ORAL health care MANAGEMENT

Recommendations for Long-Term Care Facilities

DentaQuest

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health
Bureau of Oral Health and Dental Services

University of Delaware | Center for Disabilities Studies

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Recommendations for Long-Term Care Facilities

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Delaware Health and Social Services
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TABLE OF CONTENTS

TABLE OF FIGURES

EXECUTIVE SUMMARY

This report is the product of a collaboration between the Division of Public Health (DPH), Bureau of Oral Health and Dental Services (BOHDS) and the University of Delaware, Center for Disabilities Studies, with funding from the DentaQuest Foundation. It offers guidance to long-term care facilities to improve overall oral health status among their residents.

The Centers for Disease Control and Prevention defines long-term care facilities – nursing homes, skilled nursing facilities, and assisted living facilities – as facilities that provide a broad range of services, both medical and personal care, to people who are unable to manage independently in the community.

This collaboration began in 2013 when we partnered to conduct training for nearly 300 caregivers on daily oral hygiene practices for frail elders and people with disabilities. Many of these caregivers were certified nursing assistants (CNAs) in long-term care facilities. While the participants found the content of the training useful, they routinely shared with us that the facilities they worked in lacked comprehensive systems for managing oral health. They reported inconsistent programs and schedules for assessing oral health status, a lack of tools for monitoring daily care, and barriers to referring and securing dental services for residents.

In response to these reports, the project team engaged in a multi-step process to explore the issue of oral health and dental care in long-term care facilities in Delaware and to offer strategies to improve direct care and enhance the system-level approach to care delivery. This initiative included the following components:

- Assess current oral health practice in state-licensed facilities.
- Identify gaps and promote recommended practices.
- Offer strategies to enhance the capacity of long-term care facilities to provide appropriate oral health care for this population.

Many long-term care facilities in Delaware are diligently working to deliver high-quality care but they face a variety of obstacles: lack of reimbursement for services, residents who may be non-compliant in meeting self-care goals, an inadequate number of dental professionals skilled in serving this population, and difficulty in arranging transportation for residents to see dentists in the community.

The team surveyed facility administrators to gather information about, and document, the current practice related to oral health care within residential facilities in Delaware. The survey included questions about routine assessment, daily oral care plans, referral for dental care, and staff training. The findings indicate a lack of consistency and structure in managing oral health care across and within facilities:

- Only 63 percent of administrators report using a standard assessment tool to guide staff in monitoring oral health for residents; and only 24 percent report routinely using that assessment tool.
- While 97 percent of administrators report that staff provide, supervise, remind, or cue oral care for residents at least twice daily, only 73 percent report that all residents have an oral health care plan in place.
- An annual visit to a dental professional is required by 36 percent of reporting facilities.
- Fifteen percent of administrators report having an in-house dental professional, and 39 percent reporting having a contractual arrangement with a community-based dental professional.
- The majority of visits to dental professionals are to private practices and arranged by staff (73 percent) and/or family (64 percent).

Five key recommended oral health practices for long-term care facilities are set forth in this document.

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1. Routinely Assess Oral Health Status

- Use a standardized assessment tool to promote thorough and consistent monitoring of each resident's oral health status.
- Establish a schedule for conducting assessments at time of admission, at regular intervals depending on risk, and at the time of discharge.

2. Implement Daily Oral Care Plans

- Develop a personalized oral health care plan for each resident.

3. Facilitate Access To Oral Health Services

- Ensure that residents visit a dental professional for cleaning on a regular schedule – at a minimum of once a year.
- Ensure that residents visit a dentist for an examination at least once a year.
- Establish a referral or contractual arrangement with a dental professional in the community to facilitate residents' access to dental health services.

4. Provide Staff Training in Oral Health Care

- Provide ongoing oral health training to staff that covers how to assess and monitor oral health status and how to deliver care to residents with functional needs or complex medical conditions.

5. Actively Manage the Oral Health Program

- Create a system to monitor compliance and resolve identified issues in a timely manner.
- Integrate oral health care management into quality and performance measurement initiatives.
- Create and adopt a written oral health program management policy to guide staff activity and care plans.

INTRODUCTION

Since the U.S. Surgeon General identified oral disease as a "silent epidemic" in 2000, there has been growing evidence that oral health impacts overall health.[1]

While the causal link between oral health and general medical health is not fully understood, it is clear that unhealthy bacteria in the mouth can be harmful. Poor oral health and periodontal disease have a relationship with diabetes, respiratory infections, pneumonia, and cardiovascular disease.[2,3,4] Good oral health can also increase quality of life – allowing an individual to chew and swallow food easily, to be free of pain, and to smile confidently.[5]

As awareness of the impact of oral health grows, the climate is changing to support better oral health. There are ongoing efforts to integrate oral health into primary care. In its report, *Improving Access to Oral Health Care for Vulnerable and Underserved Populations*, the Institute of Medicine articulated a vision that integrates oral health care into overall health. The document identifies strategies to support this integration: amending regulations, increasing dental education and training, and reducing financial barriers.[6] The 2016 Older Americans Act Reauthorization included oral health screenings in the scope of health promotion and disease prevention services.[7] *The Integration of Oral Health and Primary Care Practice Initiative* outlines a draft set of core clinical competencies for primary care providers.[8] Additional emerging strategies to improve oral health include training for facility staff, the use of dental health champions, and oral health screening conducted by non-dental professionals.[9-12]

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While many long-term care facilities in Delaware are diligently working to deliver high-quality care, including oral health care, they face many obstacles. Those obstacles include: lack of reimbursement for services, residents who may be non-compliant in meeting goals for self-care, an inadequate number of dental professionals skilled in serving this population, and transportation difficulties when residents must be seen by a dentist in the community. Moreover, this report reflects that there is inconsistent guidance and oversight relative to oral health for residents in long-term care facilities in Delaware. A combination of factors threaten oral health as a priority.

First, the health system places a primary emphasis on medical care, relegating dental health to a lower priority that is not readily and easily integrated into overall health initiatives.

Second, insurance coverage for dental care is often limited or unavailable. Medicare coverage is limited to dental services that are an integral part of a covered medical procedure. This may include reconstruction following an accidental injury or extractions in preparation for radiation treatment. Medicare may also pay for examinations, but not treatment, preceding procedures requiring hospitalization (i.e., kidney transplantation or heart valve replacement).[13] Medicaid coverage varies from state to state. While most states provide some coverage – preventive or emergency – there is no minimal level of coverage required for adults. Delaware is one of four states that provide no dental services coverage to adults enrolled in Medicaid.[14]

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As they age, many residents acquire disabilities or develop secondary disabilities related to existing conditions, and may need specialized care and assistance related to behavioral issues. Dental professionals receive little training in caring for individuals with disabilities or complex health problems.

Population

In 2015, approximately 6,000 residents lived in long-term care facilities in Delaware (T. Ritter, personal communication, September 13, 2016). Nationally, it is estimated that the five long-term care services sectors – nursing homes, residential care communities, adult day health programs, home health agencies,

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and hospice programs – served about nine million (8,762,400) people in 2014.[15]

Data from the National Study of Long-Term Care Providers 2013-2014 tell us about who live in long-term care facilities.[15] Most long-term care residents are non-Hispanic white women, ages 65 and over. Users of long-term care services typically need assistance with activities of daily living, which can impact the maintenance of daily oral hygiene. Ninety-six percent of nursing home residents need assistance with bathing and 85 percent need assistance with eating. Conditions such as Alzheimer's disease or other dementias and depression can also impact the delivery of oral health care. In nursing home residents, 50 percent had some type of dementia and 49 percent had a diagnosis of depression.

Disparities in Oral Health

Older adults, people with special health care needs, racial and ethnic minorities, and those who live in poverty are more likely to have poor oral health.[16] Older African American adults are nearly twice as likely to have lost all their teeth. Adults living below 200 percent of the poverty level have higher rates of periodontitis. Older adults of Mexican American and African American heritage have higher rates of untreated dental caries.

Individuals with intellectual and physical disabilities are less likely to receive adequate oral health care.[17] Lack of dental care intensifies the rates of periodontal disease and poor dental hygiene.

- Caries rates in people with intellectual disabilities are similar to the general population. However, the rates of untreated caries are consistently higher in people with intellectual disabilities.
- Financial challenges, followed by physical accessibility issues, were the primary reasons that people with disabilities reported problems receiving dental care.[18,19]

The goals for this document are to recommend oral health care practice standards to improve the overall health status of residents in Delaware long-term care facilities; and to increase the knowledge and adoption of oral health best practices within those facilities.

In addition, this document may be instrumental in launching conversations about challenges and opportunities in promoting and improving oral health care and outcomes for Delaware adults, particularly those with disabilities and chronic conditions.

CURRENT ORAL HEALTH PRACTICES

Delaware residential facility administrators were surveyed between December 2015 and March 2016. We invited 95 administrators responsible for managing 116 facilities to participate. Forty-one administrators (43 percent) participated in the survey, representing approximately 3500 residents. The electronic survey included 32 questions about the demographic characteristics of the administrators, facility features (e.g., type of facility, target population, and size), assessment and monitoring of oral health status, policies for accessing dental care, and staff training on oral health.

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Facilities

According to Delaware Health and Social Services (DHSS), Division of Long Term Care Residents Protection, approximately 344 facilities in Delaware are licensed to provide residential care. Of these, 116 facilities have administrators who oversee staff and policy and were the target survey respondents. The remainder – 158 neighborhood homes for persons with developmental disabilities and 71 rest (family) care homes – are more family structured and are operated without an "administrator." Since the focus was to capture administrators' current practices, family-structured facilities were excluded.

The facilities represented range in size from two residents to 400 residents. These facilities fall into one of four categories: 17 facilities are private, non-profit facilities; 12 facilities are private, for profit; five are a public traded company or limited liability company (LLC); and four are government-owned (i.e. federal, state, county, or local). Administrators for 14 nursing homes, nine assisted living facilities, five group homes, and 10 facilities of other types responded. Responses also came from other types of facilities, including: a continuing care retirement community with independent living, assisted living and skilled nursing components; a rehabilitation facility; and an intermediate care facility for individuals with intellectual disability (ICF/ID).

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Survey Findings

The survey of facility administrators was conducted to gather information about, and document, the current practice related to oral health care within residential facilities in Delaware. The survey included questions about routine assessment, daily oral care plans, referral for dental care, and staff training. The findings indicate a lack of consistency and structure in managing oral health care across and within facilities (Table 1). For example:

- Only 63 percent of administrators report using a standard assessment tool to guide staff in monitoring oral health for residents, and only 24 percent report routinely using that assessment tool.
- While 97 percent of administrators report that staff provide, supervise, remind, or cue oral care for residents at least twice a day, only 73 percent report that all residents have an oral health care plan in place.
- An annual visit to a dental professional is only required by 36 percent of reporting facilities.
- Fifteen percent of administrators report having an in-house dental professional and 39 percent having a contractual arrangement with a community-based dental professional.
- The majority of visits to dental professionals are to private practices and are arranged by staff (73 percent) and/or family (64 percent).

Respondents articulated a broad range of barriers that they encounter in monitoring and providing oral health care for their residents. The most often-cited barrier was that residents refuse care (60 percent). A combination of factors may contribute to this. Residents with declining function may find it difficult to manage oral care on their own but may be reluctant to have staff support. Staff with little training in how to work with residents with functional needs or disabilities may have few strategies to employ to encourage a reluctant or resistant resident to maintain daily oral care.

Common barriers reported by administrators include the cost of care (48 percent), difficulty finding a dentist (39 percent), and transportation (39 percent). These external issues point to the current climate in Delaware that fails to promote oral health care as an essential component of comprehensive care. Only 30 percent of respondents reported no barriers to providing oral health care to residents.

The survey asked administrators how oral health was included in their overall facility management plans. Sixty-four percent of the administrators reported that oral health was an element of their quality management programs, and 67 percent reported that they had a specific written oral health policy.

Table 1. Current Practice in Oral Health Management in Long-Term Care Facilities in Delaware

Variable	Percent
ASSESSMENT	
Facility uses a standard assessment tool to evaluate oral health.	63%
Assessment is completed on a routine schedule.	24%
How often is the assessment completed? (Multiple responses allowed)	
At time of admission	48%
Monthly	13%
Quarterly	70%
Annually	52%
At time of discharge	4%
ORAL HEALTH CARE PLANS	
All residents have a completed oral health care plan.	73%
Staff provide, supervise, remind, or cue oral care for residents at least twice a day.	97%
Staff are trained to recognize and act on conditions that require a referral to an oral health professional.	79%
CARE FROM A DENTAL HEALTH PROFESSIONAL	
Annual dental visit required for all residents	36%
Facility has an established partnership with an oral health professional to deliver services	66%
Type of arrangement/relationship for providing dental services *(Multiple responses allowed)*	
Referral to dental practice	27%
In-house dental professional	15%
Contracted community provider	39%
Staff arrange visit to private practice	73%
Family arrange visit to private practice	64%
BARRIERS TO RESIDENTS RECEIVING ORAL HEALTH CARE	
Resident declines care	60%
Cost of care	48%
Difficulty in finding a dentist	39%
Transportation issues	39%
Fear	30%
Attitude	6%
No barriers	30%
ORAL HEALTH POLICIES	
Oral health is a component of the facility's quality management program.	64%
Facility has a written oral health care policy.	67%

Survey of Residential Facility Administrators on Oral Health Practices conducted by the University of Delaware Center for Disabilities Studies in 2016.

RECOMMENDED PRACTICES

Guided by the findings from the survey, the project team examined the current practice environment and identified gaps in systems-level mandates and inconsistencies in practice that provide opportunities for improvement.

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This report offers recommendations to improve practice in these areas. These are drawn from a review of the relevant research literature and a scan of policy recommendations from dental, medical, disability, and geriatric professional organizations.

Residential facilities are encouraged to move toward adopting these practices to improve the oral health status of their residents. Broad adoption of these policies will:

- Enhance data collection to document current oral health, health care status, and barriers to inform practice
- Create consistent schedules for assessments to identify and address conditions that need immediate attention by a dental professional
- Increase the number of residents who have daily oral health plans implemented
- Develop and strengthen relationships for providing care – referral and contractual – with community dental health professionals
- Enhance workforce capacity and competency to support a comprehensive oral health care program.

Broad adoption of these practices may not be easy for facilities to implement immediately. Funding for oral health activities is limited. Oral health and dental services are not always included as a covered service and not always reimbursed fully, even when covered.

ROUTINELY ASSESS ORAL HEALTH STATUS

RECOMMENDED PRACTICE

Use standardized assessment tools to promote thorough and consistent monitoring of resident's oral health status (i.e., Oral Health Assessment Tool or Section L - Oral/Dental Status. See Tables 2 and 3.)

Assessing and monitoring the oral health status of residents in a standardized way – checking and recording the same items over time – builds a system for tracking change over time for individual residents. It also supports aggregation of oral health data of the resident population as a group. This affords a mechanism by which trends might be identified (e.g., recurring gum inflammation or multiple broken teeth).

A number of tools can assist with this process. Section L - Oral/Dental Status (Table 2) is required for all facilities receiving federal Medicare dollars, although not all providers report using this tool. The Oral Health Assessment Tool for Dental Screening (Table 3) is a more robust tool that captures and scores more detailed information about oral health status.

Table 2. Section L – Oral/Dental Status

L0200. Dental	
Check all that apply	
☐	A. Broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose)
☐	B. No natural teeth or tooth fragment(s) (edentulous)
☐	C. Abnormal mouth tissue (ulcers, masses, oral lesions, including under denture or partial of one is worn)
☐	D. Obvious or likely cavity or broken natural teeth
☐	E. Inflamed or bleeding gums or loose natural teeth
☐	F. Mouth or facial pain, discomfort, or difficulty with chewing
☐	G. Unable to examine
☐	Z. None of the above were present

Source: Centers for Medicare & Medicaid Services, Minimum Data Set 3.0, Section L. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30.html

Table 3. Oral Health Assessment Tool (OHAT) for Dental Screening

Primary Care				Patient/Client:		
Initial Assessment ❍ Repeat Assessment ❍ 1 ❍ 2 ❍				Date:		
*NOTE: A Star * and underline indicates referral to an oral health professional (i.e. dentist, dental hygienist, denturist) is required.*						
Category	**0 = healthy**	**1 = changes**	**2 = unhealthy**	**Score**	**Action Required**	**Action Completed**
Lips	Smooth, pink, moist	Dry, chapped, or red at corners	Swelling or lump, white/red/ ulcerated patch; bleeding/ ulcerated at corners*		1=intervention 2=refer	❒ YES ❒ NO ❒ YES ❒ NO
Tongue	Normal, moist, pink	Patchy, fissured, red, coated	Patch that is red and/or white, ulcerated, swollen*		1=intervention 2=refer	❒ YES ❒ NO
Gums and Tissues	Pink, moist, smooth, no bleeding	Dry, shiny, rough, red, swollen around 1 to 6 teeth, one ulcer or sore spot under denture*	Swollen, bleeding around 7 teeth or more loose teeth, ulcers and/or white patches,generalized redness and/or tenderness*		1=intervention 2=refer	❒ YES ❒ NO
Saliva	Moist tissues, watery, and free flowing saliva	Dry, sticky tissues, little saliva present, resident thinks they have dry mouth	Tissues parched and red, very little or no saliva present; saliva is thick, ropey, resident complains of dry mouth*		1=intervention 2 =refer	❒ YES ❒ NO
Natural Teeth ❒ YES ❒ NO	No decayed or broken teeth/ root	1 to 3 decayed or broken teeth/ roots*	4 or more decayed or broken teeth/ roots, or very worn down teeth, or less than 4 teeth with no denture*		1 or 2 = refer	❒ YES ❒ NO
Denture(s) ❒ YES ❒ NO	No broken areas/ teeth, dentures worn regularly	1 broken area/tooth, or dentures only worn for 1-2 hours daily, or no name on denture(s)	More than 1 broken area/tooth, denture missing or not worn due to poor fit, or worn only with denture adhesive*		1 = ID denture 2 = refer	❒ YES ❒ NO
Oral Cleanliness	Clean and no food food particles or tartar on teeth or dentures	Food particles/ tartar/ debris in 1 or 2 areas of the mouth or on small area of dentures; occasional bad breath	Food particles, tartar, debris in most areas of the mouth or on most areas of denture(s), or severe halitosis (bad breath)*		1=intervention 2 =refer	❒ YES ❒ NO
Dental Pain	No behavioural, verbal or physical signs of pain	Verbal and/or behavioural signs of pain such as pulling of face, chewing lips, not eating, aggression*	Physical signs such as swelling of cheek or gum, broken teeth, ulcers, 'gum boil', as well as verbal and or behavioural signs*		1 or 2 = refer	❒ YES ❒ NO
					Completed by:	

REFERRAL ❑ Referral to oral health professional Date _____ Name _____

INTERVENTIONS ❑ Chronic disease management ❑ Acute illness management ❑ Medication review ❑ Patient/Client/Family education
❑ Referral to health professional ❑ MD ❑ Nurse/NP ❑ Dietician ❑ OT ❑ SW ❑ Community worker ❑ Other _____

NOTES:

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RECOMMENDED PRACTICE

Establish a schedule for conducting assessments at admission, at regular intervals depending on risk, and at discharge.

Adopting a routine schedule for conducting assessments will increase the likelihood of identifying problems requiring attention in a timely manner. Delaware regulations require a comprehensive assessment, including dental and nutritional status, within 14 days of admission to a long-term care facility.[20] Establishing a regular schedule for interim assessments depends on whether the resident has risk factors that may require more regular monitoring. Smoking, the use of some medications, and certain medical conditions can exacerbate oral health concerns. Weekly, monthly, or quarterly assessments may be appropriate, depending on the resident's condition.

Conducting an assessment in preparation for discharge is also recommended. Results may trigger a referral, leading to amelioration of the concern prior to discharge. At the very least, the issue will be brought to the attention of the individual, the family, or the receiving facility for follow-up.

Implement Daily Oral Care Plans

RECOMMENDED PRACTICE

Develop a personalized oral health care plan for each resident. Existing tools are available to capture brushing and flossing activity, as well as the use of products such as rinses or aids. These tools often include a mechanism for identifying problem areas that call for referral.

The foundation of a healthy mouth is **routine** daily oral hygiene practices to keep teeth or dentures, gums, and surrounding tissue free of bacteria. Brushing and flossing every day is essential. The other essential element of a comprehensive oral care plan is routine visits to a dentist for professional cleanings and regular examinations, which will be addressed in the next section, "Facilitate Access to Dental Health Services."

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When used consistently, a mouth care plan can generate critical information to guide the delivery of oral health care (see sample plans on the pages that follow). Such documentation reflects the frequency of care: brushing, flossing, or using rinses or other products. Mouth care plans can also document a resident's skills for brushing and other mouth care; what assistance is needed; and if special tools or human aid is recommended.

A complete care plan will also have a method for collecting information on problems identified during daily care (i.e., broken teeth or inflamed gum tissue). Regular use, and updating, of the oral care plan provides a historical record of care and changes in function that can be useful for guiding, planning, and documenting changes in status. The Overcoming Obstacles to Oral Health – Daily Mouth Care Plan (Table 4) was developed by a team at the University of the Pacific Arthur A. Dugoni School of Dentistry. It offers a comprehensive template to capture current oral care, tools, and products used, behavioral components, and use of dental services. The Resident's Mouth Care Plan (Table 5) offers a simplified alternative for capturing these elements.

Table 4. Overcoming Obstacles to Oral Health – Daily Mouth Care Plan

Resident's Name: _____ Date_____

Assessed By (Staff) _____ (Dental Professional)_____

Assessment

Describe current daily mouth care plan

(Natural Teeth & Dentures) Dentures ❒ Y ❒ N

Daily Tooth/Denture brushing ❒ 1x ❒ 2x ❒ 3x

Brushes Own Teeth/Dentures

If yes, for how much time?_____

Daily flossing ❒ Y ❒ N

Daily mouth rinse ❒ Y ❒ N

Dentures stored ❒ Wet ❒ Dry

Physical challenges to mouth care ❒ Y ❒ N

Describe _____

Behavioral challenges to mouth care ❒ Y ❒ N

Describe _____

Create-A-Plan: Tools and Products

Tools		
TOOTH BRUSHES	❒ Electric ❒ Adapted ❒ Two-sided ❒ Standard ❒ Denture TB	❒ 1x/day ❒ 2x/day ❒ 3x/day
BETWEEN TEETH	❒ Inter-proximal brush ❒ Adapted floss holder ❒ Super floss ❒ Standard floss	❒ 1x/day ❒ 2x/day ❒ 3x/day
AIDS	❒ Mouth prop ❒ Perio-Aid ❒ Rubber tip stimulator ❒ Disclosing tablets	❒ 1x/day ❒ 2x/day ❒ 3x/day

Products	Use	Medications	Use
Xylitol: ❒ Mints ❒ Rinse* (can use swab) ❒ Spray ❒ Gum	3x/day	❒ Chlorhexidine	7 days out of each month
❒ Floride Rinse (can use swab)	2x	❒ Floride varnish	4x/year
Floride Toothpaste ❒ Standard ❒ Sensitive ❒ Denture Cleaner	2-3x day	❒ High Concentration Fluoride Toothpaste ❒ MI Paste	At least 1x day
Dry Mouth Products ❒ Gel ❒ Spray ❒ Rinse* (can use swab) ❒ Toothpaste ❒ Baking Soda	At day 1x day	❒ Other _____	

Table 4 (continued) Overcoming Obstacles to Oral Health – Daily Mouth Care Plan

Create-A-Plan: Physical/Behavior Plan

Level of Participation
- ❒ Full Participation
- ❒ Partial Participant-Can complete some tasks
- ❒ None– Person is completely dependent.

Prompts to use:
- ❒ Physical (hand-over-hand)
- ❒ Physical (touch)
- ❒ Pointing
- ❒ Verbal

Creating Conditions for Success

Person	**Who will work with individual?**	❒ Caregiver	❒ CNA	❒ Family Member
Place	**Best position**	❒ Bedside ❒ Couch	❒ Wheel-chair ❒ Recliner	❒ Bean bag chair ❒ Other
Time	**Best time or day**	❒ AM_____	❒ PM_____	❒ Other_____

Involve the Individual

List Choices offered: (Ex. Do you prefer the couch or bedside? Which flavor toothpaste?
A. _____
B. _____
C. _____

Limit Setting by individual: (Ex. I can brush the top teeth for 20 seconds, then you take over.)
A. _____
B. _____
C. _____

List Rewards Offered: (Ex. Keep rewards healthy - a TV show, Xylitol mints, music, book)
A. _____
B. _____
C. _____

Desensitization: Use gradual introduction (Ex. Start with the person holding a hair brush, then a toothbrush,then hold the toothbrush to the lips.) Steps being worked on:
1. _____
2. _____
3. _____

Shaping: Use rewards when a task is completed in the direction of a goal. (Ex. As the person completes each task, expect more from the next task before the reward is given.) Steps being worked on:
1. _____
2. _____
3. _____

Professional Dental Care Plan

Last dental cleaning appointment: Date _____ Next Appointment Date _____
Dental Check-up recommended every: _____Months Type of Dental setting: ❒ Dental office ❒ no special considerations ❒ Dental office (check one) – ❒ No special support ❒ oral/conscious/deep sedation/ ❒ behavior/physical supports ❒ Hospital or Surgi-center ❒ Will not tolerate any of the above settings (RDhAP)
Dental Provider Name: _____ PH: _____
Address: _____ Email: _____

Table 5. Resident's Mouth Care Plan

Week of: _____

Name:

Date of last Dental Exam and Cleaning/Prophylaxis:

	Sun.	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.
Date							
Daily Brushing	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Morning							
Afternoon							
Evening							
Floss/interdental							
Morning							
Afternoon							
Evening							
Rinse/Spray used							
Morning							
Afternoon							
Evening							

Area of concern identified:	Top Jaw	Lower Jaw	Date Found	Date Reported	Date Resolved
Gums are red					
Gums are bleeding					
Brown/Black area on tooth					
Broken Tooth					
Swollen Area					
Individual expresses pain in an area					
Other					

Resident's Level of Participation:
_____ Full: Self Care/Independent
_____ Partial: Needs some assistance
_____ Completely dependent

Referral/Avenue for Treatment:
_____
_____
_____

Obstacle inhibiting treatment:
_____
_____
_____

Facilitate Access to Oral Health Services

RECOMMENDED PRACTICE

Ensure that residents visit a dental professional for cleaning on a regular schedule – at a minimum of once a year.

Daily oral care is only one part of maintaining a healthy mouth and also contributes to improved overall health and quality of life. Visiting a dental professional regularly is also an essential component of recommended oral care. Routine cleanings and visits to evaluate and address identified problems must be included in a comprehensive oral health program.

The American Dental Association recommends regular dental visits and suggests that the interval be determined by a dentist based on an individual's current oral health status and past dental history.[21] The schedule should be created in consultation with a dentist, who may recommend that residents with identified risk factors have a more frequent visit schedule for routine cleanings and assessments (i.e., every four or six months).

Conditions warranting more frequent visits include those increasing risk for periodontal disease (e.g., diabetes, smoking, or interleukin-1 genetic variations) or other conditions (e.g., dysphagia). Individuals who are low-risk for dental issues may only need to see a dental professional annually for a cleaning.[22]

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RECOMMENDED PRACTICE

Ensure that residents visit a dentist for an examination at least once a year.

In addition to professional cleanings, examinations allow dentists to check for cavities, oral cancer, and gum disease, which do not always cause pain until the advanced stages of the disease.

RECOMMENDED PRACTICE

Establish a referral or contractual arrangement with a dental professional in the community to facilitate access to dental health services for residents. Some residents may have existing relationships with community dentists and may choose to continue those relationships. Others may need assistance in identifying a dentist who can provide immediate and ongoing care.

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Once a schedule is established for assessing the condition of a resident's mouth, it will be critical to have a protocol for following up on any identified problems.

While some residents may have existing relationships with community providers, and the means and capacity to visit a local dentist, some residents may not have an existing relationship with an oral health professional.

Creating an established referral relationship may take many different forms. Some facilities may have a dentist on staff or under contract to care for residents in-house. Other facilities may contract with a community provider to be available to respond to urgent conditions.

Given that many residents may not have insurance to cover dental care, ensuring access to dental care may be challenging but worth the effort.

The Division of Public Health's Bureau of Oral Health and Dental Services maintains a list of dental clinics that provide low-cost or special dental services. Visit http://www.dhss.delaware.gov/dhss/dph/hsm/files/oralhealthresources.pdf or call 302-744-4554.

Provide Staff Training in Oral Health Care

RECOMMENDED PRACTICE

Provide ongoing oral health training to staff on how to assess and monitor oral health status and how to deliver care to residents with functional needs or complex medical conditions. Offer training to all staff involved in direct care, including dentists, hygienists, nurses, Certified Nursing Assistants, and Certified Medical Assistants.

Resources are available to build workforce capacity for delivering timely and culturally competent oral health care. Once implemented, a successful training program should be offered to new and current staff, with refreshers and updates provided periodically.

This section presents eight training programs that can bring skills and strategies to residential care staff to implement oral health care programs. Some trainings are specific to oral health and others are more focused on medical care to populations that are likely to be residents of long-term care facilities. Each training provides material tailored to enhance the capacity of staff to implement and monitor oral health care programs. Other sources of training are professional organizations, federal and state funding agencies, and local dental professionals.

TRAINING PROGRAMS

Overcoming Obstacles to Oral Health

Developed by the Pacific Center for Special Care at the University of the Pacific, Arthur A. Dugoni School of Dentistry, this unique program provides resources and information for direct caregivers about oral health for people with disabilities and frail elders.[23] The material for administrators and trainers provides suggestions for facility administrators, directors, supervisors, and trainers about how to create and implement an oral health program in an organization. http://ebusiness.ada.org/productcatalog/598/Managing-Your-Practice/Overcoming-Obstacles-to-Oral-Health/P030

Dentistry in Long-Term Care: Creating Pathways to Success

This online continuing education course can help expand a dental practice to nursing homes, assisted living facilities, and senior centers.[24] Nursing home residents face the greatest barriers to accessing dental care of any population group. Older Americans are also keeping their teeth longer and developing dental problems as they become dependent on multiple care systems for a variety of needs. Providing dental care to nursing home residents makes a difference in people's lives and can be personally and professionally rewarding for dental professionals who are up to the challenge. http://www.ada.org/en/education-careers/continuing-education/long-term-care-course

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Smiles for Life: A National Oral Health Curriculum

Smiles for Life: A National Oral Health Curriculum was originally developed in 2005 by the Society of Teachers of Family Medicine Group on Oral Health.[25] Its initial goal was to provide oral health educational resources to physicians in Family Medicine residency programs. The third edition of *Smiles for Life*, released in 2010, continues its broad focus on all primary care clinicians, while adding a module on the oral examination and opportunities for interactive on-line learning opportunities that focus on individual learners and small groups. *Smiles for Life* was honored by the American Dental Association and the American Academy of Family Physicians in 2011 with letters of commendation. *Smiles for Life* is now the nation's most comprehensive and widely used oral health curriculum for primary care clinicians. Eighteen national organizations endorsed it, and numerous professional schools and post-graduate training programs incorporated it into their curriculums. http://smilesforlifeoralhealth.org/

Practical Oral Care for People with Developmental Disabilities

This series of publications developed by the National Institute of Dental and Craniofacial Research is designed to equip dental professionals with the basic information they need to deliver quality oral health care to people with special needs. This series also offers continuing medical education for providers.[26] https://www.nidcr.nih.gov/OralHealth/Topics/DevelopmentalDisabilities/

Healthcare Access for Persons with Disabilities (Parts 1 & 2)

While not specific to dental care, these two courses are designed to increase the capacity of health care professionals to provide quality health care for persons with disabilities.[27] They are approved for continuing education by the Centers for Disease Control and Prevention for physicians, nurses, certified health education specialists, and other health professionals. One course focuses on caring for individuals with physical and sensory disabilities. The second course addresses caring for individuals with developmental disabilities (including intellectual disability, autism spectrum disorders, and cerebral palsy). http://nisonger.osu.edu/education-training/ohio-disability-health-program/disability-healthcare-training/

Physician Education in Developmental Disabilities – Webinar Series

This 12 credit-hour webinar series is offered through the American Academy of Developmental Medicine and Dentistry. The series is designed to enhance the practice skill of primary care physicians and residents who would like to provide better care to their adult patients with developmental disabilities. http://aadmd.org/page/pedd-webinar-series

Resource Modules on Health of People with Intellectual Disabilities

These modules are designed to teach about the adult phase of the life course continuum of health and health care for people with developmental and intellectual disabilities (ID).[29] Trainees gain knowledge and perspective concerning: common health issues for adults with ID; socio-cultural influences on health of adults with ID; self-determination and person-centered care as essential elements of health promotion and health care for adults with ID; and communication skills as they relate to health and wellness. http://www.iddhealthtraining.org/

Best-Practice Geriatric Oral Health Training

The University of Iowa developed this curriculum to teach providers about the role of oral health in promoting quality of life for older adults. It presents a simple model and set of tools and techniques that can be used to improve oral health care. The sections on the Oral Health Assessment Tool (OHAT) and the Oral Health Care Plan (OHCP) contain interactive practice exercises, as well as printable copies of these tools. https://www.healthcare.uiowa.edu/igec/resources-educators-professionals/dentistry/demographic.asp

Actively Manage the Oral Health Program

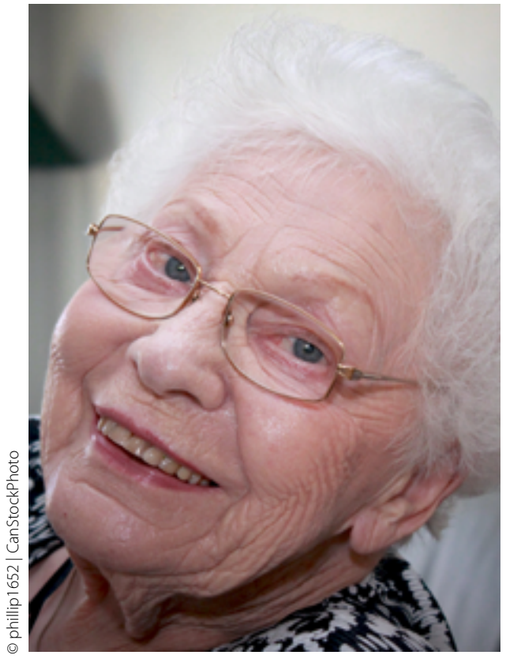
RECOMMENDED PRACTICE

Create a mechanism to monitor compliance and resolve identified issues in a timely manner. Identify a champion to lead the oral health program and be the responsible party for monitoring and reporting on compliance with the plan.

Implementing a plan to monitor compliance with the oral health program is critical to achieve the desired outcomes. Evaluating how closely plans are followed and whether actions are leading to intended outcomes will allow for course correction. Each step in the oral health care program – assessment, daily oral care, or visits to a dental professional – requires adherence.

Identifying a dental health champion within the facility to lead the initiative may be successful in achieving positive outcomes.[10, 31] The champion may be a health professional, a manager, or an advocate who understands the importance of overall health. Designating a lead person – whether a staff member or other champion – to coordinate all elements of the oral care program is recommended. This person can also be responsible for reporting to the administrator on progress.

The nation is engaged in efforts to improve the quality of medical care delivered to the patient population. This affords



RECOMMENDED PRACTICE

Integrate oral health care management into quality and performance measurement initiatives.

opportunities to integrate oral health into existing medical quality and performance measures. Efforts to embed oral health into primary care delivery also support the integration of oral health into quality and process improvement initiatives. Table 6 offers sample measures to add to existing measures to monitor progress on oral health program management.[32]

Table 6. Sample Measures to Understand Impact of Oral Health Integration Effort

Clinical Process Measures	Percentage of patients given: • A written or verbal risk assessment or screening questions • An oral exam • A referral to a dentist, if indicated based on findings
Intervention Measures	Percentage of patients in need given: • Dietary counseling • Oral hygiene training • Risk behavior education • Fluoride varnish and/or other fluoride supplement therapy • Medication adjustment to address dry mouth
Care Coordination and Referral Process Measures	• Number of referral agreements in place with local dental partners • Percentage of referred patients with a completed dental referral
Patient Experience Measures	• Percentage of patients satisfied with the preventive oral health care offered or coordinated by primary care • Percentage of patients who received useful oral health information, dietary counseling, or oral hygiene training
Practice Experience Measures	• Percentage of staff trained to deliver oral health preventive services • Percentage of staff with demonstrated knowledge of oral health clinical content • Percentage of staff satisfied with dental referral process

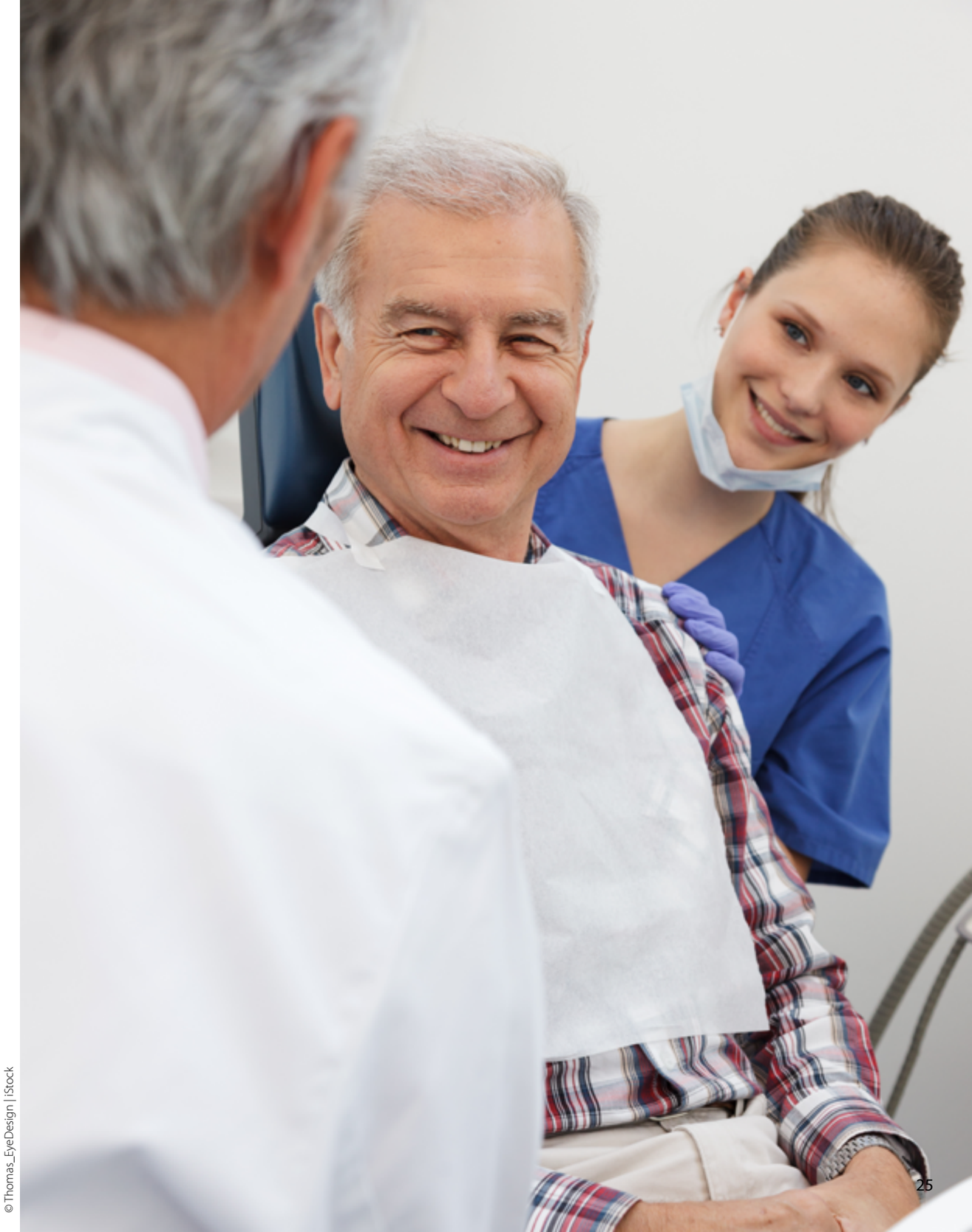
Source: Hummel J, Phillips KE, Holt B, Hayes C. Oral Health: An Essential Component of Primary Care. Seattle, WA: Qualis Health; June 2015.

RECOMMENDED PRACTICE

Create and adopt a written oral health program management policy to guide staff activity and care plans.

Creating a written policy to guide activity within facilities has many benefits. The process of drafting and adopting the policy can clarify the procedures that management and funding agencies expect to be performed. Disseminating the policy to staff can lead to revelations about knowledge and practice limitations, which in turn can underscore domains that require further professional development. Having a written policy outlining the preferred practice within a facility also is useful for resolving issues related to procedural compliance among staff and can provide documentation if legal issues arise.

Most importantly, creating a written policy provides the opportunity to build consensus within teams about the care goals and the next steps needed to provide the best oral health outcomes for residents.



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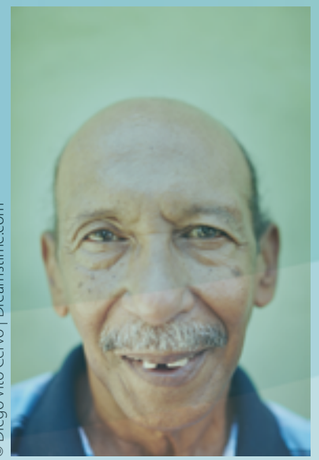

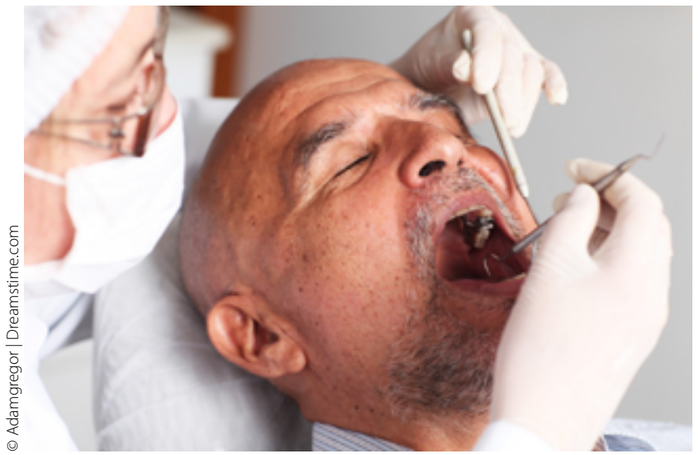

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