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Royal Commission into Aged Care Quality and Safety

Future Design of the Aged Care System

Australian Dental Association NSW

22nd January 2020

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Australian Dental Association NSW

Our mission is to advance dentistry to improve the health of every Australian.

The Australian Dental Association NSW (ADA NSW) is the peak body representing the dentistry profession in NSW and the ACT. Our membership comprises 70% of dentists and 79% of dental specialists. Our purpose is to have the best dentists in the world in a nation with the best oral health. We are proud of our legacy of advancing dentistry since 1929 and we are honoured to represent a profession that aims to improve the health of every Australian.

ADA NSW provides this submission to the Royal Commission into Aged Care Quality and Safety to address the acknowledged deficiencies in oral health care for older Australians. With adequate funding, there are currently a number of well-developed and researched programs in existence in NSW and the ACT that can be scaled up and adequate workforce capability to address the unmet needs within this vulnerable population. This submission was developed in collaboration with multiple stakeholders referenced in the covering letter and we acknowledge their contributions and support for this submission.

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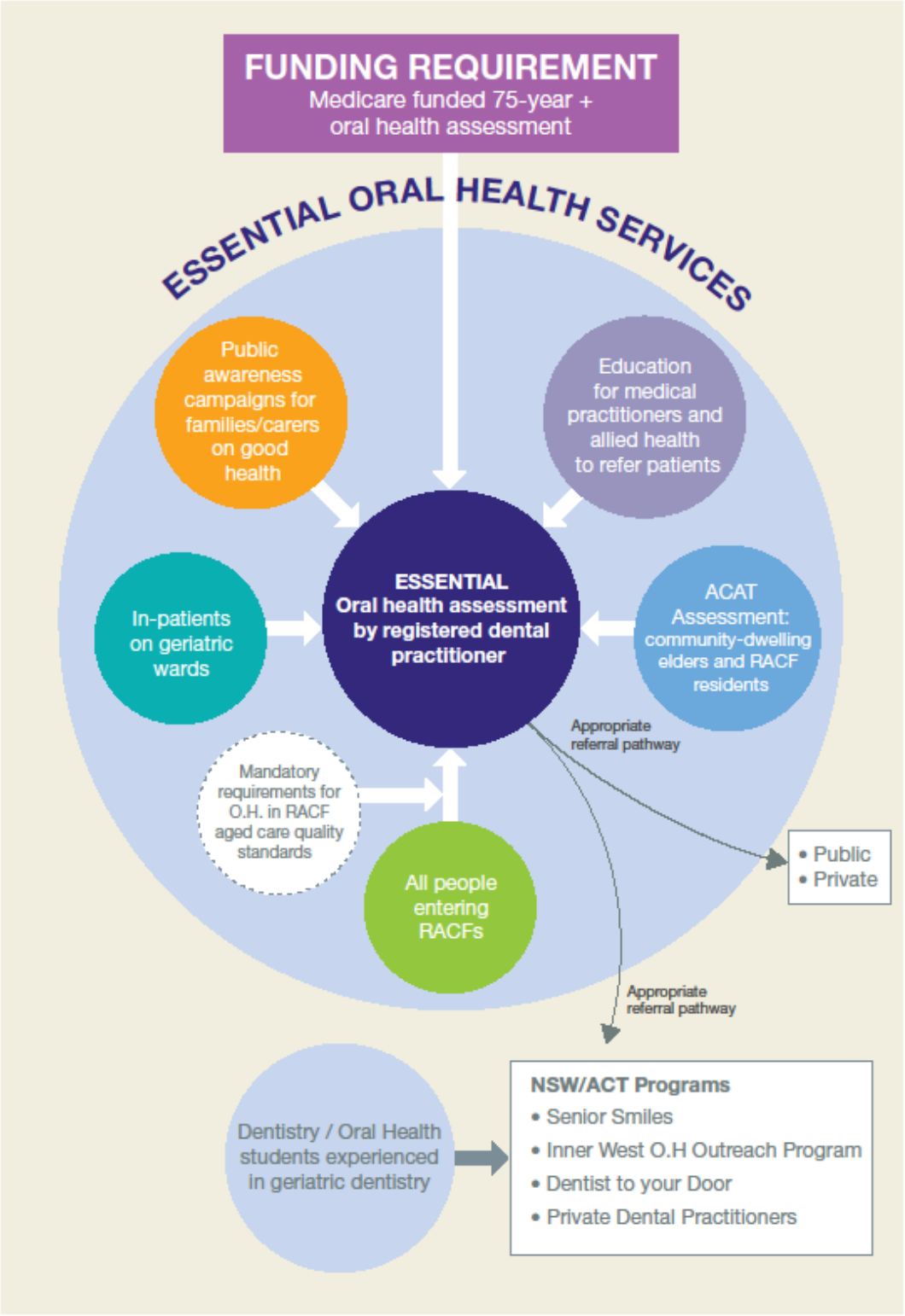
Good Oral Health for Older Australians



Executive Summary

Access to appropriate oral health care services is not a privilege but a basic human right. However, this is not the case for a large proportion of the older adult Australian population. So many of them suffer such poor oral health and dental pain that it has led to it being identified as a key issue in the Royal Commission's Interim Report[1] released in October 2019. The report highlighted *"that substandard care is much more widespread and more serious than we had anticipated"*. The Royal Commission acknowledged insufficient attention to oral health, leading to excruciating dental pain and secondary conditions such as malnutrition and risk of pneumonia, as a major quality and safety issue. Older adults living both in the community and in Residential Aged Care Facilities (RACFs) are seen to undergo rapid deterioration of their oral health as their frailty increases and they become more and more dependent on others to fulfil their basic oral care and personal hygiene needs.

The Royal Commission has called for input into the design of aged care services for our nation's future. However, despite poor oral health and lack of appropriate oral health services being identified, the consultation paper offers little in the way of solutions to address this. ADA NSW and its key collaborators bring to the attention of the Royal Commissioners into Aged Care Quality and Safety, the programs currently available to address the oral health needs for older Australians in NSW and the ACT. These programs span community-based and residential settings, private and publicly-funded models and capitalise on the provision of oral health care by the full range of registered dental practitioners (Dentists, Dental Prosthetists, Dental Hygienists and Oral Health Therapists) working cooperatively within a team, maximising their individual scopes of practice.

Currently in NSW these models of care are available and ready to be scaled up to provide the services older Australians require to address the gap in their unmet oral health care needs. Although quite diverse in their service delivery, the important common key to the success of these programs is that oral health care needs to be monitored and delivered by registered dental practitioners. Staff without oral care training, such as residential aged care staff or community carers, whilst responsible for assisting and/or performing daily oral hygiene such as toothbrushing and denture cleaning, most often do not possess the knowledge, skills or time within their busy work day to become responsible for driving improvements in the oral health of this vulnerable population.

Whilst Medicare looks after the general health of our older adults – the mouth gets left behind. Making oral health assessments a routine, Medicare-funded procedure for those Australians who are 75 years and older, would come some way towards improving the oral health and general health of this target population.

[1] Royal Commission into Aged Care Quality and Safety. Interim Report: Neglect. October 2019. https://agedcare.royalcommission.gov.au/publications/Pages/interim-report.aspx

Summary of Recommendations

Funding Requirement

- A Medicare-funded oral health assessment by a registered dental practitioner for those over 75 years to facilitate regular oral health visits and reduce the unmet oral health care needs of older Australians.

Mandatory Oral Health Assessments

- Every resident entering a Residential Aged Care Facility (RACF) must have an oral health assessment by a registered dental practitioner to inform their ongoing oral hygiene measures, schedule regular oral health care, determine referral pathways and provide required oral health treatment.
- Aged Care Assessment Team (ACAT) Assessments for community-dwelling elders and RACF residents should include direct questions on oral health that lead to timely referrals for them to receive an oral health assessment.
- Oral health assessment by a registered dental practitioner during admissions to in-patient geriatric hospital wards to educate family members and carers, formulate oral care plans and recommend preventive strategies that prevent a rapid decline in oral health.

Establish Referral Pathways for Ongoing Oral Health Care

- Every older adult must have access to assistance with/provision of basic oral hygiene measures including toothbrushing and denture cleaning and have an appropriate oral health referral pathway identified for them whether they are community-dwelling or living within a RACF.
- Ensuring that the changes to the Aged Care Quality Standards[2] introduced in July 2019, apply to oral health care and are enforced.
- All RACFs should have a direct and ongoing relationship with local dental practitioners (private and public) to facilitate the oral health of their residents and provide ongoing education and awareness programs for RACF staff.
- Ongoing support for the existing oral health education and awareness programs, involving local dental practitioners, that target family members and carers of community-dwelling older adults.

[2] Aged Care Quality Standards (July 2019**).** https://www.agedcarequality.gov.au/providers/standards

Awareness Campaigns

- Public awareness campaigns targeting the importance of good oral health for good general health aimed at older Australians and their carers should be developed and promoted widely in NSW and the ACT.
- Increased education and exposure to geriatric oral health care for dental practitioner students leading to greater familiarity with the aged care sector and greater acceptability of working with older adults following graduation. Increased education and awareness for health practitioners to improve patient referrals for oral health assessments.

Background

In addition to increases in the proportion of older Australians projected for the future decades, the number retaining their teeth is also improving over time. The percentage of people over 65 years with some of their own teeth has risen from just over 50% to almost 75% in the past thirty years.[3] Whilst this is an excellent outcome in terms of improvements in oral health, it also results in vast amounts of unmet need with regard to the care and maintenance of natural teeth in a population who are often frail and dependent on others for personal care.

Older Australians have been identified as a priority population group by the NSW Ministry of Health.[4] The overall health of this group varies widely, with some remaining fit and active and others experiencing complex medical issues leading to severe frailty and loss of independence. People with the poorest oral health are those with low socio-economic status, residents in RACFs and Indigenous Australians. It is now widely accepted that poor oral health influences general health. Whilst other allied health services such as podiatry are provided via Medicare to older Australians to assist with mobility and the prevention of falls, there are no such provisions made for oral health. Acute and chronic medical conditions can be exacerbated by poor oral health resulting in hospitalisation or death.[5,6,7] Leaving no doubt, therefore, that the current widespread neglect of oral care for older Australians contributes not only to individual pain and suffering and lowered quality of life but also presents a significant burden on Australia's health resources and public health dollars.

ADA NSW supports and advocates for the core principles of oral care for older adults as set out by both NSW Health and the World Health Organisation, including:

- Improving the oral health of older adults is a high priority and must be the responsibility of the whole health care sector – including government, non-government and private providers[8]

[3] Australian Institute of Health and Welfare Dental Statistics and Research Unit Research Report No. 42. Projected demand for dental care to 2020. https://www.aihw.gov.au/reports/dental-oral-health/projected-demand-for-dental-care-to-2020/contents/table-of-contents

[4] NSW Ministry of Health. Oral Health 2020: A strategic framework for dental health in NSW. Sydney: NSW Ministry of Health. 2013

[5] D'Aiuo F. *et al.* Evidence summary: The relationship between oral diseases and diabetes. British Dental Journal. 222: 944-8, 2017.

[6] Dietrich T. *et al.* Evidence summary: The relationship between oral and cardiovascular disease. British Dental Journal. 222: 381-5. 2017

[7] Daly A. *et al.* Evidence summary: The relationship between oral health and dementia. British Dental Journal. 223:846-53. 2017

[8] Oral Health 2020: A Strategic Framework of Oral Health of Older People in NSW". Centre For Education and Research on Ageing, NSW, 2015

- Recognising the range of complex economic, social and behavioural factors that determine oral health for older adults[9]

- Integrating oral health with general health care using a holistic approach that addresses common risk factors and leads to improvements in overall health[10]

- Identifying major barriers as well as key facilitating factors to oral health services for older people[11]

- Pursuing opportunities for the establishment, continuation or improvement of oral health services and health promotion programmes.[12]

With these guiding principles in mind, it is clear that Australia must put oral health on the agenda and provide a truly holistic, patient-centered approach to the care of our older Australians. It is time for the care of the mouth to be considered an integral part of overall health care. The Australian Dental Association's "The Australian Dental Health Plan"[13] advocates for a Seniors Dental Benefits Schedule to provide Medicare-funded oral health services targeted at older Australians in the same way as the Child Dental Benefits Schedule covers eligible children. The dental profession is committed to providing these services to the Australian community and has successful models of care operating within NSW and the ACT that with adequate support can be scaled up to become standard practice and improve the wellbeing of older Australians. Oral health should not be seen as a privilege but a basic human right, ensuring that this vulnerable sector of our community can live free from oral pain and be able to gain adequate nutrition, communicate freely and have the best possible quality of life.

The currently available programs and services that exist in NSW and the ACT will be discussed in more detail (pages 20-23). In order to support these services, there will need to be changes to existing protocols and procedures to ensure that appropriate and timely routine daily oral hygiene measures are carried out and regular oral health assessments are conducted to identify the ongoing needs of this vulnerable group. These funding and regulatory changes are essential in the improvement process, as without adequate financial support and mandatory requirements for oral services these improvements will not be possible. The required funding and regulatory changes will also be discussed in more detail on pages 17-19 of this document.

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[9] *ibid.*
[10] *ibid.*
[11] Petersen PE. et al. Community Dental Health 27 (Suppl. 2) 257–268, 2010
[12] *ibid.*
[13] Australian Dental Association. The Australian Dental Health Plan. Achieving Optimal Oral Health. 2019 file://svr-ada-fp01.adansw.local/Common/Communications/Sarah/Current%20Work/Aust-Dental-Health-Plan-2019-FINAL.pdf

The state of oral health for older Australians

The determinants of oral health are complex, involving socio-economic, cultural, dietary and various other individual health literacy and behavioural factors. Oral disease has a significant impact not only on individuals but also on families and the wider community through economic costs and health systems. The overall health of Aboriginal and Torres Strait Islander people is poorer than their non-Indigenous counterparts and their oral health is no exception.[14]

The most common consequences of poor oral health are pain, infection and tooth loss which further compromise the health of older Australians, the majority of whom suffer from systemic chronic disease. Good oral health is an essential part of good general health, not only for good oral function and aesthetics but because of the impact it has on the chronic disease burden. The well-recognised associations between poor oral health and chronic conditions such as cardiovascular and respiratory diseases and Type 2 Diabetes make it a growing public health issue. In 2007, the economic impact of poor oral health for older Australians was estimated to be more than $750 million per annum.[15]

A quarter of the adult Australian population over 65 years has complete tooth loss. Factors impacting on complete tooth loss include low socio-economic status, holding a government health card, not having private health insurance and living outside of capital cities.[16] Almost all people with complete tooth loss wear dentures to improve their function and appearance. Adequate cleaning and maintenance of dentures is required for optimal function and health of the oral tissues. Over a quarter of surveyed older adults with complete tooth loss reported difficulties in eating some foods. [17] The provision, assessment and maintenance of dentures and good oral health of those without teeth is an essential part of their overall health care requirement. However, only 50% of surveyed adults with complete tooth loss reported visiting a dentist in the past 5 years.[18] Both registered dental prosthetists and dentists within the public and private healthcare systems can provide these services for the older adult population.

[14] NSW Aboriginal Health Plan 2013-2023. NSW Ministry of Health 2012. https://www.health.nsw.gov.au/aboriginal/Publications/aboriginal-health-plan-2013-2023.pdf

[15] Econtech. Economic analysis of dental health for older Australians. Final report, 2007. Produced for COTA Over 50s and the Australian Dental Industry Association.

[16] Australian Institute of Health and Welfare Dental Statistics and Research Unit. 2008. National Survey or Adult Oral Health 2004-06: New South Wales.

[17] Australian Institute of Health and Welfare Dental Statistics and Research Unit. Oral health and access to dental care – older adults in Australia.2005

[18] i*bid.*

Today, the majority of the aged population have some or all of their teeth. A minimum of 20 teeth is generally considered to provide satisfactory function for chewing and enabling adequate nutritional intake. However, research on community-dwelling older Australian men found that only 39% achieved this goal.[19] The social consequences of good oral health should also be considered, with almost 20% of older adults reporting they were uncomfortable about the appearance of their teeth.[20] Generally, oral care for this group is more complex than for those without teeth. With a lack of routine daily toothbrushing and a soft, sugary diet, oral health shows a continual and often rapid decline with age as shown by higher prevalence of dental caries and periodontal disease.[21] Further complications arise from complex restorations (crowns, bridges and implants) placed at an earlier age that require particular attention and more complex ongoing daily care and maintenance. In addition to co-existent diseases, the large number of medications taken by many older adults often affects salivary flow, further compromising oral health and increasing the risk of dental caries.

Dental caries and periodontal disease are the most common chronic diseases in Australia. Despite being extremely common, they are usually not identified by RACF staff or carers, due to gaps in their knowledge and understanding and reticence to look in residents' mouths. Both are preventable by ensuring that older adults have access to a nutritious diet that is low in sugar and by the provision of simple, regular, preventive oral health care (toothbrushing, denture maintenance, application of preventive oral care products) and access to timely dental care for more complex dental needs. However, the oral health status of the frail elderly is equally poor whether they live in a RACF or are being cared for at home. As this population transitions from independent living to needing assistance with their daily activities, levels of dental plaque, calculus and food debris can become extremely high due to a number of significant barriers to the provision of adequate oral hygiene measures. Within the majority of RACFs minimal oral hygiene care is provided as more urgent needs such as toileting, bathing and feeding are prioritised by the already over-stretched facility staff. The elderly have been known to go days, week and even months without having any of their routine oral hygiene needs met. Residents with dementia and other cognitive disabilities can be challenging for staff to manage, creating further barriers to the provision of even simple oral care, such as toothbrushing. In addition, their inability to report oral health problems and pain may mean that significant oral health issues go unnoticed.

[19] Wright FAC. *et al.* Oral health of community-dwelling older Australian men: the Concord Health and Ageing in Men Project (CHAMP). Australian Dental Journal. 2018. 63:55-65

[20] i*bid.*

[21] Australian Institute of Health and Welfare Dental Statistics and Research Unit. 2008. National Survey or Adult Oral Health 2004-06: New South Wales.

Along with our ageing population, rates of oral cancer will continue to rise as it is a disease that is most prevalent in older age groups, with associations to excessive alcohol use and cigarette smoking. Men are three times more likely than women to be diagnosed with oral cancer. In NSW in 2014, there were over 1100 new head and neck cancers, with many of these occurring in the mouth.[22] Oral cancer screening during routine oral examinations by registered dental practitioners, facilitates early identification for those who attend oral care assessments regularly. This is important because oral cancer rarely manifests as pain in its early stages and often goes undetected by patients.

Poor oral health has significant impacts on general health and quality of life. Chronic oral infection can complicate the medical management of diabetes, chronic heart failure and respiratory diseases. The pain from infections may also affect mood and behaviour, especially for people with cognitive impairment, who find it difficult to self-report their pain and discomfort.[23] Poor oral hygiene significantly increases the risk of pneumonia in patients with swallowing impairments.[24] While poorly fitting dentures, oral infections and persistent mouth pain can lead to poor nutrition due to decreased ability to chew, loss of appetite and limitations of food selection. Poor nutritional status can also be a cause of muscle loss, which may result in decreased mobility, instability and falls. Older people have the highest rates of fall-related hospitalisations accounting for almost 66%.[25]

Research shows that older Australian men in the community have significant oral health needs that are not met - including dental caries and periodontal disease.[26,27] Ninety-seven percent of assessed participants showed significant gum disease and rates of active tooth decay were also high.[28] One in five had difficulties chewing hard foods and self-reported discomfort when eating.[29] As lower chewing ability places older Australians at risk of nutritional deficiencies, this unmet need impacts general health outcomes.

[22] NSW Government. HealthStats NSW. http://www.healthstats.nsw.gov.au/Indicator/can_incdth_type/can_incdth_type_grp_snap

[23] Oral Health 2020: A Strategic Framework of Oral Health of Older People in NSW". Centre For Education and Research on Ageing, NSW, 2015

[24] van der Maarel-Wierink C*. et al.* Oral health care and aspiration pneumonia in frail older people: a systematic literature review. Gerodontology. 2013; 30: 3–9

[25] Oral Health care for older people in NSW. A toolkit for oral health and health service providers. 2014. https://www.health.nsw.gov.au/oralhealth/Publications/oral-health-older-people-toolkit.pdf

[26] Wright FAC. *et al.* Oral health of community-dwelling older Australian men: the Concord Health and Ageing in Men Project (CHAMP). Australian Dental Journal. 2018. 63:55-65

[27] Wright FAC. *et al.* Chewing function, general health and the dentition of older Australian men: The Concord Health and Ageing in Men Project. Community Dentistry and Oral Epidemiology 2019. 47:134–41

[28] Wright FAC. *et al.* Oral health of community-dwelling older Australian men: the Concord Health and Ageing in Men Project (CHAMP). Australian Dental Journal. 2018. 63:55-65

[29] Wright FAC. *et al.* Chewing function, general health and the dentition of older Australian men: The Concord Health and Ageing in Men Project. Community Dentistry and Oral Epidemiology 2019. 47:134–41

Barriers to access of oral care services for older Australians

Oral health care needs within RACFs, including oral health assessment on admission, basic daily oral hygiene measures (toothbrushing and denture cleaning) and access to professional oral health care are not being met. This is an unacceptable situation that must be urgently addressed.

There is no current data on whether older Australians in assisted-living and home-care situations are able to access suitable oral health care in a timely fashion, but anecdotal evidence suggests that significant barriers to care also exist amongst this population.

More than one in three older adults need help with daily activities including oral care.[30] The barriers associated with access to oral care for older Australians only begin here. There are many barriers that need to be addressed in order to facilitate the care that this priority population deserve. Broadly, they can be discussed under the headings – accessibility, affordability and acceptability.

Accessibility

- Dependent older adults require assistance to ensure daily oral hygiene measures (toothbrushing, denture cleaning and the application of preventive oral care products) are met. Those with dexterity issues only, may be assisted by the provision of modified oral hygiene aids, such as toothbrush grips and floss holders to enable them to carry out their own daily routine. Others with severe frailty and cognitive impairments will be entirely dependent on family members and/or carers for toothbrushing and denture cleaning. In these cases, the knowledge, beliefs and attitudes towards oral care of those assisting will impact heavily on the level of care achieved.
- The mobility limitations of older Australians impact heavily on the types of dental services they can access. The most independent adults may be able to access their usual public or private dental services but as frailty increases, it becomes increasingly difficult.
- As older Australians become increasingly frail, the state of their overall health is significantly determined by the awareness, motivation, knowledge and beliefs of those that care for them.
- Complex issues around consent and restraint further limit the accessibility of providing daily oral hygiene measures, thorough oral examinations and dental treatment to those with cognitive impairment and/or resistant behaviours by RACF staff, carers and dental practitioners.
- Within RACFs, access to oral hygiene measures and oral care is generally poor, except in the facilities that have established models of care (discussed pages 20-23). RACF staff are under significant budgetary and time pressures that lead to oral care often being neglected. Over-worked staff struggle to provide other basic and essential needs such as toileting, bathing and feeding and so toothbrushing and denture cleaning fails to be provided, especially to residents who are resistant.

[30] Australian Bureau of Statistics. 4430.0 – Disability, Ageing and Carers, Australia: Summary of Findings 2015. https://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/2B056B8FE240D738CA2581A000206EAE/$File/a%20profile%20of%20older%20people%20in%20australia.pdf

- The absence of timely oral health assessments, oral care planning, education and access to qualified dental practitioners for older Australians living in RACFs, impacts directly on their health, wellbeing and quality of life. Most RACFs do not have standard access to oral health care and the majority of residents do not have their basic daily oral health care needs met. Dental practitioners find providing dental treatment in RACFs difficult. Lack of access to a suitable treatment area with adequate lighting and mobile dental equipment as well as the difficulties in obtaining consent, all impact on their ability and willingness to provide oral care services. There are no Medicare provisions for oral care services in RACFs, further complicating access.
- Public dental services have long waiting lists and where domiciliary programs are unavailable, access is limited by transport requirements that may be complex as levels of frailty increase.

Affordability

- There is no Medicare-funded dental service for older Australians. There is not even provision for a Medicare-funded oral health assessment in the 75-year health assessment. This leaves many older Australians unable to access the oral care services they need.
- One in six Australians over 75 years reported they would have difficulty paying a $100 dental bill but for Indigenous Australians 75 years and older, the figure is 47.6%.[31]
- More than a third of older adults don't have private health insurance (PHI), placing considerable constraints on the affordability of oral care services despite the poor benefits paid.[32]
- Research shows that almost 70% of those people 75 years and older with PHI visit the dentist regularly compared to only 42% of those without PHI.[33]
- High costs of RACFs, home-care packages and medications impact the financial resources of families and limit their ability to afford the oral health care services they need.

Acceptability

- Patients with cognitive impairment and communication difficulties often find even the most basic oral hygiene measures, such as toothbrushing and mouthrinsing challenging. Many require general anaesthesia to facilitate urgent dental treatment, such as tooth extraction. Complex co-existing diseases and limited access to general anaesthetic oral health services present further barriers to timely urgent care.
- Fear and lack of training and experience limits the acceptability of oral health services in the Aged Care Sector. This is two-fold, affecting the provision of adequate daily oral care by RACF staff, carers and family members but also relates to dental practitioners' reticence to provide services to older Australians.

[31] Australian Institute of Health and Welfare Dental Statistics Research Series. 2007. Dental Generations the National Survey of Adult Oral Health 2004–06

[32] Council of the Aged (COTA) State of the (Older Nation). 2018. https://www.cota.org.au/wp-content/uploads/2018/12/COTA-State-of-the-Older-Nation-Report-2018-FINAL-Online.pdf

[33] Australian Institute of Health and Welfare Dental Statistics Research Series. 2007. Dental Generations the National Survey of Adult Oral Health 2004–06

- RACF staff are usually not able to identify major or minor oral health conditions, meaning that residents often wait an excessive period of time before dental treatment is facilitated for them. Residents with specific medical conditions affecting salivary flow (eg. Diabetes, Sjogren's syndrome and head/neck radiotherapy) and on multiple medications require special oral care attention to maintain their oral health.
- The increasing complexity of older Australians' declining general health and chronic diseases, managed by multiple medications impacts their willingness and ability to maintain good oral health.
- Interdisciplinary collaboration between RACF staff, medical teams (including GP, Dietician and Speech Pathologist) and dental practitioners is difficult when the oral health services are ad hoc or episodic in nature. Effective collaboration is one of the keys to the successful models of care available in NSW and the ACT that are discussed on pages 20-23.

Funding and regulatory requirements to achieve minimum standards of care

If oral health outcomes are to improve in this population, it will require changes at both the policy and practice levels. Facilitation of a patient-centered and holistic approach to accessible oral care for all older Australians can only be achieved in an environment of inter-professional collaboration, underpinned by practical and achievable policy implementation within the aged care sector.

Independent adults living within the community must have access to appropriate oral health care that meets their economic, geographic and cultural requirements. It is recognised that many older adults have increased vulnerability to oral disease due to their chronic diseases, multiple medications, significant limitations in mobility, marked changes in diet and possibly a reduction in capacity to undertake personal oral care measures. Indigenous older adults require access to oral health care services that are culturally-appropriate and organised, funded and delivered in such a way that the significant disparities existing between Indigenous and non-Indigenous Australians are addressed.[34]

Medicare-funded Oral Health Assessment for older Australians (75+ Years)

The Grattan Report[35] released in March, 2019 highlighted the poor state of oral health for key high-risk groups including low income adults and Indigenous Australians. Low-income people are nearly three times as likely as high-income people to avoid some foods because of their teeth, and more than twice as likely to suffer toothache or have concerns about their dental appearance. Oral health problems are widespread among Australian adults, but they afflict low-income people disproportionately.

The Royal Commission "Aged Care Program Redesign. Services for the future" consultation paper 1. released in December 2019[36] highlighted that the Australian Government financial support for the health needs of older people relies on several common principles, including that:

"The cost of care should be affordable to individuals. This involves the Commonwealth underwriting some of the cost of essential care for all people and supplying additional assistance where individuals are unable to afford the cost of their care or to make use of the mainstream financing arrangements."

Clearly, this is another example where the mouth and oral health services have been left behind the rest of the body and general health services respectively. This situation either implies that oral health care is not considered essential or that all older Australians are able to afford oral health care – neither of which is the case.

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[34] NSW Aboriginal Health Plan 2013-2023. NSW Ministry of Health 2012. https://www.health.nsw.gov.au/aboriginal/Publications/aboriginal-health-plan-2013-2023.pdf

[35] Duckett, S., Cowgill, M., and Swerissen, H. (2019). Filling the gap: A universal dental scheme for Australia. Grattan Institute. https://grattan.edu.au/report/filling-the-gap/

[36] Royal Commission into Aged Care Safety and Quality. Consultation Paper 1. December 6 2019. https://agedcare.royalcommission.gov.au/publications/Documents/consultation-paper-1.pdf

Without financial support provided by the Australian government, such as a Seniors Dental Benefits Schedule as set out in The Australian Dental Association's Australian Dental Health Plan[37] that incorporates a Medicare-funded Oral Health Assessment for people 75 years and older, it will be impossible to move towards minimum standards of oral care for older Australians. A fully-funded oral health assessment carried out by a registered dental professional is crucial to improving the oral health and general health of the elderly. The reasons for this are that:

- the mouth is an important part of the body and as such it must be examined in the course of the in-depth medical assessment identifying health issues and conditions that are potentially preventable or amenable to interventions in order to improve health and/or quality of life
- it forms an important touch-point where patient's ongoing oral health requirements, including their daily care, additional preventive interventions, treatment requirements and future regular assessments can be identified and managed
- It facilitates inter-professional collaboration between the health professionals caring for a patient.

Aged Care Assessment Team (ACAT) Assessment

Older adults seeking and requiring community-based or RACF support services should undergo a Medicare-funded oral health assessment by a registered dental practitioner. This should become a standardised and mandatory part of the ACAT assessment procedure.

Particularly within community- or home- based care, strengthening of the oral care component of Aged Care Assessments (ACAT) would assist in the provision of regular oral health assessments by a dental practitioner and support access to appropriate ongoing homecare, preventative measures and restorative dental treatment.

The inclusion of questions about oral care visits and daily oral care routines should form a mandatory part of the standard ACAT assessment. This simple step would raise awareness with ACAT teams, carers and families and be a catalyst to refer patients to dental practitioners for essential oral care assessments and treatment.

[37] Australian Dental Association. The Australian Dental Health Plan. Achieving Optimal Oral Health. 2019 file://svr-ada-fp01.adansw.local/Common/Communications/Sarah/Current%20Work/Aust-Dental-Health-Plan-2019-FINAL.pdf

Aged Care Quality Standards

Those living in RACFs require oral health care to be provided as part of their overall health care plan and referral pathways must be readily available. Daily oral hygiene requirements, including toothbrushing and/or denture cleaning should be provided by RACF care staff, supported dental practitioners. Appropriate referrals for oral health care within or outside the RACF should be made whenever necessary. Those with significant chronic illnesses and/or dementia require specialised dental services, which should be available on site within all RACFs, to ensure that their oral health needs are met.

Transportation

Appropriate and timely, transportation arrangements must be available to older Australians, whether they are community-dwelling or living within RACFs, enabling their access to the oral care services they require.

Awareness Campaigns

All health care providers, including dental practitioners, must be educated on the importance of good oral health for older adults and the ability to provide appropriate referral pathways for patients. Carers of older adults living both in the community and in RACFs should be educated and enabled to provide daily oral hygiene measures for those in their care. Medical/Allied health practitioners should be alerted to refer patients for professional oral health assessments wherever necessary. Oral health must be seen as part of general health with interdisciplinary teams working together to provide holistic care for older adults living in the community and in RACFs.

NSW Models of Care

The oral health care needs of older adults in NSW and the ACT varies considerably depending on their level of independence, place of residence, socio-economic status, cultural background, indigenous status and individual circumstances and beliefs. There is not a single model of care that can address the needs of every individual. However, within NSW and the ACT there are several models of care that provide oral health services to older Australians. These programs vary from public to private and from community-dwelling to residential-care sectors. Each of these programs are underpinned by the dedication of those that have established them and the many committed staff who provide care.

Currently in NSW and the ACT there is capacity for these programs to be scaled up to provide the required services to older Australians and close the gap in their unmet oral health care needs.

Senior Smiles Program

Developed at the Faculty of Oral Health, University of Newcastle by Associate Professor Janet Wallace, this program commenced in January 2014. The preventive model of oral health care involves the placement of a registered Oral Health Therapist (OHT) or Dental Hygienist (DH) within RACFs to provide oral health risk assessments, oral healthcare plans, individual daily toothbrushing and denture care plans for RACF staff to follow, oral health education and establish referral pathways within the public and private sectors that address complex dental treatment needs.

As an integral part of the Senior Smiles Program, private dentists and dental prosthetists are recruited to provide services within participating RACFs. The provision of services is facilitated by the OHT/DH who can liaise with the patient's family, the RACF staff and gain the required consent for treatment prior to the dentist's or prosthetist's attendance, thus streamlining the process.

Depending on the number of residents, the OHT/DH requires 1-2 days per week to manage the oral health in a RACF. Following a successful pilot program in 5 RACFs on the NSW Central Coast, additional funding has enabled the second phase of implementation in a further 5 RACFs extending into the Hunter Valley and Sydney. Phase 1 and phase 2 of the Senior Smiles research was funded by philanthropic grants, the positive outcomes from the research has seen a number of RACFs implement the program by paying the OHT/DH directly from RACF budgets.

This program has been evaluated for clinical outcomes and acceptability [38] and cost benefit analysis has also been undertaken.[39] The conclusions of the clinical evaluation were that the Senior Smiles model of care was successful in providing oral health care for older people living in the piloted RACFs and could be extended to additional RACFs in other areas.

[38] Wallace J. *et al.* Senior smiles: Preliminary results for a new model of oral health care utilizing the dental hygienist in residential aged care facilities. International Journal of Dental Hygiene. 2016. 14: 284-8.
[39] Kent Surrey Sussex, Academic Health Science Network. Senior Smiles: Cost Benefit Analysis. 2019

The cost benefit analysis concluded that via the benefits including better oral health, improved nutrition, lower risk of pneumonia, lower GP visits and avoided hospital admissions, Senior Smiles was estimated to be able to deliver $2.40 benefits to the healthcare system and a further $3.18 in social benefits for every $1 invested, if it was rolled out widely to RACFs.

The Senior Smiles program is ready to be scaled up in RACFs throughout NSW and the ACT. RACFs should be responsible for funding the placement of OHTs/DHs to manage oral health within their facility as part of holistic care for all residents. Current and projected capacity exists within the workforce to enable roll out of the program within the state and potentially Australia wide.

Inner West Oral Health Outreach Program

This program[40] established by the Centre for Education and Research on Ageing (CERA), Concord Repatriation General Hospital by Professor Clive Wright has been running for over five years, providing publicly-funded outreach oral health services to RACFs within the Sydney Local Health District. OHTs/DHs provide assessments, diagnostic and preventive oral services and oral health education within RACFs and establish referral pathways for additional care. The Better Oral Care in Residential Care model[41] provides the foundation of care with some modification to meet individual RACF needs. This includes establishing individual daily toothbrushing and denture cleaning plans for residents. Eligible patients can be treated under the NSW Health Oral Health Fee for Service Scheme (OHFFSS) [42] by the visiting private dental practitioners. Those not eligible can elect to see the visiting dental practitioners through direct financial arrangements (including PHI or Department of Veterans Affairs (DVA) scheme) or elect to see a dental practitioner of their choice. This program undergoes ongoing evaluation of both the clinical outcomes and acceptability, and costings via the public OHFFSS.[43]

Scaling up this publicly-funded program to other Local Health Districts will require additional funding support. Workforce capability exists dependent on additional funding. The Centre for Oral Health Strategy, NSW Health have indicated that the current uncertainty around funding provided via the Federal/State Government National Partnership Agreement leads to only short-term contracts being offered which is another significant barrier to extension of these types of program throughout the state.

[40] Wright F.A. Clive, et al. "Residential age care and domiciliary oral health services: *Reach-OHT* – the development of a metropolitan oral health programme in Sydney, Australia." Gerodontology 2017;00:1-7. https://doi.org/10.1111/ger.122282.

[41] Better oral health in residential care model. https://agedcare.health.gov.au/publications-articles/resources-learning-training/better-oral-health-in-residential-care-training

[42] NSW Health. Oral Health Fee for Service Scheme. https://www.health.nsw.gov.au/oralhealth/Pages/nsw-oral-health-fee-for-service-scheme.aspx

[43] Chu S. *et al.* Inner West Oral Health Outreach Program. Activity Report – January to December. 2017

Resi-Dental

The Resi-Dental Care Program is a NSW Premier's award-winning initiative of Hunter New England Oral Health Service, coordinated by Ms Karen Sleishman. Resi-Dental provides oral health education for carers and residents and also works collaboratively with private dental practitioners to coordinate and support the provision of dental care in RACFs.

The greatest barrier identified by private dentists to providing care at aged care facilities was access to dental equipment. Resi-Dental sourced suitable portable dental equipment for use in RACFs, including a specifically-designed reclining wheelchair to address the work health and safety issues of dental practitioners when providing dental care away from their well-equipped dental surgeries.

An instructional DVD assists participating dentists, covering setting and packing up of equipment, tips on treating the elderly and background information on the Better Oral Health in Residential Care education and training package.[44]

The program coordinator liaises between RACFs and participating private dental practitioners to ensure all needs are met and the portable dental equipment is available and delivered for the rostered dates.

As with the Inner West Oral Health Outreach program, this public-private program requires the support of government-funded oral health staff in addition to the willingness and ability of private dentists for the program to run effectively.

Dentist to your Door (D2D)

This portable private practice model of care developed by Dr Mark Wotherspoon in the Wagga Wagga area, provides basic diagnostic, preventive and restorative dental services to those in the community for whom transport to a regular fixed clinic is impractical or impossible. D2D is a portable dental service provided by a registered dental practitioner that treats patients at their point of care, such as an RACF, hospital, group home or private residence. It has the advantages of requiring relatively low capital outlay and causing minimal disruption to RACF administrator, staff or patient/carer routines.

The model is easy to adopt, relatively low risk and can be utilised by private dentists, prosthetists, dental hygienists, oral health therapists and public oral health service clinics. It can be used to directly support other existing programs such as the Senior Smiles program and outreach programs without duplication of resources. Where required procedures are identified as being beyond the scope of D2D a suitable and timely referral pathway is initiated.

While D2D is aimed primarily at privately-funded patients, it can also provide services for DVA and OHFFSS qualified patients.

[44] Better oral health in residential care model. https://agedcare.health.gov.au/publications-articles/resources-learning-training/better-oral-health-in-residential-care-training

Individual Private Dental Practitioners

There are a number of dedicated private dental practitioners across NSW and the ACT who provide various services to our older Australians. These practitioners vary from Special Needs Dental Specialists to Dentists, Dental Prosthetists, Oral Health Therapists and Dental Hygienists. They work in their local regions to provide services ranging from "relief of pain" care to comprehensive oral care for the most complex dental patients. They provide services both in the community and in RACFs as required and are often poorly remunerated when considering the complexities of the required oral health services, the time required to provide them and travel to and from the facilities and the lack of any Medicare-funded support.

Workforce Capacity

The Grattan Report[45], released in March 2019 has summarised the current Australian Dentistry workforce status, reporting that:

- The number of dentists in Australia has grown faster than the population over the past decade
- Australia still has fewer professionally active dentists, relative to the size of our population, than many other OECD countries despite the rapid growth of the dental workforce in the past decade
- An increasing proportion of dentists are working part-time
- The move towards part-time work appears to have been driven, in part, by insufficient demand for dental services rather than dentists' preferring more leisure and less labour.

Based on this, it appears the existing dental workforce has some spare capacity.

In NSW, there are two university training programs providing graduate Dentists and Oral Health Therapists with adult scope of practice. In the 2019 year in NSW, there were 86 OHTs and 97 Dentists who graduated. The Australian Dental Association National Graduate Survey (2018) indicated that approximately 20% of surveyed graduate dentists from the previous 6 year cohorts were experiencing difficulty in obtaining their desired amount of work. With good exposure to and experience in aspects of general geriatric dentistry during the training programs and adequate funding for geriatric oral health services, there is currently adequate workforce capacity to provide improved oral health services to our older Australians population.

[45] Duckett, S., Cowgill, M., and Swerissen, H. (2019). Filling the gap: A universal dental scheme for Australia. Grattan Institute. https://grattan.edu.au/report/filling-the-gap/

Recommendations

Within our ageing population, older adults are retaining more of their natural teeth, have more complex medical conditions and more difficult oral health prevention and maintenance requirements. New skills, programmes and services within the private and public sectors will be needed to effectively manage the oral health care needs of this priority population. These increased resources for service provision, education and training will need to be supported via government and private funding to ensure that our older Australians are able to access the oral health services they deserve.

Funding Requirement

- Every 75+ year-old in Australia is eligible for Medicare-funded health assessments, but the mouth has been left out of health. The inclusion of a Medicare-funded oral health assessment by a registered dental practitioner for those over 75 years would facilitate more regular oral health visits and reduce the unmet oral health care needs of older Australians.

Mandatory Oral Health Assessments

- Every resident entering a RACF must have an oral health assessment by registered dental practitioner to provide the basis for ongoing regular oral hygiene measures, schedule regular oral health care, determine efficient referral pathways and provide input to the RACF on links between the resident's oral health and their general health status.
- Aged Care Assessments (ACAT) should include direct questions on oral health that lead to timely referrals for older adults to receive preventive oral care and management to address their currently unmet needs. The addition of the simple question "Have you seen a Dental Practitioner in the past 12 months?" in the ACAT assessment, leading to referral for a comprehensive oral health assessment would facilitate more regular oral health visits.
- Patients admitted to in-patient geriatric hospital wards are often at a cross-road between independent living and requiring residential care. An oral health assessment by a registered dental practitioner during admission, presents a unique opportunity to educate family members and carers, formulate oral care plans and recommend preventive strategies that avoid a rapid decline in oral health.

Establish Referral Pathways for Ongoing Oral Health Care

- Ensuring that Standard 3 of the Aged Care Quality Standards[46] introduced in July 2019 as it applies to oral health care is enforced and operating efficiently:
    - Each consumer gets safe and effective personal care, clinical care or both that is best-practice, tailored to their individual needs and optimises their health and wellbeing
    - Deterioration or change in health condition is recognised and responded to in a timely manner
    - Timely and appropriate referrals for care

[46] Aged Care Quality Standards (1 January 2020**).** https://www.agedcarequality.gov.au/providers/standards

- Every older adult must have access to assistance with/provision of basic oral hygiene measures including toothbrushing and denture cleaning and have an appropriate oral health referral pathway identified for them whether they are community-dwelling or living within a RACF.
- In RACFs there must be ongoing support for residents' oral health care plans, including daily toothbrushing and/or denture cleaning and a referral pathway for oral care services. This cannot be achieved by RACF staff alone, as they are not equipped with the knowledge or skills to perform this important role. All RACFs should have a direct and ongoing relationship with local dental practitioners to facilitate the oral health of their residents. For example, the Seniors Smiles program recommends one registered dental practitioner employed one day each week, for every 100 residents, to facilitate this outcome.

Awareness Campaigns

- Public awareness campaigns targeting the importance of good oral health for older Australians should be developed and promoted widely by NSW/ACT Health and peak health organisations. Currently there is a perception that oral disease is a normal part of ageing. Highlighting the importance of oral health for good oral function and aesthetics, good nutrition and good overall health and wellbeing to older Australians and their families and carers is essential.
- Oral health education and awareness programs for home-care and RACF staff are available. The challenge is to maintain education and awareness in a workforce that is often transitory. A direct and ongoing relationship with local dental practitioners can facilitate the ongoing education and awareness within community programs and RACF.
- Increased education and exposure to geriatric oral health care for dental practitioner students leading to greater familiarity with the aged care sector and greater acceptability of working with older adults following graduation. Currently, within most student programs, there is limited focus on this area. Improving training and exposure to issues of the aged is an important step to engaging dental practitioners in RACFs. The Senior Smiles program provides an excellent model, as exposure of OHT/DH students to RACFs during their training has resulted in greater acceptability of the University of Newcastle, Bachelor of Oral health graduates to work within the aged care sector.