Issues and Challenges in Special Care Dentistry

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One of the neediest yet most underserved groups of dental patients in the United States today is the special needs population. This is a rather diverse group of children and adults, including those with disabilities—whether medical-related, mental, or psychological—and those with physically handicapping conditions that require more than our routine approach to care.

The U.S. Census Bureau estimated that 20 percent of the population has some type of disability, with about 12 percent being severely disabled. In addition, more than a third of adults over age sixty-five are severely disabled. With our population of seniors growing, this group of underserved special needs patients in particular is expected to increase.

The U.S. Surgeon General’s 2000 report on oral health in America cited significant disparities in access to dental care services for the disabled and noted that these children and adults are at greater risk of developing oral diseases. Various studies support this assessment, with higher-than-normal rates of caries, oral pain, gingival infection, periodontal disease, untreated tooth decay, and other dental problems noted among people with various disabling conditions. While physical and mental disabilities themselves often make it difficult for special needs patients to visit a dental office, this access problem can be largely attributed to two major obstacles: an inability to afford preventive and treatment-related dental services and the limited number of dental professionals providing such care to this population.

Consider, for instance, that Medicaid reimbursement rates for dental care are minimal to nonexistent. For example, more than 1.5 million mentally retarded or developmentally delayed adults rely on Medicaid, which does not cover dental care. The access problem has been worsened in part by the trend to deinstitutionalize most adults with disabilities over the past thirty years and to bring them into communities where their dental care access is no longer centralized. Studies of these patients show they have a higher than average proportion of missing-to-filled teeth. Clearly, there is a gap between the need for and provision of dental care to this population. Many communities, however, lack dental professionals with either the training or willingness to work with these patients.

Medicare for seniors also provides little in the way of dental care coverage. The statute specifically excludes any coverage for “services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth.” There are a few narrow exceptions for which coverage is allowed, such as: 1) dental care that is an integral part of providing a covered medical procedure (for example, a tooth extraction done as part of repairing a fractured jaw); 2) maxillofacial surgery to address pathologic and traumatic conditions; 3) tooth extraction to prepare the jaw for radiation treatment; and 4) an oral examination prior to kidney (but no other organ) transplant.

The Balanced Budget Act of 1997 provided for a study of “medically necessary dental services.” Legislation introduced that year provides coverage for a few other dental services deemed cost-effective and also laid the groundwork for covering various other situations that may later be deemed worthwhile to cover from a purely budgetary standpoint. In other words, policy dictates that the cost of adding coverage for a particular dental service must be offset fully by reducing the hospitalization costs related to not providing the dental service.
It is important to note that various studies indicate there is limited high-quality scientific evidence to support much of the way dentistry is practiced today, particularly related to dental care and its relationship to serious medical conditions elsewhere in the body. This explains in part why the Institute of Medicine Committee, charged with examining the evidence for extending Medicare dental coverage for special needs patients, identified only these few medical conditions and related dental services that might qualify as “medically necessary.”

Unfortunately, the definitions and language narrowly focus on dental care for “underlying medical conditions,” which suggests that the mouth is in some way different and isolated from other parts of the body. Noting this quandary in their 2000 report, the IOM Committee suggested that Congress update the statutory language regarding Medicare coverage. As of yet, little attention has been paid to this recommendation.

These low compensation rates combined with the complex management issues and additional time and staffing that are required to serve special needs patients explain in part the limited number of dental professionals currently working with this needy population.

A more important factor, however, seems to be that dental students are not being exposed to caring for disabled persons during their undergraduate and postgraduate education. According to Sheldon Bernick, D.D.S., former president of the Academy of Dentistry for Persons with Disabilities, more dental school undergraduate programs provided both didactic and clinical courses in caring for special patients during the 1960s and 1970s than they do today. Now, however, the academy’s surveys suggest only a handful of schools do so, and very few provide clinical services for special needs persons.

Some practitioners who work with disabled patients estimate that most (with mild to moderate disabilities) are treatable by general dentists. With little experience in handling these patients, however, fear—about how to manage their needs and how other office patients may react—is a pivotal factor in whether care is provided at all.

Clearly, this gap between the need for oral health care services among special needs patients and their access to such care requires a multistep approach. More educational programs to train providers with the specialized skills required to treat special needs patients should be developed and widely implemented. Incentives could be added to encourage participation in these programs. Outreach programs at the state and local level must be developed to meet the needs of patients who cannot receive care in a traditional dental office. Publicly funded or subsidized oral health care programs should be established to serve this population. Lastly, increased reimbursement rates are needed to compensate for the increased time and staffing required to properly care for these patients and to attract more caregivers to undertaking the additional training needed to provide such care.

As Gordon Christensen, D.D.S., board member of the National Foundation for Dentistry for the Handicapped, has noted, “There appears to be money for bombs and many other seemingly less important areas, but little to treat these needy people.”

REFERENCES