient population, and issues related to the public funding of health care for those unable to afford services.

Paul Mulhausen, MD, MHS

Given the demographics of an aging society, we are all becoming geriatricians. Given the burden of disability in this aging society, we are all being called on to serve people who are faced with the challenges of disability. Are we competent in our care of people across the entire spectrum of care, the entire spectrum of function, and across degrees of vulnerability? An adequate response requires that all healthcare professionals achieve a discipline specific set of core competencies in the care of the vulnerable aged and disabled. The health sciences disciplines are going to need faculty to help teach these competencies. We struggle with what the competencies are, how to prioritize them within a curriculum and to identify mechanisms and delivery models that can close the gaps in service. We function in an environment where the pursuit of excellence in geriatric care and the building of a career of service to vulnerable elderly carry huge opportunity costs. These costs challenge faculty recruitment, faculty training, faculty retention, workforce development and access to care.

Exciting opportunities exist for engaging direct care service providers, like certified nursing assistants, in prevention. Educating existing and newly defined allied dental professionals allows us to leverage our expert knowledge base in the application of service and improving access. The expansion of geriatric content curriculum in undergraduate and postgraduate training experiences for young dentists and allied dental professions holds great promise. However, the impact of educational innovation and expansion requires contextual changes. First, it requires a workplace in which competencies are perceived as valuable. Second, it requires that educational institutions truly value the faculty who nurture this knowledge base, as members of the academy.

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Policy Implications - Improving Oral Health for Older Adults and Persons with Disabilities

Burton L. Edelstein, DDS, MPH

Effecting federal policy change requires that we understand our issues within the context of a much more complex setting. When members of congress are approached with requests for support, they may ask themselves several questions:

- What really happens if we do nothing?
- How consequential and severe is the problem, especially compared to other problems?
- Why can't someone else address the problem, e.g. state government?
- What can be done that is really effective and costs little or nothing?

The historic separation of the medical and dental professions has:

- lead to the appearance that oral health is independent of general health
- resulted in the concept that dental care is more elective and aesthetic than medically essential
- created the assumption that oral diseases are not consequential or worthy of public attention
- been reinforced by political activity seeking exclusion of dental coverage in public programs (e.g. Medicare)

For policy makers, oral health is a niche issue that is deserving of attention within the context of other issues, but not necessarily in its own right. It needs to be hooked to other policy issues that are determined by the political environment. Currently, across the political spectrum, there is agreement that cost, quality, and access are significant issues. The liberal faction may view this in terms of equity or school readiness whereas the conservative faction may think more in terms of military readiness and employability. Regardless, oral health can be attached to these hooks especially if our messages are expressed so that they resonate with the intended listeners.

The policy making process is absolutely endless. To organize a campaign in support of oral health for vulnerable adults and be effective, we must do the following and be persistent:

- Develop the data, evidence and arguments
- Identify best practices, best examples
- Frame the arguments and the "asks"
- Prepare to defend the arguments against counter-arguments
- Identify proponents and opponents, negotiate to extent possible
- Engage a high profile spokesperson

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Robyn I. Stone, DrPH

We need to adopt an opportunistic approach to the current political environment. The Affordable Care Act has demonstration authority where dentistry can be engaged in integrated care programs like medical home or accountable care organizations. There are opportunities through Title VII and the expansion of the Federally Qualified Health Centers (FQHCs). Being part of an integrated approach will determine whether dentistry is included in discussions or not. Opportunities also exist at the local level, through organizations like the Area Aging Agencies (AAAs) and special needs organizations. Partnerships with like-minded stakeholders will improve the chances for successful change. An evidence base of data is critical to success. Not only does the scope of the problem need to be well delineated, but suggested approaches for solution have to be backed by evidence. The community level also can be a fertile ground for change, working through senior centers, independent living centers or the local FQHC. The world is moving toward integration. The only way that oral health can be effectively integrated into the mix is for dentistry to engage, organize demonstration activities and pilots, and commit to working in coalitions with others who are concerned about the same end result.

Conference Summary and Call to Action

Linda C. Niessen, DMD, MPH

We have covered a lot of ground in this conference. Here is a summary of what we heard:

- There are more older and disabled adults with more teeth and greater dental needs living in many diverse settings. The integrity of the profession is at stake in how it deals with the needs of this population. Bringing care to people in various long-term care settings is needed and physicians can be more fully engaged in identifying oral health needs.
- Having a disease free mouth is part of overall health as well as quality of life. Being free from infection and discomfort enables chewing comfortably, speaking clearly, smiling, and interacting with others. However, oral health care is not reimbursed by Medicare and even Medicaid for adults in most states, so it is handled as something outside of mainline medical care.
- Oral health is a disgrace for people with disabilities. Oral care delivery systems that reach people where they live have to be reimbursed and cost effective. There are new innovative models being tested. However, financial viability may rely on patient and payment mix.
- The educational system needs to be restructured to meet the oral needs of our special care populations, including the expansion of geriatric and special care content at the pre-doctoral and postdoctoral levels. Educational institutions need to value these competencies. Consideration should be seriously given to making Special Care a dental specialty.
- For change to occur, our story needs to be compelling, our arguments well framed and champion(s) identified. Ongoing, persistent, active work is required every step of the way from legislation to regulation to appropriation. Meeting the dramatic oral health care needs of these populations requires expanding the number of caregivers invested in oral health improvement beyond dentistry, adapting successful models and developing new models of affordable, high quality oral health delivery systems and crafting new legislative solutions. The goal should be the creation of an integrated network of oral health that links care, financing, and reimbursement between the medical and dental systems to reduce cost through improved efficiency.
- The mental health community waged a war to achieve parity in reimbursement for mental healthcare. We need to understand that process, because we need to declare war to achieve parity in reimbursement for oral healthcare.
- To achieve our goals we will need to work on coalition building, volunteerism, and public private partnerships as new ways to create networks that expand our voice and our ability to improve the oral health of these populations.

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As a result of this conference,

- What will you do differently?
- What will you go back to your communities to do?
- What are you willing to take on?
- Will you become an advocate for increasing access to affordable healthcare for disabled and older adults based on the demographic imperative?
- Will you increase your collaborations with your social services, dental and medical colleagues based on the oral systemic linkages?
- Will you examine innovative delivery systems and new methods of financing and reimbursement?
- Will you commit yourself to educating the next generation of dental and medical professionals together, putting them in the same room taking advantage of the richness of our academic health science centers where medicine, dentistry, pharmacy and law are on the same campus?
- Will you let your voice be heard and ensure that reimbursement for oral health is included for vulnerable populations as part of our healthcare system?

In order to reach these populations we need to find solutions. To quote Thomas Friedman, we need to be “dreamers in action, not martyrs in waiting.”

Beth Truett

We need to think about change by asking, “How do we take care of the aged, blind, and disabled with good, overall healthcare and with good oral care?” We need to focus on changing situations rather than changing people. Hayagreeva Rao in Market Rebels: How Activists Make or Break Radical Innovations, suggests that change can be accomplished by employing WUNC, an acronym which stands for Worthiness, Unity, Numbers, and Commitment. Would reducing the number of emergency room visits for dental related problems be a rallying point for us? We may need to seek unlikely partners. We lack pictures that illustrate our issues. A Mission of Mercy event for older adults with media coverage could put a face on the issue. We need to gather large numbers of people, make it easy to participate, and practice message simplicity. Requests need to be based upon very simple steps. We need simple messages that people can understand.

One of the strategies of Oral Health America’s Wisdom Tooth Project is the creation of an online community and portal where various groups can talk to one another: caregivers, families, seniors, organizations, professionals, and the community. We need to tap the growing volunteer work force. We need to adopt a business strategy and use the resources of the business community. The mental health movement was successful in part because business and medicine collaborated. We need to execute, that is the job of leaders.

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Recommendations

All participants at the conference participated in the generation of recommendations. The following day, a small group consisting of the planning committee members, invited presenters, reactors and some organizational representatives considered the input from the previous day and refined the overall recommendations. Further refinement was accomplished through post-conference review by the National Elder Care Advisory Committee via electronic communication and teleconference.

In keeping with the spirit of the conference, the compiled recommendations represent the collective wisdom of a variety of stakeholders who want to improve the overall health of vulnerable adults by improving the health of their mouths. It is the belief of the conference planners that positive improvement is more likely to occur when varied voices speak as one for change. However, the recommendations should not be viewed as a working agenda for any specific organization, including the ADA which served as the convener. Rather the conference was intended to stimulate thinking and establish a communication network among varied groups.

Oral Health Delivery Systems

Establish Delivery Systems that meet the needs of Vulnerable Adults

- Develop financially viable models of care and replicate existing models of care that bring services to places where vulnerable adults live and receive general health services, social services and education services, e.g. PACE (Program for All-inclusive Care of Elderly) programs and Apple Tree Dental
- Enhance communication, collaboration, and referrals within and among dental professionals and other health professionals through the use of interoperable electronic health records and tele-health technology.
- Identify and disseminate information about sources of expertise and oral health care for vulnerable adults.
- Educate and provide guidance for general health and social service professionals about oral health prevention and treatment in order to function and make appropriate referrals within a comprehensive health home.
- Expand the reach of the dental team into community settings through enhanced roles of current members and consideration of new members.
- Allow members of the dental team to function in community settings under standing orders from dentists per state statute.
- Develop the legal and regulatory framework, including liability coverage regulations and informed consent guidelines to support new community-based models of care.
- Develop a policy statement about community-based care for vulnerable adults.

Long-term Care

- Develop and disseminate standardized oral health protocols initiated on admission.
 - Include procedures for:
 - Oral health screening on admission
 - Triage and Risk Assessment
 - Education
 - Prevention procedures

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- Treatment of oral disease
 - Establish reimbursement mechanisms for implementing standardized oral health protocols.
- Create positions for Dental Directors who can work in collaboration with Medical Directors and other organization staff.
- Develop mechanisms to finance and support dental director positions parallel to mechanisms for medical and pharmacy directors.

Finance

- Pass the Special Care Dentistry Act. Ensure that Medicaid covered services for aged, blind and disabled adults include comprehensive preventive and restorative dental care in outpatient and inpatient settings, application of preventive medications (i.e. fluoride varnish) by non-dentists, and reimbursement for behavioral management (via appropriate codes), and home-based care (via care location codes).
- Expand federal sources of support for patient services, education and research in oral health for frail elders and adults with disabilities (i.e. Title VII supported primary care dental residency programs and targeted research).
- Expand the evidence base and prepare advocacy positions to support payment for dental care that supports treatment of general health conditions.
- Educate dentists and the nursing homes industry about Incurred Medical Expense (IME) allowance in long-term care facilities.
- Give elders the option of funding their own dental insurance in retirement.

Education

Educate the general public about the importance of oral health for frail elders and adults with disabilities.

- Develop a public awareness campaign on the importance of oral health for frail elders and adults with disabilities.
- Work with Oral Health America's *Wisdom Tooth* project.
- Provide information and web links about oral health for frail elders and adults with disabilities to national advocacy organizations that work with these populations.

Educate general health and social service professionals about oral health for frail elders and adults with disabilities.

- Develop competencies in oral health for students of medicine, nursing, nurse practitioners, physician's assistants and pharmacists.
- Analyze core curriculum in general health and social service professions and develop resources for missing oral health content.
- Foster collaboration among advocacy organizations for frail elders and adults with disabilities to provide educational programs on oral health at national and local meetings.
- Work with the Accreditation Council on Graduate Medical Education (ACGME) and other general health accrediting bodies to increase the number of hours on oral health in general health curricula.

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- Develop and disseminate clinical practice guidelines for managing oral disease in long term care and other institutional settings.
- Disseminate the Overcoming Obstacles to Oral Health training program and guidelines to caregivers of frail elders and adults with disabilities.

Enhance education of oral health professionals on providing oral health care for frail elders and adults with disabilities.

- Analyze pre-doctoral dental and dental hygiene curricula and provide guidelines and resources to improve education on providing oral health care for frail elders and adults with disabilities.
- Encourage the inclusion of clinical treatment of frail elders and adults with disabilities as a requirement into CODA Accreditation standards for pre-doctoral dental and dental hygiene students. Expand education on treating frail elders and adults with disabilities in post-doctoral dental education programs with an emphasis on Advanced Education in General Dentistry (AEGD) programs and General Practice Residency (GPR) programs.
- Provide incentives for AEGD and GPR programs to add a second year emphasizing treatment of frail elders and adults with disabilities.
- Encourage treatment of frail elders and adults with disabilities as a mandatory component of post-doctoral residency education, particularly AEGD and GPR programs.
- Expand educational opportunities for practicing oral health professionals in treatment of frail elders and adults with disabilities.
- Expand education about alternate practice models in continuing education programs.
- Expand the faculty in dental education programs to include faculty members with experience in treatment of frail elders and adults with disabilities.

Research

- Disseminate existing research and data about the importance of good oral health to maintain general health and quality of life.
- Promote widespread use of surveillance tools like the *ASTDD Basic Screening Survey for Seniors*.
- Promote continued research on
 - The general health implications of oral disease.
 - The cost of oral neglect.
 - Savings for other systems when oral health services are provided.
 - The impact of the loss of Medicaid adult dental benefits for states that previously had such coverage.
 - Barriers to achieving good oral health in long-term care facilities.
- Recalculate the cost of providing oral health coverage through Medicaid for seniors and adults with disabilities.

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Policy and Advocacy

- “Declare War” on oral neglect for frail elders and adults with disabilities through positive efforts such as a public awareness campaign and education, and through penalties and litigation as a last resort.
 - Brand the effort and create a national communication campaign
 - Identify a national spokesperson or celebrity champion
 - Use the oral/systemic health connection in the messaging
 - Emphasize the impact on downstream medical expenses, reduced morbidity and mortality
 - Communicate the cost of neglect
 - Create and promote an annual event such as a Mission of Mercy (MoM) for frail elders and adults with disabilities –to provide care for individual need as well as highlight challenges preventing vulnerable adults from receiving care.
 - Provide media training for advocates.
- Develop and disseminate a national training initiative required by the Centers for Medicare & Medicaid Services (CMS) for nursing homes and nursing home surveyors regarding the oral health section of the Minimum Data Set (MDS) to ensure accurate patient assessment and compliance with follow-up activities.
- Promote the dental director model within long term care facilities, and educate the medical directors of these facilities about the importance and value of having a dental director.

The National Coalition

- Develop a policy statement about the need for a national coalition on vulnerable adults
- Launch a national coalition on Oral Health for Vulnerable Elderly and Persons with Disabilities
- Develop a mechanism to identify and engage members for the coalition.
- Develop mission and vision for the coalition focusing on the “cost of neglect”
- Develop the capability to identify and catalog national efforts to improve health of vulnerable populations and explore opportunities to join or focus those efforts on oral health. An example is the National Priorities Partnership convened by the National Quality Forum under HHS

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Appendix 1: Speakers Biographies

Douglas B. Berkey, D.M.D., M.P.H., M.S.

Dr. Douglas Berkey has a distinguished career as a dental educator and champion for geriatric dentistry. He is currently a professor in the Department of Applied Dentistry at the University of Colorado School of Dental Medicine, where he served for eleven years as the department chairman. He returned to Colorado following a two year appointment as the first distinguished professor of Geriatric/Special Care Dentistry at the University of North Carolina at Chapel Hill School of Dentistry. Dr. Berkey was awarded the American Dental Association (ADA) Geriatric Oral Health Care Award, named a Pew National Dental Leadership Fellow and a Fulbright Scholar Finalist. He has served as President of the Geriatric Oral Research Group of the International/American Association for Dental Research (IADR/AADR), Colorado Delegate to the Council of Faculties and Chair of the Gerontology and Geriatrics Education Section of the American Dental Education Association (ADEA).

Sarah Crane, M.D.

Dr. Sarah Crane is a Consultant in Primary Care Internal Medicine and a specialist in Geriatrics at the Mayo Clinic in Rochester, Minnesota. She has published previously in the areas of common infections in the elderly as well as care for high-risk frail elders. She is a nursing home medical director and has significant experience in nursing home patient care.

Teresa Dolan, D.D.S., M.P.H.

Dr. Teresa Dolan is a professor and dean at the University of Florida College of Dentistry. She was a Robert Wood Johnson Foundation Dental Health Services Research Scholar, and she completed a Veterans Administration Fellowship in Geriatric Dentistry. She joined the faculty of the University of Florida in 1989 as the director of geriatric dentistry. She was awarded the Geriatric Dental Care Award from the American Dental Association in 1991. In 1995 the American Board of Dental Public Health awarded her Diplomate status. Dr. Dolan previously served on the Executive Council of the American Association of Public Health Dentistry, and she received the President's Award for service to this organization in 1999. Her research has focused on access to care issues, oral health promotion, and appropriate oral health outcomes for older populations. She has published extensively in the area of geriatric dentistry and geriatric dental education.

Chester W. Douglass, D.M.D., Ph.D.

Dr. Chester Douglass is a Professor Emeritus of Oral Health Policy and Epidemiology. He has published more than 150 papers in peer-reviewed journals covering a variety of topics in health policy, oral epidemiology, and dental public health, in which he is a boarded specialist. He served as principal investigator for the New England Elders Dental study, which produced 19 important papers on the epidemiology of dental diseases in the elderly. Dr. Douglass's research combines dental care policy and financing issues with oral epidemiology research. These studies have demonstrated the increase in need for dental care and decrease in the supply of dental care that will occur over the next 20 years. Dr. Douglass served as chair of the Department of Oral Health Policy and Epidemiology at the Harvard School of Dental Medicine from 1978 to 2008.

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Burton L. Edelstein, D.D.S., M.P.H.

Dr. Burton Edelstein, a pediatric dentist, is Columbia University Professor of Clinical Dentistry at the College of Dental Medicine and Professor of Clinical Health Policy and Management at the Mailman School of Public Health. He is also President of the Children's Dental Health Project, a nonprofit policy agency committed to improving children's access to oral health. After 20 years of clinical private pediatric dental practice, Burt's career shifted to health policy when he served as a 1996–97 Robert Wood Johnson Health Policy Fellow in the Office of the US Senate Minority Leader where he worked primarily on health coverage legislation. Burt worked with the US Department of Health and Human Services as an oral health consultant to the Administrator of HRSA, chaired the US Surgeon General's Workshop on Children and Oral Health, and authored the child section of the Surgeon General's Report.

David Fray, D.D.S., M.B.A.

Since 2002, Dr. David Fray has been Chief of the Developmental Disabilities Division in the Hawaii Department of Health. This Division provides Medicaid and community support services statewide to more than 3,000 persons with neurotrauma, developmental and intellectual disabilities through 60 community provider agencies. Currently Dr. Fray is the Vice President for Education on the Board of the American Academy of Developmental Medicine and Dentistry. He is a faculty member of the John A Burns School of Medicine, Department of Pediatrics, LEND program. Previous positions are Director of Developmental Disabilities in Arkansas, Assistant Director of Mental Health, Director of the Arkansas Health Center, part time dental school faculty, and the co-founder of two community health clinics. He is a board certified health care administrator and a licensed nursing home administrator. He has owned two private dental practices and provided risk management and expert testimony for several malpractice insurance carriers. His professional interests are in the areas of autism and elder care.

Raymond F. Gist, D.D.S.

Dr. Gist practices general dentistry in Flint, Michigan and is president of the American Dental Association. He recently completed a four-year term on the ADA Board as the trustee from the Ninth District. His previous responsibilities with the ADA include serving as a delegate and on the Reference Committee on Dental Benefits, Practice and Health. He is a past president of the Michigan Dental Association, the Genesee District Dental Society and the Mid State Dental Study Group. In addition, he is a Fellow of the American College of Dentists, the International College of Dentists and the Pierre Fauchard Academy. He received his dental degree from the University of Michigan School of Dentistry and was a Captain in the U.S. Air Force before entering private dental practice.

Paul Glassman, D.D.S., M.A., M.B.A.

Dr. Paul Glassman has a long career working with special needs populations in a variety of practice and community settings and in developing community-based systems to improve oral health for people with special needs. He is currently professor and director of Community Oral Health at the University of the Pacific, Arthur A. Dugoni, School of Dentistry in San Francisco. In addition, he is a former president of the Special Care Dentistry Association. He is also co-director of the Pacific Center for Special Care at Pacific and co-director of the California Statewide Task Force on Oral Health for People with Special Needs and Aging Californians. Dr. Glassman currently serves as the Chair of the American Dental Association's National Elder Care Advisory Committee.

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Michael Helgeson, D.D.S.

Dr. Helgeson is a founder of Apple Tree Dental, an innovative non-profit organization that operates special care dental clinics and delivers on-site care at more than 100 collaborating urban and rural community sites including Head Start Centers, schools, group homes, and nursing facilities. Apple Tree's community collaborative practice model has been replicated in North Carolina and Louisiana and has received recognition from the Surgeon General, the American Dental Association, Oral Health America and the Robert Wood Johnson and Kellogg Foundations. Following dental school, he completed a two year post-graduate program in geriatric dentistry and then served four years in the United States Public Health Service. Dr. Helgeson has served as president of both the American Society for Geriatric Dentistry and the Special Care Dentistry Association. Dr. Helgeson currently serves on the American Dental Association's National Elder Care Advisory Committee.

Kevin T. Hendler, D.D.S., F.A.S.G.D., D.A.B.S.C.D.

Dr. Kevin Hendler is the Director of Geriatric Dentistry at the Ina T. Allen Dental Center in Atlanta, Georgia and an assistant professor in the Division of Geriatric Medicine and Gerontology at Emory University School of Medicine. The dental center provides comprehensive dental care for older adults and is part of the Wesley Woods Center which is a geriatric medical and residential complex at Emory University. Dr. Hendler is a Fellow of the American Society for Geriatric Dentistry and a Diplomate of the American Board of Special Care Dentistry. He currently serves as the President for the Special Care Dentistry Association and is a past president of the American Society for Geriatric Dentistry.

Paul Mulhausen, M.D., M.H.S.

Dr. Mulhausen is the John McMaster Ristine, MD, Geriatric Education Professor at the University of Iowa Carver College of Medicine (UICCOM). Dr. Mulhausen is a geriatrician and Professor (Clinical) of Medicine. He received his medical degree from the University of Minnesota in 1987 and completed his postgraduate training at the Duke University School of Medicine. He is Board Certified in Internal Medicine and holds a Certificate of Added Qualifications in Geriatric Medicine. Dr. Mulhausen is the director of the HRSA-sponsored Iowa Geriatric Education Center and former program director for the HRSA-sponsored UICCOM Interdisciplinary Geriatric Fellowship. Dr. Mulhausen maintains an active practice in geriatrics, long term care, and internal medicine. He is medical director for a community nursing care center, a VA Home-Based Primary Care program, and a not-for-profit provider of hospice services.

Jonathan Musher, M.D., C.M.D.

Dr. Musher is a family practitioner and a fellowship-trained geriatrician. He is a diplomat of the American Board of Pain Management as well as a charter Certified Medical Director through the American Medical Director's Association. Dr Musher is Chair of Family Medicine at Suburban Hospital/Johns Hopkins Medicine and is currently in private practice in Chevy Chase, Maryland. Prior to establishing his private practice Dr. Musher served for 10 years as the Vice President of Medical affairs for Beverly Healthcare, the largest nursing home company in the world.

Dr. Musher is President of Metropolitan Physicians' Practice and is actively involved in family medicine and geriatrics. Dr. Musher has over 25 years of clinical hands-on medical experience. His expertise spans the spectrum of acute care and long-term care services, from inpatient and ambulatory care through home and hospice care to skilled nursing care. He has published and lectured extensively in the areas of Geriatrics, Long Term Care, and Medical Direction.

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Dr. Musher is a Past President of the American Medical Directors Association (AMDA), Immediate Past Chair of the AMDA Foundation, a member of the AMDA Public Policy Committee, and was a recent delegate to the White House Conference on Aging.

Linda C. Niessen, D.M.D., M.P.H.

Dr. Linda Niessen currently serves as Vice President, Chief Clinical Officer for DENTSPLY International where she oversees clinical education, professional relations and corporate communications. She holds a faculty appointment as clinical professor in the department of restorative sciences at Baylor College of Dentistry, Texas A&M University Health Science Center in Dallas. She is a diplomate of the American Board of Special Care Dentistry and the American Board of Dental Public Health.

Robyn I. Stone, Dr.P.H.

Dr. Stone is a noted researcher and internationally recognized authority on long-term care and aging policy and has held senior research and policy positions in both the U.S. government and the private sector. She is currently the executive director of the Institute for the Future of Aging Services (IFAS) at the American Association of Homes and Services for the Aging in Washington, DC. While at IFAS, she has developed and directed a number of national programs including the Center for Medicare Education, the Better Jobs Better Care National Program and the National Initiative to Link Affordable Senior Housing with Health and Supportive Services. She was a political appointee in the Clinton Administration, serving in the U.S. Department of Health and Human Services as Deputy Assistant Secretary for Disability, Aging and Long-term Care Policy and as Assistant Secretary for Aging.

Beth Truett

Beth Truett is President and Chief Executive Officer of Oral Health America (OHA), an organization dedicated to improving oral health, especially for America's most vulnerable citizens. Based in Chicago, OHA was founded in 1955 and works to connect communities with resources to provide access to care, education and public policies. Truett came to OHA in September 2008 with significant corporate and non-profit leadership experience, serving previously as the Executive Director of Chicago Lights, a community outreach organization that annually serves 7,000 Chicagoans who face the challenges of aging, poverty, access to education and healthcare.

Mary Wakefield, Ph.D., R.N.

Dr. Mary Wakefield is currently the administrator of the Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services. She was previously associate dean for rural health at University of North Dakota (UND) School of Medicine and Health Sciences, a tenured professor, and director of the university's Center for Rural Health. She has served as chief of staff to two U.S. senators, as director of the Center for Health Policy, Research and Ethics at George Mason University, and worked as a consultant to the World Health Organization's Global Programme on AIDS. In announcing Dr. Wakefield's appointment to HRSA, President Obama said, "As a nurse, a Ph.D., and a leading rural health care advocate, Mary Wakefield brings expertise that will be instrumental in expanding and improving services for those who are currently uninsured or underserved."