

North Carolina Special Care Dentistry – A National Model

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Back in the 1990s, there was very little talk about “special care dentistry” [1], but the North Carolina Dental Society (NCDS) recognized the need for a statewide dental care program focused on the frail elderly and those with intellectual and developmental disabilities. Little did the NCDS know that North Carolina would be the center of a significant senior adult growth spurt, or that the simultaneous deinstitutionalization of those with intellectual and developmental disabilities (I/DD) would strain care resources at the community level.

In 1990, the Americans with Disabilities Act, further defined in 1999 by *Olmstead v L.C.*, created the framework for those with I/DD to live their lives as fully included members of the community. Dentists were unsure how to respond: they did not have the training or skills to care for these patients, plus their offices were not built to allow wheelchair access. Because of this, I/DD group home administrators were left with few options: their clients were aging out of pediatric practices, the University of North Carolina School of Dentistry in Chapel Hill had a long waiting list of referrals, and hospital operating rooms were difficult to access.

This statewide growth required a different program approach. Special equipment needed to be designed and manufactured and software created to communicate with facilities, responsible parties, patients, and third-party payors. On-the-job training was required because no institution in the country was teaching how to deliver on-site care to arguably one of the most difficult-to-serve patient demographics in dentistry. At this time, advocacy efforts from groups supporting special needs patients came to

the fore. Simultaneously, counsel from the North Carolina Board of Dental Examiners and malpractice providers helped define the risks of providing care for a completely new population. The workable solution for providing care proved to be a nonprofit model that received capital funding from foundations, retainer fees from facilities, and fee-for-service for dental care. It was not traditional dentistry, but this was not a population served by that model.

Carolina's Mobile Dentistry (CMD) (1997), and later the independent nonprofit Access Dental Care (2000), were formed to meet this need. (CMD became part of Access Dental Care in 2015.) These models were based on a simple concept: provide patients in skilled nursing homes, group homes, and Programs for All Inclusive Care of the Elderly (PACE) the same quality of care on site that anyone in the general population gets from their local dentist. These initial efforts have now produced a national model for providing comprehensive, quality care to those with intellectual and developmental disabilities and the medically compromised.

Access Dental Care now has a total of 200 facilities statewide served by five teams (each with a dentist, hygienist, and two assistants). During a typical day, each team can travel up to one and a half hours one way, unload two operatories of dental equipment into a facility, see 15-18 patients, reload the equipment, and return to home base. A successful day has the inherent challenges of preparing the facility for a visit, requiring facility cooperation during the clinic day, managing difficult patients, and communicating with responsible parties pre- and post-treatment.

The preponderance of special care needs is among older patients. North Carolina's older adult population will double in the next 20 years and its oldest group (aged 85+) will have a staggering growth of 114% [2]. A microcosm of this senior growth, Brunswick County is currently the fastest growing county in North Carolina with 20% of residents aged 65+; the county is predicted to have more residents aged 65+ than under age 18 by 2031 [3]. The older adult population now accounts for 34.4% of Brunswick County's total population because it is a major retirement destination [4].

There are enormous access-to-care challenges for those with I/DD seeking routine, comprehensive dental care. Those responsible for helping these patients get care may be turned away because of a patient's behavior and Medicaid payor status. Often, providers are concerned about the length of time it might take to treat an I/DD patient [5]. As noted by the National Council on Disability, dental care is a frequently forgotten area within the overall health care equation, dental offices are often inaccessible, and their equipment may not accommodate many disabilities [6, 7]. As was also noted, even when the physical environment has been adapted, a lack of understanding of disability issues among health professionals can minimize the effectiveness of the services provided, thus creating another roadblock for those claiming their health care rights. Insufficient dental school training in this space is a major contributing factor.

The Future in North Carolina

By 2030, there will be 10 ADC dental teams serving communities throughout North Carolina. Nursing home and group home facilities will all be within a one-hour drive of each team, be visited every six weeks, and have 24/7 emergency services. Six fixed special care clinics will serve those living in the community at-large. For more information, visit www.accessdentalcare.org. NCMJ

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