

SUMMARY

Santa Fe Group Salon:

[Expanding Oral Healthcare Access for America's Seniors](#)

By Joan Wilentz

The Santa Fe Group set ambitious goals for its salon in Arlington, Virginia, September 28-30: 2016: no less than elaborating policies and options for seniors to gain access to oral healthcare—maybe adding coverage for dental services in Medicare. The Santa Fe Group, founded 20 years ago as a dental think tank, is composed of leaders in the health professions who hold periodic “salons,” scholarly meetings for discussions of issues important to dentistry. This year’s salon was dedicated to a recently deceased Santa Fe member, the distinguished cardiothoracic surgeon, mentor, and administrator, John Charles Baldwin.

[Dr. Michael Alfano](#), Professor, Dean and Executive Vice President Emeritus of New York University and Santa Fe’s current president, opened the meeting noting that the topics the salons explore generally involve partnering with concerned organizations. Thus the salon on modernizing dental school curricula was conducted in collaboration with the American Dental Education Association and a priority to improve oral cancer diagnosis engaged the American Dental Association.

The Arlington salon was exceptional in the sheer number and range of interested parties participating, most of whom were already on board to “put teeth into Medicare,” as one enthusiast put it. Over 150 representatives of academia, government agencies, public health and advocacy organizations, foundations, health insurers, dental, nursing and other health professional groups attended the three-day meeting. Among them: Families, USA, the Kaiser Family Foundation, the Coalition for Oral Health in Aging, Oral Health America, The DentaQuest foundation, United Health Care, and the American Dental Association. The audience would

meet in small groups at the end of the meeting to make recommendations and propose next steps.

Why Now?

Three major forces are driving the move to improve access to oral care for seniors at this time. The first is need. The number of older Americans continues to grow dramatically, with an estimated 10,000 of the 72 million Baby Boomers reaching retirement age every day. While they can expect their medical healthcare costs to be covered by Medicare, dental care was explicitly excluded when the program was enacted in 1965. So at the time of retirement, when most elders face reduced incomes, paying for dental care may be problematic.

The second force, as evidenced by the Santa Fe audience, is *social capital*, a term that describes the collective force that individuals and groups can muster when they find common cause and work to achieve a benefit for society at large.

The third force is moral imperative. As Dr. Alfano observed, “Providing oral care for seniors is simply the right thing to do.” There is no reason why seniors who can’t afford dental care should have to suffer pain, discomfort, poor diets, loss of self-esteem and withdrawal of social contacts because of the condition of their mouths or missing teeth.

However, he also presented a very practical argument for adding oral care to Medicare, one that would be highlighted throughout the meeting. Maintaining a healthy mouth may actually reduce **medical** costs for the elderly. The reason lies in the bilateral connection between the mouth and the body, between oral and systemic disease. A prime example is periodontal disease. If untreated, this chronic infectious and inflammatory disease of the gums, common in older adults, not only can lead to tooth loss, but can increase the risk for or worsen systemic conditions also common in aging: diabetes, cardiovascular disease, stroke among others.. Dr. Alfano cited a number of studies by private health insurers and others that convinced the companies that coverage of dental care for their elderly enrollees with comorbid disease could

save thousands of dollars per patient per year in costs of medical treatments and, importantly, in reduced hospitalizations. In the aggregate the result could save tens of billions of dollars in Medicare healthcare spending for the country as a whole. The public needs to hear that message, Dr. Alfano said, pressing a need for prospective publicly funded demonstration projects to establish the evidence. That evidence in itself would be a strong selling point to budget-minded legislators since the savings in medical expenditures might more than cover the cost of adding oral healthcare to Medicare.

Dr. Alfano next introduced individuals who brought greetings from two organizations that will play a major role if changes in Medicare are to be effected: The American Dental Association, represented by the current President Dr. Carol Summerways, and the Centers for Medicare and Medicaid Services (CMS), represented by the Chief Dental Officer, Dr. Lynn Mouden.

[Dr. Summerhays](#) spoke of the need for a broad public/private coalition to advance oral care for seniors. She mentioned ADA's National Elder Care Advisory Committee, which supports legislative reforms, helps to build the knowledge base, and educates seniors and dentists on elder oral care. Continuing education programs and support of opportunities for dental students to work with seniors are also growing. Finally, she noted that ADA's National Health Policy Institute has built a database and analyzed state-by-state dental systems, using the data to inform policy decisions and promote expanded dental benefits in Medicaid. All this is part of ADA's effort to "mend the broken dental safety net," she said.

[Dr. Mouden](#) remarked that when he became Chief Dental Officer at CMS in 2012 he was asked what his goals were. He said he wanted to assure that all children received the dental benefits they were entitled to in Medicaid and the Children's Health Insurance Program—but that he would also like to see dental care for seniors added to Medicare. Toward that end he is raising awareness, mentioning a congressional hearing where it was apparent that many legislators themselves do not realize that the Social Security Act establishing Medicare in 1965 excludes dental services. He is also exploring expanding provisions that have since been added to

Medicare for “medically necessary dental care,” and envisions that CMS’s new Center for Innovation can be a vehicle for projects demonstrating the savings in healthcare costs for systemic disease made possible by dental coverage.

10 Commandments of Oral Care

Following the ADA and CMS greetings, Dr. Alfano introduced the keynote speaker at the salon, [Dr. Terry Fulmer](#), whose talk emphasized the messages she urged needed to be heard by family members, nurses, physical therapists and other caregivers if they are to provide oral care for older adults. Dr. Fulmer’s career reflects a lifelong dedication to nursing and to geriatrics. She served most recently as the Dean of the Bouve College of Health Sciences at Northeastern University, and is currently President of the John A. Hartford Foundation, which focuses on health care for older adults. She framed her messages in terms of 10 commandments for caregivers:

1. No ageism! There should be no denigrating, dismissing or ignoring the needs, especially oral healthcare, of older adults.
2. Explain the oral-systemic connection. The Santa Fe audience knows this well, but non-dental caregivers rarely do.
3. Recognize that “no oral health” equates to “no (good) nutrition.”
4. Don’t chintz on oral care supplies in the service carts for patients on the floors of hospitals or nursing homes.
5. Understand that “no teeth” does not mean “no pain.”
6. Educate! Many caregivers have no idea of the dental limitations in Medicaid and Medicare.
7. Appreciate that people with dementia need oral care, too.
8. Educate non-dental health professionals by providing oral care protocols. Many want to help but haven’t a clue.
9. Understand that a patient with oral discomfort is never going to be comfortable, no matter what else may be wrong. Nothing’s ever going to go right.
10. Act like the patient is your mother—and understand that actions like cleaning up teeth with food debris and tartar is going to hurt.

Among the questions that followed Dr. Fulmer’s talk was how to initiate oral care, say, on a patient floor in a hospital setting. Dr. Fulmer said that making a dental professional available to the head nurse, someone who could provide protocols, answer questions, and provide feedback would work. She said that nurses are motivated to improve their patients’ health and

comfort and seldom refuse to follow through when informed of what new actions they can undertake in that regard.

Who are the Elderly?

Health economists, epidemiologists, public health dentists and other experts, including the authors of a white paper distributed as background to attendees, were among the many presenters who assembled baseline demographic and other data to characterize the older generations.

- *Their numbers.* There were 43 million American 65 years or older in 2012—14 percent of the U.S. population of 314 million at the time. That number is expected to increase to 20 percent by 2030, with the greatest growth among those over 85 (swollen by the baby boomers). These “oldest old” will number 8.5 million by 2030.
- *Their incomes.* Median income of older Americans in 2012 was \$33,848. However, 21 percent of Hispanics, 18 percent of blacks, and 12 percent of Asians, compared to 7 percent of whites, had incomes at or below the federal poverty level that year (\$11,720 for a single person; \$23,492 for a family of 4).
- *Their diversity.* America’s elders are racially and ethnically diverse and will grow more so. The percentage of Hispanics is expected to increase from 8.3 percent in 2012 to 18.4 percent in 2050; Asians will go from 3.8 to 7.1 percent, blacks from 8.8 to 12.3 percent. In contrast, the percentage of whites will drop from 86 to 77 percent.

Some conclusions that can be drawn from the figures are that the groups that will significantly expand their share of the elder population are also the groups where the lowest incomes are concentrated: racial and ethnic minorities. Not surprisingly, each of these variables, race or income, alone, has long been associated with having poorer oral health. This has been demonstrated time and again in data from national surveys like the National Health and Nutrition Examination Survey (NHANES), the National Health Interview Survey (NHIS) and other reliable sources.

The Oral Health of Elders

Tooth loss. Complete loss of teeth in persons 65 and older was found in 29 percent of non-Hispanic blacks, 24 percent of non-Hispanic Asians and 21 percent of Hispanics, compared to 17 percent of whites. (NHANES 2011-2012 data)

Dental caries. Rates on untreated caries in the 65+ generation were highest among the poor (40 percent) and near poor (33 percent) compared to 12 percent for the non-poor. In terms of race/ethnicity, untreated caries was found in 41 percent of non-Hispanic blacks and 27 percent of Hispanic and Asian elders, compared to 16 percent in whites. (NHANES 2011-2012)

Periodontal Disease. Data from NHANES 2009-2010 found the prevalence of periodontal disease was associated with multiple variables: age, sex, income, education, race and ethnicity. It is higher in men, Mexican Americans, those 65 or older, those with less than a high school education, with incomes below 100 percent of the federal poverty level, and current smokers.

To be sure, there have been improvements in oral health of the nation over the decades. In particular, retiring baby boomers represent a generation that grew up with fluoridated water and toothpaste. As a result, many will have preserved their teeth and expect to keep them as they age. For them, **teeth matter**. So it may come as a shock to them to discover that Medicare will not cover dental care expenses except in rare instances.¹ For poor seniors who are also eligible for Medicaid (about 20 percent of seniors, so-called dual eligibles) the picture is not much brighter. The range of adult dental services Medicaid provides varies from state to state, with some states providing no coverage at all. So unless seniors can afford private dental insurance or pay out of pocket, there are serious barriers, including bureaucratic hurdles, such as finding dentists who accept Medicaid patients, that severely limit access to publicly funded dental care.

The Insurance Story

Dr. Richard Manski, Chair of dental public health at University of Maryland School of Dentistry made these points clear in his presentation, based on his extensive studies of dental access, utilization and cost. People with dental insurance are more likely to see a dentist in a given time period, he noted, and that generally yields good outcomes: they are more likely to keep their

¹ Medicare will pay for dental care prior to some organ transplants, radiation treatment for cancer and complete jaw reconstruction following injury.

teeth and have decent oral health. But even with dental insurance, which 58 percent of working Americans under 65 have, utilization rates average only around 66 percent—something attendees need to consider when drafting a dental service option in Medicare.

With retirement, the picture changes dramatically. Now only 38 percent of seniors have dental insurance, a percentage that predictably declines when sorted by race, income and education, but also by age: the percentage of insured elders drops to 27 percent for those over 74. Not surprisingly, a graph of the sources of payment for senior dental services shows that 70 percent were paid for out of pocket.

The Consequences

The statistics on oral disease in America's elders are disturbing in their own right but were made vividly graphic in the case study photos shown by Dr. Judith Jones, Boston University Henry M. Goldman School of Dental Medicine and Dr. Elisa Chavez, University of the Pacific Arthur A. Dugoni School of Dentistry, two specialists in geriatric dentistry. The severely swollen gums and infection in one of Dr. Jones' patients who was barely able to open his mouth required multiple treatments and in-hospital surgery, incurring a total cost of \$39,000, a situation that could have been prevented had the patient been seen early on. Dr. Chavez focused on the body side of the connection between the mouth and body: the effects of systemic disease and disease treatments on the oral cavity. One of her patients had extensive gingival swelling caused by an anti-hypertension drug, for example. More commonly, she noted that many medications used daily by older adults cause xerostomia, dry mouth, increasing the risk of dental caries because of the reduction in the flow of saliva with its many tissue-protective properties. Adults who are cognitively or physically impaired due to stroke or dementia may simply forget or be unable to clean their teeth and need help. Poorly controlled diabetes can have adverse effects on periodontal disease and vice versa. These cases demonstrate the need to educate and improve communication between medical and dental personnel so they can work as a team in patient care, the specialists stressed. Training family members or other caregivers on the importance of performing dental hygiene when the patient

is unable is equally important. Both underscored Dr. Fulmer's concerns about ageism and the need to make clear that good oral health is of intrinsic importance. Too many people believe that declines in oral health are inevitable with aging, and worse, that the loss of teeth is unimportant, say, in comparison to the loss of a limb.

Much of the discussion that followed these presentations echoed those sentiments, seeing many of the issues raised reflected in the long separation of dentistry from medicine and the perception of its lesser status. If a dental benefit in Medicare is to be implemented and if it's going to work, there will have to be better contact and a deeper understanding between the disciplines— enough to generate the teamwork needed. But education, health promotion and health literacy, especially oral health literacy, will also be essential for the general public as well, to overcome barriers to care and improve access and utilization. Some suggestions toward those ends included bringing dental professionals into senior centers or other gathering places for retirees. Workforce issues also came up, with dental hygienists and other trained non-dentist professionals viewed as important resources to call upon to serve an increased caseload of seniors once access is expanded. In the case of nursing home or other resident facilities for seniors, it was suggested that these practitioners could play an essential role by providing quarterly dental hygiene treatments preceding an annual checkup by dentist.

[Selling the Product](#)

While the salon presentations up to this point had amply demonstrated the need for an oral healthcare benefit, success in selling the benefit to policymakers, legislators and other gatekeepers requires ingenuity and hard evidence. Three speakers addressed these needs couching their arguments in terms of defending a "value proposition," described as corporate boardroom jargon to mean *"a statement that identifies a benefit to a consumer and that relates to that consumer in ways that are quantifiable and offer 'the best deal around'."*

Arguing the case that improving access to oral care reduces the risk and improves outcomes for systemic diseases was Dr. Ira Lamster, Dean Emeritus of Columbia University College of Dental

Medicine and currently at the University's Mailman School of Public Health. He stated that at least 10,000 papers generated over the past 20 years have explored the oral-systemic disease connection. The case is strongest for periodontal disease in relation to cardiovascular disease, diabetes and certain pregnancy outcomes, based on multiple epidemiologic, animal model, case control and other studies. As well, there is biological plausibility: For example, it appears that certain toxic products of periodontal bacteria may interfere with healing after a myocardial infarct. Periodontal pathogens may also be at the root of systemic inflammation that induces atherosclerotic thrombogenesis.

In the case of diabetes, the connection is bilateral. Patients with poorly controlled diabetes are at increased risk for periodontal disease while the presence of poorly controlled periodontal disease exacerbates diabetes. Not every published study is positive, he noted, mentioning one diabetes trial in which periodontal disease care had little effect on diabetic control. But for the most part the evidence has been supportive. In addition to the CVD and diabetes associations, Dr. Lamster reported growing reports of oral infections in relation to respiratory disease, rheumatoid arthritis, osteoporosis, chronic kidney disease, allergic rhinitis and metabolic syndrome. He is optimistic that the robust and growing evidence for oral-systemic disease connections is at last re-connecting the mouth to the rest of the body. It is also raising awareness and gaining respect for the research of dental scientists in the medical community as dental articles find their way into prestigious medical journals.

Selling an oral benefit must also overcome cultural biases that oral care is less important than medical care and that it declines in old age anyway so it doesn't matter. On the contrary, the evidence presented on oral care and quality of life by Dr. Jed Jacobsen of Delta Dental of Michigan, Ohio, Indiana and South Carolina made it abundantly clear that oral health matters a lot. To make policymakers appreciate that, he said you have to remind them of what having teeth enables: you can talk clearly. You can express your emotions. You can smile. You can eat a healthy diet, and not be forced to eat mush—which is likely to be calorie-rich and also short

circuits the time saliva can circulate protectively. Further, he noted that when people meet they look at hair, eyes and mouth, so a mouth in poor condition is a social liability.

He went on to mention the threats to oral health that accrue in aging, like the 400 medications that cause dry mouth, which affects 30 percent of seniors, or the oral cancers “that kill one American every hour of every day of every week of every month and year,” deliberately choosing this graphic mode of expression because “you have to get the attention of policymakers.” Moreover, if you are fortunate to survive oral cancer, the cost of repair and reconstruction make this cancer the most costly of all cancers to treat. Nor is the cost of oral cancer the only costly oral disease. Dr. Jacobsen compiled a list of the 10 leading diseases Americans experience in terms of frequency and cost. Dental caries was number six.

Further evidence of the value of oral health came from Dr. Marko Vujicic, a health economist at ADA’s Health Policy Institute. His group at HPI have recently completed a two-year study, Oral Health and Well-being, based on a survey over 50,000 adults with data collected by state, age and income. The survey asked why people did not go to the dentist more often and how the state of their oral health affected their lives. Overwhelmingly the leading cause for not going to the dentist was cost—even among high-income individuals, even those with dental insurance. As for how their oral health status affected them otherwise, he cited as examples the 29 percent of low income adults in the state of Washington who said they “very often” had trouble biting and chewing foods and another 14 percent who “very often” avoided smiling. Thirty percent of low-income adults in Florida said that that their oral health affected interviews for a job.

His group also re-ran 20 years’ worth of NHANES data finding that the rate of untreated caries in children has been falling significantly, but to their surprise, untreated caries has been on the rise in adults and low income seniors.

But will it Sell to Congress?

Granted that the data reported by Drs. Vujicic and Jacobsen further underscored the importance of oral health, will policymakers buy it? In particular will they accept the idea that adding a dental benefit to Medicare will result in offsetting savings in other medical costs? Dr. Vujicic reminded the audience that the fate of any proposal to amend healthcare law will be subject to the dispassionate scrutiny of Congressional Budget Office analysts and others looking at the bottom line. All the same, he believes a strong case can be made, citing two recent studies. One was conducted by his team at HPI comparing newly diagnosed diabetic patients given periodontal treatment matched with a group not given treatment, over a two-year period. The savings in medical costs for the treated group amounted to \$1,800, or \$900 per patient per year. If the cost of the perio treatment was deducted, the savings were still on the order of \$750 a year. The other study compared results of periodontal disease treatment vs no treatment in patients with congestive heart failure, stroke, or diabetes, in each case showing sizable savings in the treatment group.

In the discussion that followed, members of the audience appeared more cautious. There were concerns that the term periodontal disease is not well defined. Rather than describing a single entity the disease reflects multiple phenotypes and genotypes, with the implication that future treatments should more appropriately be individualized using “precision medicine” approaches. Some thought it would be better to avoid the cost-savings arguments altogether and stick to the intrinsic importance of oral health in and of itself. Others argued for the release of the data that dental insurers have been accumulating in their claims studies over the decade. However, this appears unlikely because of contractual agreements that assure that the data is proprietary and so must remain private. There was also some discussion on how long clinical trials need to be run to establish the advantage of dental treatments and the need for prospective trials rather than retrospective and cross-sectional studies. Some proposed that perhaps the best strategy to achieve seniors’ access to care was to take an incremental approach. It may be easier to persuade Congress to add to the list of “medically necessary dental care” in Medicare rather than to opt for a comprehensive package.

Lessons from Medicare History

In planning the salon the organizers assigned a workgroup the task of defining what a dental benefit added to Medicare would look like and how much it would cost. They also were curious on how successful past attempts to amend Medicare have been. Accordingly, they invited Jonathan Oberlander, Ph. D, a professor of social medicine at the University of North Carolina Chapel Hill School of Medicine to review Medicare's 51-year history. He is the author of *The Political Life of Medicare* and he made clear in his 7 point review that changing Medicare will not be easy:

1. To begin with, he noted that Medicare was initially proposed as a compromise when it was clear that Congress would not pass a program of national health insurance following World War II . As originally envisioned, Medicare would help older Americans on Social Security pay for the catastrophic costs of medical care, primarily hospitalizations. The design and funding of Medicare followed the Social Security model.
2. Little thought was given to coordinating hospital and outpatient care when Medicare was finally enacted in 1965. The emphasis was on acute conditions, not chronic illness. Only late in the debate was funding for outpatient care by physicians added, creating the familiar Medicare Part A, hospitalization, and Part B, outpatient care.
3. There are many "holes" in Medicare. There are high deductibles and cost-sharing, no cap on out-of-pocket spending, no long-term care or nursing home insurance. For these reasons most people on Medicare supplement it with some sort of medi-gap insurance. "you would think that adding benefits to Medicare would be popular with lawmakers, always looking for causes that would appeal to constituents," he said, " but you would be wrong." In spite of many attempts, not much has changed in Medicare over the decades. Yes, here is now hospice coverage and some additions for prevention efforts. Yes, there is now a prescription drug benefit, but that endeavor alone has a long history of attempts and failures.
4. Medicare politics is budget politics. From the outset, Congress has viewed Medicare as a runaway train and moved to constrain costs. The role of the Congressional Budget Office dominates and its analysts are very skeptical of proposals that promise cost savings with additional forms of coverage. This was the argument for adding prevention coverage to Medicare, but it hasn't worked. Prevention adds costs. He urged caution in arguing that a dental benefit would be cost-effective; it might be counterproductive.

5. Medicare politics is also Trust fund politics. Medicare Part A funding is based on payroll taxes with revenues varying over time. When calculations suggest that the Trust fund will run out of money in less than a decade there are moves to cut costs. This happens even though the probability/possibility that Medicare funding will run dry is zero.
6. Medicare politics also reflects the larger dynamics affecting American society and the current political scene. The hyperpartisanship of Congress and the deep ideological divide apparent, not only in Congress but across the nation, may generate fierce opposition to a health policy proposal to add a dental benefit to Medicare. If the addition is also seen as adding to the federal deficit the proposal may be doomed.
7. ...But maybe not. Dr. Oberlander actually ended his presentation on an upbeat note. The actual cost of a dental benefit is probably modest and the groundswell of support from a broad coalition of consumers and organizations in addition to the dental community, might be enough to sway Congress and gain bipartisan support. And if Congress wants to act, it finds a way, even if it adds to the deficit.

A Benefit Package

The process used to flesh out what a dental benefit would look like and how much it would cost was complex and detailed and is still ongoing. Santa Fe members are working in collaboration with the advocacy organization *Oral Health, America* and created Advisory and Review groups to oversee the plans proposed by a Development group at every step of the way. As well, there are consultations with actuaries, insurers, and other experts and the use of standard databases to calculate costs

Dr. Judith Jones, the geriatric dentist who had described some of her patients in an earlier talk, summarized the process and the decisions that guided the benefit design to date. The first decision was to add the dental benefit to Part B. As she put it, Part B covers outpatient services in treating the body so there is a logical fit: the mouth is part of the body and dental care is an outpatient service.

Enrollment in Part B is elective. There is no charge for coverage for certain low-income seniors but higher income individuals pay a monthly premium which is indexed to their tax returns. Because of the high concentration of serious oral health problems in the poor and near poor,

the work group decided that the dental option should be available at no cost to seniors whose incomes are below 200 percent of the federal poverty level (FPL)—a number which represents about 1/3 of all seniors. Higher income seniors would pay a premium of \$32 for the proposed dental option, a figure that would stay the same at all levels of higher income.

Dr. Jones explained that the \$32 figure for the dental option allows the plan to pay for itself. The work group chose this approach rather than argue that providing dental care for seniors would result in reduced Medicare spending for selected chronic diseases. Nevertheless, they looked again at the two studies Dr. Vujcic had cited, considering them particularly strong examples. Calculations based on multiplying the number of seniors who only have diabetes or only have congestive heart failure or only stroke by the cost savings in disease treatments per year per patient receiving dental care, yielded the impressive total of \$59 billion in medical cost savings. Even when an independent analysis of the data from one insurance company study was conducted in which the patients receiving dental care were divided according to whether they were compliant or non-compliant with their medical treatment, there were still costs savings in both groups. There is definitely something there, Dr. Jones stated.

Basic and Moderate Packages

The \$32 would cover a basic “global” set of dental services: diagnosis, prevention, non-surgical periodontal treatment, extractions and fillings. The idea would be to prevent inflammation, stabilize and prevent future disease. The work group also developed a second higher tier of services to cover more extensive and expensive procedures including crowns, bridges, root canals, dentures and two mandibular implants to support removable dentures. Several scenarios were suggested for the second level which would include the basic package plus an additional co-pay, in one example e \$31.58 to cover the basic services plus a co-pay of \$414.14 and in other examples co-pay with varying levels of cost-sharing according to the nature of the procedure provided.

The Assumptions

For the \$32 premium to pay for itself the work group made a number of assumptions including how many elders would use the service per year, the number/variety of services rendered and how much the dental provider should be paid. To calculate reimbursements they chose the 50th percentile of the usual customary and reasonable (UCR) fees for dental procedures, which are coded and compiled in a national database of commercial charges, opting to pay dental providers 70 percent of those charges, which would amount to a payment of \$584 a year to providers in the basic package. (The range of reimbursements, based on other dental benefit payment schedules, is from 60 to 80 percent, so they chose the midpoint.) Other assumptions were that utilization rates would be around 65 percent (closely matching the rate reported by Dr. Manski), with more women utilizing services than men (55 percent compared to 45 percent). Finally, they calculated that the level of services provided was neither too little, nor too much, but “just right” (they called it the “goldilocks” level). Putting all these assumptions together plus some adjustments for pent up demand and other factors, resulted in this bottom line:

The total annual cost for the basic global benefit for 37 million enrollees with provider compensation set at 70 percent of usual and customary charges= \$16,853 billion.

Dr. Jones concluded her presentation acknowledging the many questions that remained, describing the groups’ efforts as ongoing.

Comparisons with Private insurance

Dr. Jeff Chaffin, Vice-President and Dental Director of Delta Dental of Iowa, who was a member of the dental option work group, followed Dr. Jones’ summary with a brief overview of private dental insurance plans that is somewhat at odds with the Medicare option proposed so some dialogue would be advisable. For one thing, he noted that most dental insurance plans grew out of programs to cover children’s dental needs. So, for example, the plans generally do not pay for services resulting from abrasion, wear or loss of vertical dimension, which are more common in aging. Plans also do not pay for a filling that needs to be replaced in under two

years since the original restoration was made but that situation might not be appropriate for an older patient with xerostomia. His graphs of trend data showed that insured dental services are increasingly provided through Preferred Provider Organizations, but that payments to dentists are declining, an unfortunate situation given persistent high student loan indebtedness. Again he urged further discussions with the option group to reconcile differences.

The Q and A that followed the dental benefit presentations began with comments from a representative of a Medicare advocacy organization who pointed out that several features of the proposed dental benefit were inconsistent with how Part B is organized today. While totally sympathetic with raising the bar for non-payment of a part B premium to individuals with incomes below 200 percent of the poverty level, the current level is only 135 percent, which would make paying an additional \$32 a month premium difficult if not impossible. Further, only 25 percent of part B premiums actually contributes to the cost of outpatient coverage; the rest comes from the Trust fund. Dr. Jones replied, saying that option was a first attempt and she welcomed opportunities for further discussions and changes. Some suggested that the option should lean more toward prevention than restoration, which prompted Dr. Chaffin to comment that the way dental insurance is set up incentivizes treatment. A question for Dr. Oberlander concerned the early days of the Medicare debate when, the speaker thought, there were discussions about adding dental care. He wanted to know what happened. Dr. Oberlander said that the emphasis was on acute conditions and there were serious concerns about the uncertainty of what additional coverage would cost. Also, advocates thought that additions to Medicare could be made in due course. A serious concern raised by one attendee was that in order to be covered by Medicare individuals have to be eligible for Social Security, a requirement that might eliminate recent migrants, people who have never worked and others who are likely to be the very people living in abject poverty most in need of oral care. Some questions concerned how the dental option would be reconciled with dental services received by seniors eligible for Medicaid. Yes, that needs to be addressed, Dr Jones said, again reminding the group that we are still in early stages.

The Role of the Consumer

How much do consumers know or care about oral health in aging? Speakers throughout the day had alluded to some of the misguided beliefs and biases with regard to oral health and aging as well as the shock that some retirees experience when they learn that Medicare does not pay for dental care. Enlisting the support of consumers in increasing access to oral care for seniors will require raising their oral health literacy and employing marketing strategies that will get the general public behind the movement. Toward that end the salon invited Peter Mitchell, Chairman and Chief Creative officer of Marketing for Change. He provided one example of a way to mobilize public support.

He based his approach on public opinion surveys he conducted. If you ask people whether they like the idea of adding dental care to Medicare, he said, 72 percent say yes. On the other hand, 6 out of 10 had never even thought about it, so they are essentially unengaged. Nor do they know that the Affordable Care Act does not include dentistry (except for children).

So one way to get them engaged is through posters—essentially advertising. He concluded his talk by displaying sample designs he had tested. “People don't like it when you take something away from them,” he said, so the poster that said “Congress gets dental care after 65 but you don't!” was one of the most effective in getting attention and approval. Other designs that played well with consumers included “Medicare does not believe you have teeth” and “Smiling Not Allowed.”

The Audience Responds

Peter Mitchell's talk concluded the formal presentations for the day but time was left for a new form of audience participation. Drs. Linda Niessen, Dean of NOVA Southeastern University College of Dental Medicine, and Teresa Dolan, Vice President, DentsplySirona, invited attendees to download a smart phone app that would allow attendees to respond to questions about the presentations they had heard. Some questions asked for a single word to describe their reaction and these words appeared in a word cloud on a screen with the most frequently

reported words in larger size. Thus the answer to the first question on how people felt about the prospects of achieving a dental option for seniors, the dominant words were excited, hopeful and optimistic. But on how long that would take the group chose 6 to 10 years rather than a shorter time. The word cloud produced in response to the main obstacles impeding progress included Congress, partisanship, cost and dentists. With respect to the evidence that providing dental care could reduce medical costs for certain diseases, about half the audience was very convinced with others either not or only somewhat convinced. Overall the responses were upbeat seeing positive outcomes and indicating commitment to make a dental option happen.

The morning of the last day of the meeting attendees divided into four working groups to comment, debate, and propose recommendations and next steps in:

[Development of a benefit option and strategy for implementation that will target the triple aim: optimizing costs, driving outcomes and fostering health literacy to improve patient experience](#)

The four groups consisted of:

Health Policy (targeting the triple aim)

Health Economics (Optimizing costs)

Oral/Systemic Connections (Driving better outcomes) and

Oral Health Literacy Campaign (Improving patient experience)

Each group was asked to address four questions:

- 1 What action steps or data are needed to move forward?
- 2 What, specifically, are the outcome measures in each area?
- 3 What infrastructure is needed to complete the action or capture the data?
- 4 Who will take the lead, champion and guide the proposed actions?

Following two hours allotted for the working group sessions, the attendees reconvened to hear the reports of their deliberations.

Health Policy

Dr. Ron Inge, Chief Dental Officer, Delta Dental Plan of Missouri, one of the moderators of the Health Policy work group, stated that the members felt that the best way to move forward was to ask not what other health groups can do for the dental community to achieve our goals, but what we can do for them. This message was brought home to the group by the story of a patient with end stage renal failure. Medicare would pay for his dialysis and for a kidney transplant, but the patient's nephrologist told him that a kidney transplant would not be possible because the infection in his mouth would cause the transplant to fail. The man had no idea of the problem, nor any way to resolve it. But the dental community came to the rescue.

The oral care was provided and the patient got the kidney transplant. Stories like this are not confined to renal disease. We need to reach out to other groups, find a place at their table. Dr. Inge commented that at the same time Santa Fe was holding its salon the American Diabetes Association was meeting in the same hotel. We could be bringing messages of cost savings and better outcomes when dental care is provided, making it clear to other groups that we are not asking for a pot of new money but pointing to ways to reduce costs.

In summary, he proposed that the way forward should be incremental, reaching out to groups outside dentistry, telling stories that resonate with them and the public at large, partnering and working collaboratively so that ultimately we create a health initiative *for all* that includes oral health.

Ralph Fucillo, President DentaQuest Foundation and the DentaQuest Institute, who co-moderated the group, added that there were members in the audience representing the Oral Health 2020 organization, which has established contacts beyond the dental community. He suggested that salon members could approach them and ask how their networking process was working and whether a real people's movement is developing.

Health economics

Dr. Dolan spoke for the health economics group, saying she felt at times like an air traffic controller with many planes flying over and under each other. It was a very diverse multidisciplinary group, appreciative of the hard work of those who developed the dental benefit plan presented at the salon yet wanting to go back to address fundamental issues. Should coverage be universal? Or apply only to the poor or dual eligibles? Should the process be incremental, adding to medically necessary dental care or proceed with a basic bundle of services? Should the option be put in Part B or elsewhere? Should the emphasis be preventive or restorative?

The group was also aware of the need to build demand and hence the importance of research to generate good stories to tell and hard evidence to back up statements on costs and outcomes. The group agreed that achieving a dental option was a multi-year project but proposed as a tangible next step convening a panel of health policy experts to address the kinds of questions they had raised.

Oral/Systemic Connections

Dr. Harold Slavkin, President and Dean Emeritus of the Herman Ostrow School of Dentistry, University of Southern California, said that one of the big ideas that emerged from the oral/systemic session he moderated was an expansion of what it means when you say oral/systemic connections. Normally the association is that the mouth is connected to the cardiovascular system or to the nervous or to the endocrine system. But the mouth is also connected to self-esteem and to the sense of self and to how you are perceived by your family and loved ones and these behavioral aspects of the mouth's connectivity are extremely important. As an example, he mentioned that his home town, Los Angeles, has the largest concentration of homeless people in the country, and in efforts to provide some relief to the those affected, USC's dental school opened a free dental clinic in 2000 to serve 'Skid Row' inhabitants. After 16 years in operation he can report that of all the actions taken to improve mental health and well-being of the Skid Row clientele, the dental clinic ranks at the top. The ability to look in the mirror and see a mouth that has been repaired and restored, permitting its owner to smile does wonders for mental health.

With regard to the medical cost savings reported by dental insurers and the ADA when dental care is provided to patients with systemic disease, the group believes the evidence "very compelling," but recommends that 4 or 5 demonstration projects, using quality metrics, be conducted at diverse sites around the country. Some might be conducted at Federally Qualified Community Health Centers, some in connection with a large insurer like Kaiser Permanente and some in the private sector. It would be good if some of these locations included other health specialties like physical therapy, pharmacy, social services and others, creating opportunities

for interactions. Dr. Slavkin also reminded the audience that expanding access to oral care for seniors also means employing mobile dental units or other means of bringing dental care to the disabled and others who are incapacitated.

Oral Health Literacy

Our group began by reviewing the definition of oral health literacy, said Dr. Dushanka Kleinman, School of Public Health, University of Maryland College Park, citing an Institute of Medicine report that emphasizes its comprehensive nature. While the need for oral health literacy transcends all groups, be they providers, policymakers or consumers, the highest priority targets consumers. Success here will depend on adequate funding, appropriate messaging and outreach to peers, engaging community leaders and getting their feedback. Working directly with patients and caregivers is also necessary. It will be important to bring community leaders together and establish who will take the lead. The group thought a logical choice would be advocacy groups, using the term to apply to lay organizations and professional groups such as nutritionists, information specialists and others.

To advance oral health literacy for policymakers the watchwords are *communication, consistency and coordination*, spread across a broad spectrum of policymakers, Dr. Kleinman said. The same words apply to providers, and similarly across a broad spectrum—not just to physicians and dentists, but nurses, physical therapists, social service workers and other professionals and their academic counterparts in professional schools. Cultural competence goes along with oral health literacy and as providers gain understanding and confidence they should also be encouraged to talk to peers in other health disciplines, and in this way help break down own the siloes that continue to separate them.

Finally, the group emphasized that oral health literacy applies across the life span. It should begin with educating pregnant women and continue through the school age years and behind to the very seniors who are the focus of this salon meeting.