State Healthcare Innovation Plan (SHIP), Patient Centered Medical Home (PCMH)
Transformation Webinar 4: Oral Health Strategies

Notes

September 25, 2017

Lawrence Brown: Welcome to the SHIP PCMH Transformation Webinar Number 4 on Oral Health and the medical home.

This webinar is being recorded for the purpose of taking notes. I will now hand over the call to Lori Weiselberg from Health Management Associates.

Lori Weiselberg: This is my second year as a PCMH coach for the Idaho SHIP. My background is in public health. For the last 25-plus years, I have worked both in public health and primary care, with a particular focus on prevention and management of chronic conditions. I want talk a little bit about oral health and my experience in that. My first job ever was working as a dental assistant in my dad's dental practice. That was many moons ago. More recently have been able to take on more and more projects in oral health, as I think our country is recognizing the increasing importance of oral health.

In the last year, I worked on an oral health needs assessment and strategic plan for a county in Ohio. I also work for the state of Oregon and assisted with oral health implementation and integration in practices through their coordinated care organization. I am really glad to share some of what I have come to learn in the context of PCMHs.

We wanted to start with a polling question. We wanted to have people indicate whether your clinic has had any level of integration with oral health. So if you want to respond to the poll and just say "Yes" if you have had any level of experience in this with your current practice, or "No" if you have not.

Lori Weiselberg: [Poll results] It looks like more have experience than not. That is terrific. We know that one of the most valuable things that we can do as facilitators in the PCMH SHIP is to provide opportunities for you to share among yourselves, among one another. So at the end of the presentation, we'd like to have a couple of volunteers who indicated "Yes" to take a few minutes to share their integration experience and any lessons learned. We will be coming back to you. If you have answered "Yes," if you want to think about whether you would like to volunteer and do a little presenting at the end, please do.

I would like to go onto the next slide, slide three, which is learning objectives. I will just quickly review what I hope to accomplish today. We would like to identify oral health prevention needs and opportunities in Idaho. We would like to discuss the alignment of oral health care in PCMH. We would like to describe a continuum of oral health integration in primary care. We would like to also identify the NCQA's (National

Committee for Quality Assurance) PCMH competencies addressing oral health and describe Qualis' Oral Health Delivery Framework. Qualis Health is an organization that developed a delivery framework that I think is very good; we will be talking about that a little bit more.

Next is: identify how your primary care practice can begin to integrate or further integrate oral health in primary care. And, lastly, to identify tools to assist with integration across the continuum.

Oral health as a public health issue. The first ever Surgeon General's report on oral health called *Oral Health in America* was produced in 2000. It was David Satcher at the time. He identified oral disease as a silent epidemic and quoted what C. Everett Koop said almost 20 years before that, which is: "You cannot be healthy without oral health." Koop also said, "Fluoridation is the single most important commitment a community can make to the oral health of its children and to future generations."

Actually, the first ever State of Idaho's report on oral disease was produced in 2014, not long ago, called *The Burden of Oral Disease in Idaho 2014*. The story that document tells really is that the population – is that you have a double whammy, that the population receiving community water fluoridation pretty recently, in 2012, was only 36 percent, and that 42 of Idaho's 44 counties are designated as Dental Health Profession Shortage Areas.

That has resulted in – and here are some of the findings from that report – is that dental caries in primary or permanent teeth among children, young children, six to nine years of age, is on the high side. 65 percent actually have had dental caries between the ages of six and nine. That has actually gone down in the recent past. Not too much so, but you are trending in the right direction; it has gone from 65 percent to 62 percent in 2013. Now the Healthy People goal for 2020 is 49 percent. Overall in the US, in some of those earlier years, was 54 percent. You can see that there is trending in the right direction, but there is a way to go. It is really challenging without widespread water fluoridation.

As we look at untreated dental decay among children of the same age – so six to nine years of age – so, again the blue. Blue is bad; this is untreated decay. We want the blue part of the bar to be low. Despite practically the entire state being designated as a Dental Health Profession Shortage Area, you've reduced this and exceeded the Healthy People 2020 target, which is great. The rest of the country however has reduced even further the untreated decay in this age group on average from about 28 percent to 16.9 percent from the year 2000 to about 2010. Again, you are trending the right direction, doing better. You have a lot of things against you, but you are doing better than that Healthy People 2020.

The Idaho report also spoke about tooth loss due to dental caries or periodontal disease among adults. Looking at older adults, age 65 to 74 years, that actually increased just a slight amount from 15 percent in 2000 to 16 percent in 2013. Again, tooth losses are represented by the blue. Blue is bad here; staying steady between those two time points. However, you have exceeded the Healthy People 2020 goal, which is great.

The oral health delivery system in the U.S. currently fails to reach the populations with the highest burden of oral disease. This results in pervasive oral health disparities for

low-income, minority, rural, and other underserved populations. What we are assuming is to effectively combat oral disease, we need to expand the oral disease prevention workforce and intervene earlier in the course of the disease. That is where you folks come in.

Primary care capacity is limited also in Idaho. However, we feel like there are a number of things folks can do in primary care that can assist in prevention of oral disease. Primary Care Provider teams have the skills, the resources, the tools, and scope of practice really required to intervene in the oral disease process and to improve the health status of patients. Involving primary care teams in prevention and early detection, particularly in dental shortage areas, really maximizes the health care workforce by preserving the time and skills of dentists to manage complex oral disease. This is the same in any specialty, right? We are just looking at the specialty of dental care and dentists as a specialty, just like we look at pulmonology or cardiology.

Again, we need more dentists, but given the shortage, we want to make sure dentists are working at the top of their license. That means relying more on registered dental hygienists in the dental office for prevention, and continuing public health department involvement in prevention. Also, that we prepare our primary care teams to do as much as they can, given their time constraints, to do more on the prevention side. Really, just because it makes sense.

How do we distinguish what is provided by dental care and dental offices versus primary care? I really like this graphic, because it really clearly defines and distinguishes those things that are purely in the dental care realm and those things that are purely in primary care, and that overlap of prevention of oral disease. Looking at risk assessments, dietary counseling, oral hygiene training, smoking cessation, fluoride varnish, fluoride supplementation, antibiotic rinses, and screening for oral disease - those kinds of things are perfectly appropriate to be done in both the dental care setting and the primary care setting.

Idaho has several resources – there are several statewide partners in prevention. The first one that I am going to speak to is the Idaho Oral Health Program. We actually have, I believe, a couple of folks from that program on the line today. At the end, when there are questions that are Idaho-specific, they will be helping me out with that. Angie Bailey is one of those folks, and she is the Director of the Oral Health Program. The Oral Health Program works with public health districts throughout the state to provide preventive oral health services and education to at-risk children, adolescents, and pregnant women.

Activities conducted in public health settings by nurses and registered dental hygienists include the fluoride varnish programs that are in the Women, Infants, and Children (WIC) clinics and in Early Head Start and Head Start centers. They do a lot of school-based dental sealant work, and with the schools that have greater than 35 percent free and reduced school lunch; really targeting those lower-income folks with enhanced endorsement of registered dental hygienists, oral health screenings, assessments, and education. And with dental home referrals to all children that are seen in fluoride varnish programs and in the school-based sealant clinics. It is that kind of education, prevention, and referral. There are several other functions related to essential dental public health that the program is involved with as well.

Slide – Idaho Statewide Partners in Prevention – brings together community champions to strengthen the infrastructure. They recently hosted an oral health convening focused on medical-dental collaboration, and really focused on the PCMH as well, patient-centered care.

Idaho Oral Health Alliance is a statewide nonprofit representing oral health in Idaho. It is leading oral health integration in the private sector and is currently developing a clearinghouse. We know that one of the main problems that many of these folks have in primary care related to oral health is that we do not have places to refer people who don't have insurance or have limited insurance. The Idaho Oral Health Alliance is actually developing a clearinghouse or a referral line for private dentists who agree to take a limited number of uninsured patients and they are seeking grant dollars to fund that. Hopefully, they will be successful in that. They are modeling this program after the Genesis Clinic in Boise. If we can put in place a volunteer network of dentists in regions throughout the state, I think that would be a great benefit.

The next is the Idaho Primary Care Association that I am sure many of you are familiar with. They have newly dedicated a staff person to work with Federally Qualified Health Centers (FQHCs) and other Idaho clinics on oral health integration and medical-dental collaboration projects. That is terrific that there is a dedicated staff person. I know that many of you are working with that person and that organization on such projects, so it is great.

Some of the research that I have done, I understand that – and this is kind of a well-kept secret in some areas – that there was a policy memo from Health Resources and Services Administration (HRSA) at the federal level a few years ago that clarified that FQHCs can contract with private dentists in their service areas and pay them the FQHC enhanced rate. This is something that is being used in other states. I do not believe it is being used much in Idaho, but it is something to consider and another way to kind of expand that network for uninsured and underinsured.

Bringing oral health into the PCMHs, again, the separation of the mouth from the body has been built into the cultures of medicine and dentistry for generations. They have separate training programs, separate professional identities, separate delivery systems, and different payment structures. As a consequence, not dissimilar to behavioral health, collaboration between medicine and dentistry really rarely occurs. Proactive coordination of care is central to primary care's relationship with medical specialties and can easily be applied to oral health services. Again, just changing the paradigm and viewing dental care as another specialty by routinely assessing oral health and actively – dentistry that is standard among health professionals across disciplines.

A continuum of oral health promotion in primary care discusses three levels of integration. Well, it is really three levels of the continuum: Coordinated, Co-located, and Integrated. Coordinated is just basically minimal collaboration or collaborating at a distance. Co-locating, again, is having a dental health professional in the primary care practice Integrated is full integration, so looking at common electronic medical record, dental professionals being part of the primary care team; a more full integration.

There was an integration study that was developed by the National Association of Community Health Centers recently on oral health integration in FQHCs. It is a great

report. The resulting report – called “Integration of Oral Health in Primary Care in Health Centers: Profiles of Five Innovative Models." It highlights health centers with successful models along that continuum of oral health promotion in primary care. I'm going to talk briefly about types of integration models that emerged from that study that happen to fall across that continuum of Coordinated, Co-located, and Integrated, in that order, that emerged from that study.

The first one is an example of a coordinated dental-primary care relationship; this is Bluegrass Community Health Center in Lexington, Kentucky. They basically had their primary care team members expand their role and trained existing primary care teams to provide limited oral health care during the primary care appointment. There is a clinical assistant, either a CNA or an RN, that does the risk assessment, the review of medical/social history, and direct inquiry.

Then, the Primary Care Provider (PCP) conducts an oral health evaluation, which is at a greater level of detail. Then the PCP and the clinical assistant apply fluoride varnish to children. The clinical assistant and then the PCP provide some oral health education and prevention education. The electronic health record (EHR) is used to identify need and produce referrals. They have some documentation that they do in their EHR on frequency of dental visits of their patients and when they need a referral.

The next one is a co-located example. This is where a clinic – this is Salina Family Health Center in Salina, Kansas – added a Registered Dental Hygienist to the primary care team. Again, that person is located within the primary care practice. The Registered Dental Hygienist reviews the patient schedule each morning (the schedule of primary care patients), and flags patients to visit during the day. That person conducts an oral health risk assessment, and then the PCP conducts the oral health evaluation. The dental hygienist does the fluoride varnish and education and also serves as a liaison between primary care and dental referrals, both to their onsite clinic as well as dentists in the community. Again, that is co-located, but they also connect with and coordinate with community dentists that are no located on site.

The next one is Yakima Valley Farm Workers Clinic, and that is in Washington and Oregon. They added a dental outreach coordinator to their primary care team and have a co-located dental clinic at their primary care practice. They also added this kind of outreach coordinator who really leverages their integrated EHR to coordinate and make dental appointments for primary care patients. The way they have arranged the way they do this work is that they have a clinical assistant reviewing the medical and social history, direct inquiry, length of time from their last dental visit, and document that. The clinical assistant and then the PCP provide the oral health evaluation; and then clinical assistants and dental assistants provide the fluoride varnish.

They also have an onsite WIC Clinic. The WIC clinic assistant and dental care team provides education, depending on where that person is that day. Then there is that dental outreach coordinator that I mentioned that generates dental referrals automatically for patients who had not received dental care in the last six months, or manually as needed if they are not in the system. That coordinator tracks and closes the loop on those dental referrals just like you do for other specialties. This is integrated. Appointments are made in the co-located clinic or in nearby dental clinics immediately following a patient's primary care visit or shortly thereafter.

Those are the three different examples that came out in that FQHC study.

Let us talk about how this fits with your transformation to a PCMH and looking at knowing and managing your patients. This is one domain of PCMH, which you are probably intimately familiar with by now. KM 01 is a core standard and everyone needs to do that one. That says: documents an up-to-date problem list for each patient with current and active diagnoses and that includes oral health. We want to make sure that that is addressed in that element.

The next one is an optional one. Again, it is for credit. It is KM 05, and that is to assess oral health needs and provide necessary services during the care visit based on evidence-based guidelines, or that you coordinate with oral health partners.

The next one under knowing and managing your patients is 23. It is another optional credit element and it is providing oral health education resources to patients.

The other domain that includes oral health is performance measurement and quality improvement. QI 01 again is core. Both of these are core and it: monitors at least five clinical quality measures across the four categories: immunizations, other preventive care, chronic or acute [care], and behavioral health. Other preventive care, obviously dental care as well - Oral health.

QI 08 is another core one and this is basically building on QI 01, which is basically setting a goal and acting to improve those measures that you have selected in Q1 01. Again, you could be improving other preventive care. So that could be on all children, certain ages, you want to do fluoride varnish regularly. Or, it could be as simple as doing oral screening or evaluation and ensuring referrals and intervening to make sure that you meet your goals.

I mentioned that Qualis Health had that framework, that delivery system framework for oral health. I think it is really helpful in kind of framing how we go about doing this work. It is pretty simple. In that document – and I will give you the link to that at the end, which I think is a really helpful one – it has all sorts of workflows and kind of elaborates on each of these a little bit more. It is starting with asking about oral health: risk factors and symptoms. Looking – you know, doing an oral health evaluation and deciding on the most appropriate response, acting to offer preventive interventions or referral for treatment, and then documenting the structured data for decision support and population management.

We are going to look at each of these a little bit more deeply. The first one, again: Ask. Ask about symptoms that suggest oral disease and factors that place patients at increased risk for oral disease. Just a couple of quick questions could be asked to elicit symptoms of oral dryness, of pain or bleeding in the mouth, oral hygiene, dietary habits, and length of time since the patient was last seen by a dentist. Those questions can be asked verbally, included in a written health assessment, risk assessment, and/or incorporated into an existing assessment that you might have.

The second one is looking for signs that indicate oral health risk or active oral disease. Assessing the adequacy of salivary flow, looking for signs of poor oral hygiene, white

spots or cavities, gum recession, inflammation and conducting an examination of the oral mucosa and tongue for signs of disease. Many of you might be saying, "I was never trained in this. I don't really know what to look for." At the end of the webinar, we're going to talk about some resources that can really help you prepare and be competent and confident in knowing what to look for, what to ask, and what to do.

The third is to decide; decide on the most appropriate response. Reviewing information gathered and sharing results with patients. Determining the action based on standardized criteria based on answers to those screening questions and the assessment findings, and also the input from the patient. There are different cultures, so we talk about preferences, goals, and the values of the patient and family. When I was doing the needs assessment work in Ohio, there were several Appalachian communities. The expectations for keeping one's natural teeth were so low that everyone would say, "Oh, by the time I'm in my 20s or 30s, I'm going to lose all my teeth just like my parents and my aunts and uncles." Changing some of those expectations is another thing that I think primary care can do as well, helping people to have higher expectations for keeping their teeth and keeping their mouth healthy.

Next one is act; act by delivering preventive interventions and/or placing an order for a referral to a dentist or a medical specialist. Those might include changes in medication list to protect the saliva, the teeth, and the gums, fluoride therapy, dietary counseling, oral hygiene training; and, therapy for tobacco cessation, alcohol, drug addiction, those kinds of things that have direct impact on oral health.

The final one was to document; document the findings as structured data, and to organize the information for decision support for the next time you meet with that patient, to measure care processes and monitor clinical outcomes so that quality of care can be measured. That you could, again, structure data so you can pull it and have a baseline and have a goal and see how you are improving over time. This is just an example of what an oral health screen might look like: an oral exam, the date of the last visit to the dental provider, and last periodontal exam. Did the patient have any natural teeth present? Did you do a visual exam? Etcetera. Any other interventions that you might have done – fluoride or referral, education, etcetera, to document.

This is a workflow example for a primary care team. This is one that has a little bit of an expanded team. It has a health educator and a referral coordinator. I know not all of your clinics have that. This is taken directly from that Qualis Health document that I referred to a couple of times already. They have other workflows for clinics that are smaller and more streamlined and where the clinician and the medical assistant does everything. We have the patient checking in. We have a medical assistant, for example, rooming the patient. In addition to those usual care tasks, they might ask a couple of oral health risk assessment questions, screening questions, and order and pend the dental referral if the screening questions are positive.

The next is the clinician conducts the encounter. They review the answers to the oral health questions, examine the mouth, sign the referral, enter additional oral health orders, update the problem list for oral health, and print an after-visit summary that includes oral health information. Then if there is a health educator, we have dietary counseling and oral hygiene training. Again, if there is the referral coordinator – there'd

be some referral coordination. Fluoride varnish can happen here or elsewhere in this flow. Then the patient leaves with the referral. It is just an example.

We are talking here about an incremental approach to implementation. Because as you look at that workflow, you might say, "We really don't have the staff at this point to do all of that, but we might be able to take some steps toward this." Some examples of incremental approaches might include just beginning with screening your patients for signs and symptoms of early disease, and developing a structured referral process for a dentist. I mean, that is real basic, but it can really be high-impact.

The next is offering fluoride varnish for pediatric patients, per the U.S. Preventive Services Task Force (USPSTF) and American Academy of Pediatrics (AAP) guidelines. Consider indications for fluoride varnish for high-risk adults, another incremental approach.

Next could be focusing on patient/caregiver risk assessment and risk reduction through patient education, dietary counseling, oral hygiene training, or identifying a particular high-risk population. It could be children or adult patients with diabetes, pregnant women. Then begin with a pilot before expanding the population or expanding practice-wide. Just focus on this particular patient population and see how it goes. Over time, continue to pursue progressively higher levels of integration, with the goal of having all patients receive oral health preventive services and structured referrals from the primary care team over time as your staffing model allows.

Primary care practices may not have all the capacities or resources of an advanced primary care practice. That full framework may not be possible right away. Le u's think about some priority populations or high-risk populations, target populations.

Most children visit their PCP routinely, as we know, for Well-Child care, immunizations, and school or sports physicals. Offering oral health care as a standard component of routine Well-Child care really expands access, including the opportunity for referrals for most children and adolescents.

The USPSTF – so they have recommendations. Their Grade B recommendations – they are evidence-based recommendations. Preventing dental caries in children zero to five years old, they recommend that primary care clinicians prescribe oral fluoride supplementation starting at age six months for children whose water supply is deficient in fluoride and that is for the majority of Idahoans. The task force recommendations that primary care clinicians apply fluoride varnish to the primary teeth of infants and children starting at the age of primary tooth eruption and there is reimbursement for this. Reimbursement is for the application of topical fluoride varnish by a physician or other qualified health care professional. Here is a Current Procedural Terminology Codes (CPT) code and the ICD-9.

The USPSTF is an independent group of national experts in prevention and evidence-based medicine.

A clinical report published in 2014 on "Fluoride Use and Caries Prevention in the Primary Care Setting," the AAP recommends that Fluoride varnish – at least once every six months, and preferably every three months, starting at tooth emergence. So the

USPSTF didn't specifically recommend the frequency of application. So I just pulled this up and look at the AAP's recommendation. And in September of 2015, fluoride varnish was added to the Bright Futures Guidelines and integrated into the periodicity schedule for Bright Futures. So that is children.

Next is pregnant women and other high-risk population. The vast majority of pregnant women nationally receive prenatal care in the first trimester of pregnancy from a PCP or from a midwife or a physician specialist.

Next bullet – the data is a little dated. This is 2004 actually, but at that point in time – and there have not been lots of other studies that I've found about it – only 50 percent of pregnant women with dental problems visited a dentist during pregnancy. Despite evidence showing that dental care, including x-rays, local anesthesia, and oral pain medication is safe throughout pregnancy, many dentists mistakenly believe – and still believe – that dental care could put pregnant patients at risk, and they delay it until after delivery. Something to be aware of and, again, looking at pregnant women as a potentially high-risk population.

Next, people with diabetes are another high-risk population. Most patients with diabetes see their primary care team on a regular basis for chronic illness care – screening, medication management, and self-management support. People with diabetes are at high risk for oral health complications, and untreated oral disease can complicate diabetes, as we know. Preventive oral health care aligns perfectly with chronic illness care in the medical home. Oral health self-care messages reinforce nutrition messages as we address diabetes care. Again, another high-risk population.

Next, oral health integration resources: Smiles for Life curriculum. It is a really terrific curriculum and a nationally recognized curriculum. There are free continuing education credits for physicians, for nurses, for others. It is a national oral health curriculum designed to enhance the role of primary care teams in oral health and specifically geared toward primary care. It consists of eight, 45-minute, online modules that cover core areas of oral health relevant to health professionals.

I was talking about, first you do the evaluation; then you do a screening; then you do this; then you put on fluoride varnish…and people might feel like, yikes. I never was exposed to that, I don't know what questions to ask, etcetera. So, spending a little time with this, you will feel comfortable, and will be prepared to do it.

The first is the relationship of oral and systemic health; child oral health; adult oral health; acute dental problems – so you can recognize those: pregnancy and women's oral health; caries risk assessment; fluoride varnish and counseling; the oral exam; and also a specific oral health module focused at a geriatric population. The source is at this Website: www.smilesforlifeoralhealth.org.

Here are a couple of other things that I referenced during the course of the presentation: one of them is that Qualis Health framework that we talked about called "Oral Health: An Essential Component of Primary Care." Here is the link. All of these webinars are put on the SHIP's portal and you will have those links right there. I really do think this is a must-read if you are considering this for the first time.

The next one is an oral health integration toolkit. This is something that Jeanene Smith that many of you have as a PCMH coach, and myself, put together with resources for supporting oral health integration in Oregon. They are all relevant to the work that you might do in Idaho. It is just a plethora of resources, depending on the type of population you are looking at or the type of integration work that you want to do and is extremely comprehensive. You might want to start with Smiles for Life first and this white paper. Then, as you dig deeper, take a look at this toolkit, as it might have some things that you're working on and help you with.

Next, barriers. No barrier is insurmountable. As we talk about some of the barriers to care – and some of them are very real but they can all be overcome. And they have been overcome in resource-constrained primary care settings. Time is usually the first barrier that we hear. You can say that oral health risk assessment and screening can be done probably in about 12 seconds. This is research that Qualis did and is included in the paper. With fluoride varnish, it adds about two to three minutes to a Well-Child visit. These are reasonable time additions.

Education or experience – other limiting factors. People do not feel comfortable, confident, and competent in doing this work. We talked about the oral health delivery framework, Qualis' work, and the Smiles for Life curriculum. We would encourage you to invite a local dentist, particularly as you are first developing those referral relationships, to provide an in-service for your care team. Identify a PCP oral health champion, someone who is really into this and wants to get more into this, who can be a resource for your other providers in your practice.

The next is payment limitations. That is real. From the interviews that were done in the Qualis study, they say that physicians are still seeing the same number of patients post-implementation and this is significant integration of oral health into primary care. We know that Medicaid and commercial health plans are providing coverage for fluoride varnish and supplementation for children in Idaho. Commercial insurance for oral health anticipatory guidance in Well exams is taking hold. I am not sure if that is in Idaho, and we can talk about that because we have some of our Idaho experts – oral health experts on the webinar.

Care coordination payments to support structured referrals that exists in other states, and consider that for Idaho and future opportunities in value-based payment models like Accountable Care Organizations. As we move toward value-based payment and alternative payment models, this will all be something to consider.

Next is any questions or comments, discussion, and your experience. Again, I believe we have Angie Bailey, the health program manager for oral health at the state of Idaho on the line as well. Why don't we open up and see if there are any quick questions or comments. Then if we can have a couple of volunteers share their experience of integration, that would be a great way to use the rest of the time. Thank you.

Participant: Hi. This is Vicky Peterson at Clearwater Valley Hospital & Clinics in Orofino, Idaho. I am here with my assistant clinic manager, Shannon Hill. I just wanted to say: we actually implemented a couple years ago the oral fluoride with our Well-Child checks and we were not sure how it was going to go to start, but it has actually been quite smooth. The provider goes in, sees the child, does the assessment and then the provider and the

nurse or MA apply the fluoride. It has not added much time to our visits, and it has been a very nice addition.

Lori Weiselberg: That is terrific. Thanks for sharing that. Anything else that you do related to that? Any other kind of oral health intervention or screening, evaluation?

Participant: Well, this is Shannon Hill and I am the assistant clinic manager. And we also give out toothbrushes on our Well-Child exam.

Participant: And we make referrals. We have a couple local dentists that we will do referrals to also.

Lori Weiselberg: Great. Sounds good. Terrific. You are doing this incremental approach, and you're saying: "In these Well-Child checks, we are going to do the fluoride varnish, we are going to give a toothbrush and encourage good oral hygiene and refer."
That is wonderful. Anything else you would like to share?

Participant: No. I think that is it. Just that it is doable.

Lori Weiselberg: That is great. Terrific. Thank you. Anyone else like to share their experience? Anyone doing evaluations or screening?

Lawrence Brown: If you would like to contribute to the discussion, just go ahead and raise your hand, and I will bring you onto the line.

Lori Weiselberg: Especially if there are any FQHCs that are currently involved with the primary care association initiative, it would be great to hear about that a bit. Or, Angie, if you are on the line and you'd like to contribute anything, that would be great too.

Lawrence Brown: Angie, your line is unmuted if you do have something to contribute.

Angie Bailey: Perfect. Thank you so much. Yes. This is Angie Bailey with the Idaho Oral Health Program. Great – wonderful webinar. And I'm excited to hear about the success, especially from Vicky and Shannon up north. I know we have a lot of FQHCs across the state that are doing some things, and some that are beginning to do more. So I'm excited to see how this leads to – and what it leads to in the future.

Lori Weiselberg: Great. Angie, if you know anything about reimbursement, I think payment limitations are probably one of the key barriers, in addition to time and education. Would you say right now that Medicaid and commercial health plans are providing coverage for fluoride varnish and supplementation for kids in Idaho, kind of across the board?

Angie Bailey: We know that Medicaid does provide reimbursement for fluoride varnish to primary care clinicians. We still have some private insurers that we are working with to get that going. We met with them from the IOHA board probably two years ago, and most of them were on board. We met with Regence and PacificSource and Blue Cross Blue Shield, and they were all on board. I know we still have some PCPs that are having problems being reimbursed.

Lori Weiselberg: Okay. That is good to know. Sounds like there are a lot on board, that is great. In terms of screening or evaluation, are there any particular tools that are being used more often in Idaho than not? Or ones that you recommend be used?

Angie Bailey: I know through the St. Luke's Oral Health Learning Collaborative, we have recommended the oral health risk assessment from the AAP. You already referenced all the Qualis guides as well, and I think they have some tools in there too. I think you said it great: really pick a starting point, whether that is finding out if people have been to a dentist, and just doing that referral. Asking those general questions is that great place to start. You do not have to do this whole complete project. You can start out small.

Lori Weiselberg: Great. Thanks. Any other comments, questions, experiences? It looks like a lot of you have had experience. Do not be shy.

Lori Weiselberg: For those of you who may have said "No," if you would like to ask a question about how to get started, or if there is any concerns that you have, any barriers that you perceive that maybe we can help you overcome.

Lawrence Brown: It looks like no hands raised or further questions in the queue at this time.

Lori Weiselberg: Thank you so much for coming out and participating in the webinar. we look forward to working with you on this issue on your coaching calls. Thanks everyone for participating. Take care.

Lawrence Brown: Thank you all. Bye.