Response to the

Alberta MLA Task Force on Continuing Care Health Service and Accommodation Standards

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The Alberta Dental Hygienists' Association (ADHA) welcomes the opportunity to submit our feedback on the 2005 draft *Continuing Care Health Service and Accommodation Standards*.

By way of introduction, the ADHA is the professional organization responsible for the registration and certification of dental hygienists in the province. We are currently governed by the Dental Disciplines Act. In its regulatory role, the ADHA is responsible for public protection by establishing requirements for entry-to-practice and continuing competence; setting standards of practice and codes of ethics; and managing complaint and discipline matters.

Dental hygienists have been practicing in Alberta since 1951. The province's sole dental hygiene educational program was established at the University of Alberta in 1961. Dental hygiene students graduate from the U of A after completing a three year diploma or a four year degree program. There are currently over 1600 registered dental hygienists actively practicing in all regions of the province, providing oral health care services in settings that include dental practices, regional health authority facilities and hospitals. Dental hygienists work in interdisciplinary environments, directly with individual clients or with client groups ranging from prenatal classes to seniors and special needs groups.

Dental hygienists develop and conduct health promotion programs; assess the health of teeth and gums and screen for oral cancer; provide individualized care plans for clients; implement programs and therapies that help prevent tooth decay and periodontal (gum) disease; provide complex clinical therapy treatments such as scaling and root planing; and conduct follow-up evaluations, including referrals for further dental treatment.

ORAL HEALTH CARE MUST BE AN INTEGRAL PART OF CONTINUING CARE

The ADHA is aware that the Task Force will hear from many individuals, health professions and agencies during the consultation process and that each group will provide you with comprehensive responses specific to their knowledge and experience.

The ADHA response will provide comments on the draft standards in relation to the oral health needs of individuals receiving continuing care. We would be pleased to provide research articles related to oral health in continuing care facilities, on request, if you would find that helpful to your deliberations.

Oral health is essential to general health and well being throughout our lives. Poor oral care and resulting poor oral health impacts individuals in a variety of ways, including:

- pain and infection,
- compromised ability to meet nutritional needs,

- reduced ability to speak and communicate effectively,
- social isolation, and
- increased risk of systemic infection and disease.

The majority of residents or clients who receive health services in a continuing care program are dependent on caregivers to assess their oral health condition and help manage their daily oral hygiene. However, due in part to limited knowledge about oral conditions and the many other demands and responsibilities placed on caregivers, assessments and the daily care essential for maintaining oral health is generally severely compromised or overlooked completely. As a result, many Albertans in continuing care programs have oral diseases and conditions which go unrecognized and untreated.

The stereotype of the older person being toothless or wearing complete dentures is outdated. Over 60% of seniors have some or all of their own teeth. It is also known that there is a high incidence of oral disease, including dental caries (decay), periodontal (gum) disease, yeast infections and other oral sores and lesions among seniors living independently in their own homes, and those living dependently in lodges and long term care facilities. Epidemiological studies now suggest that older adults in Canada are more likely than 14 year-olds to develop dental caries, with approximately 70% of these individuals having root caries.

There is much evidence to show that preventive programs including dietary control of refined carbohydrates, improved daily oral hygiene practices and the application of re-mineralizing and antimicrobial agents are effective ways to prevent tooth and root caries for older adults.

Of the soft tissue diseases in the mouth, periodontal (gum) disease is the most common amongst individuals with their own teeth. This chronic infection is caused by bacteria that accumulates in plaque. Approximately 80% of adults exhibit some form of periodontal disease. Most people are aware that periodontal disease causes bleeding gums, recession of the gums, mouth odour, and in its late stages contributes to the medical effects of poor nutrition due to discomfort or inability to chew comfortably as a result of periodontal abscesses and tooth loss. Periodontal disease has now also been implicated in heart disease, stroke, diabetes, pneumonia and respiratory disease.

Another serious soft tissue disease of the mouth is oral cancer. Oral cancers account for 3 to 4% of all cancers. Approximately 75% of all oral cancers are due to current or previous tobacco use, alcohol use or both. 85% of oral cancers occur in those over 50 years of age. Oral cancer is one of the most debilitating forms of cancer as either the cancer itself, or the treatment for the cancer, usually seriously affects a person's ability to swallow, to speak, and in many cases, results in major facial disfiguration and social isolation. As with other cancers, early detection of oral cancer is critical.

Screening for oral cancer and other oral diseases is important for individuals who have some or all of their own teeth as well as for those who no longer have their own teeth or wear dentures.

Systemic diseases and the use of medications often impact the oral health of older adults and those in care making them more likely to experience xerostomia (dry mouth), hypersensitivity, periodontal deterioration, infection, oral cancer and temporal mandibular joint (TMJ) disorders. In addition, the physical, mental, and functional deficits experienced by Albertans receiving continuing care make self-care difficult and access to dental care an extreme challenge, thereby increasing their oral health problems.

ADHA General Comments on the Draft Standards

The ADHA strongly supports establishment and implementation of provincial standards, monitoring mechanisms, quality improvement processes and enforcement of such standards and processes for supportive and long-term care accommodation. However, we do not understand why it is being proposed that the standards apply only to publicly funded health care services and programs. It is our belief that the standards should apply to all continuing care services, whether privately or publicly funded. We also believe that the standards of continuing care should apply to all clients, not just those who are in care for a period exceeding three months.

The ADHA was pleased to read that the standards have taken into account both “best practices” and “evidence based” protocols. Standards based on “best practices” and “evidence” are valid, can be universally applied, are measurable, and can assure accountability and quality of care. Such standards should be established as a requirement that must be met.

We support the proposed uniform, province-wide implementation of the interRAI Minimum Data Set (MDS) 2.0. However, we are very concerned that the quality indicators included in Appendix E of the draft Standards have eliminated the MDS 2.0 oral health indicators and triggers. Oral health indicators and triggers should also be an integral part of determining “unmet health care needs”.

Comments on Standards Related to Ensuring Quality Health Services

The ADHA strongly supports the guiding principles and vision that frame these standards - a focus on wellness and prevention; client centred access to information and privacy; individual and shared responsibility; effectiveness and efficiency; and an inter-sectoral approach.

The standards in this section of the document are based on use of the MDS 2.0 tool to develop integrated care plans for each individual client; to ensure the appropriate provision of services or referral for such services; and to monitor and evaluate effectiveness of interventions. ADHA strongly supports this initiative. However, as mentioned above, oral health cannot be ignored as part of the client assessment, care plan or follow-up evaluations.

Basic oral health care must be integrated into continuing care and oral health care providers must be considered a part of the continuing care team, as need is identified.

Standard 1.11 (a) lists a variety of "basic professional health clinicians" but excludes the regulated oral health care professions such as dental hygienists, denturists or dentists who provide basic clinical services related to oral needs. Although oral health care services are generally provided on a fee for service basis rather than being covered by health care insurance, they are still integral to the health of all individuals.

The section on nourishment and hydration is another logical place to include reference to oral health care providers. Eating problems can often be related to oral health conditions. For those who have their own teeth, decayed teeth, loose teeth and oral lesions often compromise nutrition by preventing proper chewing and/or swallowing. Tooth sensitivity causes individuals to avoid particular types of foods and to experience pain with various temperatures of food. Loss of weight due to illness or poor nutrition results in dentures no longer fitting properly. Improperly fitting dentures results in oral lesions, discomfort and inability to chew properly and speak clearly. Consultation with or referral to an oral health care provider could be the solution to the nourishment problems of some clients.

We are very concerned that standards related to therapeutic services (1.17) and allied services (1.20) fail to include reference to oral health care services or providers. Oral health professionals, dental hygienists in particular, have long been involved in preventive programs and wellness promotion initiatives. Standard 1.21 fails to include any reference to oral health care services or providers. Oral health promotion and preventive strategies such as dietary control of refined carbohydrates, improved oral hygiene and regular applications of re-mineralizing and antimicrobial agents to prevent dental caries and periodontal disease is far more cost effective and convenient for individuals in continuing care than allowing conditions to reach a stage that requires complex and expensive dental treatment. A number of these preventive procedures could effectively be provided by personal care attendants following in-service training.

Recommendations Regarding Oral Health Care Standards in Continuing Care

It is our recommendation that, at a minimum, the following be implemented as part of the new *Continuing Care Health Service and Accommodation Standards* and that the definitions in Appendix B be amended to include reference to oral health care services or providers in keeping with these oral health care standards:

• MDS 2.0 intake assessment to include oral health indicators such as presence or absence of natural teeth; use of full or partial dentures; broken, loose or decayed teeth; broken, damaged or ill-fitting dentures; red, swollen or bleeding gums; abcesses, yeast infection, herpetic or other lesions; pain or other oral complaints; self-care ability related to mouth care.

• an oral health care plan be included in the managed care plan and discussed in a family consultation

• daily mouth care for both dentate and edentulous clients

• referral processes in place for emergent and other dental care, including standards regarding timeliness of referrals and interventions

• ongoing assessment and re-evaluation of oral health, at least annually.

There are successful precedents for taking this approach. The Task Force may find it helpful to review the licensing requirements for continuing care facilities in British Columbia and Ontario in regard to requirements for provision of basic oral health care services.

Conclusion

The oral health of individuals in continuing care is generally poor. This population exhibits an increased risk of oral infections such as periodontal disease, caries, inflammatory mucosal disorders, and denture-related problems. Poor oral health has been associated with systemic infections and complications such as respiratory infections, nutritional inadequacies, control of diabetes, and heart disease. The maintenance of basic oral health for individuals in continuing care is of significant value as it has a direct impact on overall health.

Achievement and maintenance of optimal health and well-being, independence and quality of life as identified in standard 1.6(b) cannot be attained unless the oral health needs of each individual are considered and addressed.

The Alberta Dental Hygienists' Association affirms our profession's interest in contributing to planning and policy development affecting continuing care health services and reiterates our recommendation for inclusion of required oral health care standards as an integral part of the new continuing care health service standards.