



Identifying Priorities for and Strategies to Optimize Oral Preventive Service Delivery in Pediatric Primary Care Settings in NH



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Executive Summary

Tooth decay is the most common chronic childhood disease. The American Academy of Pediatrics (AAP) recommends the following oral preventive services be provided as part of routine pediatric primary care practice: periodic oral health risk assessments; fluoride supplementation for children meeting certain criteria; fluoride varnish application; anticipatory guidance to promote regular tooth brushing, reduced sugar consumption, monitoring of child brushing until age eight; and identification of a dental home by age one (American Academy of Pediatrics [AAP], 2014). National data suggests that though pediatricians affirm the importance of delivering oral preventive services, their actual delivery of these services is sub-optimal (Quinonez et al., 2014). This report summarizes findings of a project conducted by New Hampshire Pediatric Improvement Partnership (NHPIP) to 1) assess the current status of and barriers and facilitators to the delivery of oral preventive services in pediatric primary care practices in NH, with a particular focus on children under six years, and 2) identify strategies to optimize the delivery of oral preventive services in pediatric primary care settings. Information was collected through review of existing research, key stakeholder interviews, a survey of pediatric/family physician clinicians, and a survey of the major medical payers in NH.

NH children under six years are much less likely than their older counterparts to have seen a dentist in the past year (National Survey of Children's Health [NSCH], 2011-2012), making delivery of oral preventive services in primary care services even more critical. NSCH 2012 data reveals that roughly 60% of NH children less than six years had visited the dentist in the past year compared to 94% and 92% respectively of children 6-11 years and 12-17 years (NSCH, 2011-2012). The literature, available data, and stakeholders identified young children from low income families as the prioritized target population for enhanced oral preventive service delivery in primary care. This population frequently experience multiple factors, such as no dental insurance, special health care needs, cultural and linguistic barriers, setting them at high risk for poor oral health.

Although most NH pediatric/family physician clinicians report being somewhat or very familiar with the AAP recommendations for oral preventive service delivery, actual implementation varies by service. Results indicate a fairly high and consistent delivery of anticipatory guidance, oral assessments, and provision of fluoride prescriptions between birth and six years. Implementation of risk assessments, referral to a dental home, and application of fluoride varnish represent areas of opportunity.

Barriers to oral preventive service delivery in primary care include: limited time, limited provider clinical knowledge/training, reimbursement issues, limited communication between the medical and dental community (particularly at the local level), and family-related challenges. Facilitators to address these barriers include synergizing efforts with existing state oral health plans, existing efforts in NH to expand access to oral health care, a plethora of tools to build clinical skills and assist in adapting office workflows to incorporate oral preventive service delivery, and the future availability of dental claims data to better assess oral service utilization.

Based on assessment findings, recommendations to optimize delivery of oral preventive services in primary care settings include:

1. At the local/regional level, promote the development and dissemination of resources and pilot projects to build and sustain relationships between pediatric/family physicians and dentists caring for young children.
2. At the state level, bring together medical and dental professional societies to assure consistent oral health messaging to families of young children, and facilitate joint policy development to address systems-level barriers to pediatric oral preventive services delivery.
3. Promote awareness about, and conduct pilot projects to, explore new models to support primary care practices in delivering recommended pediatric oral preventive services.
4. Develop and implement an educational campaign targeting families, particularly those at high-risk, as well as medical and dental care providers that “Baby Teeth Matter.”
5. Develop a one-stop shopping mechanism that makes it easier for busy primary care clinicians to find tools to integrate oral preventive services delivery that match their own learning needs and clinic capacity.
6. Continue to track and respond to challenges associated with reimbursement for oral preventive services.
7. Conduct additional research to better understand the extent to which NH children are receiving recommended oral preventive services as well as the oral health needs of children/youth with special health care needs or from families of different cultures and/or where English is the second language.

Background

Tooth decay is the most common chronic childhood disease. Data from the NH 2013-2014 Healthy Smiles, Healthy Growth assessment found that 35.4% of third-grade students statewide had experienced tooth decay, 8.2% had untreated tooth decay, and only 60.9% had dental sealants. Significant sub-state variations in pediatric oral health status exist (Martin et al., 2014). Third-graders in Coos County and the City of Nashua experienced the highest prevalence of tooth decay (56% and 48.5% respectively) while Rockingham County third-graders experienced the lowest (21.3%) (Martin et al., 2014).

National data suggests that though pediatricians affirm the importance of delivering oral preventive services, their actual delivery of those services is sub-optimal. The American Academy of Pediatrics (AAP) recommends the following oral preventive services be provided as part of routine pediatric primary care practice: periodic oral health risk assessments; fluoride supplementation for children meeting certain criteria; fluoride varnish application; anticipatory guidance to promote regular tooth brushing, reduced sugar consumption, monitoring of child brushing until age eight; and identification of

a dental health home by age one (AAP, 2014). A 2012 national survey of AAP members found that roughly half of surveyed clinicians reported providing oral preventive services. Of these, few reported engaging in these activities with “most patients”; only 7% reported fluoride varnish application with greater than 75% of their patients (Quinonez et al., 2014). Common barriers included lack of training, time, and reimbursement. NH-specific data for the same measures of adherence to AAP recommendations are not available, but anecdotal evidence from practitioners and thought-leaders on oral health issues in NH indicate that the same gaps exist in this state. The American Academy of Family Physicians (AAFP) guidelines for oral preventive service delivery to young children are more limited than those of the AAP. The AAFP includes only two of the above AAP recommendations of fluoride supplementation and administration of fluoride varnish as both have received a Clinical Preventive Service Delivery Grade B designation (American Academy of Family Physicians, 2014).

While many in NH agree that oral preventive service delivery in primary care could be improved, barriers to their delivery are not completely clear. Reimbursement challenges, particularly for the Medicaid population, have been identified as an issue in NHPIP conversations with stakeholders. However, other barriers and possible strategies to address them are not completely understood. For example, how well (or not well) medical insurance coverage and dental insurance coverage provide for the range of oral preventive services for children.

Primary care providers can play a pivotal role in promoting the oral health of children in New Hampshire. In this state, the proportion of children with health insurance coverage and the proportion receiving preventative care visits are both high. Identifying how to maximize these robust interactions in the medical home setting to affirm the importance of oral health and bridge a family’s connection to a complementary dental health home represent huge opportunities for New Hampshire. Having a better understanding of existing limitations and variations in oral preventive service need and delivery in NH is needed to 1) identify where to target future quality improvement (QI) work and 2) design a QI project that effectively addresses both the office and systems changes required to enhance oral preventive services delivery in primary care settings.

Methods

This project included a review of existing research, key stakeholder interviews, a survey of primary care providers, and a survey of the major medical payers to 1) assess the current status of and barriers and facilitators to the delivery of oral preventive services in pediatric primary care practices in NH, with a particular focus on children under six years, and 2) identify strategies to optimize the delivery of oral preventive services in pediatric primary care settings.

Background research was conducted to better understand the oral health status of NH children under six years and the context for oral health preventive service delivery in primary care. Staff reviewed available national and state oral health data sources, as well as published and “grey” literature. In addition, interviews with state and national programs/efforts to improve oral preventive service delivery in pediatric primary care were conducted. Staff reached out to the pediatric improvement partnerships in Maine and South Carolina about their quality improvement learning collaboratives to improve oral

preventive service delivery in pediatric primary care. A matrix of findings from the background data collection and literature reviewed was developed. Conversations with state and national programs informants were summarized and key themes identified.

Interviews with key NH pediatric oral health stakeholders were conducted to better understand sub-state variations in oral health, relevant systems/policy issues, and local “best practices” for oral preventive service delivery in primary care. The ten interviewees included a family practice physician, two pediatricians, NH Oral Health Coalition (NHOHC), NH Oral Health Program, NH Dental Society, NH Academy of Pediatric Dentistry, HNH Foundation, Northeast Delta Dental, NH Medicaid, and NH Special Medical Services. The interviews were summarized and key themes were extracted.

In November 2015, a survey was distributed to primary care clinicians in NH to understand adherence to AAP recommended oral preventive services for young children and assess facilitators and barriers to oral preventive service delivery. The survey was distributed through available direct emails to pediatric and family practice clinicians as well as via the listservs of the NH Pediatric Society, the NH Academy of Family Physicians, and the NH Nurse Practitioner Association. As an incentive to participate, clinicians completing the survey were entered into a raffle for an Amazon gift card. A total of 102 primary care clinicians completed the survey. See Table 1 for a demographic breakdown of respondents.

Table 1. Survey participant demographics

Demographic Breakdown of Primary Care Clinicians Participating in NHPIP Oral Health Survey, Fall 2015 (N=102)	
Professional Degree	
MD/DO	99
NP	3
Area of Practice	
Family Medicine	43
Pediatrics	54
Combined Internal Medicine and Pediatrics	5
Years Practiced (one respondent did not answer)	
0-5 years	8
6-15 years	45
16-30 years	40
30+ years	8

A survey was also distributed to seven of the major medical payers in NH to better understand reimbursement for oral preventive services in primary care. As necessary, NHPIP staff followed up with respondents to clarify nuances about billing and reimbursement. A table summarizing the name of the oral preventive services reimbursed, the requisite billing code, and any pertinent guidelines governing reimbursement was developed (see Appendix A).

Following the information gathering phase, the NHPIP coordinated in collaboration with the NH Oral Health Coalition (NHOHC) and Center for Health Analytics (CFHA) at the Institute for Health Policy and Practice (IHPP) a forum of key state stakeholders to share assessment results and garner stakeholder feedback. NHOHC presented results of a baseline survey of non-traditional oral health service providers in NH. IHPP's CFHA reviewed results of a project focused on preliminary analysis of dental claims data from the NH Comprehensive Healthcare Information System.

Results

Information collected through this assessment process was synthesized and are presented below based on the key question they answer.

Which NH Children Should a Quality Improvement Project to Improve Delivery of Oral Preventive Services Target?

NH children under 6 years are much less likely than their older counterparts to have seen a dentist in the past year (National Survey of Children's Health [NSCH], 2011-2012). The most recent data (2011-2012) from the NSCH reveal that approximately 60% of NH children less than six years had visited a dentist in the past year. This rate is considerably lower than those for NH children 6-11 years and 12-17 years (94% and 92%, respectively). The most recent data available (2009-2010) from the National Survey of Children with Special Health Care Needs (NS-CSHCN) indicate that approximately 90% of NH children and youth with special health care needs (CYSHN) less than 18 years old had a dental visit in the last year (NS-CSHCN, 2009-2010). Analysis of 2012 dental claims data compared to NH Census estimates shows that approximately 32% of NH children less than five years old may not have dental insurance (internal analysis, Institute for Health Policy and Practice, 2016).

Though the oral health status of NH children is favorable compared to children nationally, room for improvement exists. Nationally, the proportion of children less than six years of age with an oral health problem was 11% in 2011-2012, while in NH the proportion was 6.3% (NSCH, 2011-2012). Also in 2011-2012, the percent of NH children with an oral health problem nearly tripled from 6% of those less than six years to almost 18% of those 6-11 years (NSCH, 2011-2012). This result raises the possibility that delayed access may have a role in increased dental problems in future years.

Variation in oral health status based on socioeconomic status, geography, and age exist. Data from the 2013-2014 NH Healthy Smiles Healthy Weight Survey of third graders reveal that children receiving free and reduced lunch have about 30% more oral decay present than children that do not receive it (Martin et al., 2014). The percent of third-graders with previous decay is two to three times higher in Belknap (47%), Strafford (47%), and Coos (56%) than in Rockingham County (21%) (See Figure 1). Though no reliable data about the oral health status of minority children is available, results from the survey of NH pediatric and family practice clinicians conducted for this project found that roughly 60% did not know of a local dental provider that could accommodate a family with limited English proficiency. NH ranks 44th nationally in terms of percentage of population with access to a fluoridated water supply (46%) (ADA Health Policy Institute, 2015). Only 11 towns in NH fluoridate their water supply (Concord, Dover,

Durham, Hanover, Laconia, Lakeport, Lancaster, Manchester, Lebanon, Madbury, and Rochester (NH Department of Environmental Services, 2010)). Finally, both the literature and key state oral health stakeholders interviewed for this project identified children less than three years as at high risk for poor oral health.




Percent of Children with Tooth Decay Relative to Availability of Oral Preventive Services

County	Decay Experience*
Belknap	46.70%
Carroll	35.90%
Cheshire	42.40%
Coos	56.00%
Grafton	43.10%
Hillsborough	36.10%
Merrimack	39.40%
Rockingham	21.30%
Strafford	46.60%
Sullivan	45.50%
NH Total	35.40%

* Decay Experience Data from the NH 2013-2014 Third Grade Healthy Smiles-Healthy Growth Survey

Legend

Oral Health Data Points

-  Community and School Based Dental Health Programs
-  Pediatric Dental Offices
-  Pediatric Primary Care Offices Currently Applying Fluoride Varnish

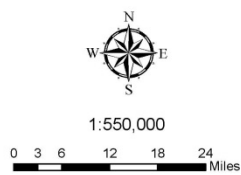
Political Boundaries

-  State
-  County
-  City/Town

Data Sources:

Data for the community and school based dental health programs and the pediatric primary care offices currently applying fluoride varnish were provided by the NH Oral Health Coalition.

Political boundaries were extracted from New Hampshire Political Boundaries at 1:24,000 Scale data set (NH GRANIT, 2013).



February, 2016

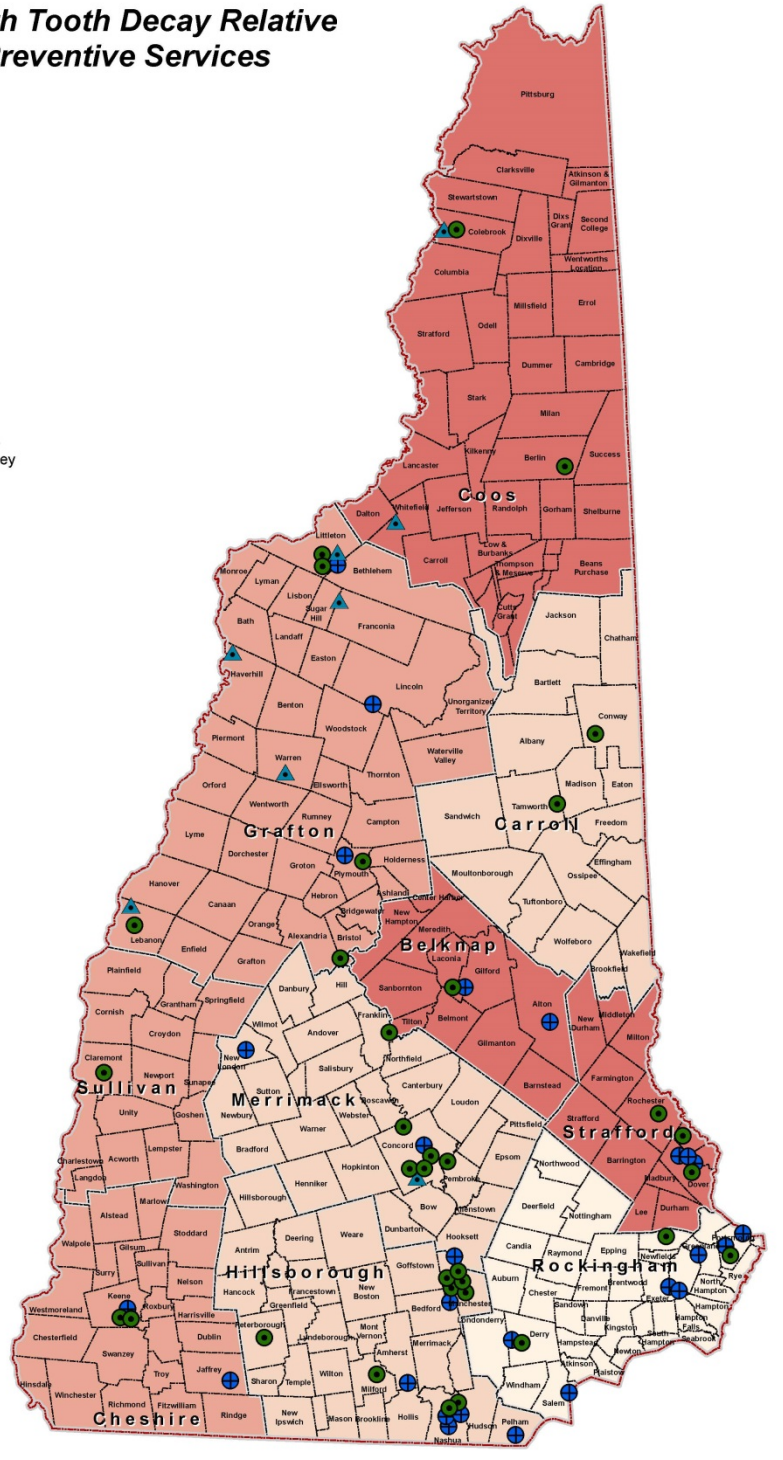


Figure 1. Map of the Percentage of children with tooth decay relative to the availability of oral preventive services.

To What Degree Are Recommended Oral Preventive Services Delivered in Primary Care Setting to Children Under Six Years in NH?

The primary care office provides a promising venue to address the oral health of young children. In the first three years of life, families are scheduled to see their child's primary care provider 10 times for well child visits. In 2011-2012, 95% of NH children under six years had a preventive medical visit in the past year; this compares to roughly 60% for a dental visit (NSCH, 2011-2012). Encouragingly, the survey of family physicians and pediatricians conducted for this project reveal that roughly 95% of clinicians see themselves as very or somewhat responsible for the oral health of children under six years in their care.

Although most clinicians reported being somewhat or very familiar with the AAP recommendations for oral health preventive service delivery, actual implementation of the guidelines varies by service. The survey for this project showed that nearly 80% of NH pediatric and family practice clinicians reported being somewhat or very familiar with the AAP guidelines for oral preventive service delivery to young children (See Figure 2).

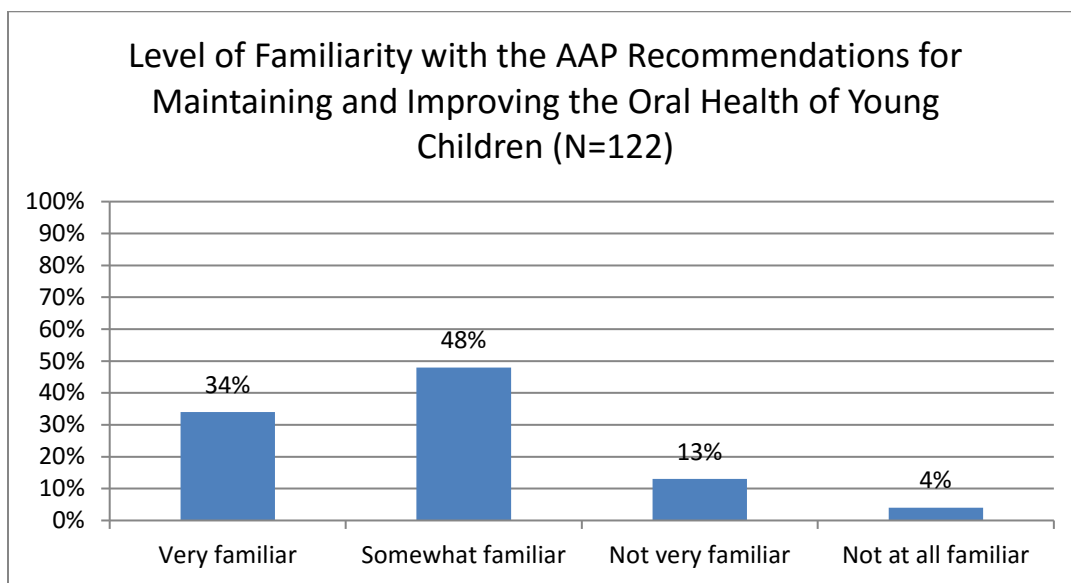


Figure 2. Clinician familiarity with the AAP oral preventive service recommendations.

Survey results indicated a fairly high and consistent delivery of anticipatory guidance, oral assessments, and provision of fluoride prescriptions between birth and six years (See Figures 3-5).

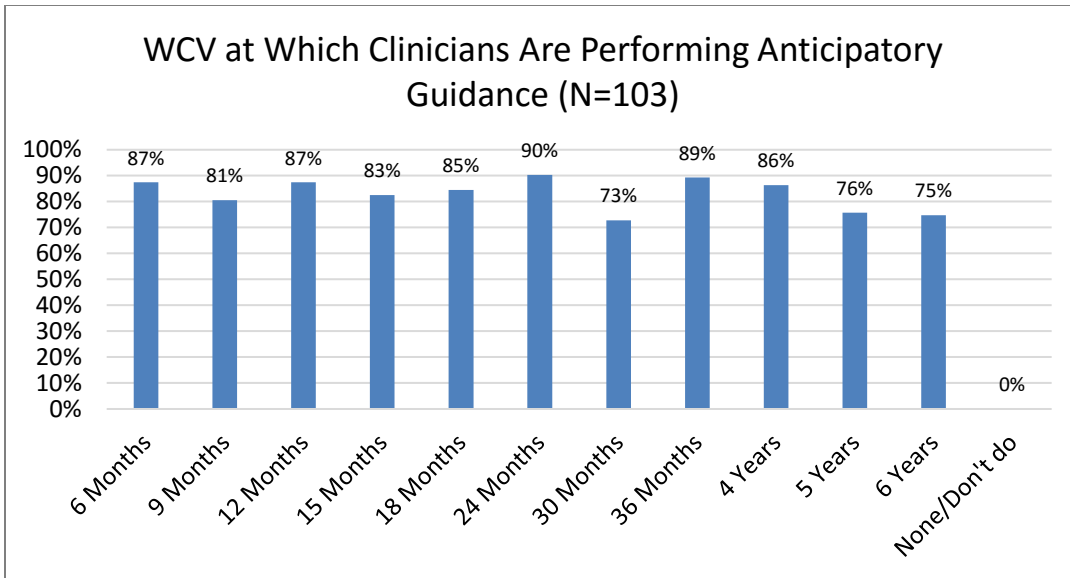


Figure 3. Well-child visits that clinicians reported performing anticipatory guidance.

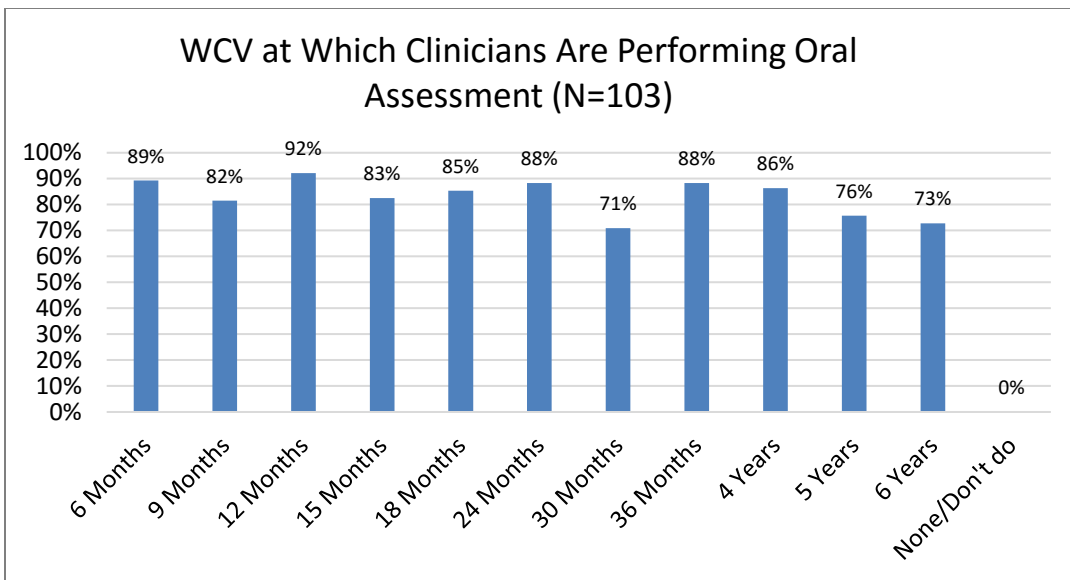


Figure 4. Well-child visits that clinicians reported performing oral assessment.

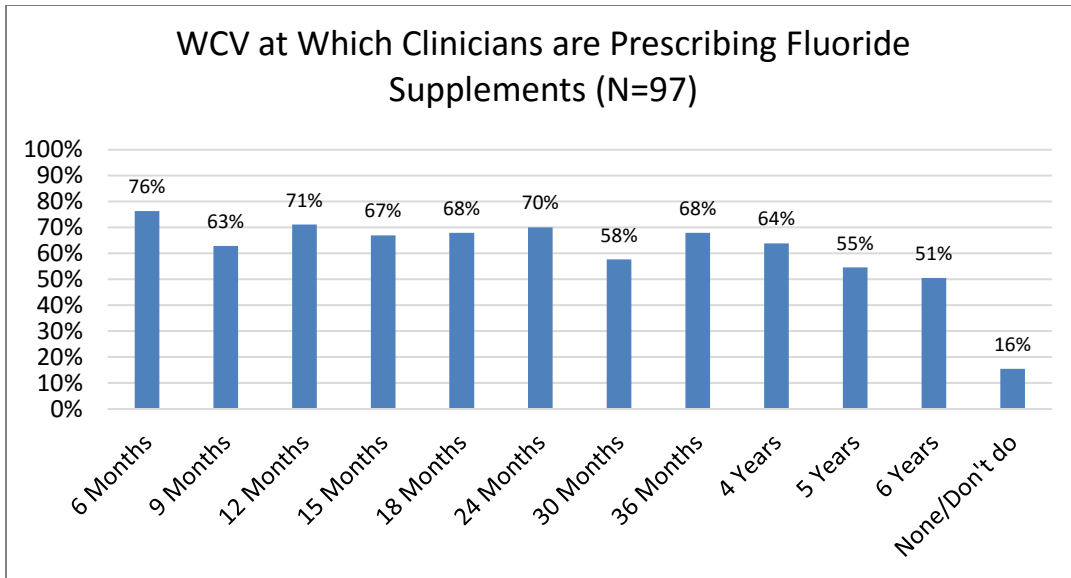


Figure 5. Well-child visits that clinicians reported prescribing fluoride supplements.

Implementation of risk assessments, referral to dental home, and application of fluoride varnish represented areas of opportunity (See Figures 6-8). Implementation of risk assessments ranged from a low of 46% of providers conducting one at the 30 month visit to a high of 75% at the 12 month well child visit.

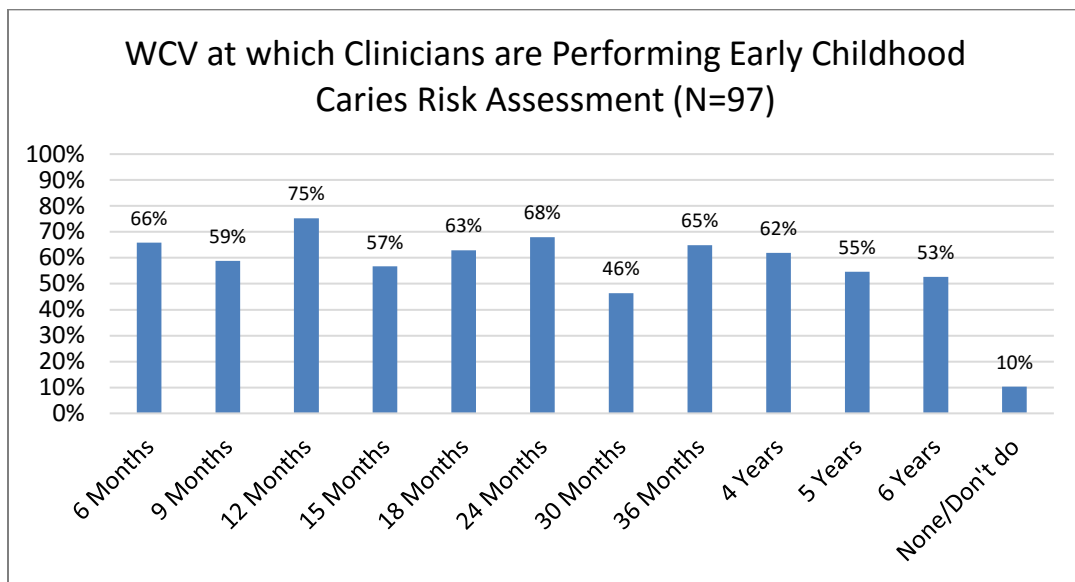


Figure 6. Well-child visits that clinicians reported performing early childhood caries risk assessment.

Although referral to a dental home is recommended by age one, only 14%, 12%, and 53% of surveyed clinicians addressed this topic at the 6, 9, and 12 month visit, respectively.

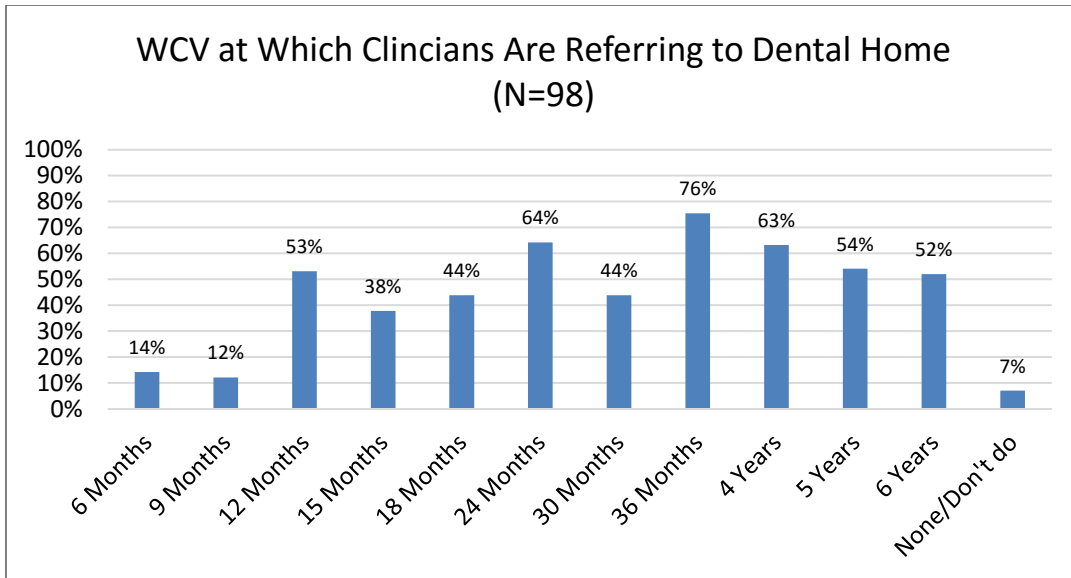


Figure 7. Well-child visits that clinicians reported referring children to a dental home.

Seventy percent of surveyed clinicians did NOT perform fluoride varnish application. This result mirrors those from of a 2016 survey conducted by the NH Oral Health Coalition which found only nine family physician or pediatric primary care practices statewide reported application of fluoride varnish (see Figure 1).

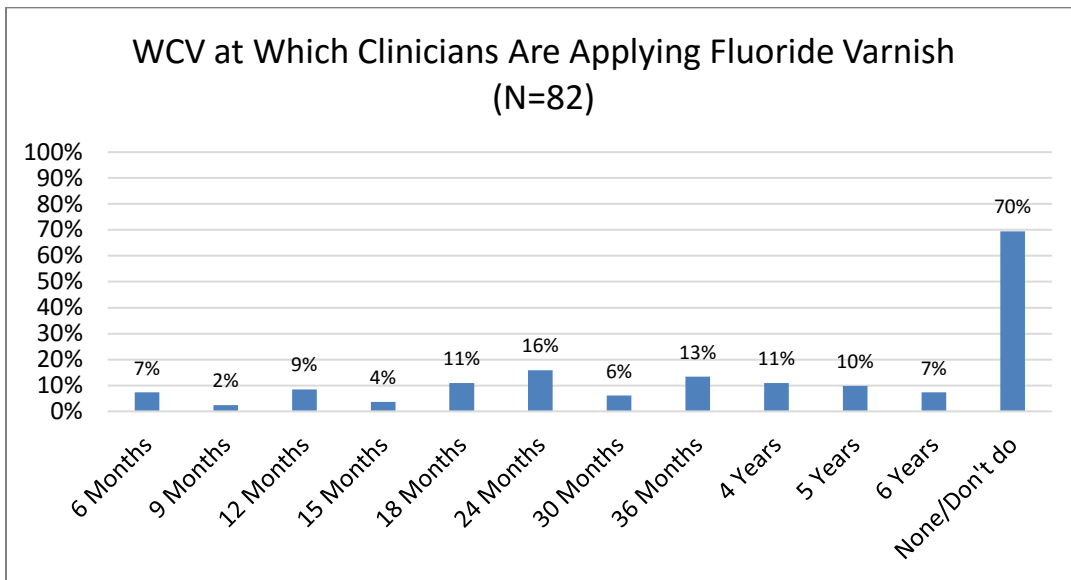


Figure 8. Well-child visits that clinicians reported applying fluoride varnish.

Barriers to Oral Preventive Service Delivery in Primary Care Settings

Within the office setting challenge to oral preventive service delivery in primary care included: limited time, limited provider knowledge/training, and reimbursement issues. Systems-level barriers included reimbursement, limited communication between the medical and dental community (particularly at the local level), and family-related challenges.

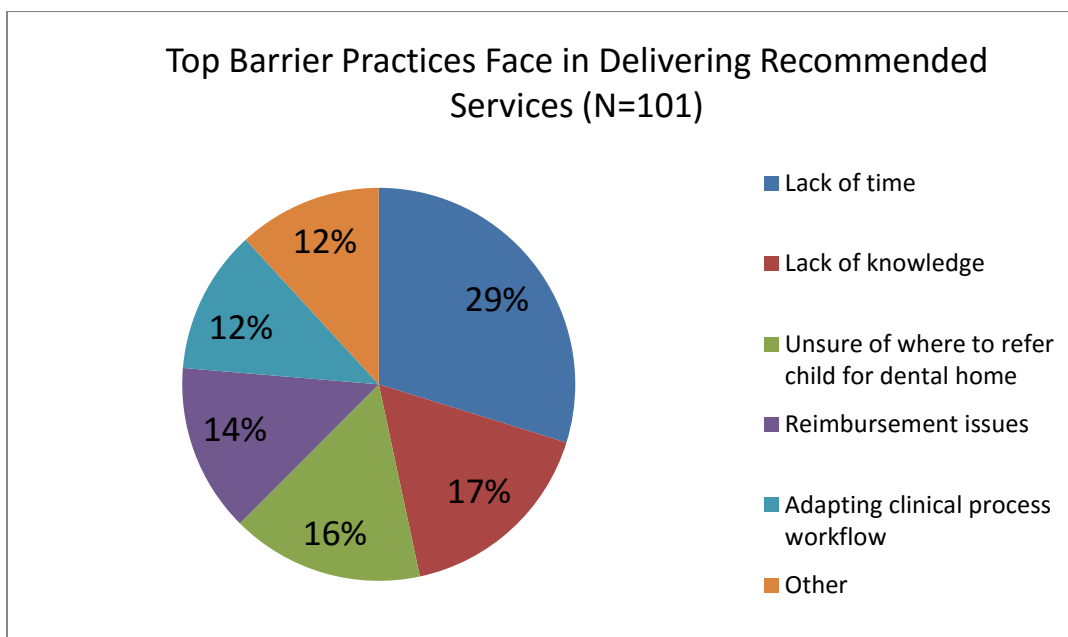


Figure 9. Top barriers NH primary care clinicians identified in delivering the recommended AAP oral preventive services in the office.

Lack of Time

Lack of time to integrate oral preventive services delivery into an already packed well-child visit, and the need to re-work clinical workflows were mentioned consistently in background research, key informant interviews, and clinician survey responses. In the provider survey, 29% of clinicians indicated that lack of time and 12% identified challenges with workflow design as the primary barrier to integration of oral preventive services delivery in the well-child visit. (See Figure 9).

Limited Clinical Knowledge and Skills

Seventeen percent of family physicians and pediatric primary care clinicians participating in the survey selected lack of clinical knowledge and skills as the top barrier to integration of oral preventive services in primary care (See Figure 9). Relatedly, the literature and key informant interviews indicated that primary care clinicians receive limited exposure to oral health concepts during medical school. Not only do clinicians need to know how to perform oral health exams and apply fluoride varnish, they need to be able to address parent concerns, particularly with fluoride use. Furthermore, medical clinicians (and

dental clinicians) need to understand oral health considerations/risks experienced by children/youth with special health care needs; for example, medications that contain sugar, special diets, or difficulty with oral hygiene due to mobility/physical impairments (Holt, Barzel & Bertness, 2014).

Uncertainty about where to refer a child for a dental home represents another significant barrier, with 16% of surveyed clinician indicating this issue as the top barrier to oral preventive service integration (See Figure 9). This issue becomes more acute when looking at vulnerable sub-populations. For example, 58% of clinicians surveyed did not know where to refer a child of a family that does not speak English well/at all; 44% did not know where to refer a child under 3 years; 33% did not know where to refer a child with physical, behavioral, or mental health issues; and 29% did not know where to refer a child with Medicaid dental coverage (See Figure 10). Key stakeholder interviews and literature corroborate these findings as well; in particular, the concern about lack of dental providers accepting Medicaid. According to a recent state profile produced by the American Dental Association (ADA), approximately 45% of NH dentists accept Medicaid (ADA Health Policy Institute, 2015).

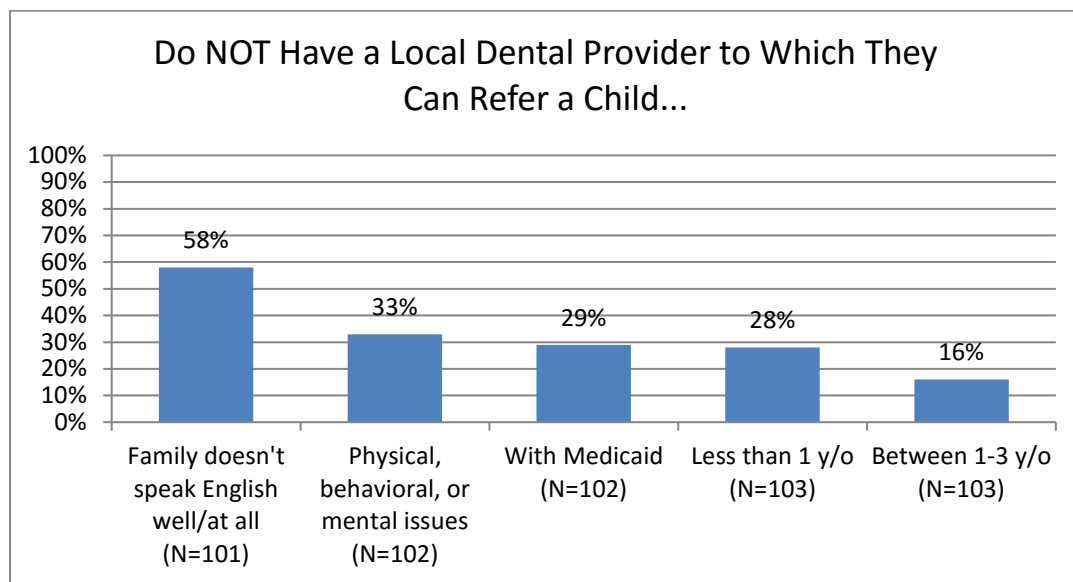


Figure 10. Proportion of clinicians that do not have a local dental provider to which they can refer a child.

A few on-line tools exist to help medical clinicians/families find dental providers, but limitations exist. The American Academy of Pediatric Dentistry's (AAPD) website (<http://www.aapd.org/>) offers a "Find a Pediatric Dentist" search tool that allows the user to locate the nearest pediatric dentist, but not all dentists who serve children are pediatric dentists. The ADA's website allows the user to find a local ADA member by specialty and geography (<http://www.mouthhealthy.org/en/find-a-dentist?source=Societies&medium=quicklinks&content=FindADentist>). Neither site indicates who is accepting new patients, takes Medicaid, or is able to accommodate children with disabilities. The recently updated "Insure Kids Now" Website (<https://www.insurekidsnow.gov/state/find-a-dentist/index.html>) appears to be the best tool to find dentists that accept NH Medicaid, are taking new patients, speak different languages, and can accommodate special needs children. Dental provider information was updated mid-June 2016 and has increased dramatically. A recent search revealed 105

NH dentists who care for children, take Medicaid, and are accepting new patients. Though this site is promising, finding a dental home for a child may still be difficult. For example, in querying this database no NH dental provider reported being able to accommodate a Spanish-speaking family. Compounding the issue further is a lack of clarity about where to refer children with no dental insurance. In an interview with a primary care clinician about where he refers a family with no dental insurance, this individual reported reaching out to clinicians in his practice network about possible dental care options.

Reimbursement

Perceived lack of and confusion about reimbursement represents both an office setting and systems-level barrier to oral preventive service delivery in primary care. Reimbursement issues were noted as the top barrier to oral preventive services delivery by 14% of clinicians surveyed in this project. In May 2014, the United States Preventive Task Force (USPTF) gave a Level B recommendation for primary care clinicians to prescribe oral fluoride supplementation starting at 6 months for children whose water supply is deficient in fluoride and to apply fluoride varnish to the primary teeth of all infants and children starting at the age of the primary tooth eruption (USPTF, 2014). The Affordable Care Act requires medical insurers to cover all USPTF recommendations graded B or higher, thus starting in May 2016 this service is now reimbursed for children up to age 6 (American Medical Association, 2015). Fluoride varnish and fluoride supplements are included as part of Medicaid's Early and Periodic Screening, Diagnostics, and Treatment (EPSDT) program (Centers for Medicare and Medicaid Services, 2013). All other oral preventive services (the oral health exam, risk assessment, anticipatory guidance) are considered to be part of routine well-care and paid as services delivered under the well-care visit code.

The NHIP survey of major NH carriers (NH Health Families, Cigna, Anthem, Harvard Pilgrim, Well Sense, Community Health Options, and Minute Man) confirmed that all reimburse for fluoride varnish application and supplementation, however questions about appropriate billing exist. Clarification is needed about who can apply fluoride varnish (only the child's MD/DO/NP or can an MA/RN apply it?) and if only AAP approved oral health trainings fulfill the required training mandate. Medical payers are still transitioning from dental codes to medical codes for payment of fluoride varnish, leading to denied claims due to an incorrect code. Please see Appendix A for a summary of medical insurance payer reimbursement policies. Finally, anecdotal evidence suggests integrating use of medical insurance to cover sedation for children/youth with special health care needs who may require this service to receive preventive oral health care is problematic.

A third reimbursement issue involves the low Medicaid fee schedule for dental care. Dental Medicaid rates have not increased in 10 years. Due to inadequate reimbursement, just under half of dental providers in NH accept Medicaid. As such, the pool of dentists available at the local level to take care of this at-risk population may be smaller.

Limited Communication between the Medical and Dental Community

Communication between primary care and dental providers at the local level is sub-optimal. Forty-four percent of primary care clinicians reported having no direct communication with dentists in their local area (See Figure 11). Though the reasons for this limited communication are not totally clear, anecdotal evidence from an interview with a dentist suggests that lack of time/priority may be a factor. This dental provider recounted trying to connect with a pediatric primary care office to meet with their clinician team, but after multiple failed attempts, just stopped trying. Communication issues were also raised by key informants with respect to medical and dental clinicians sending contradictory messages, for example at what age a child should see a dental provider. Better communication between the two could help to increase dental home referral rates, consistent messaging, and provide medical clinicians with access to oral clinical expertise and dental clinicians access to medical care expertise.

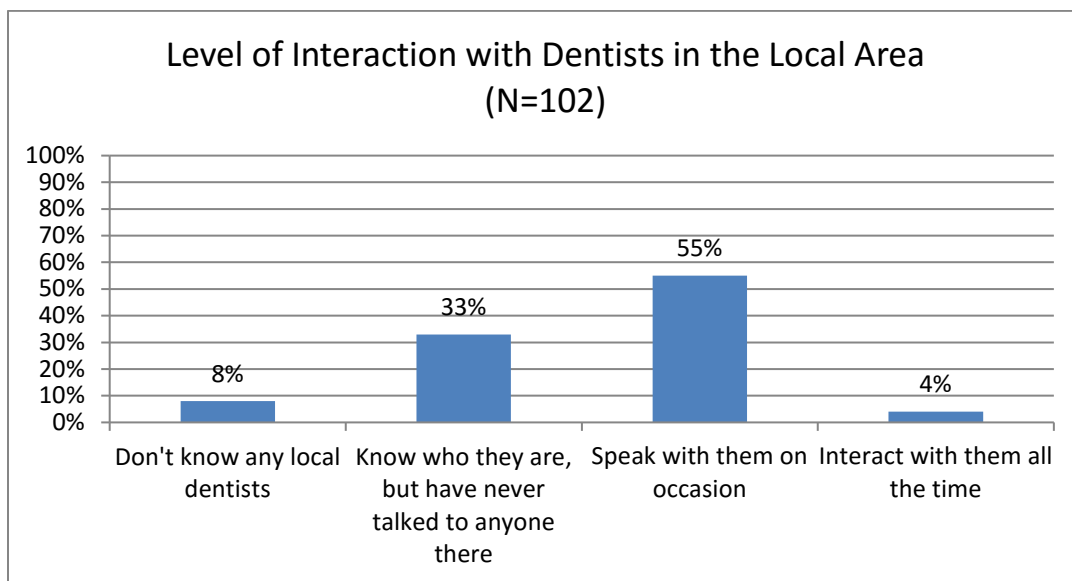


Figure 11. Medical clinicians' level of interaction with local dentists.

Family-related Challenges

When a dental home referral does occur, families still may face barriers in optimally supporting the oral health of their children. Thirty-five percent of NH family physicians and pediatricians surveyed reported the top barrier families face in promoting their child's oral health is lack of dental insurance. Other barriers include lack of awareness of and/or inability to promote good oral health habits (26%), local dental providers not accepting the family's dental insurance (10%) and lack of family "bandwidth" to add another thing to their plate (10%) (See Figure 12). These challenges were reiterated in stakeholder interviews. Implementation of preventive oral health services in primary care is even more crucial for families without dental insurance.

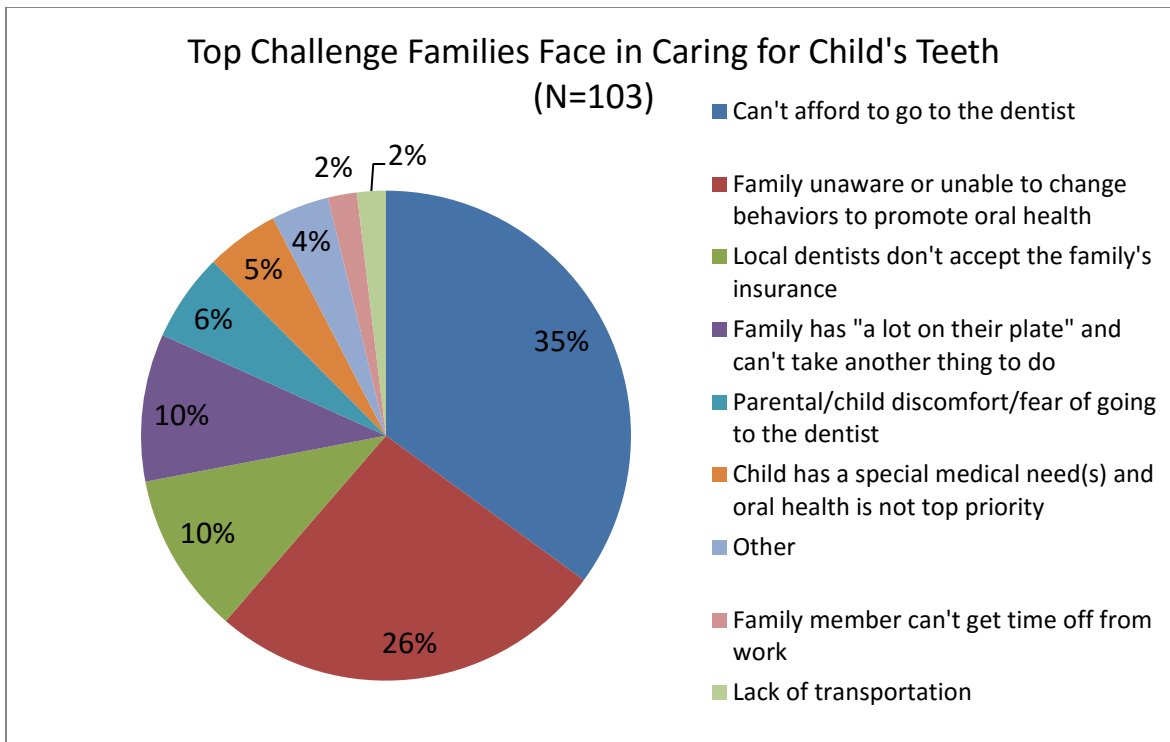


Figure 12. Clinician perspective regarding the top challenge that families face in caring for their child's teeth.

Facilitators to Oral Preventive Service Delivery in Primary Care Setting

Background research and interviews with key stakeholders also revealed a number of facilitators to enhancing oral preventive service delivery in pediatric primary care settings.

Synergy with Existing State Oral Health Plans

The updated NH Oral Health Plan contains as one of its three priority goals "a health care system that values and integrates oral health and overall health." (Auerbach & Baum, 2015). The plan also outlines a set of strategies to promote dental-medical integration including:

Objective 3.1: Integrate fluoride varnish, risk assessment, anticipatory guidance, and referrals into the well-child visits at 10 primary care practices by 2020.

Objective 3.2: Create a model for an oral health and medical information sharing system by 2020.

Objective 3.3: Decrease ER utilization by 20% for non-traumatic dental services by 2020 and develop models for referral protocol for emergency rooms by 2018.

Objective 3.4: Increase the number of individuals from identified higher risk populations who are receiving services at FQHCs, which provide integrated dental care either directly or through paid referral by 2020. Populations include, but are not limited to, people with disabilities, homeless, those with HIV, elderly, veterans, and mentally ill.

Objective 3.5: Provide at least 20 training programs to a minimum of 100 health professionals in all NH health settings using an evidence-based oral health curriculum by 2020.

Objective 3.6: Encourage the Integration of oral health care modules into current and future health professional educational curricula in New Hampshire by 2020.

Source: 2015 NH Oral Health Plan

Inclusion of medical-dental integration objectives in the state oral health plan affirms and raises awareness about the importance of this issue to promoting the oral health of NH residents. In 2015 the NH Dept. of Health and Human Services' Oral Health Program released its five-year communication plan to promote key oral health messages to identified priority audiences. Year two of the plan targets conducting a campaign directed at families with children under age five about the importance of taking care of "baby teeth." (NH Department of Health and Human Services, 2015).

Investments and Different Models Available to Increase Access to Oral Health Care

Background data collection revealed numerous efforts across the state to identify and promote access to a dental home for children under six years. For example:

- HNH Foundation and Neil and Louise Tillotson Foundation investments to promote access to dental services for children in Coos County.
- An increasing number and dispersion of pediatric dentists in the state. Twenty seven pediatric dental practices (See Figure 1) are located in NH. The number of pediatric dentists has increased from 24 to roughly 40 pediatric dentists (Commission to Study Pathways to Oral Health Care in NH, 2015). Interviews with dental clinicians revealed that many pediatric dental practices have the capacity to care for more children. Unfortunately, some pediatric dental practices, particularly in more rural settings, have reduced their hours due to low patient volume.
- The NH Oral Health Coalition recent inventory of non-traditional settings for oral health delivery to children identified a wide array of programs delivering oral health services, including mobile dental clinics, WIC clinics, co-location of dental and primary care services at Community Health Centers, and school-based clinics.
- Expansion of RSA 317-A, the Dental Practice Act, to include use of allied health professionals, Public Health Dental Hygienists and Certified Public Health Dental Hygienists.

Resources to Enhance Primary Care Provider Knowledge, Skills, and Efficiency in Delivering Oral Preventive Services

A plethora of resources exist to support primary care providers with expanding their oral health knowledge and integrating oral preventive services into their well-care visits. Two well-known and evidence based curriculums are Smiles for Life developed by Dr. Hugh Silk and recently updated in June the American Academy of Pediatrics' (AAP) EQIPP Module on Oral Health. In collaboration with Dr. Silk, the NH Oral Health Coalition during the past year has provided short on-site trainings to nine family physician and pediatric offices using the Smiles for Life Curriculum. This curriculum builds primary care provider knowledge and skills to provide recommended oral preventive services, including fluoride varnish application. It also provides fiscal/administrative assistance to operationalize and bill for

services rendered and helpful tools such as the Smiles for Life App that providers can use to conduct risk assessments. Dr. Silk has recently received another grant to bring this training to additional practices in NH during 2016-2017. He is also re-working the curriculum to be able to provide clinicians Maintenance of Certification (MOC) Part 4 credits (to maintain board certification, doctors are required to complete a MOC Process. Part 4 of the process includes conducting a quality improvement project. Physicians must accrue 100 Part 4 points every five years.). Based on the Smiles for Life Curriculum, the May 2016 Children's Hospital at Dartmouth Annual Pediatric Conference included a presentation and hands-on workshop on fluoride varnish application. Participating clinicians showed great interest and enthusiasm at both. The AAP offers an EQIPP course focused on oral health in primary care. This curriculum is free to AAP members and also conveys MOC Part 4 Credits. In addition to the aforementioned resources are a plethora of webinars, factsheets, and websites covering different aspects of oral health and delivery of oral health services.

Access to Dental Claims Data

Future access to dental claims data will provide an unparalleled opportunity to answer questions about oral preventive service utilization of young children in NH. For example, determining the proportion of NH one year olds that have seen a dentist for preventive care. The ability to link medical and dental claims files could provide a clearer understanding of the degree to which children/youth with special health care needs receive recommended oral preventive services as well.

Results from the Forum

As previously mentioned, a forum was held in March 2016 to share the findings summarized earlier in this report, as well as findings from NHOHC and CFHA projects. A total of 35 stakeholders attended this forum including state oral health agency leadership, dentists, dental hygienists, dental insurers, medical insurers, medical clinicians, and community oral health programs. This said, attendance of *practicing* primary care and dental clinicians was limited. Participants reported high satisfaction with the forum format. Please see Appendix B for a summary of the forum evaluation results.

Stakeholders affirmed the importance of all children under six receiving recommended oral preventive services, with a strong emphasis placed on young children from low income families. Children from low income families frequently experience multiple risk factors, such as no dental insurance, special health care needs, cultural and linguistic barriers, setting them at high risk for poor oral health.

The below bullets outline the top barriers to oral preventive service delivery in primary care settings identified by forum stakeholders. Participant feedback mirrored those listed in the above barriers section. New feedback received at the forum is bulleted underneath its respective barrier domain. A complete summary of all feedback received at the forum can be found in Appendix C.

- Limited communication between medical and dental
 - Turf issues (Perception that medical providers are doing work that dentists do).
 - Use of different terms and billing terminology.

- Identifying appropriate referrals to dental homes
 - Need to build capacity of general dentists to see children under three years.
 - Require Medicaid recipients to have a designated dental home provider as they do for primary care.
 - Could employers play a role in linking employees to a dental home?
 - Where to refer families with no dental insurance?
- Promoting family awareness about the importance of oral health to the overall health of their child and the importance of regular preventive services
 - Defining to families what a dental home is and the value of having one
 - Placing valuing of oral health on the same level as valuing of overall physical health
 - Families need to receive a consistent message about the importance of oral health for young children multiple times in multiple settings (primary care, dentist office, WIC clinic, day-care/pre-school).
 - Require and oral health exam as a requirement for school entry (similar to immunizations)
- Primary care clinician training on oral health/oral preventive services delivery
 - Use physician and dentist oral health champions to encourage colleagues.
 - Provide “carrots” to incentivize physicians to enhance oral preventive service delivery, for example, offering opportunities to earn Maintenance of Certification Part 4 Credits.
- Address reimbursement issues relative to dental and medical insurance reimbursement for oral preventive services

Recommendations to Optimize the Delivery of Oral Preventive Services in Primary Care Settings

Based on assessment findings, recommendations to optimize delivery of oral preventive services in primary care settings include:

1. **At the local/regional level, promote the development and dissemination of resources and pilot projects to build and sustain relationships between pediatric/family physicians and dentists caring for young children.** Specific ideas include:
 - ✓ Developing a generic slide set about the importance of dental-medical collaboration that could be tailored by stakeholders across the state to catalyze regional conversations.
 - ✓ As suggested by a Forum participant, develop a crosswalk of the relevant oral health terms/codes used in the medical and dental communities.
 - ✓ Create an on-line, searchable database of information collected by the NH Oral Health Coalition’s baseline survey of non-traditional settings for oral health care. This resource could be disseminated to primary care clinicians to help families with no dental insurance locate options for getting oral care for their children.

- ✓ As suggested at the forum, fund a regional NH Public Health Network to brainstorm and pilot different mechanisms to connect dentists and primary care clinicians in their region. Successful approaches could then be replicated in other public health regions.
2. **At the state level, bring together medical and dental professional societies to assure consistent oral health messaging to families of young children, and facilitate joint policy development to address systems-level barriers to pediatric oral preventive service delivery.**
For example,
 - ✓ Agree on and disseminate to each constituent group a consistent message about when children should see a dentist, stance on water fluoridation, and fluoride supplementation practices.
 - ✓ Identify common policy areas of interest (e.g., strengthening the Adult Medicaid benefit, adequate medical and dental payment for oral preventive services to kids).
 3. **Promote awareness about, and conduct pilot projects to, explore new models to support primary care practices in delivering recommended pediatric oral preventive services.**
 - ✓ Use the intelligence currently being captured by the NHOHC about existing efforts to address 2015 NH Oral Health Plan objectives to identify emerging models for how practices can better deliver oral preventive services in primary care settings.
 - ✓ Pilot test different models of oral preventive services delivery as no one model will work in every medical office setting. Some clinics may be able to use existing practice staff/resources to integrate oral preventive services delivery into their current well-child care services. Other offices may not have the capacity to do this. Thus exploring alternate delivery models such as integrating a certified public health dental hygienist to conduct oral preventive service delivery may be more palatable. Piloting these new models in primary care offices that serve a high proportion of low/lower middle income families that live in areas without a fluoridated local water supply would also maximize impact.
 4. **Develop and implement an educational campaign targeting families, particularly those at high-risk, as well as medical and dental care providers that “Baby Teeth Matter.”** The campaign could stress the importance of oral health to the overall health of a child, a consistent message of key oral hygiene behaviors, and help for families with no dental coverage. Existing tools to potentially build from include best practices for pediatric oral health messaging developed by the Frameworks Institute (who developed the “Watch Your Mouth” Campaign previously done in NH) and the “Happy Teeth, Happy Babies” campaign from Colorado.
 5. **Develop a one-stop shopping mechanism that makes it easier for busy primary care clinicians to find tools to integrate oral preventive services that match their own learning needs and clinic capacity.** Illustrative ideas include:

- ✓ For the “do it yourself” clinician, having a list of curriculums that s/he can “run with” (for example the aforementioned Smiles for Life Curriculum or updated AAP EQIPP module on oral health).
 - ✓ For clinicians who want a little more help, put links to the NH Oral Health Coalition to participate in a one-time Smiles for Life training.
 - ✓ Offering a short list of key tools to support integration of oral preventive service delivery. For example, turn-key tools (such as Smiles for Life App) for implementing oral health risk assessments, a coding/reimbursement worksheet, a link to the expanded “Insure Kids Now” listing of dentists serving children in NH, and links to resources to learn about the oral health concerns of children/youth with special health care needs.
6. **Continue to track and respond to challenges associated with reimbursement for oral preventive service delivery.**
- ✓ Continue to check in with medical payers about billing codes and policies regarding fluoride varnish application.
 - ✓ Develop, continually update, and disseminate a short reference sheet of how to bill for fluoride varnish application in the primary care setting
 - ✓ Exploring how medical and dental insurance work (or don’t work) in tandem with each other, particularly as it relates to covering sedation for children requiring this service to receive their oral preventive services.
7. **Conduct additional research to better understand the extent to which NH children are receiving recommended oral preventive services as well as the oral health needs of children/youth with special health care needs or from families of different cultures or for whom English is a second language.** For example,
- ✓ Using dental claims and Census data to identify at a state and sub-state level the proportion of one year olds with at least one preventive dental visit claim.
 - ✓ More information is needed about oral health status and preventive care utilization care of children with special health care needs. Linkage of medical and dental claims data could provide a new avenue to answer these questions.
 - ✓ A better understanding is needed about the oral health status of and barriers to accessing dental care faced by families from different cultures/who speak different languages. Exploring collaborative opportunities with the NH Office of Minority Health and Refugee Affairs as well as the NH Health and Equity Partnership could help garner this needed information.

Though oral health is critically linked to the overall health and development of young children, in NH, delivery of recommended oral preventive services in primary care settings is not ideal. The above recommendations provide a potential pathway to optimize oral preventive service delivery in pediatric primary care settings to all NH children. Vetting these strategies with key stakeholders, particularly practicing dental and pediatric/family physician clinicians, to maximize impact is also recommended next step.

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Appendices

Appendix A: Medical Insurance Reimbursement Policies for Oral preventive services as of 6/24/2016

	Anthem-	Community Health Options-	Harvard Pilgrim-	Minuteman-	NH Healthy Families-	Well Sense-	Cigna
Fluoride Varnish							
Reimburse	Yes	Yes	Yes	Yes	Yes	Yes (w/ WCV)	Yes
Code	99188	D1206	99188	D1206	D1206	99188	99188
Age Range Covered	0.5 - 5	Birth - 5	Birth - 5	Up to 19	0.5 - 5 ¹	6-36 months	Recommended up to 6 yrs but no age edit in claims systems
Times/Year	USPSTF guidelines ²	3	4	One per 90 days	2	2	No frequency edit
Who must do it	MD/DO/PA/NP	No restrictions			MD/DO/PA/NP	MD/DO/PA/NP	Contracted HCP
Topical Application of Fluoride³							
Reimburse	Yes (part of WCV)	No	Yes (part of WCV)	Yes	Yes	No	Yes
Code	N/A		N/A	D1208	D1208		Covered as pharmacy benefit
Age Range Covered	0.5 - 5		Birth - 5	Up to 19			
Times/Year	USPSTF guidelines ⁴		2	One per 90 days			
Who must do it	MD/DO/PA/NP		No restrictions				

¹ <http://www.fromthefirsttooth.org/healthcare-providers/state-pages/new-hampshire/>

² USPSTF does not provide a recommendation for the frequency of FV application citing insufficient evidence.

³ Topical application of fluoride includes fluoride supplementation

⁴ USPSTF has no "specific recommendations on dosage and timing" as no studies addressed this. Therefore, USPSTF makes no recommendation.

	Anthem-	Community Health Options-	Harvard Pilgrim-	Minuteman-	NH Healthy Families-	Well Sense-	Cigna
Oral Risk Assessment							
Reimburse	Yes (part of WCV) ⁵	No	Yes (part of WCV)	No	No	No	Yes (part of E+M visit)
Code	N/A		N/A				
Age Range Covered	General examinations		Birth - 19 ⁶				
Times/year	Per AAP guideline ⁷						
Who must do it	Per AAP guideline ⁸		MD/DO/PA/RN				
Oral Exam							
Reimburse	Yes (part of WCV)	Yes (part of WCV)	No	Yes	No	No	Yes (part of E+M visit)
Code	N/A	N/A	N/A	1110 (over 14)/1120 (under 14)			
Age Range Covered		Birth - 17		Up to 19			
Times/year		No limit		2 (calendar year)			
Who must do it		No restrictions					
Anticipatory Guidance							

⁵ USPSTF recommendation for PCP conducting OHRA is insufficient. However, AAP recommends that OHRA be done "periodically."

⁶ Survey response for small group plans

⁷ AAP recommends that OHRA be done [periodically](#).

⁸ AAP makes no recommendation besides recommending pediatricians to do the assessment. Unclear if recommendation extends to NP, PA.

	Anthem-	Community Health Options-	Harvard Pilgrim-	Minuteman-	NH Healthy Families-	Well Sense-	Cigna
Reimburse	Yes (part of WCV)	Don't Know	Yes (part of WCV)	No	No	No	Yes (part of E+M visit)
Code	N/A	N/A	N/A				
Age Range Covered							
Times/year							
Who must do it							
Dental Home Referral							
Reimburse	Included in care coordination fee PMPM for physicians enrolled in EPHC	Don't Know	Don't Know	No	No	No	Yes (part of E+M visit)
Code	No code inclusion	N/A	N/A				
Age Range Covered	By age 1						
Times/year							
Who must do it							

Appendix B: Forum Evaluation Responses 3/29/16

Total Evaluations Completed: 16

The purpose of this SESSION was to present and gather stakeholder feedback on new data available through three oral health projects conducted by: NH Oral Health Coalition, NH Pediatric Improvement Partnership, and the UNH Institute for Health Policy and Practice.

1. To what degree did this session serve its purpose?

A lot	15
Somewhat	1
A little	0
Not at all	0

2. What did you like best about this session?

- Interacting with other stakeholders and seeing the partnerships and projects that are working in NH
- Great overview of all OH data and how data integrates across all projects
- World café; good questions, great information. Great overall!! Meeting a lot of people who are full of resourceful information.
- Claims presentation and world café
- Survey data
- It presented a number of facets of oral health delivery/billing/etc; in one place
- Content was excellent! Well organized event
- Break out session “World Café”
- Loved the World Café Format!
- To hear others’ ideas and readiness to act on specific avenues
- It reinforced that we are in action for the population that is underserved
- Learned new information
- Nice to see how projects complement each other and validate work/findings to date
- The sessions on each data set were just the right length/provided just the right depth of information/detail. I liked how the sources and outcomes varied, but the connections between them were clear
- World café format provided a good conduit for meaningful conversation. Information was relevant and to the point.
- Research reflects [illegible] to pedi

3. How could this session be improved?

- Longer or more breakouts
- Claims data presentation: could be presented from a higher perspective – eg. What are key points and takeaways
- Invite physicians the next time

- It was great!
 - More medical providers at session
 - As always, it would be great to receive a participant/contact list
 - More time on “World Café”
 - Slides from Willard were too small to read even from the front. Smaller number of [illegible] would have been more impactful
 - Maybe have included Nancy Martin’s data
 - I appreciate wanting to save paper resources but I would have liked hard copy handouts with two per page so we could see detail of charts, maps, etc...or if you had emailed earlier I could have printed my own copies
 - No comments for change
4. Please feel free to write below any comments/thoughts about the content or format of the session.
- Enjoyed the interactive parts
 - World café ++
 - Great format
 - Include overview of 2015 burden key findings to help set context for world café
 - Good update on multifactorial approach to issues
 - The networking time at the beginning was valuable and if there were a participant list in front of us, could be even better
 - It was great, I loved getting the info and then discussing application. I’d have loved paper copy of all 3 to make notes
 - I felt heard at this session – I thought the facilitators were well prepared and skilled at consolidating
 - Informative and helpful. The [illegible] eye for the Café interesting and thought provoking
 - Content was good. Liked format of café
 - Very helpful to have this information presented and discussed. We hear about these projects but it is helpful to discuss what they mean.
5. Please feel free to write below any additional questions/feedback about the data presented during the session.
- Please provide slides for all presentations. Great job!
 - Great data but resources, referral dentist Medicare/Medicaid providers, still missing
 - Thank you to everyone involved – this is all very important data, critical to the future planning of oral health care in NH
 - Wonder about some of the PCP responses. Suggest presenting to NH Ped Soc
 - Really hard to read some of the slides, both on the screen and in the hard copies
 - Will this be available to reference online? If so, when?

- I would like to see an Advanced Dental Hygiene Practitioner at the Master's Level (UNH) to integrate an MPH/MS degree – More cost effective additional provider who can be a conduit for access and appropriate care
- Thank you!
- Need to include private sector and what they provide
- Shared during world café tables

Appendix C: Summary of Feedback Received at Stakeholder Forum on 3/29/16

Question #1

A) Who are the priority pediatric populations to target for future work to enhance oral preventive service delivery in primary care settings?

Pediatric Populations at High Risk for Poor Oral Health	Number of stakeholders that identified each population as a priority
Living in low income families	8
WIC and Headstart	5
CYSHN	4
Children < 3 yrs	4
Without dental insurance	4
Who do not speak English	3
Living in Lakes Region/Lower Carroll/Upper Strafford/Belknap	2
Living in __ (fill in area not identified) _____	0
Living in Coos County	0

B) Why did you identify that population and what strategies could we use to address?

Low income

- Have the most access issues (transportation, insurance, geographic etc)
- Most likely visit medical office more often than dental so it is a good place to target
- Low income families tend to fit into the most categories (e.g. do not speak English, no dental insurance, geographic areas etc.)

WIC/Headstart

- Meet people where they are (e.g. WIC)
- Families already have the confidence/trust in services at WIC
- NH Oral Health Program already providing oral health services in 3 WIC clinics and at Headstart
- Opportunity to partner medical with education and address the CYSHN
 - Also have a high percentage of Medicaid children
- Important to integrate teachers and education as children often attend school regularly and teachers are concerned with students overall wellbeing
- Also helps to address that some children may have speech problems due to undiagnosed oral health problems

CYSHN

- Could be better treated in a medical office where CYSHN are more often than a dental office so most likely more comfortable. Medical providers tend to see more CYSHN so they are better experienced in working with them.

Less than 3

- Family understanding of importance of oral health in young children
- Provider understanding of the importance of this population (both medical and dental)
- Importance of starting earlier to make the most progress
 - Parents say it is difficult to get their children to do x, y, z (e.g. brushing teeth) but if started young and made it a priority they may not be as much of a struggle

Without Dental Insurance

- These are the kids who fall through the cracks (if not Medicaid eligible, not a CYSHN, etc)

Who do not Speak English

- If don't have access to translator, can use the Translator App
- Having someone in office who can speak other languages (Spanish, French, Chinese, etc)
- Using an older child who can speak English and native language to translate between family member and provider

Living in Lakes Region/Lower Carroll/Upper Strafford/Belknap

- Belknap

Overall Thoughts/Strategies

- Coordination of Services:
 - How do we leverage existing programs?
 - Have a dental provider in the medical setting- Doesn't add more work for the medical provider, the child receives care from an expert, the child is already at the medical office so doesn't need to make another trip
- A family's experience with dentistry has a lot to do with the value that they place on oral health for their children
- Stress the importance of addressing oral health *early* to families, medical and dental providers, teachers
- The recommendations sometimes made by providers are impossible. Have too high of expectations and families feel they have failed from the start.

Question #2

A) What are the most important barriers to address to optimize delivery of oral health preventive services in primary care settings for children under 6 years?

Barriers	Number of stakeholders that identified each barrier as a priority
Limited communication between dental and medical system	9
Identifying an appropriate referral for a dental home	7
Promoting family awareness about value of oral health and getting regular care	6
Primary care clinician training in oral health/preventive services	5
Integrating oral health preventive services into office workflow/EHR	4
Child has no dental insurance	3
Reimbursement for oral preventive services (Dental insurance)	3
Reimbursement for oral preventive services (Medical insurance)	2

B) What are the most promising solutions to pursue?

Limited communication between dental and medical system

- Building partnerships between medical and dental providers
- It can be a turf battle
- Different coding/terms for same procedures
- Public Health regions should coordinate dental and medical meetings
- Regional conversations between dentists and PCPs
 - Include NPs and PAs
 - Show example of medical-oral integration in NH

Identifying an appropriate referral for a dental home

- Need to identify appropriate referral to dental home
- ER referral to dental home
 - Dentists at ER?
 - Don't need extraction- Do prevention
- Engaging employers for referral
- Educate dentists on the importance of seeing children less than 3
 - Highlight the opportunities: get more into a dental home

Promoting family awareness about value of oral health and getting regular care

- Importance of oral health in young children

- Define dental home
- Baby teeth matter campaign
- Oral health is part of overall health
- Start early –preschool and before
 - Educate preschool directors and early head start
- Families need to get the message from all settings (pediatrics, OBGYN, schools etc)
 - Duplicate best practices for getting the message out from elsewhere

Primary care clinician training in oral health/preventive services

- MOC for PCPs on oral health
- Capstone project?

Integrating oral health preventive services into office workflow/EHR

- Updated list of dentists on EHR system for easy referral (search by zip code)
- Integrate dental hygienist into medical settings

Reimbursement for oral preventive services (Medical insurance)

- Medicaid: Required to have dentist assignment like PCP requirement

Other

- Oral exam as a requirement for school entry (like immunizations)
- Deploy Champions