

NATIONAL ORAL HEALTH CONFERENCE 2011

Presentation Title: Connecting the Docs – Linking the Medical and Dental Delivery Systems for Improved Oral Health: Changing the Standard of Well-Child Care to Include Oral Health

Date of Presentation: 04/12/11

Presenter (Name and credentials): Laura Smith, MPA

Learning Objectives:

1. The purpose of this session is to discuss strategies to change the standard of well-child care to include oral health in Washington State in order to intervene early to prevent disease.
2. The pilot projects and current interventions to train and coach primary care medical providers will be discussed.
3. Lessons learned will be shared in engaging the primary care medical community, connecting them with dental resources in their community and promoting early intervention with parents with young children.

- Vision: all infant and toddler well-child visits include oral health preventive services
 - Oral screening, risk assessment, oral health education/anticipatory guidance, fluoride varnish application, dental referrals as needed
- The case for oral health preventive services
- The training
 - Target large healthcare delivery systems
 - In-office 1 ½ hr CME
 - Include all providers and staff
 - Didactic and hands-on training
 - Trainers: physicians, dentists
 - Conducted/supported by WA Dental Service Foundation
- Group Health Pilot and Outcomes
- Toolkit
- Coaching
- Reimbursement for Oral Health Services:
 - Medicaid
 - Washington Dental Service
- Access to Baby and Child Dentistry (ABCD) Program for dental referrals
- Building demand for primary care providers and parents
- Outcome metrics
- Influencing primary care education: National Interprofessional Initiative on Oral Health
- Lessons Learned

Attendee notes:

Key slides

Vision

- All Infant & Toddler Well-Child Visits include:
 - Oral screening
 - Risk assessment
 - Oral health education/anticipatory guidance
 - Fluoride varnish application
 - Dental referrals as needed

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The Case for Oral Health Preventive Services

- Addressing overall health already
 - Add oral health screening
- Dental disease is a behavioral disease
 - OH anticipatory guidance is critical
- Focusing on prevention
 - Fluoride varnish prevents/reverses early disease
- Assessing risk
 - Not all kids at high risk; target use of limited resources

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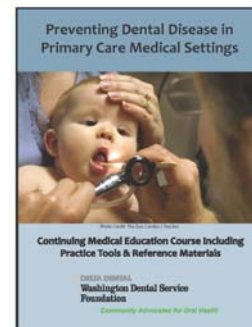
The Training

- Target large healthcare delivery systems
 - Group Health
 - Providence Health Services
 - Highline Medical Services
 - The Everett Clinic
- Incorporate into clinic work flow, electronic health records
- Build seamless business processes

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Toolkit

- Pocket-sized provider reference guide
- 3 Simple Steps
- Documentation samples
 - Paper
 - Electronic
- Billing:
 - Medicaid
 - WA Dental Service



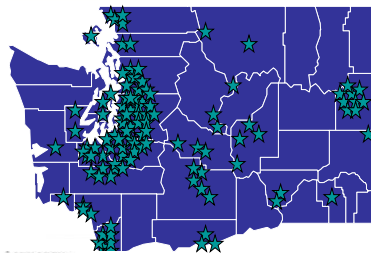
Access to Baby and Child Dentistry - The Referral Source for Low-Income Children



Goal: Improve young children's oral health - more kids getting dental care

- Medicaid-eligible children birth to five years
- Focused on prevention
- Training and enhanced reimbursement to dental offices
- Outreach & case management to families

PRIMARY CARE TRAININGS: 2002-2010



Trained:
-1,570 Primary Care Providers
-1,783 clinic staff

Approximately 31% of practicing primary care MDs have been trained

DELTA DENTAL
Washington Dental Service
Foundation
Community Advocates for Oral Health

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Key concluding points:

1. Primary care medical providers want to address oral health in the context of their patients' overall health and indicate that training, reimbursement and referral sources are critical.
2. Oral health can be efficiently included in well-child checks and parents are overwhelmingly receptive to oral health preventive services being provided in medical offices.
3. While training is necessary, follow-up coaching is important to achieve commitment, comfort, and confidence in delivering the services and sustained adoption.

Key website links:

Washington Dental Service Foundation's website: www.KidsOralHealth.org
& www.DeltaDentalWA.com/Foundation

NATIONAL ORAL HEALTH CONFERENCE

Presentation Title: Connecting the Docs – Linking the medical and dental delivery systems

Date of Presentation: April 12, 2011

Presenter: Susan Cote, RDH, MS

Learning Objectives:

1. Describe From The First Tooth Initiative; purpose and goals.
2. Identify barriers and challenges in adopting early childhood oral health prevention and fluoride varnish into the medical home.
3. Identify opportunity and strategies in adopting early childhood oral health prevention and fluoride varnish into the medical home.

Outline of Presentation:

1. Purpose of From The First Tooth (FTFT)
2. Demographics of Maine children 6 - 42 mos
3. FTFT Phase One Pilot
 - a. Description of the partnering organizations
 - b. Lessons learned
4. FTFT Expansion Strategies
 - a. Health system partners
5. Results To Date
6. Policy Implementations
7. Reimbursement Strategies
8. Conclusion

Attendee notes:



From The First Tooth

The purpose is to improve the oral health of Maine's children by:

- Increasing children's access to preventive oral health services
- Providing a model to integrate early oral health as the *standard of care* for all children in medical practices through:
 - Oral health screening
 - Fluoride varnish
 - Parent/caregiver education and counseling
 - Referral to a dentist

Phase One – Two Year Pilot

Phase One provided training and funding to a diverse group of medical and social service organizations representing different kinds of populations and regions.

The Sadie and Harry Davis Foundation reimbursed participating practices \$10 per fluoride treatment - **for all children** regardless of family SES or insurance status.

On the basis of outcomes and lessons learned, From The First Tooth has extended its reach throughout Maine, to include *all children ages birth through age 3 ½*.

Lesson Learned

Lessons from Phase One are invaluable and provide a firm base for expansion, along with previous experience of the health systems and other partners.

Aligning incentives is a must: standards of care, patients, health professionals, systems, payors; this takes time and leadership.

Focus is on keeping it simple and creating systems that reinforce behavior change for health professionals, patients and families.

Expansion Strategies – Health System Partners

- Improve quality, efficiency, and access of oral health care through regional collaboration.
 - **MaineGeneral Health** (Augusta and Waterville)
 - **Eastern Maine Healthcare Systems** (Bangor)
 - **MaineHealth** (Portland)
- Focus initially on setting with high MaineCare patient populations.
- Utilize physician champions to recruit other physicians.
- Train practice teams and identify specific staff roles, work flow processes.
- Provide tools, resources and on-going support .
- Establish relationships with dental providers and identify referral networks are essential.
- Work with private medical insurance payors and large self- insured employers to include fluoride varnish as a covered benefit in their health plans.

Results To Date

Estimated number of medical settings in Maine serving children = 350

- Number of medical settings trained = 73 (21%) *
 - 18 Pediatrics, 34 Family Practice, 14 Federally Qualified Health Centers, 7 Rural Health Centers
- Number of medical settings recruited = 47 (13%) *
* Training provided by From The First Tooth and Kids Oral Health Partnership

Total number of children in Maine (ages 6 mos to 42 mos) = 41,155 (2010)

- Number of children that received at least one fluoride varnish:
 - Phase One (2008 – 2009) = 3,029
 - Expansion - 2010 = 6,139

MaineCare Data (2010)

- 21% of all paid units for children dental services was provided by non-dental providers, i.e. pediatricians for fluoride varnish. **

**Annual Report to the Joint Standing Committee on Health and Human Services regarding Improving Access To Dental Care for Children with MaineCare Coverage, February 15, 2011

Policy Implementation

- **August 2008** – Endorsement from Maine Chapter of the American Academy of Pediatrics, Maine Dental Association, Maine Medical Association, Maine Academy of Family Physicians, Maine Osteopathic Association, and Maine Primary Care Association.
- **October 2008** – MaineCare started to reimburse medical providers for fluoride varnish.
- **September 2009** – Maine Medical Association Resolution for Oral Health Prevention into Medical Practices was approved.
- **January 1, 2010** – MaineHealth was the first employer in the state to include fluoride varnish in the system's health benefit plans.
- **July 2010** - *From the First Tooth: Eliminating Early Childhood Caries in Maine*, A White Paper Prepared By Center for Research to Evaluate and Eliminate Dental Disparities.
- **January 1, 2011** – EMHS and MaineGeneral added fluoride varnish to their system health benefit plan.

Key Concluding Points:

1. Keep the requirements simple.
2. It is essential to work with practices to determine how to best integrate oral health into their work flow processes, documentation in patient records and billing systems.
3. Clinical champions and payment incentives have facilitated early adoption and spread.
4. Providing tools, resources, and on-going support is necessary to keep the practices engaged.

Key website links: www.fromthefirsttooth.org

Presentation Title: Connecting the Docs – Linking the medical and dental delivery systems

Date of Presentation: April 12, 2011

Presenter: Gary Rozier, DDS, MPH

Learning Objectives:

1. Understand strategies implemented in North Carolina during the last decade to reduce ECC, particularly recent efforts to improve physician referral to dentists.
2. Know outcomes that have been achieved through implementation of these strategies.
3. Become knowledgeable about *Carolina Dental Home*, a guideline-based intervention for physicians and dentists designed to improve the rate and effectiveness of physicians' referrals for dentist care.

Outline of Presentation:

Attendee notes:

**Early Childhood Oral Health Programs in North Carolina:
Effectiveness of Physicians' Referrals to Dentists**

1. Oral health goals for young children in NC
2. Strategies to improve access to services
3. Brief update on status of *Into the Mouths of Babes* [IMB]
4. Brief review of evaluation questions & evidence for outcomes
 - a. Provider participation
 - b. Effectiveness of training methods
 - c. Access to preventive services
 - d. Parent satisfaction
 - e. Dentist utilization
 - f. Reduction in caries-related treatments
5. Remaining challenges to improved access
6. *Carolina Dental Home* Demonstration
 - a. Guideline-based intervention with physicians and dentists
 - b. Evaluation design
 - c. Outcomes
 - d. Conclusions about referral effectiveness
7. Overall conclusions about early childhood interventions after a decade of incremental implementation of strategies

Key slides

Goals for Early Childhood Oral Health in North Carolina

- Increase access to preventive dental services for young low-income children
- Reduce the prevalence of ECC
- Reduce treatment demands on the dental care system

Milestones in Development of Early Childhood Dental System

- 1997: Smart Smiles
- 2000: Into the Mouths of Babes
- 2006: Carolina Dental Home
- 2007: Priority Oral Health Risk Assessment and Referral Tool" (PORRT) Initiative
- 2008: ZOE: Early Head Start Initiative
- 2011: CHIPRA Connect Oral Health Quality Initiative

Evaluation Questions

- What services should PCCs provide?
- What is the best way to train them?
- How many will adopt once trained?
- Will access to preventive services increase?
- How are dental outcomes affected?
 - Dentist use (PCC's referrals and effectiveness)
 - Caries-related treatments
 - Costs
 - ECC experience
 - Oral health related quality of life

What We've Learned

- More than 3,000 providers trained
- Easily integrated into practice
- 450 participating practices
- Increased access:
 - 40% of well-child visits
 - Physician preventive visits 4x greater than dentists
 - Multiple visits 20 times greater in medical offices
- Parents report high levels of satisfaction
- Increased use of dentist services
- Reduction in caries-related treatment
- Barriers to referral for dental care

Referral Guidelines and Effectiveness?

Carolina Dental Home Demonstration

- > Uses risk based referral guidelines
- > 3-county demonstration
- > Refer child to physician with:
 - cavitated lesions to pediatric dentist
 - non-cavitated lesions or risk to GD
 - any other status to GD at 3 years of age, but continue with preventive services in medical office

Conclusions

1. Physicians will use a structured risk assessment tool after training
2. Partial adherence to referral guidelines
 - a. Under-refer high risk patients without disease
 - b. Referral rate better for those with disease
3. More likely to refer early-stage disease after training in guideline use
4. Difficult for parents to engage support for referral
5. A number of referrals don't get into system
6. Once in system, referral is moderately effective, but norms for effectiveness don't exist

Key concluding points:

1. Physicians' referrals and effectiveness can be improved with guidelines and training in their use.
2. Effectiveness of physicians' referrals can break down at any point in the multistep process.
3. Broader dissemination and evaluation of risk assessment and referral guidelines should help inform strategies to reduce barriers to adoption and implementation.

Key website links: <http://www.ncdhhs.gov/dph/oralhealth/partners/IMB.htm>