Preparing to Meet the Dental Needs of Individuals with Disabilities


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In 1957, an article in the Journal of Dental Education reported that “a course of study in dental care for handicapped children was relatively new to the dental school curriculum.” Even in the early 1970s, such care “was not considered an essential part of the dental school curriculum.” In fact, the 1979 National Conference on Dental Care for Handicapped Americans acknowledged that “one of the major unmet health needs in the United States is adequate dental care for the handicapped.” And even more recently, a 1999 editorial in Special Care in Dentistry noted that “persons with disabilities need comprehensive dental services and not just lip service.”

Almost a half-century has passed since some dental schools introduced into their curricula (usually on an elective basis) instruction in the care of patients with special needs. Those innovations were made in an effort to overcome dentists’ reluctance to treat these patients because of lack of knowledge and experience in clinical management. In that past era, individuals with disabilities had been “neglected by the dental profession . . . [because of] 1) lack of basic knowledge regarding the patient and appropriate physical and/or psychological management, 2) lack of experience in treating this category of patient, 3) presumed disruption of the usual office routine, 4) presumed need for special facilities and equipment, and 5) the possibility of inadequate compensation for increased time involvement in treatment.”

But surely, times have changed—or have they? In the mid-1970s, the Robert Wood Johnson Foundation granted $4.7 million to support projects in eleven dental schools over a four-year period. These projects were meant to develop pilot programs to provide needed information regarding appropriate curricular content and teaching methods that would be applicable in a nationwide effort to instruct and stimulate dental students in the care of people with disabilities.

Fifteen years later, in 1993, the Academy of Dentistry for Persons with Disabilities followed up the pilot projects with a survey of all U.S. and Canadian dental schools to determine the amount of curricular time devoted to the care of patients with special needs. The average number of lecture hours devoted to the dental management of individuals with disabilities in a typical four-year curriculum was 12.9 hours, and fourteen schools reported fewer than five hours of time. The average clinical instruction per student was 17.5 hours. Thirty-two schools reported fewer than ten hours in the curriculum (or five patient appointments).

In 1999, a second follow-up study showed an actual decrease in the time spent by students in the didactic and clinical phases of care for patients with special needs. Fifty-three percent of dental schools reported that they provided fewer than five hours of didactic training in special care dentistry. Clinical instruction in the care of patients with special needs constituted 0 to 5 percent of a predoctoral student’s time in 73 percent of the responding dental schools. “The results of these two studies clearly indicate that, during their predoctoral education, current dental school graduates do not gain the necessary expertise to treat the special-needs patient.”

Deinstitutionalization

During these past decades of limited change in the preparation of dental students for patients with...
special needs, the playing field has changed for one large group of individuals with disabilities: the hundreds of thousands of persons with mental retardation/developmental disabilities (MR/DD) who once were housed in large state institutions and psychiatric institutions. In the thirty-year period through the end of the 1990s, the number of institutionalized residents with MR/DD decreased by 75 percent. The number of residents with MR/DD residing in psychiatric institutions decreased by 91 percent. In the mid-1960s, there were more than a quarter of a million individuals with MR/DD in state institutions. By the late 1990s, there were fewer than 58,000 residents with MR/DD in state facilities.8

For more than three decades, changing social policies, favorable legislation for people with disabilities, and class-action legal decisions, which delineated the rights of individuals with mental retardation, have led to deinstitutionalization (that is, the establishment of community-oriented group residences and enhanced personal family residential settings) and closure of many large, state-run facilities.

The success of community-based programs depends on the availability of support services, particularly by private practitioners who 1) are convenient and accessible to the deinstitutionalized individual, and 2) are trained and willing to provide the needed care.9 The reality is that, “for some individuals with disabilities who reside in the community, comprehensive oral health care is inaccessible.”10 Staff members of community residences believe that residents receive poorer quality health care, with particular emphasis on the limitation of dental services.11

In the past, large state institutions (to some degree) offered a wide range of in-house health services provided by medical and dental staff employees. Almost all of the current community residential facilities, however, are too small to provide in-house intramural services beyond the annual examinations required in some states.12 As a consequence, the monitoring and delivery of health care can be difficult when the services and health records are disseminated among multiple providers and locations. And most important, the residents in the community facilities are dependent upon local practitioners for health services. The reality, however, as noted in the ADA 2001 report, Future of Dentistry, “is that most dental practices are organized with fully ambulatory patients as the primary, if not exclusive, focus. Disability and special needs will continue to be a significant barrier to access.”13

### Education

According to a 1964 article in the Journal of Dental Education, “The reluctance of dentists to care for disabled patients appears to be based to a considerable extent upon a general negative attitude toward the handicapped.”14 Over a decade later, the 1979 National Conference on Dental Care for Handicapped Americans reported, “Among the reasons that have been advanced as causes of this negative attitude is lack of education and experience in the treatment of these patents.”12

Yet the actual technical procedures used to treat patients with special needs usually do not differ from those used for the general population, except that certain modification of these procedures may be required. The most important aspect of student clinical practice involving patients with disabilities is learning to apply previously learned procedures to the particular situation: “The patient, therefore, is fundamental to developing the student’s proficiency and experience in treatment of the handicapped.”2

Graduates who haven’t encountered a sufficient number and variety of patients with special needs during their formal years of training “will not feel confident inviting these individuals into their private practices.”13 Should recent graduates join ongoing practices, they still may not gain sufficient experience since most private practices exclude patients with special needs from their patient pool. The result is that dentists who are willing to treat persons with disabilities often are inundated by referrals from colleagues who are not.3

### Third-Party Reimbursement

“It will be more expensive to provide dental services for persons (with disabilities) because of their special needs and complex management,” according to a 1964 article in the Journal of Dental Education.13 However, the availability of dental care for the population with disabilities is often complicated by the inadequacy of third-party reimbursement, in particular Medicaid, upon which many individuals with disabilities are dependent. These problems have been frequently documented: “[the] inadequate Medicaid fee schedule discourages dentists from participating in the program and frustrates the mandate of the Medicaid law”15; “Medicaid [dental payment] is about $40 to $70 per person com-
pared to approximately $200 to $300 per person spent among the non-poor. . . . Medicaid reimbursement levels, ranging from 10 to 50% of market fees, are grossly inadequate"13; and “reimbursement is so bad at 23.75 percent of UCR fees that patients cannot access services because of low numbers of providers.”16

Dentists do not participate in Medicaid primarily because of low reimbursement rates, the administrative burden, and the high “no-show” rate of Medicaid clients. “For the vast majority of dentists, the opportunity cost of serving a Medicaid client is far higher than the Medicaid reimbursement.”13 Now add to this the increased costs of providing care to patients with disabilities.

And there is a further complication: states are required to “provide any medically necessary services to eligible children to treat conditions discovered under the [Early and Periodic Screening, Diagnostic and Treatment] program.”17 Medicaid dental services, however, are elective for adults, and in many states care for adults is often limited to emergency dental services. As a result, children with disabilities all too often “age out of dental care.”11

The Challenge

But before the dental profession can legitimately make the case that the failure to provide needed care is a reflection of inadequate fee schedules and associated factors, we must be certain that we have prepared our graduates to provide these services.

The 1979 National Conference on Education Programs in Dentistry for the Handicapped prepared a comprehensive course outline for didactic courses, including 1) the basic sciences, 2) an introduction to the physical and psychological consequences of various disabling conditions for individuals and their families, and 3) various patient management techniques. The suggested clinical program format followed with a strong emphasis on variety and repetitive opportunities to demonstrate an appreciation of the special needs of patients with disabilities and the ability to provide the needed services.2

Programs have been developed in some schools, at both the pre- and postdoctoral levels.18-20 Earlier reports indicated that “students” perceived confidence in treating handicapped persons increased significantly as the result of specific instruction in disability management.”18 More recent studies have confirmed this finding, concluding that “hands-on experience in the educational setting produces a greater degree of comfort with this patient population.”20

And so, the questions remain: Are our dental schools (and schools of dental hygiene) adequately preparing their graduates for the reality that there are 33 million adults with severe disabilities in the United States21 and they need dental care? Or does the report from the 1979 National Conference on Dental Care for the Handicapped still hold true? That report found that an impediment that “continues to exist among dental practitioners, which prevents them from providing care to handicapped patients [is] practitioners, who, as dental students, did not have training and/or experience in caring for the handicapped and who, therefore, are not emotionally or professionally prepared to do so.”2

Unfortunately, the results from current studies of dental school programs indicate little change in more than two decades! But changes in dental school accreditation to incorporate a competency-based process offer both freedom and direction to the schools. Accreditation standards through the mid-1990s required a “clinical experience designed to complement didactic instruction in the dental management of the handicapped or medically compromised patients.”22 The current competency-based review process provides wide latitude in program development, and challenges the schools to ensure that “at minimum, graduates are competent [emphasis added] in providing care within the scope of general dentistry, as defined by the school, for the child, adolescent, adult, geriatric and medically compromised patient.”23

The challenge to dental educators is to review the expected competencies of their graduates in providing dental care for patients with disabilities and to justify the outcome measures of those competencies. As one writer commented, “People with disabilities need more than lip service.”3 Furthermore, we must agree that “the true measure of a society [and a profession] lies in the way it treats its older, handicapped, and disadvantaged citizens. If this is true, then U.S. society has a way to go.”24
REFERENCES