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Special Needs Dentistry Roundtable – Summary Report

February 2022

Purpose of the Roundtable

We at FIHI want to learn from those that are practicing, seeing patients on day-to-day patients, those that are administrators in dentistry as we tackle access to dental care for Medicaid-eligible children and adults with special needs, disabilities, and serious mental illness. We want to learn and know what we don't know as we disseminate this information to stakeholders and state legislators.

Topic 1: Medicaid reimbursement and provider incentive payments

- The rate of dental coverage of all US children is above 85% with the greatest grains attributable to public insurance through Medicaid and CHIP
- Access to dental care has improved for children from low-income families in the United States in recent decades. These changes have occurred because of Medicaid expansion, growth of federally Qualified Health Centers, and development of private and not-for-profit dental care organizations.
- Studies find that larger supply of dentists was associated with lower Medicaid-funded ED visits by patients with nontraumatic dental conditions in rural counties but not in urban counties, where over 90% of all dental ED visits occurred.
- Access nevertheless remains uneven in rural areas having lower rates of care that areas of greater population density.
- Provider dental coverage alone might not reduce Medicaid-funded dental ED visits if patients do not have access to dental providers.

Question #1:

- In your opinion what can or needs to be done to improve access to dental services specifically for children and adults with special needs, disabilities, and serious mental illness?

Answers:

- **Reimbursements** can pose problems for providers when it comes to how much time is spent on a patient per service and how much money is reimbursed for that service. When taking care of patients that have behavioral issues or need special accommodations, providers take more time per patient specially if no sedation is used to manage the patient

and keep them on their chair. It may take 10 minutes to do a filling on a *normal* patient but to treat a patient with special needs it can take up 20-30 minutes. Providers are given the same reimbursement for both patients even though one requires more time commitment.

- Tied to reimbursements as well but also an issue on its own is the **additional staff and training** required for workers that are providing service to special needs population. This is not accounted for in the reimbursement for services and practices must invest their own resources to provide these trainings. On provider mentioned that they had to "write off $60,000 and limit the number of special need patients their practice saw." Time spent on coordination and paperwork also needs to be accounted and for those providers who are business owners it does not make sense financially for them to treat patients with special needs if the reimbursements do not match the time and resources needed to treat this patient population.
- **Education and inaccuracy in provider websites** also pose a problem. There is a misconception in how the term *sedation* is supposed to be used and it is often misused. The word *sedation* can be anything from nitrous oxide to being unconscious on the table. Both are **not** the same. Organizations and individuals assume that dentists' sedate patients, but dentists are not given that training in dental schools. If they want to provide sedation to patients, they must obtain additional training. Dentists also attempt to give the most conservative methods, which are less expensive. This has recently changed with organized dentistry.
- **Refusal of service is common.** The American Dental Association (ADA) recently came out with an amendment to their ethics statement that allows dentists to refuse care because someone has a disability. Patients often call the dental practice ahead of time to tell them that they or a family member has a disability and often they are told that they don't serve patients with disabilities and that they need to look for service elsewhere. There needs to be a change in this situation where dentists take patients that are more manageable and those that need more specialized care or may be more challenging can go where there is a more established protocol. Organization of this has not been done.
    - Palm Beach County has done a bit of focus and redirection to educate dentists that they can treat manageable patients and leave more complicated patients to those that have sedation permits or are hospital based. This initiative has proven to be successful because it has allowed providers to understand the patient population and realize how they can serve this community. At least 15 providers in the county have been trained to take patients that need nitrous oxide and both the patients, and the dentists feel more comfortable and taken care of. Observations from this project have shown that if you teach and provide the right kind of messaging – there can be an increase in providers for those patients that are easily managed.

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Question #2:

- What role, if any do Medicaid reimbursement rates play in provider access and care for this population?

Answers:

- Hospitals are reluctant to accept Medicaid for medical reimbursements. Even if a dentist has the hospital credentials and wants to serve special needs patients finding a hospital that will accept them to use their facilities is very difficult.
- In some cases, pediatric dentists are seeing many adults with special needs. They are doing pediatric dentistry on adult patients needing adult dentistry. There are limitations to being seen at hospitals where they do not allow dentists with the credentialing to sedate and practice even when they have both hospital credentials and sedation certifications.
- Some dentists are fortunate to work in surgery centers where they have periodontists, oral surgeons, and endodontists that have credentialing. In some cases, these places can provide interdisciplinary care. However, getting funding for this is difficult and while some patients can pay out of pocket others cannot.
    - Multi-disciplinary approach is possible sometimes, but adequate coordination is needed.

Question #3:

- What type of care coordination tools are we using now?

Answers:

- Front office staff completes the transportation and organizes who pays us. They work with the patient population.
- Schedulers that make connections with different insurance companies and handle coordination.
- Dentists themselves also do the coordination. Combining medical and dental procedures. Once the medical procedure is done and while under anesthesia completing the dental work. This saves the patient time, stress, and money while fixing their mouth at the same time.
    - Coordination with ENT and oral surgery for restorative components.
    - Coordination with community doctors, physicians, dentists, outpatient surgery centers.
    - Some issues that arise with coordination include ASC and the hospitals not wanting dentists because of the amount of money an orthopedic surgeon makes with the surgery in comparison to a dentist. The idea of them losing money by

having them practice in the hospital keeps them from supporting dentists. In addition, they don't want dentists to store any dental equipment they need or have in the hospital. They sometimes charge dentists for keeping their equipment. In the case of a colleague, they charged him $100,000 and to continue serving patients and keeping his credentials he applied and obtained a grant from the Florida Dental Association (FDA).
    - Another issue that arises in coordinated effort has to do with reimbursements from anesthesia services. There is a disconnect between the medical and dental side as to how people get paid.
- Some offices have a whole care coordination team.

Question #4:

- Has there been engagement with the state on this issue? Who are the friendly players or opportunities? For example, we had to lobby and work very hard to try innovative things with our PMP, per member per month such that we could start piloting out incentives from a managed care side. Even with health plans paying, we would work out some sort of a deal. Has anyone been amenable for these types of innovations? Seeing that you can have that wiggle room and show where there is a return or impacts to help benefit medical loss and/or return to better manage patient care of financial side but also outcomes for those patients?

Answers:

- No, we work with the Agency for Health Care Administration (AHCA) all the time and to a smaller degree with Agency for Persons with Disabilities (APD) on coordinating the care. There is a volume issue where in some cases they can do a good job but in others there are barriers that are difficult to overcome. This isn't just the case in Florida, but also the case nationally. DentaQuest is open to talking about the solutions that were described in the question.

Topic 2: Provider Best Practices for Special needs Population

- Some Key Practices:
    - Familiarity with the patient's medical history is essential. An accurate, comprehensive, and up-to-date medical history is necessary for correct diagnosis, effective treatment planning, and decreasing the risk of aggravating a medical condition while rendering care.

- The intake interview should address the chief complaint, history of present illness, medical conditions and/or illness, and should include patients' development, education level, and cognitive ability to help predict cooperation.
- Patient must be able to provide signed informed consent for dental treatment or have someone present who legally can provide this service to them.

Question #1&2:

- In your experience what are some best practices and techniques that have been shown most effective in treating children and adults with special needs, disabilities, and serious mental illness?
- How about engaging parents or caregiver? What's most difficult? What worst best?

Answers:

- UF received a private donation to build a specialized sensory machine to desensitize children on the autism spectrum. The center of autism helps train residents and faculty and hopes to branch out to train other local dentists on how to treat children with special needs. This specialized machinery will have a separate waiting room to prevent the children from being overwhelmed. It will also have dimmed lighting, soft colors on the walls, televisions, and dental pieces that make less noise.
- Dental schools need to have components of education for students and faculty to teach them how to treat patients with special needs. Once you have treated one person with autism, you treated one person with autism. Providers need to understand that the process for desensitizing or treating this population involves trial and error. One of the main things to highlight is that individuals need to get over the fear factor. It is important to have a spectrum of treatment modalities where the majority providers see that treating people with disabilities is not as "bad" as it may seem. The recommendation is for private dentists to take these modules or modalities and have an organized system to take care of patients. This does not have to take too many resources, but instead requires planning and communication.
- In collaborating with centers that took adults and provided case management with parents and caregivers and with the support from grants – a program was developed to send dental hygienists (DHs) to centers to identify the level of disability. It is important to note if they need sedation, can handle an open setting, and what would be potential issues they need to work around. The Dental Hygienists provided the dental screenings. Case managers at centers worked with caregivers and parents. When emergent care was needed, it is easy to work with caregivers and parents. However, the preventive level is difficult because oftentimes parents and caregivers are overwhelmed. They don't see dentists as often as other people do.

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Question #3:

- I am curious about your use of technology and your thoughts about opportunities and challenges. How do use social media, telehealth, and mobile. How can we use it and bring it to best practice?

Answers:

- With patients that are Autistic, parents are the ones that know what calms them down. Usually, parents bring their own iPads with music and games. They manage orthodontic work with playing on their iPads. Orthodontic work is done with patients playing on their iPads.

Topic 3: Risk management of special needs populations and issues related to ethics and liability.

Question #1,2 &3:

- How would define provider risk for this population, and what are some key areas of management, protection, or concern.
- What are some key areas of risk (and or opportunity) for Dental-Medical Integration when providing care for this population?
- Specific to dental care for this population. How do we ensure the application of the five ethical principles in managing provider risk?
    - Patient autonomy (self-governance)
    - Nonmaleficence (do no harm)
    - Beneficence (do good)
    - Justice (fairness)
    - Veracity (truthfulness)

Answers:

- Some dentists carry extra insurance because of the amount of equipment transportation going back and forth between the surgery centers. In some places, they only have the basic dental equipment and dentist must bring additional tools needed for patient care.
- In terms of risk management, informed consent poses an issue. The patient population who are adults and have intellectual disabilities cannot provide consent or make informed decisions. There are individuals that have been in legal trouble when working with this population.

- There are ways that you can get consent for patients that cannot give it. The ideal way to do this is to find if the person has a court appointed guardian or advocate. This means a judge has signed and assigned someone to make medical decisions on behalf of the patient. Often, patients have not been through the court system and have someone adjudicated to be their spokesperson. About 20 years ago, the state of Florida amended a statue to allow our patients to get informed consent without having to go to court.

Question #4:

- Was there anything else in relation to thee three topics that you wanted to make sur that we highlighted?

Answers:

- There needs to be a focus on preventive care. There seems to be a focus on special needs dentistry and restorative care, but no focus on preventive needs. There are 22 dental hygienist programs in the state of Florida, but we are not seeing more of these providers doing more for special needs programs.
- Floridians for Dental Access proposed legislation in Tallahassee to make it easier for Dental Hygienists to provide care without direct supervision of dentists.
- Previous challenges with DentaQuest in terms of prevention included not recognizing D4910 code which was connected to periodontal maintenance. Most special needs adults need this every three month. Challenges like this are needed to be overcome and need to be more preventive in nature to allow providers to see their patients and prevent progression of disease.
- The discussion of the special need population is a broad category. There is a wide range of diseases and conditions that are summed up into this broad category and the range of time needed for care varies between condition.
- Throughout the state of Pennsylvania, mobile dental anesthesiologist bring their equipment to private dental offices to sedate patients and allow dentists to safely treat patients with special healthcare needs. The anesthesiologists and dentists each work under their individual malpractice license.
    - In visits to these programs in the Pittsburg, Pennsylvania area – anesthesiologists can sedate 300 patients a month in private dental offices.
    - In the Ocala, Florida dental practice there are quite a few special needs patients using behavioral modifications and 10 mg of Valium if tolerated and needed.
        - There are many patients that need care with severely infected teeth and nowhere to send them from immediate sedation.
        - All the patients are fee-for-service. In 2006 there were a Med Waiver provided but they refused to authorize restorative treatment on many of

the patients treated. This Med Waiver limited the practice's ability to treat patients and no longer participated in the waiver.

    - There are many patients in the office that must be sedated to safely treat them.
    - Florida would benefit from having mobile anesthesiologists in private dental offices.
- It has been an issue with the Board of Dentistry for years – where people that are not dentists certified for sedation are not allowed. This should be presented to the Board of Dentistry since the medical profession does not seem to have a problem with it.
- Nutrition and the amount of retiring dentists are also issues for concern that should be addressed.