Collaborative Preventive Community Based Care Serving People with Disability

Texas Oral Health Coalition Summit
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Neither I, nor members of my immediate or extended family have any financial relationship with commercial entities that may be relevant to this presentation.

The opinions expressed in this presentation are those of the speaker and not necessarily those of the University of Texas School of Dentistry at Houston.

The opinions expressed in this course should not be construed as advice to care for specific patients.
OVERVIEW

- Policy Issues create Health Disparity for people with disabilities
- The shift from Biomedical Restorative Care to Technical Innovative Preventive Models
- Medical and Dental Collaborative Integrative Models of Care Improve Patient Health
OBJECTIVES

• Understand collaborative preventive care in non-traditional settings increasing individual, family and care giver support to achieve oral health.

• Learn innovative strategies to improve Medicaid Alternative Home and Community Based Program participants' oral health outcomes.

• Be able to advocate oral health disparities for people with disabilities to bring equity to the promise of oral health in US federal statutes.
AADMD Advocates For:

- Collaborative Integrated Delivery of Quality Health Care and training for professionals.
- Reducing government’s barriers to health care among people with disabilities which requires a trained workforce, curriculum, data, research and adequate funding.
AADMD Actions:

- Collaborative Integrated Practice Model
- Advocacy Effort with HRSA for MUP
- Professional Education Curriculum Project
- Accreditation Standards for Medical/Dental
  - CODA: Council on Dental Accreditation Standard
  - Medically Underserved Populations Resolutions
    - AADMD, AMA, ADA, ACP, APHA

Fragmentation of care contributes to poor outcomes and increased mortality.
Current Policy of the United States

All People With Disabilities Are Viewed as Capable Of Growth And Development And Shall Have The Full Opportunity For Normal Everyday Experiences With People Without Disabilities.

DD Act of 2000
DD Act of 2000: Bill of Rights

- USC Title 42, Chapter 144, Subchapter 1 Part A, Section 15009

- Community Integration Mandate
  - Meet Minimum Standards for...
    - ... Appropriate and Sufficient Medical and Dental Care
  - Prohibition of the use of physical restraint... unless absolutely necessary to ensure the immediate safety...

- Effective: October 30, 2000

- In addition to constitutional rights for all
Mortality at Titanic
by passenger class, women and children

From Broom L & Selznick P, 1968
LIFE EXPECTANCY AND INCOME FOR SELECTED COUNTRIES AND TIME PERIODS

![Graph showing life expectancy and income per capita for different years and periods.](image)

World Bank Development Report 1993
Longevity factors:

- **40% - Individual Behaviors (most important)**
  - Prevention
  - Tobacco and alcohol
  - Exercise and obesity

- **30% genetics – This may change**

- **20% environment and public health**
  - Immunization, pollution, stress

- **10% - health professional procedures**
  - Some health maladies can be “fixed”
  - Person Centered Partners in Prevention

*Source: McGinnis, Foege, 1993; McGinnis, et al. 2002; Perlman et al. 2012*
Health Disparity VS. Health Equity

- Inequity = unfair and avoidable outcomes
- Inequality can be due to genetics = fair but regrettable
- Disparities are evident world-wide
- Many disability groups cannot access care
- US Government determines “Medically Underserved Populations” ..... by Zip Code!
The Case for Designating People with I/DD as MUP

April 8, 2014

There are millions of Americans with disabilities lacking adequate health care because of a lack of primary care providers who are properly trained to treat them. In 2000, Healthy People 2020 cautioned that “as a potentially underserved group, people with disabilities would be expected to experience disadvantages in health and well-being compared with the general population.” Unfortunately, that statement continues to be correct. In particular, people with intellectual and developmental disabilities (I/DD) remain subject to significant health care disparities.

Right now, people with ID/DD are not included in the federal government’s definition of Medically Underserved Populations (MUP). That is why it is very important that awareness of this issue be spread so that the Health Resources Services Administration can take action to include people with ID/DD in the MUP definition. Failing that, Congress should act to ensure this community’s inclusion in the official definition. By including people with I/DD in the federal definition of a Medically Underserved Population, people with intellectual and developmental disabilities will have access to better quality health care now and into the future.
“Telemedicine is a powerful tool that helps overcome major obstacles low-income and underserved children and families face in obtaining the health care they need,” said Wendy Lazarus, Founder and Co-President of The Children’s Partnership. “For children living in medically undeserved areas—both rural and parts of urban areas—telemedicine can address health care provider shortages, transportation costs, and lost time from work and school, by using technology to bring the care to where the children are.”
TelAbility
An Internet-Based Telehealth Program For Young Children with Disabilities
http://www.telability.org

- Connect people in different locations in North Carolina to increase access to specialized healthcare services for families and decrease professional isolation
- Serve as a resource for parents and professionals seeking credible and reliable information on topics related to children with disabilities

Joshua Alexander, MD
Director of Pediatric Rehabilitation and TelAbility Program Director
UNC School of Medicine

Juliellen Simpson-Vos, M.Ed
TelAbility/WATCH Project Director
Welcome to the Heartland Regional Genetics and Newborn Screening Collaborative. We are a collaborative network of genetics and newborn screening providers, advocates and other stakeholders from Arkansas, Iowa, Kansas, Missouri, Nebraska, North Dakota, Oklahoma, and South Dakota.
Person with Developmental Disability with local team members:

- Developmental Pediatrician
- Gastroenterology
- Dentistry
- Neurology
- Dental Hygiene
- Psychiatry
- Dentistry
- Behavioral Therapy
- Pharmacy
- Primary Care
Creating a Telemedicine System

- Recognize the need and patient population
- Determine the appropriate type of Telemedicine model
- A Champion for Your Cause
- A Collaborative Coordinator
- Health Care Experts
- Technological Support
- Financial Stream
Social Determinants of Health

• Are the economic and social conditions –
• And their distribution among the population –
• That influence individual and group differences in health status.

• Reference:
“Social Determinants of Health”

- Social-Physical-Economic-Services Determinants
  - Income & income inequality
  - Education
  - Race/ethnicity/gender & related discrimination
  - Built Environment
  - Stress
  - Social support
  - Early child experiences
  - Employment
  - Housing
  - Transportation
  - Food Environment
  - Social standing

SURVEILLANCE!!!
HOW DO WE DEFINE DISABILITY?
Who are People with Disabilities?

- **Mental Disability**: an impairment in the ability to think or learn, or that affects a person’s behavior or perception.
  - Examples include intellectual disabilities, attention deficit hyperactivity disorder, dementias and various mental illnesses.

- **Physical Disability**: an impairment that affects the body’s ability to function normally.
  - Examples include conditions ranging from paralysis to multiple sclerosis, as well as conditions for which symptoms may not be evident, such as immune disorders like lupus or HIV/AIDS.
ADL: Activities of Daily Living
Figure 6
PREVALENCE OF COGNITIVE DISABILITY IN THE U.S., 2012

- Intellectual Disability: 4.92 Million (17%)
- Alzheimer's: 4.63 Million (16%)
- Severe, Persistent Mental Illness: 11.78 Million (42%)
- Stroke: 0.80 Million (3%)
- Brain Injury: 6.23 Million (22%)

Total: 28.36 Million Persons

United States: Prevalence of Disability

• Approximately 50 million Americans (19.3%) have disability of some type—
  – More than 25 million people have specific, chronic disability lasting at least 1 year

• Likelihood of disability increases with age, but nearly 70% of people with severe disabilities are children or working age adults

PUBLIC SPENDING FOR DISABILITY BY CATEGORY: 2013

Income Maintenance for LTC Recipients
$12.34 Billion

Long Term Care
$147.30 Billion

Health Care
$153.97 Billion

Income Maintenance
$253.14 Billion

Special Education
$85.13 Billion

Total: $651.88 Billion

Source: Braddock (2015), University of Colorado School of Medicine, Department of Psychiatry.
Federal Definition of Developmental Disability

Results in **functional** limitations in three or more of the following areas of life activity:

- self care
- learning
- mobility
- self-direction
- receptive or expressive language
- capacity for independent living
- economic self sufficiency
Prevalence of Intellectual Disability

Estimate of persons with Intellectual Disability in a population is 0.70 % to 1.25 %

David Braddock PhD
University of Colorado
“Disparities by race/ethnicity in estimated ASD prevalence, particularly for Hispanic children, as well as disparities in the age of earliest comprehensive evaluation and presence of a previous ASD diagnosis or classification, suggest that access to treatment and services might be lacking or delayed for some children.”

Source: CDC Report – http://www.cdc.gov/mmwr/volumes/65/ss/ss6503a1.htm

Surveillance Summaries / April 1, 2016 / 65(3);1–23
Medicare’s Role for People with Disabilities
Key Medicare Benefits

• Medicare benefits include:
  – Inpatient hospital care
  – Physician visits
  – Durable medical equipment/prosthetics
  – Prescription drugs

• Facilitates access to specialty care
Limitations of Medicare

Gaps in coverage include:

– Long-term services and supports
– Dental care and dentures
– Hearing aids
– Routine eye care and eyeglasses
– Routine foot care
– Limited mental health services
Arthritis and Periodontal Disease

Periodontal Disease Treatment

Self-reported rheumatoid arthritis prevalence was 3.95%

Patients not referred for periodontal treatment (0.66 %)

Reported in the general population (1.0%).

Of those referred patients with rheumatoid arthritis - 62.5%

Advanced forms of periodontal disease

Self-reported prevalence of cardiovascular disease

Diabetes mellitus

Researchers, based on data derived from self-reported health conditions, conclude that there is good evidence to suggest that individuals with moderate to severe periodontal disease are at higher risk of suffering from rheumatoid arthritis and vice versa.
Diabetic Oral Conditions

Dry Mouth
Can result from medications

Fungal Infections
High blood sugar levels or taking antibiotics

Poor Healing
Poor control increases chance of infection after dental surgery
Oral Health and Diabetes

82% of diabetic patients with severe periodontal disease have experienced one or more major cardiovascular, cerebrovascular or peripheral vascular events.

Compared to only 21% of diabetics without periodontal disease.
Drugs that cause Dry Mouth

Amantadine Hydrochloride
Amaphen
Ambenyl Cough Syrup
AMB 60/580 Tabs
Ambien
AmBisome Inj
Amerge Tabs
Amerified Liquid
Amerituss AD Liquid
Amfamox
Amlodipine and Benazepril HCl
Amlodipine Besylate
Amlodipine Maleate
Ammonium Chloride
Amoxapine
Amoxicillin
Amphetamine
Amphetamine Aspartate
Amphetamine Sulfate
Amfotericin B
Amvaz Tabs
Amylase
ANA – Kit
Anafranil Caps
Anaprox
Anaprox HD Liquid
Anaprox DM Liquid
Anaprox DS
Anaspire
Anaspz Tabs
Anastrozole
Apresazide Tabs
Apropine Syrup
Apropine Tabs
Apro-Flurbiprofen
Aquatab-C Tabs
Aquatab-D Dose Pack Tabs
Aquatab-D Tabs
Aquatensen
Arava Tabs
Arco-Lase Plus Tabs
Arfonad Ampuls
Arthritis Foundation Tabs
Arthrotec Tabs
Asacol Suppositories
Asacol DR Tabs
Asendin Tabs
Asimia Caps
Aspirin
Aspirin with Codeine #3 Tabs
Aspirin with Codeine #4 Tabs
Astelín Nasal Spray
Astramorph PF Inj.
Atapryl Children’s Allergy Liquid
Atarax
Atebol
Atebol Tabs
Atrobel
B&O Supprettes
B-A-C
Baclo
Baclofen
Baclohexal
Bactroban
Balamine DM Oral Drops
Balamine DM Syrup
Balsalazide Disodium
Balsalazide suppositoria
Baltusin HC Liquid
Bandol
Banflex HC Tab.
Banflex Inj.
Banophen Allergy Elixir
Banophen Tablets and Caps
Banthine Tabs
Barbidonna No. 2 Tabs
Barbiphen Tablets
Barbiphen Tabs
Barbiphen Tablets
Barbiphen Tablets
Barbies Tablets
Barbitone Tablets
Barbitone Tablets
Bayer Select Maximum
Bayer Select maximum
Becloforte
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Beconase Inhalation Aerosol
Beconase Allergy
Beconase AQ Spray
Becotide
Becotide 100
Becotide 250
Becotide Aerosol
Bel-Phen-Ergot S SR Tablets
Beldin
Belix
Bellacane SR Tabs
Benadryl Cough Medicine
Benadryl Dye-Free Allergy Liquid-Gels
Caps
Benadryl Family Dry
Benadryl Family Original
Benadryl Inj.
Benadryl Maximum Strength
Bentyl
Bentyl
Benylin Cough Syrup
Benzhexol
Benzoic Acid
Benaproxine HCl
Benztrazole
Benztrazole
Benztrazole Mesylate
Bepridil HCl
Betaferon
Betaferon
Betaferon
Betaferon
Betaxolol HCl
Betaxolol HCl
Betamethasone Dipropionate
Betaxolol HCl
Betamethasone Dipropionate
Betaxolol HCl
Betaxolol HCl
Betaxolol HCl
Betaxolol HCl
Betaxolol HCl
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Bexarotene
Bexarotene
Bexarotene
Biethylamylamine
Bidist ER Tabs
Bidist D Tabs
Biohist-La Tabs
Biotech Cold & Flu
Biperide
Bismuth Subsalicylate
Bispironol Fumarate
Bitolterol Mesylate
How Can I Monitor Geriatric Patients That Cannot Come to My Office?
The MouthWatch Solution

The MouthWatch Intraoral Camera
- Affordable, less than $229
- Multi-platform integration
- Easy-to-Use

MouthWatch Connect Software
- Store and forward platform
- HIPAA-Compliant
- Accessible via browser or app
- Works in single user or group setting
- Useful care reminders, treatment notes and easy appointment requests

COURTESY: Brant Herman SlideShare, MouthWatch, Inc.
https://www.mymouthwatch.com/teledentistry.php
Silver Diamine Fluoride Has Efficacy in Controlling Caries Progression in Primary Teeth: A Systematic Review and Meta-Analysis.

Chibinski AC¹, Wambier LM, Feltrin J, Loquerio AD, Wambier DS, Reis A.

Abstract
A systematic review was performed to evaluate the efficacy of silver diamine fluoride (SDF) in controlling caries progression in children when compared with active treatments or placebos. A search for randomized clinical trials that evaluate the effectiveness of SDF for caries control in children compared to active treatments or placebos with follow-ups longer than 6 months was performed in PubMed, Scopus, Web of Science, LILACS, BBO, Cochrane Library, and grey literature. The risk of bias tool from the Cochrane Collaboration was used for quality assessment of the studies. The quality of the evidence was evaluated using the GRADE approach. Meta-analysis was performed on studies considered at low risk of bias. A total of 5,980 articles were identified. Eleven remained in the qualitative synthesis. Five studies were at "low," 2 at "unclear," and 4 studies at "high" risk of bias in the key domains. The studies from which the information could be extracted were included for meta-analysis. The arrestment of caries at 12 months promoted by SDF was 66% higher (95% CI 41-91%; p < 0.00001) than by other active material, but it was 154% higher (95% CI 67-85%; p < 0.00001) than by placebos. Overall, the caries arrestment was 89% higher (95% CI 49-138%; p < 0.00001) than using active materials/placebo. No heterogeneity was detected. The evidence was graded as high quality. The use of SDF is 89% more effective in controlling/arresting caries than other treatments or placebos. The quality of the evidence was graded as high.

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KEYWORDS: Cariostatic agents; Child; Dental caries; Systematic review

PMID: 28972954 DOI: 10.1159/000478668
Introducing Advantage Arrest™, the first and only silver diamine fluoride available in the United States.

Silver Diamine Fluoride has been used extensively in numerous countries around the globe for decades. Advantage Arrest silver diamine fluoride 38% will change how you offer your patients the protection they deserve. Advantage Arrest:

- Provides immediate relief from dentinal hypersensitivity
- Kills pathogenic organisms
- Hardens softened dentin making it more acid and abrasion resistant
- Does not stain sound dentin or enamel
- Can provide important clinical feedback due to its potential to stain visible or hidden lesions
- Comes in an 8 mL, controlled-drop dispenser bottle

Advantage Arrest silver diamine fluoride is only available directly from Elevate Oral Care.

Place your order below or call us at 877-866-9113 for more information.

http://www.elevateoralcare.com/
People with Chronic Disabilities, 2003

- Put off/postponed care due to cost: 37%
- Trouble finding a doctor who understands my disability: 25%
- Doctor would not accept my health insurance*: 17%

Note: Among non-elderly adults ages 18 to 64 with chronic disabilities. *Among those with insurance.

2. Community Fiscal Effort for I/DD Services

- Hawaii: $2.31
- Texas: $1.53
- United States: $3.81
- Southwest (AR, LA, NM, OK, TX): $2.44

Source: State of the States in Developmental Disabilities Report, 2017
David Braddock PhD, Coleman Institute
University of Colorado
National Core Indicators™

• National Core Indicators (NCI)™
• State IDD Agency performance measures.
• Core indicators - standard measures including employment, rights, service planning, community inclusion, choice, and health and safety.
• NCI™ is a collaboration of participating states, HSRI, and ...
• NASDDDS > National Association of State Directors of Developmental Disabilities Services
Dentist visit in past year:
• African American, Non-Hispanic respondents are significantly less likely than White, Non-Hispanic

Flu vaccine in past year:
• African American, Non-Hispanic respondents are significantly less likely than White, Non-Hispanic respondents to have had a flu vaccine
“Black and Latino adults with intellectual and developmental disabilities were significantly more likely to be in fair or poor health and mental health than White adults with intellectual and developmental disabilities.”

In addition, they found that “black and Latino adults with intellectual and developmental disabilities were significantly more likely to report fair or poor health and mental health than those without intellectual and developmental disabilities.”

7. Individual and Family Support Spending per Capita of General Population

<table>
<thead>
<tr>
<th>Region</th>
<th>Per Capita</th>
</tr>
</thead>
<tbody>
<tr>
<td>New England (CT, ME, MA, NH, RI, VT)</td>
<td>$30</td>
</tr>
<tr>
<td>Southeast (AL, FL, GA, KY, MS, NC, SC, TN)</td>
<td>$41</td>
</tr>
<tr>
<td>Southwest (AR, LA, NM, OK, TX)</td>
<td>$50</td>
</tr>
<tr>
<td>Northwest (AK, ID, OR, WA)</td>
<td>$77</td>
</tr>
</tbody>
</table>

8. Home and Community Based Services (HCBS) Waiver Federal-State Spending per Capita

<table>
<thead>
<tr>
<th>Region</th>
<th>Per Capita</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hawaii</td>
<td>$75</td>
</tr>
<tr>
<td>Texas</td>
<td>$35</td>
</tr>
<tr>
<td>United States</td>
<td>$107</td>
</tr>
<tr>
<td>Southwest (AR, LA, NM, OK, TX)</td>
<td>$61</td>
</tr>
</tbody>
</table>
How Well Does Your State Serve People with Disabilities?

Posted on July 16, 2015 by Shelly DeButts

Arizona, Maryland, Missouri, New York & Hawaii Top 2015 Case for Inclusion Rankings

United Cerebral Palsy (UCP) released the 2015 Case for Inclusion today, an annual report and interactive website used to track state-by-state community living standards for Americans living with intellectual and developmental disabilities (ID/DD).

To download and read the entire Case for Inclusion report or explore the data, visit cfi.ucp.org.
How Policy Decisions Impact Inclusion

• Does a State spend on bricks or services?
• Do families control spending decisions?
• Do States use creative Medicaid options to fund dental services for adults with developmental and intellectual disabilities?
• Are people allowed to have consumer directed Medicaid options in their home?
• Does the need to protect jobs impact funding?
How Policy Decisions Impact Inclusion

• Are people with disabilities given the power to live by “self determination”, OR
  Are they treated as a commodity?
  – Controlled by case managers
  – Served by service providers with profit motive
  – Denied home based services by legislatures that do not understand the impact of costly large institutions creating long HCBS wait lists
Select a State  Oklahoma

Overall ranking (best = 1, worst = 51)

2015

Additional Highlights

Oklahoma has 2 large state facilities housing 47 Americans at a cost of $385805 per person per year.

Oklahoma participates in the National Core Indicators, the premier quality assurance program, and reported their 2015 NCI survey data.

Oklahoma has a waiting list that would require the program to grow by 179% on average to accommodate the need.

Number of residents at large state facilities

People served: ICF-DD and HCBS

Number of people on waiting lists

Average cost per person: ICF-DD and HCBS (multiply by $1,000)

Supported or competitive employment

Portion of people and dollars in community (HCBS)

Number of families receiving support
Arkansas has 5 large state facilities housing 906 Americans at a cost of $122275 per person per year.

Arkansas participates in the National Core Indicators, the premier quality assurance program, and reported their 2015 NCI survey data.

Arkansas has a waiting list that would require the program to grow by 83% on average to accommodate the need.
Texas has 13 large state facilities housing 3362 Americans at a cost of $194,180 per person per year.

Texas participates in the National Core Indicators, the premier quality assurance program, and reported their 2015 NCI survey data.

Texas has a waiting list that would require the program to grow by 368% on average to accommodate the need.
Additional Highlights

Mississippi has 6 large state facilities housing 1139 Americans at a cost of $123735 per person per year.

Mississippi participates in the National Core Indicators, the premier quality assurance program but did not report their 2015 NCI survey data.

Mississippi did not report how many people were on the waiting list.
Select a State: Hawaii

**Overall ranking (best = 1, worst = 51)**

<table>
<thead>
<tr>
<th>Year</th>
<th>Rank</th>
</tr>
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<tbody>
<tr>
<td>2015</td>
<td>5</td>
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</table>

**Additional Highlights**

Hawaii has no large state facility keeping Americans isolated from the community.

Hawaii participates in the National Core Indicators, the premier quality assurance program, and reported their 2015 NCI survey data.

Hawaii has no reported waiting list.

**People served: ICF-DD and HCBS**

<table>
<thead>
<tr>
<th>Year</th>
<th>ICF-DD</th>
<th>HCBS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>2,714</td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td>2,363</td>
<td></td>
</tr>
<tr>
<td>2007</td>
<td>2,422</td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td>2,506</td>
<td></td>
</tr>
<tr>
<td>2009</td>
<td>2,559</td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>2,541</td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td>2,556</td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>2,544</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>2,641</td>
<td></td>
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<tr>
<td>2014</td>
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</tbody>
</table>

**Average cost per person: ICF-DD and HCBS**

(multiply by $1,000)

<table>
<thead>
<tr>
<th>Year</th>
<th>ICF-DD</th>
<th>HCBS</th>
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<tbody>
<tr>
<td>2005</td>
<td>$100</td>
<td>$36</td>
</tr>
<tr>
<td>2006</td>
<td>$111</td>
<td>$36</td>
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<tr>
<td>2007</td>
<td>$110</td>
<td>$40</td>
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<td>2008</td>
<td>$112</td>
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<tr>
<td>2009</td>
<td>$100</td>
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<td>2010</td>
<td>$136</td>
<td>$40</td>
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<tr>
<td>2011</td>
<td>$98</td>
<td>$40</td>
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<tr>
<td>2012</td>
<td>$96</td>
<td>$40</td>
</tr>
<tr>
<td>2013</td>
<td>$118</td>
<td>$39</td>
</tr>
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**Supported or competitive employment**

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<tr>
<td></td>
<td>10%</td>
<td>8%</td>
<td>7%</td>
<td>13%</td>
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</tr>
</tbody>
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**Number of families receiving support**

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<tbody>
<tr>
<td></td>
<td>2,145</td>
<td>2,739</td>
<td>931</td>
<td>1,806</td>
<td>1,740</td>
<td>1,740</td>
</tr>
</tbody>
</table>

**Portion of people and dollars in community (HCBS)**

- **% of people**
  - 2005: 96%
  - 2006: 97%
  - 2007: 97%
  - 2008: 97%
  - 2009: 97%
  - 2010: 97%
  - 2011: 97%
  - 2012: 97%
  - 2013: 97%
  - 2014: 97%

- **% of dollars**
  - 2005: 93%
  - 2006: 92%
  - 2007: 92%
  - 2008: 92%
  - 2009: 94%
  - 2010: 93%
  - 2011: 93%
  - 2012: 93%
  - 2013: 92%
  - 2014: 92%
## Comparative Analysis of Medicaid HCBS (1915 & 1115) Waivers and State Plan Amendments

<table>
<thead>
<tr>
<th>Features</th>
<th>§1915(c)</th>
<th>§1915(i) SPA</th>
<th>§1915(j) SPA</th>
<th>§1915(k) SPA</th>
<th>§1115</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authority Type</td>
<td>Waiver</td>
<td>State plan option</td>
<td>State plan option</td>
<td>State plan option</td>
<td>Secretarial waiver</td>
</tr>
</tbody>
</table>

Source: NASDDDS.org
Robin Cooper MSW, Suzanne Crisp
National Association of State Directors of Developmental Disabilities Services
<table>
<thead>
<tr>
<th>Features</th>
<th>§1915(c)</th>
<th>§1915(i) SPA</th>
<th>§1915(j) SPA</th>
<th>§1915(k) SPA</th>
<th>§1115</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combining Service Populations</td>
<td>Home and Community-Based Services Waiver</td>
<td>State Plan Home and Community Based Services</td>
<td>Self-directed Personal Assistance Services (PAS)</td>
<td>Community First Choice Option</td>
<td>Research and Demonstration Project Waiver</td>
</tr>
<tr>
<td>Combining service populations is limited to:</td>
<td>States may combine service populations.</td>
<td>States may combine service populations.</td>
<td>States may combine service populations.</td>
<td>States may combine service populations.</td>
<td>States may combine service populations.</td>
</tr>
<tr>
<td>1) Aged/Disabled</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) Intellectually Disabled or Developmentally Disabled</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3) Mentally Ill</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>4) Any subgroup of the above</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caps on Individual Resource Allocations or Budgets</td>
<td>Allowed.</td>
<td>May determine process for setting individual budgets for participant-directed services.</td>
<td>May determine process for setting individual budgets for participant-directed services.</td>
<td>May determine process for setting individual budgets for participant-directed services.</td>
<td>Budget neutrality must be maintained. Caps or benefit limits may apply.</td>
</tr>
<tr>
<td>Allowable Services</td>
<td>Statutory Services: Case management services Homemaker/home health aide services &amp; personal care</td>
<td>See §1915(c) services. Includes both §1915(c) statutory services and “other” category of services.</td>
<td>• Personal care or related services. • Home and community-based services otherwise available to the participant under</td>
<td></td>
<td>State decides what services are covered, subject to CMS approval.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>MUST COVER:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Assistance w/ ADLs, IADLs, &amp; health related tasks.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Acquisition, maintenance &amp; enhancement of skills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Features</td>
<td>§1915(c) Home and Community-Based Services Waiver</td>
<td>§1915(i) SPA State Plan Home and Community Based Services</td>
<td>§1915(j) SPA Self-directed Personal Assistance Services (PAS)</td>
<td>§1915(k) SPA Community First Choice Option</td>
<td>§1115 Research and Demonstration Project Waiver</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------------------------------</td>
<td>-------------------------------------------------------</td>
<td>-------------------------------------------------</td>
<td>---------------------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>Approval Duration</td>
<td>Initial application: 3 years Renewal: 5 years</td>
<td>One-time approval. Changes must be submitted to CMS and approved. If using targeting option, renewal every 5 years.</td>
<td>One-time approval. Changes must be submitted to CMS and approved.</td>
<td>One-time approval. Changes must be submitted to CMS and approved.</td>
<td>Initial application: 5 years Renewal: 5 years</td>
</tr>
<tr>
<td>Reporting</td>
<td>Annual reports.</td>
<td>Annual reports.</td>
<td>Annual reports and triennial health and welfare reports required.</td>
<td>Annual reports on expenditures and utilization and quality measures</td>
<td>Monthly progress calls, quarterly and annual progress reports.</td>
</tr>
<tr>
<td>Administration &amp; Operation</td>
<td>Administered by the Single State Medicaid Agency (SSMA). May be operated by another state agency under an interagency agreement or memorandum of understanding.</td>
<td>Administered by the Single State Medicaid Agency (SSMA). May be operated by another state agency under an interagency agreement or memorandum of understanding.</td>
<td>Administered by the Single State Medicaid Agency (SSMA).</td>
<td>Administered by the Single State Medicaid Agency (SSMA). May be operated by other entities as approved by CMS.</td>
<td></td>
</tr>
<tr>
<td>Features</td>
<td>§1915(c)</td>
<td>§1915(i) SPA</td>
<td>§1915(j) SPA</td>
<td>§1915(k) SPA</td>
<td>§1115</td>
</tr>
<tr>
<td>----------</td>
<td>----------</td>
<td>--------------</td>
<td>--------------</td>
<td>--------------</td>
<td>--------</td>
</tr>
<tr>
<td>Purpose</td>
<td>Home and Community-Based Services Waiver</td>
<td>State Plan Home and Community Based Services</td>
<td>Self-directed Personal Assistance Services (PAS)</td>
<td>Community First Choice Option</td>
<td>Research and Demonstration Project Waiver</td>
</tr>
<tr>
<td>Purpose</td>
<td>Provides Home and Community-Based (HCBS) Services to individuals meeting income, resource, and medical (and associated) criteria who otherwise would be eligible to reside in an institution.</td>
<td>Provides HCBS to individuals who require less than institutional level of care and who would therefore not be eligible for HCBS under §1915(c). May also provide services to individuals who meet the institutional level of care.</td>
<td>Provides a new State Plan participant-directed option to individuals otherwise eligible for State Plan Personal Care or §1915(c) services.</td>
<td>Provides a new State plan option to provide consumer controlled home and community-based attendant services and supports. Provides a 6% FMAP increase for this option.</td>
<td>Authorizes the DHHS Secretary to consider and approve experimental, pilot or demonstration projects likely to assist in promoting the objectives of the Medicaid statute.</td>
</tr>
</tbody>
</table>
| Requirements That May Be Waived | • Statewidenseness  
• Comparability  
• Community income rules for medically needy population | • Comparability  
• Community income rules for medically needy population | • Statewidenseness  
• Comparability | Community income rules for medically needy population | Secretary may waive multiple requirements under §1902 of the Social Security Act if waivers promote the objectives of the Medicaid law and intent of the program. |
Is Private Coverage Enough?

- Half of non-elderly persons with severe disabilities are covered by private health insurance
- High rates of unemployment among people with disabilities limits their access to employer-sponsored insurance;
- Individual market coverage is often inadequate, unavailable, or unaffordable to people with disabilities
- Private coverage is structured for healthy, working populations and rarely provides adequate coverage for people with disabilities.
- Replacement of the ACA imperils people with disabilities

UNITED STATES DATA OF HOME AND COMMUNITY BASED SERVICES (HCBS)

HCBS WAIVER PARTICIPANTS

ADJUSTED WAIVER COST PER PARTICIPANT

Source: Braddock et al., Coleman Institute and Department of Psychiatry, University of Colorado, 2014.

Copyright © 2017, The State of the States in Developmental Disabilities Project
10. Average Annual Cost of Care in State-Operated 16+ Person I/DD Institutions: 2015

State/Region | Annual Cost
--- | ---
Arkansas | $152,213
Hawaii | $164,032
Illinois | $142,120
Michigan | $234,445
Minnesota | $256,400
Mississippi | $234,445
New York | $450,484
Oregon | $234,445
Texas | $256,400
UNITED STATES | $256,400
Vermont | $234,445

Average cost per resident per year in State-operated institutions including developmental centers, training centers, state schools, and designated I/DD units in state psychiatric hospitals. (Excludes nursing facility spending.)

Fourteen states no longer fund state-operated institutions for 16 or more persons: Alabama, Alaska, District of Columbia, Hawaii, Indiana, Maine, Michigan, Minnesota, New Hampshire, New Mexico, Oregon, Rhode Island, Vermont, and West Virginia. States with a “blank” have no remaining institution.

Copyright © 2017, The State of the States in Developmental Disabilities Project
HCBS WAIVER PARTICIPANTS

Source: Braddock et al., Coleman Institute and Department of Psychiatry, University of Colorado, 2014.

http://stateofthestates.org

ADJUSTED WAIVER COST PER PARTICIPANT

HAWAII

PERSONS WITH I/DD BY SIZE OF SETTING: FY 1996-2013
<table>
<thead>
<tr>
<th>Region</th>
<th>Persons on Medicaid 1915(c) HCBS Waiver Wait Lists</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>582,066</td>
</tr>
<tr>
<td>Alabama</td>
<td>2,610</td>
</tr>
<tr>
<td>Alaska</td>
<td>982</td>
</tr>
<tr>
<td>Arizona</td>
<td>N/A</td>
</tr>
<tr>
<td>Arkansas</td>
<td>3,007</td>
</tr>
<tr>
<td>California</td>
<td>3,660</td>
</tr>
<tr>
<td>Colorado</td>
<td>3,796</td>
</tr>
<tr>
<td>Connecticut</td>
<td>2,078</td>
</tr>
<tr>
<td>Delaware</td>
<td>0</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>0</td>
</tr>
<tr>
<td>Florida</td>
<td>76,750</td>
</tr>
<tr>
<td>Georgia</td>
<td>11,242</td>
</tr>
<tr>
<td>Hawaii</td>
<td>0</td>
</tr>
<tr>
<td>Idaho</td>
<td>0</td>
</tr>
<tr>
<td>Illinois</td>
<td>29,425</td>
</tr>
<tr>
<td>Indiana</td>
<td>5,295</td>
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<tr>
<td>Iowa</td>
<td>8,775</td>
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<tr>
<td>Kansas</td>
<td>5,441</td>
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<tr>
<td>Kentucky</td>
<td>6,278</td>
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<tr>
<td>Louisiana</td>
<td>41,492</td>
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<tr>
<td>Maine</td>
<td>2,356</td>
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<tr>
<td>Maryland</td>
<td>27,129</td>
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<tr>
<td>Massachusetts</td>
<td>0</td>
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<tr>
<td>Michigan</td>
<td>14,040</td>
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<td>Minnesota</td>
<td>4,820</td>
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<tr>
<td>Mississippi</td>
<td>7,843</td>
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<tr>
<td>Missouri</td>
<td>684</td>
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<tr>
<td>Montana</td>
<td>1,298</td>
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<tr>
<td>Nebraska</td>
<td>1,299</td>
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<tr>
<td>Nevada</td>
<td>1,271</td>
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<tr>
<td>New Hampshire</td>
<td>0</td>
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<tr>
<td>New Jersey</td>
<td>50</td>
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<tr>
<td>New Mexico</td>
<td>19,269</td>
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<tr>
<td>New York</td>
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<tr>
<td>North Carolina</td>
<td>22,056</td>
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<td>North Dakota</td>
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<td>Ohio</td>
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<td>Oklahoma</td>
<td>6,933</td>
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<tr>
<td>Oregon</td>
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<tr>
<td>Pennsylvania</td>
<td>18,416</td>
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<tr>
<td>Rhode Island</td>
<td>N/A</td>
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<tr>
<td>South Carolina</td>
<td>5,656</td>
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<tr>
<td>South Dakota</td>
<td>23</td>
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<tr>
<td>Tennessee</td>
<td>7,165</td>
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<tr>
<td>Texas</td>
<td>163,146</td>
</tr>
<tr>
<td>Utah</td>
<td>2,172</td>
</tr>
<tr>
<td>Vermont</td>
<td>N/A</td>
</tr>
<tr>
<td>Virginia</td>
<td>7,779</td>
</tr>
<tr>
<td>Washington</td>
<td>1,350</td>
</tr>
<tr>
<td>West Virginia</td>
<td>2,188</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>3,963</td>
</tr>
<tr>
<td>Wyoming</td>
<td>621</td>
</tr>
</tbody>
</table>
Caries Management

Treatment Modalities for Caries Management, Including a New Resin Infiltration System

Gerard Kugel, DMD, MS, PhD; Peter Arsenault, DMD, MS; Athena Papas, DMD, PhD

October 2014 RN - Expires October 31st, 2017
Tufts University School of Dental Medicine

Abstract

Seemingly against all odds, dental caries still affects most people in the U.S. While fluoridated products, school-based screening and cleaning programs, better patient education, and professional and chemotherapeutic interventions have all impacted certain populations, caries is still the most prevalent chronic childhood disease and continues to affect a high percentage of adolescents, young and middle-aged adults, and seniors. Much research has proven that dental caries is not just an occasional cycle of cavitation but a complex and infectious disease process. Historically, addressing the caries challenge has relied on prevention and restoration, with no intermediary means to stop lesion progression. Recently, a technique called caries infiltration was introduced that fills the noncavitated pores of an incipient lesion with a low-viscosity resin by capillary action, creating a barrier that blocks further bacterial diffusion and lesion development. This minimally invasive method for stabilizing early lesions requires no drilling or anesthesia and does not alter the tooth’s anatomical shape. In cases of white spot lesions in the esthetic zone, it also eliminates opaqueness and blends with surrounding natural teeth. This article presents an overview of caries prevention initiatives and a case demonstrating the new caries infiltration technique. Combined with shifting the focus to caries risk assessment, this promising technology may prove to be a significant addition to the profession’s caries treatment armamentarium.

Learning Objectives:
After reading this article, the reader should be able to:

- discuss dental caries as a disease.
- explain caries management by risk assessment.
- discuss the concept of caries infiltration.
- describe the caries infiltration treatment process.

Disclosures:
The author reports no conflicts of interest associated with this work.
SDF

Historically only marketed in Asia and South America. Formulations range from 12-38%.
Silver diamine fluoride (SDF)

Ag(NH$_3$)$_2$F – silver and fluoride ions in colorless ammonia solution

Various concentrations – most studied is 38% SDF
38% SDF contains ~44,800 ppm F- (compare with 22,600 for NaF varnish)

Introducing Advantage Arrest™, the first and only silver diamine fluoride available in the United States.

Silver Diamine Fluoride has been used extensively in numerous countries around the globe for decades. Advantage Arrest silver diamine fluoride 38% will change how you offer your patients the protection they deserve. Advantage Arrest:

- Provides immediate relief from dentinal hypersensitivity
- Kills pathogenic organisms
- Hardens softened dentin making it more acid and abrasion resistant
- Does not stain sound dentin or enamel
- Can provide important clinical feedback due to its potential to stain visible or hidden lesions
- Comes in an 8 mL, controlled-drop dispenser bottle

Advantage Arrest silver diamine fluoride is only available directly from Elevate Oral Care.

Place your order below or call us at 877-866-9113 for more information.
Proposed Mechanism

- Silver-salts stimulate dentin sclerosis & calcification
- Silver nitrate acts to kill bacteria
- Fluoride aids in remineralization and prevention

Duffin protocol

25% AgNO$_3$ followed immediately by 5% NaF varnish
Repeat at 2, 4, 8, and 12 weeks

A randomized chart review from a practice utilizing this step-wise technique noted that of 578 frank, cavitated lesions (106 unique patients aged 2-12) treated with silver nitrate/fluoride varnish, only seven teeth required extraction due to progression of caries

98% of lesions remained arrested for up to 4 years

DOES SILVER DIAMINE FLUORIDE REALLY WORK?
375 schoolchildren (3-5 yo) with cavitated caries on primary anterior teeth followed for 30 months

Experimental groups: either 12 month applications of 38% SDF or 3 month applications of 5% NaF varnish (with or without excavation of infected caries)

SDF groups had nearly 2x as many arrested lesions as varnish and control groups (excavation of caries had no effect)
• 181 children (3-4 yo) with active dentinal caries followed up for 24 months
• Three groups: 38% SDF 1x/year, 38% SDF 2x/year, and Flowable GI 1x/year – all groups received soft infected dentin removal with hand instruments at baseline
• Caries arrest rates: 79%, 91%, and 82%
• Especially effective in anterior teeth and buccal/lingual smooth surfaces
Silver diamine fluoride (SDF) has been studied outside the United States since the late 1960s.

\[ \text{Ag(NH}_3\text{)}_2\text{F arrests existing active caries lesions and prevents future lesions.} \]
• 373 schoolchildren (6 yo) with cavitated caries on primary teeth and permanent molars for 36 months
• No excavation on primary teeth, infected dentin removed from permanent molars
• 38% SDF applied every 6 months
• SDF groups had more than 2x less new decayed surfaces than non-treatment group
Efficacy and safety

- SDF arrests and prevents dental caries
- SDF is not known to result in pulpal damage\(^1\)
- Primary adverse effect is that silver ions stain *carious* dentin (non-caries tooth structure unaffected). Also will stain soft tissue and clothes.
- Can place glass ionomer over stained dentin\(^2\)\(^-\)\(^3\)
- Potassium iodide has been reported to create a white precipitate\(^4\)


Knight GM, McIntyre JM, Craig GG, Mulyani. Leave decay in my cavity? You must be kidding! Dentistry Today 2010 February:130-133.


Knight GM, McIntyre JM, Craig GG, Mulyani, Zilm PS, Gully NJ. Inability to form a biofilm of Streptococcus mutans on silver fluoride and potassium iodide-treated demineralized dentin. Quintessence International 2009;40(2):155-161.
Is a drill-less dental filling possible?

Ryan L. Quock*, Shalizeh A. Patel, Felipe A. Falcao, Juliana A. Barros

Department of Restorative Dentistry and Biomaterials, University of Texas at Houston Dental Branch, 6516 M. D. Anderson Blvd., Ste. 493, Houston, TX 77030, United States

ARTICLE INFO

Article history:
Received 11 November 2010
Accepted 2 May 2011

ABSTRACT

Dental caries, a bacterial process that results in the acidic destruction of tooth structure, has historically been managed by the mechanical excavation of diseased tooth structure and then restoration with a synthetic material. The mechanical excavation of the infected site is most commonly achieved by a dental handpiece, or "drill"; this handpiece may induce stress and anxiety in many patients. Alternatively, a drill-less filling will involve the utilization of silver diamine fluoride (38%) to arrest and prevent dental caries, followed by restoration with a bonded filling material to achieve adequate seal at the lesion margins. This is a minimally invasive procedure that addresses both microbial and mechanical issues posed by dental caries.

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Healthy Teeth

Partnership for Community Inclusion (PICL)
Kauai Dental Project

HAWAII DEPARTMENT OF HEALTH
DEVELOPMENTAL DISABILITIES DIVISION
Hawai‘i Oral Health

• High Hospital anesthesia costs
• Lack of Medicaid Adult Dental
• Public dental clinics on O‘ahu
• Kauai: 300+ adults w/IDD
• High rates of dental need
1. Peer to Peer OH Trainers in Natural Environment
2. Dental Assistants: Teach Families Incremental Care
3. Recruit and Train the Dental Team:
   • Understand that behavior is communication
   • Adapt to new environments? People?
   • Use incremental non traditional approaches
1. Experience the environment incrementally
2. Establish the relationship with families
3. Earn the “Bond of Trust”
   - Earn the right to enter personal space
4. Engage the person to participate in the process
5. Effectively involve the care givers/family in P
6. Enable the dental team to understand behavior
7. Enable PICL Team: Consumer/Family/DDS
8. Establish a Virtual Dental Home
Current Public Policy of the United States

All People With Disabilities Are Viewed as Capable Of Growth And Development And Shall Have The Full Opportunity For Normal Everyday Experiences With People Without Disabilities.

DD Act of 2000
RIGHTS OF INDIVIDUALS WITH DEVELOPMENT DISABILITIES

42 USC 15009 SEC. 109

(a) IN GENERAL. -Congress makes the following findings respecting the rights of individuals with developmental disabilities:
(3) The Federal Government and the States both have an obligation to ensure that public funds are provided only... to programs in which individuals with developmental disabilities participate, that
(B) meet minimum standards relating to;
(ii) provision to such individuals of appropriate and sufficient medical and dental services;
Case Management Webinar: Understanding the Concepts and Documenting Delivery – August 31 at 12:00 Noon Central Time

Case management is techniques that engage states, MCOs, dentists, and patients that ensure needed dental services are delivered. It is an effective way of achieving early interventions, such as addressing childhood caries. As of January 1, 2017 four new CDT Codes will enable documenting case management services, and measure accomplishment.

This webinar will familiarize participants with case management concepts and the history behind these four codes. Dentist office scenarios will illustrate how these procedures are delivered and documented, and how the information is used by MCO’s and state Medicaid agencies assess program success.

Register Today

This program is a collaborative effort of the Medicaid-CHIP State Dental Association (MSDA), the Centers for Medicare and Medicaid Services (CMS), the American Academy of Pediatric Dentistry (AAPD) and the ADA. We look forward to your participation.
So, what’s the **REAL** Problem?

- 2000 & ‘01 Surgeon General Disparities Reports Ignored
- Inadequately Funded Fragmented Care (Medicaid)
- Lack of Consensus on Delivery Systems (Mid-levels)
- Employer based Health/ Dental Insurance System
  - 4% of persons with ND/ID have jobs
- Bias from the Treatment Professionals
- For Adults “Special Care” implies “Someone Else Serves”
- Poor Fluoridation in some States... esp. Hawaii
Percentage of Population on Community Water Systems Receiving Fluoridated Water, 2012
ARE SOME PEOPLE JUST TOO DIFFICULT TO SERVE AS OUR PATIENTS?
"TOO DIFFICULT TO SERVE"

FOCUSED on a Problem, not the Person

BLAMING the Person For Failure To Respond

SHIFTING Responsibility for the Person to Someone Else

SOURCE: Assets, Inc. Anchorage AK; John O’Brien
Early Intensive Behavioral Treatment (EIBT)

• Lovaas at UCLA in 1987 showed about half (9 of 19) of the children with autism who began intensive behavioral treatment prior to 4 years of age were fully included in regular education and showed significant gains in intellectual achievement (after 2 or more years of treatment)
  – (Lovaas OI, J Consult Clin Psychology. 1987; 55:3-9)

• Understands behavior as communication

• Uses functional assessment and repetition

• Follow-up of these children showed sustained gains
The A, B, C’s of Functional Assessment!

**Antecedent**
What happened just before the behavior occurred?

**Behavior**
Target Behavior - the behavior you are targeting for intervention

**Consequence**
What happened right after the behavior occurred?
Early Intensive Behavioral Treatment (EIBT)

- The Lovaas method is also known as:
  - Applied Behavioral Analysis (ABA)
  - Discrete Trials (DT) or Discrete Trial Training (DTT)
  - Intensive Behavioral Interventions (IBI)
- Involves intensive social and language one-on-one sessions with positive reinforcement
- Cost prohibitive but litigation mandated EPSDT coverage by Medicaid for equal access
- Can be used by therapists and families to improve oral health preventive care and build bond of trust with dental community coordinators and hygienists
Use a COLLABORATIVE TEAM:
Families, Behavioral Professionals
Physicians, Care Givers, Social Workers
Empower Consumers/ Peer Navigators:
Emergency Preparedness and
Oral Health Prevention
Stop Bullying: Violence Prevention
CREATE Partnerships for
Community Inclusion (PICL)
  e.g. Kauai Dental Project
Share Mortality Reviews to Advocate
to Fund Adult Oral Health Care

CATCH THE COMMUNITY WAVE!
Telemedicine: A solution to help reduce Health Disparities in those with Developmental Disabilities

Seth M. Keller, MD
American Academy of Developmental Medicine and Dentistry
Dr. Kenneth T. Bird in the Early Days of Telemedicine (circa 1970)
Benefits of Telehealth

Rural communities

- >85% of patients remain in local community
- Care in the community (lower cost) environment
- Enhanced healthcare and local economic development

Society

- Lower cost of care
- Improve outcomes
- “Green” technology
Management of Change: Transformation of Health System

• Empowerment of individuals, families & communities
• Balance wellness with care of illnesses
• Emphasis on health promotion, disease prevention, early detection & proactive management of illness, and patient involvement in own care.
Video house calls for patients with special needs

National Laboratory for the Study of Rural Telemedicine
University of Iowa, Iowa City, IA
The Smart Home

Elderly Patient Monitoring System Using a Wireless Sensor Network

PALLIKONDA RAJASEKARAN ET AL.

TELEMEDICINE and e-HEALTH JANUARY/FEBRUARY 2009
HealthCare Manager – Personalized Health Plan on iPad
The MouthWatch Solution

The MouthWatch Intraoral Camera
- Affordable, less than $229
- Multi-platform integration
- Easy-to-Use

MouthWatch Connect Software
- Store and forward platform
- HIPAA-Compliant
- Accessible via browser or app
- Works in single user or group setting
- Useful care reminders, treatment notes and easy appointment requests

COURTESY: Brant Herman SlideShare, MouthWatch, Inc.
https://www.mymouthwatch.com/teledentistry.php
The Virtual Dental Home is community-based, inter-disciplinary, geographically dispersed and internet connected basic and preventive oral health care implemented in CA and HI.
The Virtual Dental Home Concept Model

**Allied Personnel — On-Site**
Intake and periodic recall visits, record collection, communication with dentist

**Dentist — Off-Site**
Record review, decision about dental treatment—what and where

**Disease, needing in-person treatment by dentist**
- No
  - **Allied Personnel — On-Site**
    - Prevention and early intervention procedures, case management, integration into educational, social, general health systems

- Yes
  - **Dentist — On-Site**
    - Disease treatment

- **Dentist — Dental Office**
  - Disease treatment

- **Dentist — Dental Clinic**
  - Disease treatment

- **Dentist, Physician — Hospital ED/OR**
  - Treatment of serious infections, complex disease, people with complex medical or behavioral conditions

**Community Allied Personnel Care**
(least expensive, most cost avoidance)

**University of the Pacific Program management**

**Dentist Care**
(moderate cost avoidance)

**Hospital ED/OR Care**
(most expensive, least cost avoidance)

**FIGURE 1.** The virtual dental home concept model (Pacific Center for Special Care, University of the Pacific School of Dentistry, © 2012).
The New York eHealth Collaborative (NYeC) is a not-for-profit organization, working to improve healthcare for all New Yorkers through health information technology (health IT).

**Assistive Technology Communication**

- Westchester NY use of E-health
- Rochester NY shared Electronic Health Records
- Statewide Health Information Network for New York (SHIN-NY)

Facilitating communication:
- audio email
- picture-based cell phone for non-readers
Remote Communication

Tools for facilitating communication, such as audio email and picture-based cell phone for non-readers.

Cognitive Technologies

Pocket ACE (mobile phone)

Web Trek Connect E-Mail

GeoTalk Communicator
Remember to brush and floss your teeth after you eat dinner. Go to the bathroom now.
Improving the Quality of Life for Minorities with Disabilities

By Michelle Meadows

Approximately 54 million Americans have some type of disability. Before the Americans with Disabilities Act (ADA) passed in 1990, people with disabilities struggled to gain equal access to education, employment, social services, and health care. But their fight continues. Today, there are 5.5 million people with disabilities who are uninsured. People with disabilities, especially those who are minorities, are more likely to be unemployed. And, there are many schools and public buildings around the nation that are still not ADA compliant.

In an effort to increase advocacy training and improve services for minorities with disabilities across the country, leaders of the National Urban League presented a proposal to Federal agencies at a meeting in Washington, D.C., in October 1999.

The plan would call for Federal support to reach minorities with disabilities at all 215 affiliates of the League over the next six years. Founded in 1910, the National Urban League is a social service and civil rights organization with affiliates in 34 states and the District of Columbia. The League serves African Americans and other racial and ethnic minority groups.

Federal representatives at the National Urban League’s meeting included the Social Security Administration, the National Institute on Disability and Rehabilitation Research (NIDRR), U.S. Department of Education, and agencies of the U.S. Department of Health and Human Services (HHS) including the Health Care Financing Administration, and the Administration for Children and Families (ACF).

Formalizing the commitment

The National Urban League passed a resolution in 1998 that formalized the organization’s commitment to partnering for minorities with disabilities. The move included designating the National Urban League of Nebraska as the National Urban League Assistance Center and Information Clearinghouse for Minorities with Disabilities for the League. The National Urban League also formed a collaboration with the National Family for the Advancement of Minorities with Disabilities, a 300 member grassroots organization in Atlanta.

“Something we are seeing is the evolution of the present civil rights organization in this country as it becomes an advocate for people with disabilities,” according to John McCloskey, PhD, associate vice chancellor for academic affairs and chief student affairs officer at the University of Nebraska Medical Center. Dr. McCloskey is also the evaluator of a three-year League grant from ACF’s Administration for Developmental Disabilities. “The National Urban League is leading a movement that focuses on ensuring minorities with disabilities and their families,” he said.

“A big part of what we do involves educating minorities with disabilities about what they are entitled to under the law because many just don’t know,” said Fred Wright, vice president of operations for the Urban League of Nebraska and principal investigator of the ACF grant. “This involves both training our staff and empowering the people we serve.”

Now in the second year of the ACF grant, the National Urban League of Nebraska has led disability training, education, and advocacy in Milwaukee and Madison, Wisconsin; Peoria and Rockford, Illinois; York, Nebraska; and Omaha, Nebraska. The ACF funding supports outreach to 105 League affiliates over these years. Other funding sources are NEDIR and the President’s Committee on the Employment of Personen with Disabilities.

...continued on page 2
ADVISORY COMMITTEE ON TRAINING IN PRIMARY CARE MEDICINE AND DENTISTRY

The Role of Title VII, Section 747 in Preparing Primary Care Practitioners to Care for the Underserved and Other High-Risk Groups and Vulnerable Populations

Sixth Annual Report to the Secretary of the U.S. Department of Health and Human Services and to Congress

November 2006
Ensuring that Health Care Reform Will Meet the Health Care Needs of Minority Communities and Eliminate Health Disparities

A Statement of Principles and Recommendations

July 2009
National Healthcare Disparities Report 2008
Closing the Disparity Gap for Racial and Ethnic Minority Children: An Investment in Our Future

First National Child Health and Child Welfare Conference

Wednesday, October 27 - Friday, October 29, 2004
The Loews L'Enfant Plaza Hotel • Washington, D.C.
CLOSING THE GAP:
A National Blueprint to Improve the Health of Persons with Mental Retardation

Report of the Surgeon General's Conference on Health Disparities and Mental Retardation

U.S. Department of Health and Human Services • 2002
Reports don't have arms and legs. Like many others, this report will just sit on shelves unless we turn it into action. It is important to listen to those affected to learn what needs to be done, but to listen and not respond with determined action will only heighten the injustice this community has too long endured.

David Satcher, M.D., Ph.D.
Surgeon General
January 2002
Personal Strategies

- Love your families and create joint celebrations
- Develop an attitude of gratitude
- Never show frustration
- Be willing to learn from each new patient
- Never, Never, Never, NEVER GIVE UP
- Adapt your schedule and office
- Design an opportunity to celebrate
- Break it up into small steps... even smaller
- Delegate Behavioral Support to Caregivers and Parents
- Code 09920 – Behavioral support code
- Advocate for Non Traditional Delivery and Reimbursement
Summary

• People with disabilities have health disparities worldwide that are based upon practice and culture
• Problem solving requires coordination among professionals/family/caregivers/guardians
• Public Health Policies and Private Sector Partners can Create Effective Interdisciplinary Models of Care that Differ from the Current Norm
• Alternative Delivery Systems require Innovative Reimbursement and Creative Teaming
• Listen and Learn from the Other State’s Advocates
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