Oral Health Florida

HealthyMouth HealthyBody

ORAL HEALTH FLORIDA

STATE ORAL HEALTH COALITION

Annual Educational Conference

Change of Plans: The Need for Innovation

November 4-5, 2019
Hard Rock Hotel Daytona Beach
Daytona Beach, FL

About Oral Health Florida

The Oral Health Florida coalition is comprised of a broad-based group of agencies, institutions, organizations, communities, stakeholders, policymakers, leaders, and other individuals whose mission is to promote and advocate for optimal oral health and well-being of all persons in Florida. This mission is accomplished through the implementation of the Florida Roadmap for Oral Health.

OHF Board of Directors

Agenda

Monday, November 4, 2019

All meetings will take place in the Avalon Ballroom 1

9:00 AM-5:00 PM	**Registration, Check-In and Exhibits Open**
12:00–12:15 PM	**Welcome and Opening Remarks** Greg Smith, MHSM, FACHE, Managing Director, Oral Health Florida
12:15–12:50 PM	**Incorporating a Value-Based Methodology in Oral Health** Rosie Roldan, DMD, MD, Florida Dental Director, Liberty Dental Plan Florida
12:50-1:25 PM	**Dental Therapy** Sarah Wovcha, MPH, Executive Director, Children's Dental Service, Minneapolis, MN
1:25-1:40 PM	BREAK Visit Our Vendors
1:40-2:50 PM	**Use of Tele-Dentistry to Provide Underserved Populations Access to Oral Health Care** Paul Glassman, DDS, Assistant Dean for Research, College of Dental Medicine, California Northstate University
2:50-3:50 PM	**Dental Therapy and Value Based Methodology Panel Discussion** • Sarah Wovcha, MPH, Executive Director, Children's Dental Service, Minneapolis, MN • Rosie Roldan, DMD, MD, Florida Dental Director, Liberty Dental Plan Florida
3:50-4:00 PM	**Closing and Information on Yearly Meeting and Preview of Tomorrow** Greg Smith, MHSM, FACHE, Managing Director, Oral Health Florida
4:00-5:00PM	**Oral Health Florida Action Teams Breakout meetings** • School Oral Health, Sealant and Workforce Action Teams • Policy Committee & Safety Net Committee Combined • Fluoridation Action Team • Data Action Team (Join other Teams to help select data needs)

Agenda

Tuesday, November 5, 2019

All meetings will take place in the Avalon Ballroom 1

7:30 AM	**Exhibits & Registration Open**
8:00-8:05 AM	**Welcome and Overview** Greg Smith, MHSM, FACHE, Managing Director, Oral Health Florida
8:05-9:00 AM	**Risk Factors and Association of Childhood Obesity and Dental Caries** Greg Smith, MHSM, FACHE, Managing Director, Oral Health Florida **Florida Dental Provider Survey on Obesity, Dental Caries and SSBs HRSA/FDOH Project #1** Jaana Gold, DDS, MPH, PHD, CPH, Adjunct Clinical Associate Professor, Department of Community Dentistry and Behavioral Science, University of Florida, College of Dentistry
9:00-10:00 AM	**Medical Dental Integration Panel Discussion** • Kim Herremans, Executive Director, Greater Tampa Bay Oral Health Coalition • Frank Catalanotto, DMD, Professor Department of Community Dentistry and Behavioral Sciences, University of Florida, College of Dentistry • Jenny Ruffi, RDH, Central Florida Health Care CHC
10:00-10:15 AM	Break Visit Our Vendors
10:15-10:50 AM	**Success and Challenges of School Dental Outreach** Chante Miller, RDH, Suncoast Community Health Centers, Inc.
10:50-11:50 AM	**OHF Board Yearly Review and Elections** Nancy C. Zinser, CRDH, MS, OHF Board Vice Chair, Associate Dean, Health Sciences,Palm Beach State College
11:50-12:00 PM	**Closing Remarks** Greg Smith, MHSM, FACHE, Managing Director, Oral Health Florida

Conference Speakers

Dr. Frank A. Catalanotto

Dr. Frank Catalanotto is currently a Professor in the Department of Community Dentistry and Behavioral Science at the UF College of Dentistry. He graduated from the College of Medicine and Dentistry of New Jersey in 1968 and completed a post-doctoral research fellowship in pediatric dentistry at Harvard School of Dental Medicine and Children's Hospital Medical Center in Boston. He has been on the faculty of five dental schools including UFCD where he served as Dean from 1995-2002. While Dean, he initiated the UF Statewide Network for Community Health to provide increased community based educational opportunities for dental students and residents, while also significantly increasing access to oral health care for underserved patients. He also served as Chair of the Department of Community Dentistry at UFCD from 2009-2015.

Dr. Catalanotto has been active in dental education, research and advocacy organizations for much of his career. He is the co-author of more than 110 scientific publications and has been the principal investigator or co-investigator for numerous federal, state and foundation grants totaling almost $11,000,000 in external funding since returning to a faculty position at UFCD after stepping down as Dean in 2002. His academic and professional interests include community based dental education, ethics/social responsibility, oral health disparities and racial equity, advocacy for health care reform and access to dental care. In addition to the above topics, Dr. Catalanotto's current advocacy efforts, consulting activities and lectures are focused on the new emerging oral workforce models. He is a Vice-Chair of the new national organization - Coalition of Dentists for Health Equity and a Co-Chair of the National Partnership for Dental Therapy. He is a member of the Research Committee of the Beyond Flexner Alliance. Dr. Catalanotto is happy to report that there is life after being a dental school dean.

Paul Glassman, DDS, MA, MBA

Dr. Paul Glassman is the Assistant Dean for Research at the College of Dental Medicine at California Northstate University in Elk Grove, CA and Professor Emeritus at the University of the Pacific, Arthur A. Dugoni, School of Dentistry in San Francisco, CA. He has served on many national panels including the Institute of Medicine's (IOM) Committee on Oral Health Access to Services which produced the IOM report on *Improving Access to Oral Health Care for Vulnerable and Underserved Populations*.

Dr. Glassman has had many years of dental practice experience treating patients with complex conditions and has published and lectured extensively in the areas of Hospital Dentistry, Dentistry for Patients with Special Needs, Dentistry for Individuals with Medical Disabilities, Dentistry for Patients with Dental Fear, Geriatric Dentistry, and Oral Health Systems reform. He has a long career working with special populations in a variety of practice and community settings. Dr. Glassman has been PI or Co-PI on over $30 million in grants and contracts over the last 30 years devoted to community-service demonstration and research programs designed to improve oral health for people with disabilities and other underserved populations.

Conference Speakers

Jaana Gold, DDS, PhD, MPH, CPH

Jaana Gold, DDS, PhD, MPH, CPH is an Adjunct Associate at the University of Florida College of Dentistry, Department of Community Dentistry and Behavioral Science. She is also an Associate Professor in the Department of Public Health at A.T. Still University's College of Graduate Health Studies.

Dr. Gold received her DDS degree from the University of Oulu, Finland in 1992, a PhD degree in Cariology and Preventive Dentistry in 2005 and master's degree in public health in 2015 from the university of Florida. She recently graduated from the New York University (NYU) Langone Health Dental Public Health residency program.

She has 27 years of experience in teaching, research and practice in dentistry. Her research has focused in caries prevention, oral health promotion, dental education, and dental public health. Her original research work on different prevention modalities in vulnerable populations have gained national and international interest and as a result, she has served as a consultant for health departments, organizations, and researchers nationally and internationally. She has published original research in peer-reviewed journals and presented in several international and national conferences. Her latest contributions are to serve as a co-author in 2 chapters for the American Dental Association's (ADA) textbook on evidence-based dentistry.

She is an active member of several national and international dental and public health organizations and she has served in leadership roles such as a Chair for the Fellowship Committee of the American Association of Dental Research (AADR), a Secretary/Treasurer for the Cariology Group of International Association of Dental research (IADR), a Chair of the Educational Council in the American Association of Public Health Dentistry (AAPHD), a Program Chair and Section Councilor of the Oral Health Section in the American Association of Public Health (APHA), and a Chair of the American Dental Education (ADEA) EBD special interest group. She has served as a Director of Cariology Program and as a Coordinator of Preventive Dentistry for the University of Florida, College of Dentistry and as a Director of WIC Oral Health Program in Gainesville, Florida. She is active member of the Oral Health Florida (OHF) Policy Committee. In 2017, she received a national EBD mid-career faculty award, sponsored by ADA and IADR, on promoting evidence-based practice and research.

She maintains her professional practice skills through the community service activities in Gainesville, FL, and scholarship activities by collaborating with faculty at ATSU and UFCD. She lives in Gainesville Florida and is an active supporter of art and wellness programs.

Conference Speakers

Kim Herremans, RDH, MS

Kim Herremans, RDH, MS holds a Master's of Science in Education with a concentration in Clinic Administration and Public Health, a Bachelors of Science in Health Science Education and Associates in Applied Science. She currently serves as the Executive Director for the Greater Tampa Bay Oral Health Coalition.

Her recent achievements are first in the state of Florida to develop and launch Medical Dental Integration systems within Community Health Centers in and around the Tampa Bay Area. Kim's achievements include recognition by the National Institute of Dental Cranial Dental Research, Division of NIH, for utilizing evidence based research into a broad based community oral health education message and also recognized by NNOHA (National Network of Oral Health Access) as an Oral Health Champion for her achievements in expanding access to dental health care to vulnerable populations. In 2012, the Robert Wood Johnson Foundation selected her 'WIC Smiles 4 U' program as 1 of 25 top workforce innovations in oral health in the country. The same program was recognized by the Florida Taxwatch group with a Prudential Davis Productivity Award for saving Florida tax payer dollars through early oral health prevention and interprofessional collaboration and education. Kim has been an advocate for change in the state of Florida by supporting and succeeding in allowing dental hygienists to practice in health access settings and more recently, advocating for dental therapists to practice in Florida. Kim continues to support and develop an electronic oral health data tool for two community health centers for the School Based Dental Program in Hillsborough County School District, currently in its tenth year.

Kim previously was in the forefront of change to improve the process of care in dentistry as she has assisted manufacturers in the design of ultrasonic instruments. She was recognized in her field as being one of a select few dental hygienists asked to present her original Scanning Electron Microscopy research on Ultrasonic Instrumentation at the (AAP) American Academy of Periodontology's annual session. She has given many continuing dental education courses for dozens of universities and colleges around the nation, as well as, educational courses to our nation's regional dental hygiene boards. She has been instrumental in getting ultrasonic instrumentation allowed on dental hygiene boards.

Before graduating from high school, she obtained her certificate in Dental Assisting, then went on to obtain her Associate in Applied Science in Dental Hygiene at Ferris State University, her Bachelor of Science in Health Science Education at Western Michigan University, graduate studies at the University of South Florida in Public Health before obtaining her Masters of Science in Education, with a concentration in Clinic Administration at Old Dominion University. Kim is a member of the Association of State and Territorial Dental Directors (ASTDD), National Network of Oral Health Access National Network, (NNOHA), patient advocacy council for the National Institute of Dental Cranial Research (NIDCR), Floridians for Dental Health Access and life long member of the American and Florida Dental Hygienists Association. Kim has served as a dental clinician, educator, author, director, innovator, consultant, advocate and change agent in the field of dentistry.

Conference Speakers

Jenny Ruffi

Jenny Ruffi received her Associate of Science Degree in Dental Hygiene from Valencia Community College. She is a seasoned dental hygienist for nineteen years. Upon dental hygiene school, she worked in general dentistry for several years. Then she joined a periodontist, where she performed periodontal therapy and help maintain periodontal patient's oral health. Jenny has practice in both private practice as well as the world of corporate dentistry. In corporate dentistry, she reached ground breaking goals, that lead her to become a hygiene mentor. Following corporate dentistry, her heart lead her to join a community health center, where she put her hard work for building a new system to help children in need of oral health care. She initiated and built a medical dental integrated system within a pediatric medical practice. The Medical Dental Integration has been so successful and self-sustaining, that inspired Central Florida Healthcare to expand integration into both Polk and Hardee County.

Rosie Roldan DMD, MD

Dr. Roldan is the Florida Dental Director for Liberty Dental plan. In this role, she provides supervision of Florida staff dentists and dental consultants. She participates in clinical review activities. She is an active participant on the National Peer Review, Utilization Management, Credentialing and Quality Management & Quality Improvement Committees

Dr. Roldan is a board-certified pediatric dentist and a physician. She was an examiner for American Board of Pediatric Dentistry and a consultant with the Commission of Dental Accreditation. Dr. Roldan maintains membership in the American Dental Association, American Board of Pediatric Dentistry, Florida Dental Association, and the American Academy of Pediatric Dentistry. Dr. Roldan is licensed in Florida and Texas. She holds a BS in Chemistry from University of Puerto Rico, Rio Piedras; a DMD from Temple University, Philadelphia, MD from University of Texas Health Science Center in San Antonio, Certificate in Pediatric Dentistry and Internship in Pediatric Medicine from University of Texas Health Science Center in San Antonio.

Prior to joining Liberty Dental Plan, Dr. Roldan developed and implemented Nicklaus Children's Hospital Pediatric Dentistry Residency Program. She educated a cadre of 38 pediatric dental specialists who are ambassadors in their communities across the United States and Canada. Dr. Roldan increased access to underserved populations through the deployment of a mobile dental unit, incorporation of community-based education for dentists and physicians, and established of an Infant-toddler program and an adolescent program. Dr. Roldan has multiple publications in peer-reviewed journals and presentations in professional forums. Dr. Roldan secured over 5 million dollars in grants from federal and private organizations that allowed the dental program to increase its capacity and impact on the community Dr. Roldan she served as assistant professor of the Pediatric Residency Program at the University of Texas Health Science Center in San Antonio, Texas.

Conference Speakers

Gregory Smith, MHSM, PMHCI, FACHE

Greg Smith currently serves as Oral Health Florida's (OHF) Managing Director. Responsibilities include management and oversight of grants, contracts and the annual statewide conference. Greg works with members and is in a leadership role on OHF's multiple teams. These include the School Oral Health, Workforce, Fluoridation, Sealant and Data Action Teams. He coordinates and helps lead both the Policy and Safety Net Committees.

Greg has extensive experience in operations management, business development and patient care within the medical realm of healthcare ensuring patients received access and high-quality care in home health, diagnostic testing, pulmonary services, sleep medicine and medical equipment. He served as a manager and director within a hospital and clinically integrated network (CIN) focused health system. the clinically integrated network that he developed and directed a population health program. An initial project led him into the oral health field where he developed a program that reduced oral health related emergency room utilization year over year for 6 consecutive years. This program provided access and high-quality care to un/under insured residents giving them an alternative to seeking care in the emergency room. Greg continues to work within the oral health, medical, behavioral and non-profit social service sectors helping to address the social influencers/social determinants of health.

Sarah Wovcha

Sarah Wovcha is the Executive Director of Children's Dental Services in Minneapolis, Minnesota's oldest and largest provider of school and Head Start-based dental care serving over 37,000 children annually. She holds a law degree from the University of Minnesota and a master's degree from the Harvard School of Public Health. Ms. Wovcha was a participant in the passage and early adopter of Minnesota's dental therapy legislation and currently employs 8 therapists who together treat over 12,000 patients annually. As a result of her work in expanding access to dental care for low-income Minnesotans she received the 2007 Betty Hubbard Maternal and Child Health Leadership Award and the 2013 Macalester College Distinguished Citizen Award.

Chante Miller

Chante Miller is a faculty member in the dental assisting program at Suncoast Career Academy in Brandon, FL, Her specialty topics include radiology, radiographic equipment, safety, digital imaging and processing radiographs. She has also taught community dental courses at Hillsborough Community College and NYU Langone. Chante has presented at several state conferences on the dental hygiene model and she received the Presidential Citation award for her vision and commitment to the dental hygiene profession. Chante is a graduate of the University of South Florida and St. Petersberg College.

Benefits of joining LIBERTY Dental

- **We are local** with operation centers in Tampa and Tallahassee
- **Live Call Center** with multi-lingual Member Services staff
- **We administer** dental benefits for Medicare/Medicaid/ Government Programs/Commercial enrollees
- **We save you time** so you can focus on growing your business

Become a LIBERTY provider today! Register online at:
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Preventistry.org

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Value-Based Program
Provider Training , New York-October 2019
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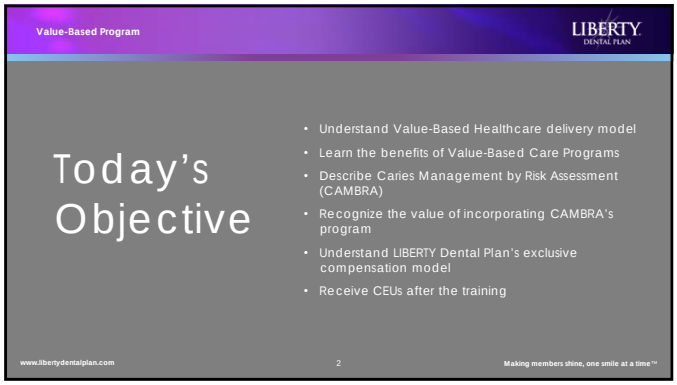
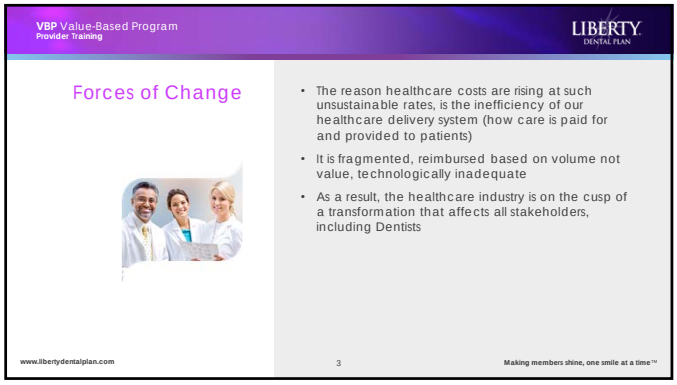

Value-Based Program
LIBERTY DENTAL PLAN
Today's Objective
• Understand Value-Based Healthcare delivery model
• Learn the benefits of Value-Based Care Programs
• Describe Caries Management by Risk Assessment (CAMBRA)
• Recognize the value of incorporating CAMBRA's program
• Understand LIBERTY Dental Plan's exclusive compensation model
• Receive CEUs after the training
www.libertydentalplan.com
2
Making members shine, one smile at a time™


VBP Value-Based Program
Provider Training
LIBERTY DENTAL PLAN
Forces of Change
• The reason healthcare costs are rising at such unsustainable rates, is the inefficiency of our healthcare delivery system (how care is paid for and provided to patients)
• It is fragmented, reimbursed based on volume not value, technologically inadequate
• As a result, the healthcare industry is on the cusp of a transformation that affects all stakeholders, including Dentists
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3
Making members shine, one smile at a time™

What Is Value-Based Healthcare?

- Value-based healthcare is a healthcare delivery model in which providers are paid based on patient health outcomes
- Under value-based care agreements, providers are rewarded for helping patients improve their health, reduce the effects and incidence of chronic disease, and live healthier lives in an evidence-based way

The difference between volume-based vs. value-based

Volume-Based Care (Fee-For-Service)	vs.	Value-Based Care
• Reactive care • Little or no emphasis in quality • Incentives are based on volume and cost • Patients are confused, frustrated with very little engagement		• Proactive care; emphasis on sustaining wellness • Value is defined as improving health and quality • Payments are based on quality improvements • Patients are valued, engaged and are at the center of the delivery model

Results vs. Service

- VBP pays for outcomes such as disease prevention, health promotion and population health
- Federal and State governments have created frameworks for **alternative payment models** in order to align payments and outcomes
- Our dental VBP model is designed to proactively prevent oral disease instead of rewarding treatment of disease

LIBERTY DENTAL PLAN

What is VBP at LIBERTY?

Value-Based Programs reward your office with incentive payments for:

- Changing practice patterns **from** restorative **to** preventive
- Practicing preventive dentistry that leads to healthy outcomes
- Encouraging patients to establish a dental home
- Engaging patients to take an active role in their own care to help ensure their oral health

LIBERTY's goals are to:

- Focus care on preventive services
- Reward providers for healthy outcomes
- Improve patients overall long-term dental health

LIBERTY DENTAL PLAN

Caries Management by Risk Assessment (CAMBRA*)

- Dental caries is chronic, transmissible and infectious and is the most prevalent disease in children and adults
- Dental caries risk increases when the cariogenic bacteria overcome the protective factors in host
- Acid-producing bacteria release acid that penetrates tooth enamel causing demineralization and caries
- Caries is a preventable medical condition and can be managed in the very early stages prior to cavitation

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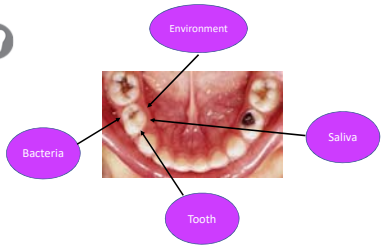
LIBERTY DENTAL PLAN

Caries Management by Risk Assessment (CAMBRA*)



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LIBERTY's VBP

- LIBERTY's VBP is based on Caries Management by Risk Assessment (CAMBRA®)*
- CAMBRA is an evidence-based approach to preventing and managing cavities at the early stages through behavioral, chemical and minimally invasive procedure
- Below is the link to learn more about CAMBRA https://www.cda.org/Portals/0/journal/journal_012019.pdf

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Caries Management by Risk Assessment (CAMBRA*) 0-5

Caries risk component	Column 1	Column 2	Column 3
Biological or environmental risk factors*		Check if Yes**	
1. Frequent snacking (more than 3 times daily)			
2. Uses bottle/non-spill cup containing other than water or milk			
3. Mother/Primary caregiver or sibling has current decay or a recent history of decay (see high risk description below)			
4. Family has low socioeconomic/health literacy status			
5. Medications that induce hyposalivation			
Protective factors**			Check if Yes**
1. Lives in a fluoridated drinking water area			
2. Drinks fluoridated water			
3. Uses fluoride-containing toothpaste at least two times daily- a smear for ages 0-2 years and pea size for ages 3-6 years			
4. Has had fluoride varnish applied in the last 6 months			
Biological risk factors - Clinical exam*		Check if Yes**	
1. Cariogenic bacteria quantity- Not currently available			
2. Heavy plaque on the teeth			
Disease indicators – Clinical exam	Check if Yes**		
1. Evident tooth decay or white spots			
2. Recent restorations in last 2 years (new patient) or the last year (patient of record)			
	Column 1 total	Column 2 total	Column 3 total
Yes's in column 1 indicates high risk Yes's in columns 2 and 3- consider the caries balance as illustrated below Final Overall Caries Risk Assessment Category (check) determined as per guidelines below			
HIGH ☐ MODERATE ☐ LOW ☐			

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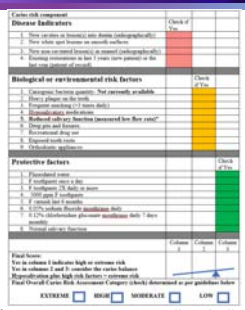
Biological or environmental risk factors*		Check if Yes**	
1. Frequent snacking (more than 3 times daily)			
2. Uses bottle/non-spill cup containing other than water or milk			
3. Mother/Primary caregiver or sibling has current decay or a recent history of decay (see high risk description below)			
4. Family has low socioeconomic/health literacy status			
5. Medications that induce hyposalivation			
Protective factors**			Check if Yes**
1. Lives in a fluoridated drinking water area			
2. Drinks fluoridated water			
3. Uses fluoride-containing toothpaste at least two times daily- a smear for ages 0-2 years and pea size for ages 3-6 years			
4. Has had fluoride varnish applied in the last 6 months			

Biological risk factors - Clinical exam*		Check if Yes**	
1. Cariogenic bacteria quantity- **Not currently available**			
2. Heavy plaque on the teeth			
Disease indicators – Clinical exam	**Check if Yes****		
1. Evident tooth decay or white spots			
2. Recent restorations in last 2 years (new patient) or the last year (patient of record)			

Caries Management by Risk Assessment (CAMBRA*) 6+



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Disease Indicators	Check if Yes		
1. New cavities or lesion(s) into dentin (radiographically)			
2. New white spot lesions on smooth surfaces			
3. New non-cavitated lesion(s) in enamel (radiographically)			
4. Existing restorations in last 3 years (new patient) or the last year (patient of record)			

Biological or environmental risk factors		Check if Yes	
1. Cariogenic bacteria quantity- **Not currently available**			
2. Heavy plaque on the teeth			
3. Frequent snacking (>3 times daily)			
4. Hyposalivatory medications			
5. Reduced salivary function (measured low flow rate)*			
6. Deep pits and fissures			
7. Recreational drug use			
8. Exposed tooth roots			
9. Orthodontic appliances			

Protective factors			Check if Yes
1. Fluoridated water			
2. F toothpaste once a day			
3. F toothpaste 2X daily or more			
4. 5000 ppm F toothpaste			
5. F varnish last 6 months			
6. 0.05% sodium fluoride mouthrinse daily			
7. 0.12% chlorhexidine gluconate mouthrinse daily 7 days monthly			
8. Normal salivary function			

Prevention of Caries*

Fluoride

- Fluoride has been a major factor in the decline in prevalence and severity of dental caries in the U.S.
- Presence of fluoride in plaque and saliva inhibits the demineralization of sound enamel and enhances the remineralization of demineralized enamel
- Fluoride also inhibits dental caries by affecting the metabolic activity of cariogenic bacteria

**See Source of Information*

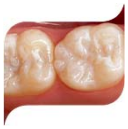
Prevention of Caries*

0.12% Chlorhexidine Gluconate Rinse

- Chlorhexidine gluconate is a broad-spectrum antimicrobial agent
- Chlorhexidine gluconate controls plaque formation and has a negative effect on gram positive and gram-negative bacteria, fungi and some viruses
- Chlorhexidine gluconate rinse has shown to decrease 97% oral bacteria

**See Source of Information*

Protective Factors & Caries Management*



Sealants

- Sealants are considered a protective factor and also a way to minimally treat caries (cavities)
- Teeth with deep pits and fissures are candidates for sealants
- Sealants protect the occlusal surface by blocking continuous attacks by plaque acids. This will prevent plaque accumulation and dissolution of minerals from the tooth tissues.
- Resin infiltrants act by concurrent sealing of the caries lesion from the oral environment, the progression of the lesion is halted

**See Source of Information*

Protective Factors & Caries Management*

Silver Diamine Fluoride (SDF)

- SDF is an option for patients at **high-risk** to arrest decay rather than definitively restore. It is considered a "non-surgical restorative therapy"
- For children with numerous cavitated lesions who may need multiple visits to complete restorative care and/or may have limited cooperation for treatment
- SDF therapy to achieve caries arrest and desensitization of lesions with no pulpal involvement can be followed at subsequent visits by glass ionomer interim restorations to prevent plaque accumulation and combined with fluoride varnish at three-month intervals to prevent new lesions

Products shown for illustrative purpose only
**See Source of Information*

Prevention of Caries*

Wellness Counseling

- Patient-centered care has found to be associated
  - Improved patient outcomes
  - Enhanced self management and medication adherence
  - Improved clinical outcomes.
- Motivational interviewing is focused on helping patients identify and resolve ambivalence about changing behavior by exploring personal perspectives and perceived barriers.
- Goal is to engage patients to take an active role in their own care is key to positive oral health outcome.

*See Source of Information

Prevention of Caries*

Periodicity of Examination

- Increases in the periodic visit is to actively engage the primary caregiver through effective communication and provide Anticipatory Guidance in caries prevention
- Determines adherence of home care in caries management
- Provides preventive care and early detection of caries

Wellness Counseling

- Determines adherence to the CAMBRA preventive plan developed
- Reinforces the preventive plan or customizes the preventive plan to the patient's needs
- Guides the patient to make choices that improve overall oral health
- Intercepts early caries development

*See Source of Information

CAMBRA Preventive Tool (Ages 0-5)

Intervention Type:	Low (D0601)	Moderate (D0602)	High (D0603)	Extreme (D0603)
Exam/Recall visits (D0150/D0120)	1 times a year	2 times a year	2 times a year	2 times a year
Wellness counseling (D9993)*	Once a year	Once a year	2 times a year	2 times a year
Prophylaxis	2 times a year	2 times a year	2 times a year	2 times a year
Fluoride varnish application	**	2 times a year	4 times a year	4 times a year
Brush with fluoridated toothpaste (1100 ppm)	2 times a day 0-2 years: smear or size of grain of rice 3-6 years: pea-sized amount	2 times a day 0-2 years: smear or size of grain of rice 3-6 years: pea-sized amount	2 times a day 0-2 years: smear or size of grain of rice 3-6 years: pea-sized amount	3 times a day 0-2 years: smear or size of grain of rice 3-6 years: pea-sized amount
Sealants		As needed	As needed	As needed
SDF utilization for any active or visible caries		As needed	As needed	As needed
Radiographs	12-24 months	6-12 months	6 months	6 months

*Not payable with an exam or a prophylaxis on same date of service

**Allowable per member's schedule of benefit

CAMBRA **Low-Risk** Preventive Tool (Ages 0-5)

Low

- Regular or recall visit - D0150/D0120 (6-12 months)
- Wellness counseling - D9993* (once a year)
- Brush at least 2 times a day with fluoridated toothpaste
  - 0-2 years (smear or size of grain of rice)
  - 3-6 years (pea-sized amount)
- Radiographs (12-24 months)

*Not payable with an exam or a prophylaxis on same date of service

CAMBRA **Moderate-Risk** Preventive Tool (Ages 0-5)

Moderate

- Regular or recall visit - D0150/D0120 (2 times a year)
- Wellness counseling - D9993* (once a year)
- Fluoride varnish application (2 times a year)
- Brush at least 2 times a day with fluoridated toothpaste
  - 0-2 years (smear or size of grain of rice)
  - 3-6 years (pea-sized amount)
- Radiographs (6-12 months)
- Active surveillance for developing lesions

*Not payable with an exam or a prophylaxis on same date of service

CAMBRA **High-Risk** Preventive Tool (Ages 0-5)

High

- Regular or recall visit - D0150/D0120 (3 times a year)
- Wellness counseling - D9993* (once a year)
- Fluoride varnish application (4 times a year)
- Brush at least 2 times a day with fluoridated toothpaste
  - 0-2 years (smear or size of grain of rice)
  - 3-6 years (pea-sized amount)
- Radiographs (6 months)
- Remineralize enamel lesions with fluoride varnish
- Sealants on occlusal surfaces
- Non-surgical management of cavitated lesions with SDF or interim therapeutic restoration (ITR) or atraumatic restorative technique (ART)
- Restoration of cavitated lesions

*Not payable with an exam or a prophylaxis on same date of service

CAMBRA **Extreme-Risk** Preventive Tool (Ages 0-5)

Extreme

- Regular or recall visit - D0150/D0120 (3 times a year)
- Wellness counseling - D9993* (once a year)
- Fluoride varnish application (4 times a year)
- Brush at least 3 times a day with fluoridated toothpaste(after every meal) and spitting the toothpaste with no rinsing; consider brushing with baking soda
  - 0-2 years (smear or size of grain of rice)
  - 3-6 years (pea-sized amount)
- Consider wiping teeth with xylitol wipes
- Sealants as needed
- Patients with limited cooperation use SDF therapy to achieve caries arrest and desensitization of lesions with no pulpal involvement can be followed at subsequent visits by glass ionomer interim restorations to prevent plaque accumulation and combined with Fluoride varnish at three-month intervals to prevent new lesions
- Radiographs (6 months)

*Not payable with an exam or a prophylaxis on same date of service

CAMBRA Preventive Tool (Ages 6+)

Intervention Type:	Low (D0601)	Moderate (D0602)	High (D0603)	Extreme (D0603)
Exam/Recall visits (D0150/D0120)	1 or 2 times a year	2 times a year	2 times a year	2 times a year
Wellness counseling (D9993)*	Once a year	Once a year	2 times a year	2 times a year
Prophylaxis	2 times a year	2 times a year	2 times a year	2 times a year
Fluoride varnish application	2 times a year	3 times a year	4 times a year	4 times a year
Brush at least 2 times a day	1100 ppm fluoride toothpaste	5000 ppm fluoride toothpaste	5000 ppm fluoride toothpaste	5000 ppm fluoride toothpaste
Rinse Chlorhexidine			10 mL once a day for 1 week each month for 1 year	10 mL once a day for 1 minute for 1 week each month for 1 year
Sealants		As needed	As needed	As needed
SDF utilization for any active or visible caries		As needed	As needed	As needed
Radiographs	12-24 months	6-12 months	6 months	6 months

*Not payable with an exam or a prophylaxis on same date of service

CAMBRA **Low-Risk** Preventive Tool (Ages 6+)

Low

- Regular or recall visit - D0150/D0120 (1-2 times a year)
- Wellness counseling - D9993* (once a year)
- Fluoride varnish application (2 times a year)
- Brush at least 2 times a day with 1100 ppm fluoride toothpaste
- Radiographs (12-24 months)

*Not payable with an exam or a prophylaxis on same date of service

CAMBRA **Moderate-Risk** Preventive Tool (Ages 6+)

Moderate

- Regular or recall visit - D0150/D0120 (2 times a year)
- Wellness counseling - D9993* (once a year)
- Fluoride varnish application (3 times a year)
- Brush at least 2 times a day with 5000 ppm fluoride toothpaste
- SDF utilization for any active or visible caries
- Radiographs (6-24 months)

*Not payable with an exam or a prophylaxis on same date of service

CAMBRA **High-Risk** Preventive Tool (Ages 6+)

High

- Regular or recall visit - D0150/D0120 (3 times a year)
- Wellness counseling - D9993* (once a year)
- Fluoride varnish application (4 times a year)
- Brush at least 2 times a day with 5000 ppm fluoride toothpaste
- Rinse with Chlorhexidine (once per day for 1 week every month at bedtime for 1 year)
- Radiographs (6 months)
- Consider SDF utilization for any active or visible caries

*Not payable with an exam or a prophylaxis on same date of service

CAMBRA **Extreme-Risk** Preventive Tool (Ages 6+)

Extreme

- Regular or recall visit - D0150/D0120 (3 times a year)
- Wellness counseling - D9993* (once a year)
- Fluoride varnish application on the first visit and reapplied every 4-6 months
- Fluoride trays with 5000 ppm F gel for five minutes daily (for patients who are not responding)
- Brush at least 2 times a day with 5000 ppm fluoride toothpaste
- Rinse with Chlorhexidine (once per day for a minute for one week every month at bedtime for a year)
- Baking soda solution: rinse ad libitum throughout the day every day (2 teaspoons in 8 ounces (250 ml) of water)
- Radiographs (6 months)
- Consider SDF utilization for any active or visible caries

*Not payable with an exam or a prophylaxis on same date of service

How Will LIBERTY Help Providers?

Products shown for illustrative purpose only

- For patients whose risk assessment requires pharmacological interventions, LIBERTY will provide the following products:
  - 5000 ppm fluoridated toothpaste
  - Chlorhexidine rinse

Incentive Payment for Healthy Outcomes

- Provider will receive an **incentive per patient** when caries risk assessment improves **and when patients remain low risk**

Extreme or High → Moderate

- From extreme or high risk to moderate – **incentive** per patient

Moderate → Low

- From moderate risk to low - **incentive** per patient

Low

- Remain as low risk - **incentive** per patient

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*Source of Information

Caries management by risk assessment: A review on current strategies for caries prevention and management
S. Uma Maheswari, Jacob Raja,[1] Arvind Kumar, and R. Gnana Seelan

Caries Management by Risk Assessment (CAMBRA): An Update for use in clinical Practice for patients Aged 6 through Adult
John DB Featherstone, MSc, PhD; Pamela Alston, DDS, MPP; Banjamin W. Chaffee, DDS, MPH, PhD; and Peter Rechmann, DMD, PhD

Caries Management by Risk Assessment: Results From a Practice-Based Research Network Study
Peter Rechmann, DMD, PhD; Benjamin W. Chaffee, DDS, MPH, PhD; Beate M.T. Rechmann; and John DB Featherstone, MSc, PhD

An Updated CAMBRA Caries Risk Assessment Tool for Ages 0 to 5 Years
John DB Featherstone, MSc, PhD; Yasmi O. Crystal, DMD, MSc; Benjamin W. Chaffee, DDS, MPH, PhD; Ling Zhan, DDS, PhD; Fancisco J Ramos-Gomez, DDS, MS, MPH

Children's Dental Services

Dental Therapy in Minnesota: A Study of Quality and Efficiency Outcomes

Sarah Wovcha, JD, MPH, Executive Director

- **CDS Mission Statement:**

  Since 1919 Children's Dental Services is dedicated to improving the oral health of children from families with low incomes by providing accessible treatment and education to our diverse community.

Children's Dental Services

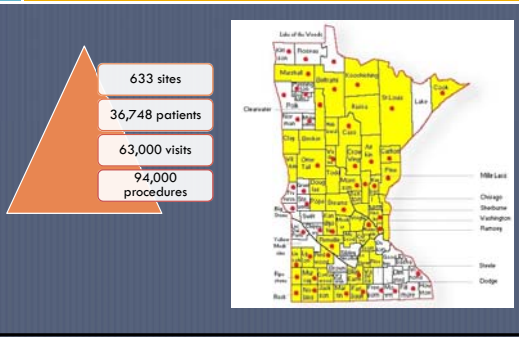
Sarah Wovcha
Executive Director

- Mother of 3 Teenagers
- Macalester College BA, 1989
- Social worker, 4 years
- University of Minnesota Law School, 1996
- Legal Aid Attorney- Family Law, Indian Child Welfare Act, 4 years
- Harvard School of Public Health MPH, 2000
- Children's Dental Services since 2001

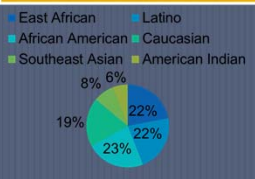
Children's Dental Service History

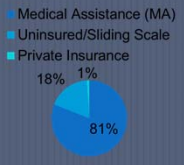
- Children's Dental Services was established in 1919 and received non-profit status in 1954
- Previously a branch of the Minneapolis Department of Health
- Minnesota's primary provider of portable dental care to low-income children
- First provider in the nation of on-site dental care in Head Start setting
- Now offers services to entire state

Service Area and Statistics



2018 Patient Demographics





- Note: 80% of sliding scale patients receive free care

Problems and Climate Preceding Advent of Dental Therapy

- -swelling patient population
  - Immigrant and refugee resettlement
- -provider shortages
  - difficulty hiring and retaining dentists (DDS)
- -sought alternatives: foreign trained dentists, mid-level providers
  - examined Alaska model, New Zealand program, research on quality and efficacy

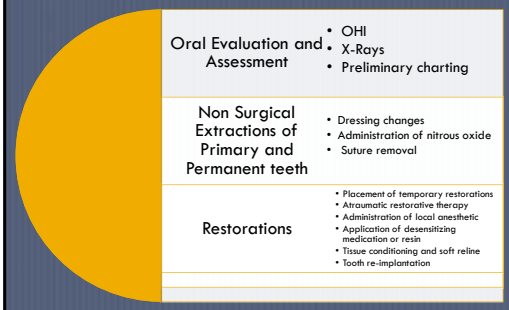
Why Advanced Dental Therapists (ADTs) are a solution

- Community-based
- More continuously present than scarce dentists
- Engage patients
- Naturally integrate preventive care and education into patient visit
- Gain expertise on limited scope of restorative procedures
- Free dentists to practice at "top of license" and focus on complex cases

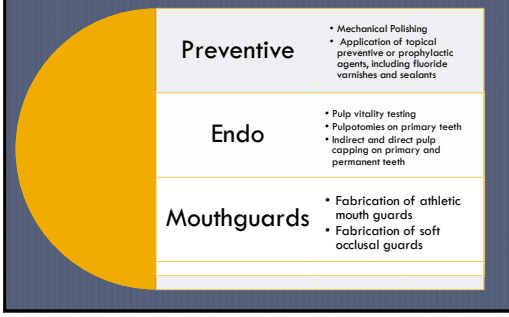
Characteristics of ADTs

- All ADT services can be provided under General Supervision.
- General Supervision is defined in Minnesota Rule 3100.0100: "The supervision of tasks or procedures that do[es] not require the presence of the dentist in the office or on the premises at the time the tasks or procedures are being performed, but requires that the tasks be performed with the prior knowledge and consent of dentist".
- ADTs will therefore directly increase access to care by providing care in rural or low-income area where access is a huge problem.
- While ADTs are not required to undergo chart review by Dentists, CDS ADTs do consult and review cases in a collaborative manner.
  - Teledentisty and frequent communication enables these reviews for Dentists practicing in Minneapolis and St Paul and for ADTs practicing in Greater MN.
- CDS currently employs 3 Dental Therapists and 5 Advanced Dental Therapists

Procedures performed by ADTs



Procedures performed by ADTs, cont'd.



Practice Settings for Minnesota ADTs

Subd. 2.Limited practice settings:
An advanced dental therapist licensed under this chapter is limited to primarily practicing in settings that serve low-income, uninsured, and underserved patients or in a dental health professional shortage area.

https://www.revisor.mn.gov/statutes/?id=150a.105

Collaborative Management Agreements

- Collaborative Management Agreement (CMA): a formal agreement detailing roles and responsibilities for dental therapists and advanced dental therapist and supervising dentists
- Statute requires all advanced dental therapists to engage in a CMA
- No more than five DTs or ADTs can enter into a collaborative agreement with a single DDS
- CMAs must include:
  - Practice settings and populations to be served
  - Any limitations of services provided by the DT or ADT and level of supervision required
  - Age and procedure specific practice protocols
  - Dental record recording and maintaining procedures
  - Plan to manage medical emergencies
  - Quality assurance plan
  - Dispensing and administering medications protocol
  - Provision of care to patients with special medical conditions or complex medical histories protocol
  - Supervision criteria of dental assistants
  - Referral and reallocating clinical resources protocol
    - Collaborating DDS accepts responsibility for unauthorized care provided by DT/ADT
- ADT/DT must submit signed CMAs to the Board of Dentistry prior to providing care

Hiring: the first ADTs In Minnesota

Christy Jo Fogarty, a graduate of Metropolitan State University, was the first ADT hired and credentialed in Minnesota.

Employed at CDS since December 2011.

Became Minnesota's first licensed ADT in January 2013.

CDS hired Elizabeth Branca, its third ADT from the Metropolitan State University Program, in June 2013.

Formerly CDS' hygienist in St. Cloud, Jodi Becker graduated from Metropolitan State University Program in June 2014

Effective Dental Teams

According to the PEW Center on the States a team approach to dentistry has been found to be the most effective and provide the most access to dental care:

"In solo private dental practices—where most dentists work—adding new types of providers and dental hygienists produced gains in productivity and increased earnings by a range of 17 to 54 percent. Dentists who operate a practice by themselves can increase their pre-tax profits by six or seven percent by accepting more Medicaid-enrolled children and hiring either a dental therapist or a hygienist-therapist".

Structure of New Dental Team

Traditional team: DDS, RDH and LDA.

Today: DDS, ADT, Collaborative Practice RDH, RDH, LDA, Unlicensed DA.

Integrating ADT:

- **Scheduling own column of patients**
- **Similar to dental school: start, prep and final checks**

Initial Questions about ADTs:

Dentists' biggest source of information about the field=local dental association

- Many questions arose about:
- -quality
- -ability to handle uncooperative patients
- -impact on patient care

Observations of ADTs:

-strong clinical skills; **Quote of one CDS dentist about working with CDS ADT:**

"***She completes fillings better than I do.***"

-significant relevant experience:

-receive more training on SSCs and motivational interviewing than most of our dentists;

-good behavior management

-mature, experienced professionals

-motivated

Issues of Quality and Risk

- ADTs and DDS undergo the same licensure exams for procedures they both provide.
- Marsh Insurance provides professional liability coverage for ADTs currently licensed as dental hygienists and members of ADHA. The cost is approximately $93/year.
- Professional malpractice insurance from various providers range in cost from $564 to $1,209 for CDS' dentists (average cost is $775/year)

CDS' data on Dental Therapy Care

- Since December of 2011, CDS' ADTs combined have provided care to over 25,000 patients. 47% have been served in portable, satellite sites; 32% in rural Minnesota.
- There have been 12 requests to see a dentist instead of a dental therapist.
- There have been no complaints of poor quality by ADTs at CDS; during the same period there were 4 complaints of poor quality against a dentist and 1 complaint against a hygienist.
- No complaints to MN BOD related to any MN ADT have been substantiated .
- Overall appointment wait time has decreased by 2 weeks; overall patient time with provider has increased by 10 minutes.
- 97% of survey respondents state that they are satisfied or very satisfied with the quality of care received by an ADT, compared with 92% satisfaction with dentists and 97% satisfaction with hygienists.
- An ADT bills and is paid the same for procedures as a dentist by both public and private insurance

Results: Production 2011

NOTE: based on billing in community clinic setting with lower than average fees

Production Summary August 2011

Provider Code	Total Production Charges	Total Hours Worked	Total Production
DR11 Endo Provider	10,040	24	$418.33
DR01	55,165	136.8	$403.25
DR20	4,178	11.5	$363.30
DR12	47,261	148.85	$317.51
DR24	36,518	120.16	$303.91
DR36	45,898	161.53	$284.15
DR38	37,646	144.96	$259.70
DR42	26,105	116.7	$223.69
DR04	878	4.65	$188.85
DR41	7,301	40.09	$182.12
DR43	8,739	51.45	$169.85
DR44	3,616	24.2	$149.42
DR30	7,678	51.83	$148.14

Results: Production 2012

Production Summary August 2012 *(CDS began tracking ADT productivity in March. ADT productivity has consistently risen since that time.)*

Provider Code	Total Production Charges	Total Hours Worked	Total Production
DR11 Endo Provider	6,420	16	401.25
DR01	66,696	130.39	511.51
DR04	2,132	4.35	490.08
DR20	4,974	12	414.50
ADT01	66,508	171	388.94
DR12	43,978	150.66	291.90
DR36	43,562	162.35	268.32
DR43	22,946	85.95	266.97
DR44	43,219	174.65	247.46
DR38	27,094	111	244.09
DR42	20,757	85.94	241.53
DR24	23,861	110.2	216.52
ADT02	9,390	52	180.58
DR41	3,017	23.55	133.79

Results: Production 2013

Production Summary August 2013

Provider Code	Total Production Charges	Total Hours Worked	Total Production
DR11 Endo Provider	8,516	16	$532.25
DR20	19,343	43.15	$448.27
DR44	53,555	138.05	$387.58
ADT01	46,755	123.5	$378.58
DR24	53,507	144.91	$361.45
DR36	42,304	140.05	$302.06
DR01	41,008	144.96	$299.66
DT01	4,277	16.3	$262.39
DR43	3,382	4.65	$207.48
DR12	57,856	171.87	$203.46
DR53	10,676	62.74	$170.16
DR04	487	3.05	$159.67

Summary of Dental team production results with integration of dental therapist (average salaries: dentist =$75/hr, dental therapist=$39/hr, advanced dental therapist=$45/hr)

- 2011: Average production of team is $280.72/hr
- 2012: Average production of team is $298.09/hr ($292.13 adjusting for fee increase); Average production of ADT is $340.35/hr
- 2013: Average production of team is $336.87 per hour ($326.76 adjusting for fee increase); Average production of ADT is $365.04/hr
- 2014-18: Average production of ADT remains $365/hr
- ADTs are vital to the financial viability of CDS; private practice dentists are seeing similar productivity and financial impact

Results: Financial Impact

DDS Cost $75/hr

ADT Cost $45/hr

ADT provides restorative care to 1,500 low-income children and pregnant women per year

Total Cost Savings using ADT Pubic Health Model:
$1,200/week
$62,400/year

Cost-Benefit Analysis based on 1 ADT providing services covered under the ADT statute for 40 hours/week in a public health dental clinic.

What's New in Dental Therapy? Teledentistry Utilization

- Remote provision of dental care/advice using information technology rather than direct contact with patient
- Accomplished via telecommunication technology, digital imaging and the Internet
- Supported by Minnesota Department of Health (MDH) and Health Resources & Services Administration (HRSA) funding

Reduces patient travel

Provides care in underserved areas

Results comparable to in-person treatment

Decreases number of appointments needed to complete care

Teledentistry Protocol

Hygiene services (including x-rays and patient assessments) provided at Rural Site A

Providers at CDS headquarters in Minneapolis review x-rays and treatment plan

On-site exam services no longer required at Rural Site A

Restorative services provided at Rural Site A

Average Time to Follow-up Care

Random Sample of 500 patients
250 received telehealth
250 received in-person exams
**Number of patients requiring follow-up care is similar for both telehealth and in-person exams*

- Dentist following conventional exam: 3.2 weeks
- Dentist following telehealth exam: 2.4 weeks
- Dental Therapist following conventional exam: 1.8 weeks
- Dental therapist following telehealth exam .8 week

Impact on the Dental Team

- Requires increased communication which has developed into cohesive team experience
- The ADTs' questions and desire to learn has spurred additional learning among DDS
- Opportunity to reflect on clinical decisions through teaching/supervising
- Frees DDS to focus on specialized restorative care (DDS appreciate opportunity to hone higher skill level & relief from routine care)
- Overall increase in quantity of care at CDS
- Overall reduction in cost of care

Rural Teledentistry Project Number of Patients Served

Dental Therapists Uniquely Filling Gaps in Rural Access

Observations:

- Graduated ADTs are in high demand for employment
  - Ability to do preventive care in portable settings is useful.
  - Ability to practice under general supervision allows flexibility and frees clinic space for additional providers.
  - Supervising dentists find that quality of care is excellent with ADTs.
  - Entire dental team is more efficient with integration of ADTs.
  - There have been no patient complaints related to any dental therapy work at CDS.
  - Flexible and transferable model of care delivery that is increasing access across Minnesota in a variety of urban and rural, public and private care settings.

RESOURCES

33

- **Dental Therapy Employer Guide:**
  http://www.mchoralhealth.org/mn/dental-therapy/references.html
- **Minnesota Board of Dentistry:**
  http://www.dentalboard.state.mn.us/Default.aspx?tabid=1165
- **University of Minnesota School of Dentistry:**
  http://dentistry.umn.edu/programs-admissions/ dental-therapy
- **Metropolitan State University :**
  http://www.metrostate.edu/msweb/explore/catalog/grad/index.cfm?lvl=G&section=1&page_name=master_science_advanced_dental_therapy

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http://www.normandale.mnscu.edu/academics/deans/pdfs/ADEAPresentation1.pdf

https://www.revisor.mn.gov/statutes/?id=150a.105

http://www.dentalboard.state.mn.us/Portals/3/Licensing/Dental%20Therapist/ADT.CMA%2012-410approved.pdf

https://www.revisor.mn.gov/statutes/?id=150a.105

THANK YOU

Questions?

Sarah Wovcha, JD, MPH
Executive Director
Children's Dental Services
612-636-1577

Oral Health Florida
HealthyMouth HealthyBody

ORAL HEALTH FLORIDA
STATE ORAL HEALTH COALITION

Risk Factors and Association of Childhood Obesity and Dental Caries

Sponsored by Oral Health Florida and the State of Florida, Department of Health

Greg Smith, MHSM, PMHCI, FACHE
Oral Health Florida Managing Director

November 5, 2019

Why?

- Obesity and oral health are correlated as both share some common risk factors like dietary (sugary soft drinks, snacks, and sugar-rich diets), genetic, socioeconomic, and lifestyle issues.
- Dental caries and periodontal disease are considered one of the greatest public health burdens because of their adverse impact on the growth and development of children.
- The World Health Organization (WHO) emphasizes the need to adopt a unified approach for the promotion of general and oral health instead of the previous single-level strategies.

Halder S, Kaul R, Angrish P, Saha S, Bhattacharya B, Mitra M. Association between Obesity Health Status in Schoolchildren: A Survey in Five Districts of West Bengal, India. Int J Clin Pediatr Dent 2018;11(3):233-237

Oral Health Florida
HealthyMouth HealthyBody

November 5, 2019

Why?

"Obesity and dental caries are widely-recognized problems that affect general health. The prevention of both dental caries and obesity have proven very difficult: children and their parents may need professional support to achieve behaviour change."

Body mass index and dental caries in children aged 5 to 8 years attending a dental paediatric referral practice in the Netherlands
Maddelon de Jong-Lenters, Paula van Dommelen, Annemarie A. Schuller & Erik H. W. Verrips
BMC Research Notes **volume 8**, Article number: 738 (2015)

Oral Health Florida
HealthyMouth HealthyBody

November 5, 2019

Why?

"Health professionals in both medicine and dentistry have been slow to implement clinical protocols to aid in the diagnosis and treatment of childhood overweight/obesity." As well, " it has been shown that health professionals also may lack self-efficacy, knowledge, and information needed to properly diagnose and address the problem."

Addressing Childhood Overweight and Obesity in the Dental Office: Rationale and Practical Guidelines
Authors: Tseng, Ray[1]; Vann, William F.[1]; Perrin, Eliana M.[2]
Source: Pediatric Dentistry, Volume 32, Number 5, September / October 2010, pp. 417-423(7)

November 5, 2019

Project Description

- Conduct evidence-based community assessments within three selected Dental Health Provider Shortage Areas (HPSA).
- Co-host in-person trainings and webinars about the risk factors and association of childhood obesity and dental caries.
- Four year project.
- Convene an Oral Health Florida Yearly Conference.

November 5, 2019

Service Areas from Which to Choose Three HPSAs

1. Miami-Dade
2. Hillsborough
3. Marion
4. Duval
5. Bradford

November 5, 2019

Community Assessment Information

- ✓ Demographic data
- ✓ Oral health data
- ✓ Key stakeholders information

November 5, 2019

Miami-Dade – Hialeah Demographic Data

- 89% of the residents are of Hispanic ethnicity compared to the state at 24%.
- 22% of the families are below the poverty level compared to 11% for the state and 15% for the country.
- Median household income is $33K which is lower than the state at $50K and the nation at $46K.
- 74% of the residents have health insurance coverage. 33% is through private insurance and 43% from public insurance.

November 5, 2019

Miami-Dade – Hialeah Oral Health Data

- 15.5% of middle and high school students are obese (White-26%, Black-23% and Hispanic 12.8%).
- Overweight status was highest among Hispanic adults at 43.3 percent but lower for obesity at 24.5 percent. Rates of obesity among the White and Black populations were 26.5 and 30.5 percent, respectively. State rates for the White, Black and Hispanic populations were 26.6, 34.0 and 27.3 percent, respectively.
- 42.6 percent of adults had a permanent tooth removed due to decay or gum disease.

November 5, 2019

Hillsborough – Egypt Lake Demographic Data

- Community - 75.5% White, 14% Black with 44% of Hispanic ethnicity.
- 16.8% of the families are below the poverty line compared to the county and state averages of 11%.
- Median household income of $42K is lower than the state and county at $51K and $54K respectively.
- 82% of residents have health insurance with 51% having private insurance and 37% public insurance.

November 5, 2019

Hillsborough – Egypt Lake Oral Health Data

- 12.7% of Hillsborough middle and high school students were obese. Obesity among Hispanic students was higher at 15.3% with Whites at 9.5% and Blacks at 9.8%.
- Obesity is highest among Hispanics at 33.7%, Whites at 24.7 % and Blacks at 25.5%.
- Only 58% of the adults visited a dentist in the past year. Rates for Blacks are 48%, Whites 65.4% and Hispanics 52.6%
- 44.9 percent of adults in Hillsborough County had a permanent tooth removed due to decay or gum disease.

November 5, 2019

Marion County – Demographic Data

- County – 82% White, 13% Black and with 12.4% Hispanic.
- 13% of the families live below the poverty line compared to the state at 11% and 15% for the country.
- Median household income is $42K which is lower than the state at $51K.
- 86.5% of the residents have health insurance coverage with 55.6% being private and 49.5% public insurance.

November 5, 2019

Marion County – Oral Health Data

- 16.2 percent of middle and high school students are obese. Obesity among Black and Hispanic students was higher at 19.1 and 19.2 percent, respectively.
- Obesity was highest among Hispanic adults in Marion County at 45.1% compared to obese Hispanics in the state at 27.3%. Obesity for Whites is 29.5% and Blacks 34%. All state rates are lower.
- Less than 60% of adults in Marion County visited the dentist in the past year. And, 54-63% had a permanent tooth removed due to decay or gum disease.

November 5, 2019

Key Stakeholders Contacted

Dental Society	Medical Society
FQHC(S)	Social Service Providers
Universities	Schools
Parks and Recreation	YMCA
Boys/Girls Clubs	Healthy Start
Boy/Girl Scouts	Faith-based organizations

❖ These Key Stakeholders were included to provide professional feedback and to help us connect with the families.

November 5, 2019

Assessment Questions – Explain the Why

Next year as part of a Florida Oral Health project, we will be conducting interviews and focus groups to gather information from the community on how best dentists and medical providers can discuss nutrition and obesity with children and their parents. What we learn will form the basis for training dentists and physicians so they can be most active in encouraging better child health. My questions today will help form the basis for both the community assessments and the training modules for the dentists and doctors.

November 5, 2019

Assessment Questions

1. Why do oral health problems happen in children in your area?
2. Why is intervention necessary?
3. What are the results of oral health problems experienced by these children?
4. What is being done or should be done to promote good oral health?
5. Why should we care about oral health?
6. Who is directly quoted (if anyone) in communications about oral health in your area?

Oral Health Florida HealthyMouth HealthyBody

November 5, 2019

Assessment Questions

7. Are you aware of a growing rate of obesity in children in this area?
8. What organizations here are addressing the obesity issue?
9. How are these organizations focusing their efforts on childhood obesity and oral health?
10. What efforts have local dentist offices taken to educate the parents of their pediatric patients?
11. What differences in obesity rates (if any) do you see in the different populations you have living here (i.e. Caucasian, Latino/Hispanic, Black, Asian)?
12. In your experience, do you have any idea on what may be causing these population differences?

Oral Health Florida HealthyMouth HealthyBody

November 5, 2019

Assessment Questions

13. Who should we reach out to when recruiting community stakeholders to participate next year in the community assessment around the issue of dental health and childhood obesity?
14. What are language barriers experienced (if any) by the children/families in accessing or understanding their oral or medical health information/education/treatment options/treatment costs/treatment?
15. What are any transportation barriers experienced by children/families when accessing oral or medical health care?
16. What are any cultural factors that may be causing poor oral health?

Oral Health Florida HealthyMouth HealthyBody

November 5, 2019

Assessment Questions

17. What are any cultural factors that may be causing obesity?
18. What are the target populations we should be addressing with this project?
19. What is the best type of interview approach/method to be used during this project?
20. What is the best timeline for meetings/interviews in order to make this project successful?

November 5, 2019

Next Steps

- Complete the Face-To-Face assessments by having visited the HPSAs at least twice and conducted at least 3 informational interviews in each HPSA.
- Analyze the data to understand the level of knowledge and engagement by the professionals and families and summarize the results by May 31, 2020.
- Develop the appropriate training tools, approach to training and curriculum recommendations by August 15, 2020.
- Working with Dr. Gold, provide trainings including face-to-face meetings, webinars, tele-conferences, and other formats of training/education.

November 5, 2019

Questions?

Contact Greg Smith
oralhealthflorida@gmail.com
Phone: 321-323-8036

November 5, 2019

Florida Dental Provider Survey on Obesity, Dental Caries and SSBs, HRSA/FDOH Program #1 - Jaana Gold, DDS, MPH, PhD, CPH

Florida Dental Provider Survey on Obesity, Dental Caries and SSBs - HRSA/FDOH Project #1

Jaana Gold, DDS, PhD, MPH, CPH
Consultant

Background

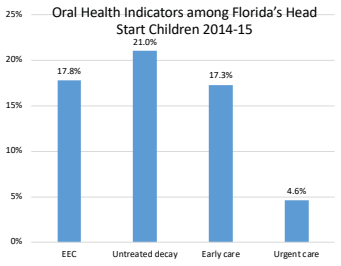
Oral Health Status of Florida's Children 2014-2015:

26 Head Start (HS) children:

- 17.8% had Early Childhood Caries (EEC)
- 21% had untreated decay
- 17.3% needed early care
- 4.6% needed urgent care

22 Early Head Start (EHS) children:

- 6% had early childhood caries
- 5.3% had untreated decay



Florida Department of Health. "The Oral Health Status of Florida's Early Head Start and Head Start Children 2014-2015." Tallahassee, Florida, 2016. http://www.floridahealth.gov/programs-and-services/community-health/dental-health/reports/_documents/oral-health-status-head-start-2014-2015.pdf

HRSA/FDOH Project #1

HRSA-18-014 - *Grants to States to Support Oral Health Workforce Activities from the HRSA Bureau of Health Workforce*

Oral health partners in Florida collaboratively developed four innovative projects that address the oral health workforce needs in Dental Health Professional Shortage Areas (HPSAs)

Project #1: *Developing Evidence-Based and Community-Informed Training for Florida's Oral Health Workforce on Risk Factors for Obesity and Dental Health*

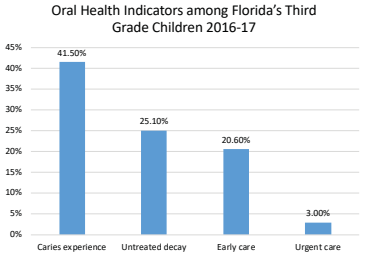
The purpose of this project is to develop evidence-based and community-informed training materials for Florida dental providers and partners to discuss common risk factors for childhood obesity and dental caries and then disseminate these trainings and tools statewide.

Background

2016-2017, Florida's Third Grade Basic Screening Survey:

- 25.1% had untreated decay
- 41.5% had caries experience
- 20.6% needed early care
- 3.0% needed urgent care

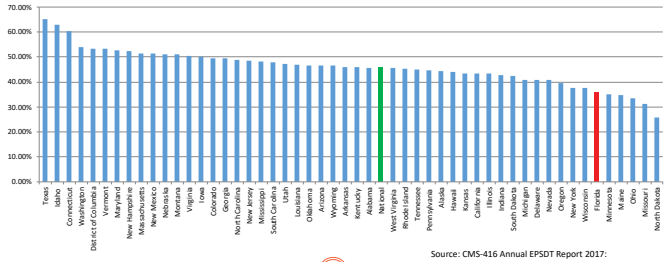
Non-Hispanic black 3rd grade children had the highest rate of untreated decay (34.6%) and highest early dental need (28.3%).



Florida Department of Health. "The Oral Health Status of Florida's Third Grade Children 2016-2017." http://www.floridahealth.gov/programs-and-services/community-health/dental-health/reports/_documents/oral-health-third-grade-2016-2017.pdf.

Background

Percentage of Total Eligibles Receiving Preventive Dental Services in 2017



Source: CMS-416 Annual EPSDT Report 2017:
https://www.medicaid.gov/medicaid/benefits/epsdt/index.html

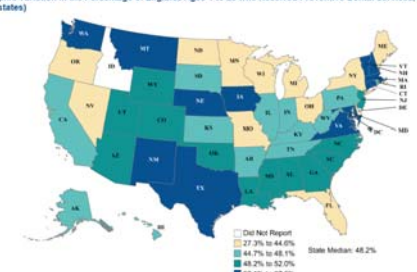
Background

- Florida surveillance data reveal high prevalence of childhood obesity, and high consumption of sugar sweetened beverages, a leading risk factor for both obesity and dental caries.
- Over one-third (36.6%) of Florida' youth (ages 10-17 years) were overweight or obese in 2016, compared to national average of 31.2%.
- In 2017, two-thirds of high school students drank soda or pop in the past 7 days and almost one in five drank soda or pop at least once a day.

Child and Adolescent Health Measurement Initiative. Data Resource Center for Child and Adolescent Health. 2016 National Survey of Children's Health (NSCH) data query. Retrieved February 24, 2018] from www.childhealthdata.org. CAHMI: www.cahmi.org.
Florida Department of Health. "2017 Youth Risk Behavior Survey Results- Florida High School Survey." Tallahassee, Florida, 2018, http://www.floridahealth.gov/statistics-and-data/survey-data/florida-youth-survey/youth-risk-behavior-survey/_documents/2017FLHI%20Summary%20Tables.pdf.

Percentage of Eligibles Who Received Preventive Dental Services (continued)

Geographic Variation in the Percentage of Eligibles Ages 1 to 20 who Received Preventive Dental Services, FFY 2017 (n = 50 states)



Source: Mathematica analysis of Form CMS-416 reports (annual EPSDT report), Lines 1b and 12b, for the FFY 2017 reporting cycle.
Note: This chart excludes Idaho, which reported the measure but did not use Child Core Set specifications.

Medicaid/CHIP

Background

- An association between obesity and dental caries, the most prevalent diseases of childhood, has been identified.
- Risk factors for both are the frequent consumption of sugar-sweetened beverages (SSBs) and frequent snacking on carbohydrate-rich foods.
- Consumption of SSBs is a modifiable behavior and reducing consumption can result in a decrease in weight.
- Dental professionals are well-positioned to evaluate children's dietary behaviors, assess risk and provide counseling to prevent obesity and dental caries.

Garcia, Raul I., et al. "Healthy Futures: Engaging the oral health community in childhood obesity prevention--Conference summary and recommendations." *Journal of public health dentistry* 77.1 (2017)
Chen L, Appel LJ, Loria C, et al. "Reduction in consumption of sugar-sweetened beverages is associated with weight loss: the PREMIER trial." *Am J Clin Nutr.*, 89(5) (2009):1299-1306.

Florida Dental Provider Survey

The purpose of this survey was to assess Florida's dental providers' attitudes and practices in providing information and services to the parents and child or adolescent patients about obesity, dental caries, and sugar-sweetened beverages (SSB).

The findings will assist in the development of suitable training strategies.

Survey Methods

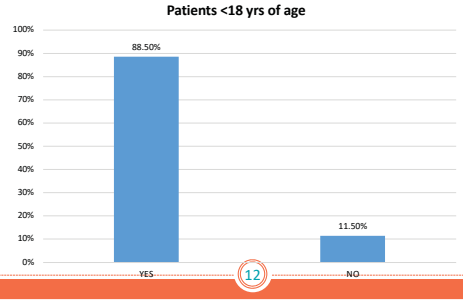
- A 19-item questionnaire was modified from other questionnaires used for similar studies
- A questionnaire was pilot tested among 6 dental providers, and 3 DOH staff members
- Survey was generated via the online survey tool Qualtrics
- The questionnaire was distributed to dental providers in Florida.
  - 200 County Health Department dental staff
  - 392 Oral Health Florida members

Survey Results

- Response rate was 37% (219/592)
- Total of 191 (87.21%) survey respondents identified themselves as Florida dental providers and consented to participate.
- Out of 219 respondents, 28 (12.79%) selected NOT to participate.

Patients in Practice

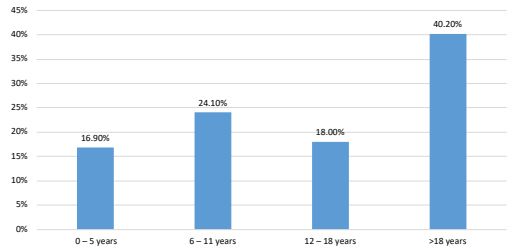
Do you treat children (patients under age 12) and/or adolescents (12 to 18 years) in your practice?



Patients in Practice

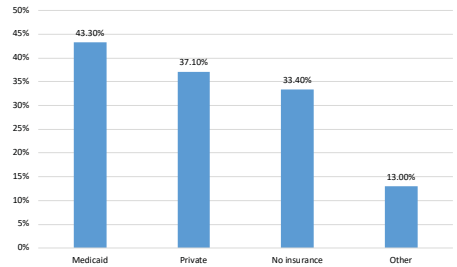
Approximately what percentage of your patients fall into the following age groups?

Patient Age Distribution (n=153)



Patients in Practice

Patients Dental Insurance Distribution (n=159)

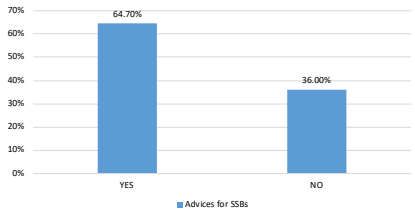


Other: Ryan White, Kidcare/HealthyKids, Argus, Sliding fee, youth offenders, discount plan, PPO, state grant or other grants

Current Delivery of Information and Services

Have parents or caregivers ever asked you for advice about their child's consumption of sugar-sweetened beverages?

Advices for SSBs (n=153)



Current Delivery of Information and Services

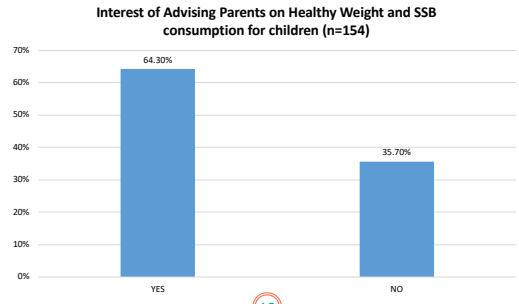
How often do you perform the listed activities in your office regarding obesity or consumption of SSB?

Question	Always	Sometimes	Never	Total
I weigh child/adolescent patients and measure their height	8.11%	15.54%	76.35%	148
I calculate and interpret Body Mass Index (BMI) scores of child and adolescent patients	5.44%	6.80%	87.76%	147
My practice/clinic provides educational materials on obesity or being an overweight child or adolescent	6.21%	18.62%	75.17%	145
My practice/clinic provides educational materials on the child's or adolescent's consumption of SSB	29.05%	30.41%	40.54%	148
My practice/clinic provides educational materials on general nutrition	33.33%	35.37%	31.29%	147
If a child or adolescent shows sign of being overweight or obese, I note it in the chart	10.96%	19.86%	69.18%	146

Current Delivery of Information and Services

Question	Always	Sometimes	Never	Total
If a child or adolescent is at risk for caries, I note it in the chart	75.84%	12.08%	12.08%	149
If a child shows signs of being overweight or obese, I talk to parents about my observations	9.86%	20.42%	69.72%	142
If a child or adolescent is at risk for caries, I talk to he/she about SSB	62.25%	21.19%	16.56%	151
If a child or adolescent shows signs of being overweight or obese, parents or patients are offered motivational interviewing or another behavior-modification program	6.38%	16.31%	77.30%	141
If a child or adolescent is at risk for caries, he/she is offered motivational interviewing or other behavior-modification programs to reduce consumption of SSB	33.33%	19.15%	47.52%	141

Interest in Providing Information and Services



Interest in Providing Information and Services

Question	Interested	Neutral	Not Interested	Total
Weigh child/adolescent patients and measure their height	25.68%	44.59%	29.73%	74
Calculate and interpret BMI scores of child/adolescent patients	23.38%	38.96%	37.66%	77
Note signs of being overweight or obese in the child/adolescent patient's chart	58.97%	33.33%	7.69%	78
Talk to parents if a child is obese or overweight	41.25%	52.50%	6.25%	80
Provide educational materials on obesity	55.13%	33.33%	11.54%	78

Interest in Providing Information and Services

Question	Interested	Neutral	Not Interested	Total
Provide educational materials on sugar-sweetened beverages	92.31%	3.85%	3.85%	78
Provide educational materials on general nutrition	92.21%	6.49%	1.30%	77
Provide a screening tool for obesity	52.63%	34.21%	13.16%	76
Provide a screening tool for consumption of sugar-sweetened beverages	83.33%	12.82%	3.85%	78
Refer a child/adolescent patient to a specialist or physician to help with weight management	47.44%	43.59%	8.97%	78
Refer a child/adolescent patient to a dietitian or nutritionist to reduce high consumption of SSB	59.74%	32.47%	7.79%	77
Refer a child/adolescent patient to a dietitian or nutritionist to reduce high consumption of SSB	59.74%	32.47%	7.79%	77

General Attitudes and Opinions

Question	Agree	Neutral	Disagree	Total
Dental providers have a role in helping patients achieve a healthy weight because of the importance of weight to general health	42.31%	51.54%	6.15%	130
Dental providers have a role in helping patients achieve a moderated consumption of SSB	89.15%	8.53%	2.33%	129
A dental provider who appears physically fit is more credible when providing obesity or overweight counseling	70.68%	19.55%	9.77%	133
Parents are receptive to weight management counseling in the dental office	11.02%	46.46%	42.52%	127
Parents are receptive to advice about consumption of SSB	67.69%	26.15%	6.15%	130
Parents are willing to pay more for a dental visit that includes childhood obesity screening	4.72%	26.77%	68.50%	127

General Attitudes and Opinions

Question	Agree	Neutral	Disagree	Total
Consumption of sugary drinks is directly related to childhood obesity	71.65%	22.05%	6.30%	127
We need national policies and programs to reduce childhood obesity	62.60%	23.58%	13.82%	123
I will provide obesity and weight management counseling at no charge	**30.77%**	37.69%	31.54%	130
I will provide advice about consumption of SSB at no charge	**76.56%**	13.28%	10.16%	128
Advising parents and patients to reduce the consumption of SSB is the most effective method for oral health professional to prevent obesity	55.38%	30.00%	14.62%	130

Barriers to Providing Information and Services – Obesity and Weight Management

Question	Major barrier	Minor barrier	Not a barrier	Total
Fear of appearing judgmental of parents and/or child/adolescent patients	60.14%	26.81%	13.04%	138
Lack of parental acceptance of advice about weight management from a dental provider	63.50%	27.01%	9.49%	137
Lack of trained personnel in my office to perform this service	39.55%	43.28%	17.16%	134
Lack of personal knowledge or training about childhood obesity/weight counseling	38.06%	40.30%	21.64%	134
Lack of time in the daily clinical schedule	50.37%	28.15%	21.48%	135
Lack of parental/patient motivation	63.43%	26.87%	9.70%	134
Lack of appropriate referral options	41.04%	43.28%	15.67%	134

Barriers to Providing Information and Services – sugar-sweetened beverages (SSB)

Question	Major barrier	Minor barrier	Not a barrier	Total
Lack of parental acceptance of advice about nutrition from a dental provider	28.03%	34.85%	37.12%	132
Lack of trained personnel in my office to perform this service	24.24%	29.55%	46.21%	132
Lack of parental/patient motivation	43.94%	31.82%	24.24%	132

Incentives for Providing Information and Services

The following factors were chosen the most:

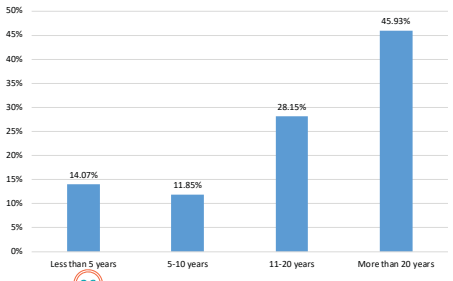
- Availability of approaches that add little or no time to a dental visit
- Clearer clinical guidelines on diet, nutrition, and obesity
- Increased availability of appropriate referral options
- Increased availability of patient education materials on obesity
- Availability of continuing education courses on overweight and childhood obesity

Participants' Demographic Characteristics

Current Position

Answer	%	Count
Dentist	60.14%	83
Dental Hygienist	17.39%	24
Dental Assistant	7.97%	11
Dental Director	8.69%	12
Other:	5.80%	8
Total	100%	138

Years in Practice (n=130)



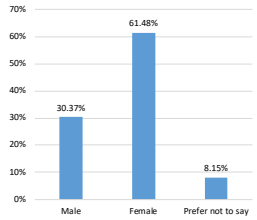
Participants' Demographic Characteristics

current employment situation and practice type

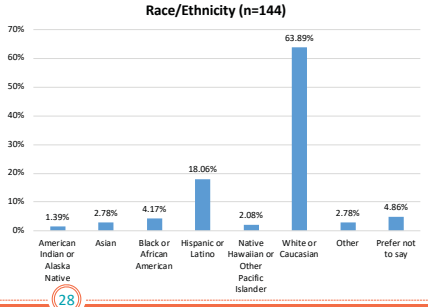
Answer	%	Count
Salaried employee	22.22%	40
Independent contractor	6.11%	11
Solo office practice (private sector)	17.78%	32
Group Practice: Single Speciality (private sector)	8.33%	15
Group Practice: Multi Speciality (private sector)	1.67%	3
VA Clinic	0.56%	1
State or Federal Correctional Facility Clinic	3.89%	7
Long-term care facility (nursing home)	0.56%	1
Military Facility Clinic	1.67%	3
Federally Qualified Health Center	2.22%	4
County Health Department	23.89%	43
Community Health Center	2.22%	4
Academic institution	5.00%	9
Specialty	1.67%	3

Participants' Demographic Characteristics

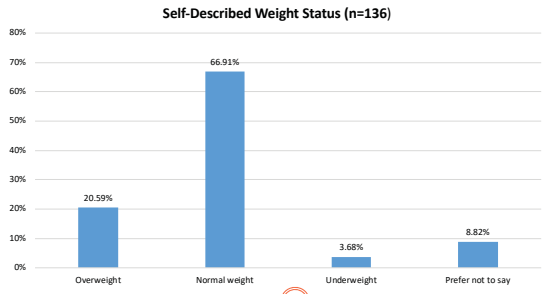
Participants' Age (n=135)



Race/Ethnicity (n=144)



Participants' Demographic Characteristics



Questions?

Contact information

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ORAL HEALTH FLORIDA

MEDICAL DENTAL INTEGRATION

November 4-5-6, 2019 Daytona Beach, FL

FRANK CATALANOTTO, DMD, PROFESSOR, DEPARTMENT OF COMMUNITY DENTISTRY, UNIVERSITY OF FLORIDA COLLEGE OF DENTISTRY

KIM HERREMANS, RDJ. MS ,EXECUTIVE DIRECTOR, GREATER TAMPA BAY ORAL HEALTH COALITION

JENNY RUFFI, CRDH, MEDICAL DENTAL INTEGRATED HYGIENIST, CENTRAL FLORIDA HEALTH CARE

Learning Objectives

- 1. **Participants will be able to describe a well functioning medical dental integration activity in a primary care pediatric setting.**
- **2. Participants will be able to list the best practices to implement and manage the delivery of high quality dental hygiene preventive services in a primary care pediatric setting.**
- **3. Participants will be able to conduct an evaluation of outcomes from a primary care based medical dental integration program**

OUTLINE OF ACTIVITIES

- **1. What is Medical Dental Integration, why should we be doing it, what are others doing?**
- **2. How we got started, What are keys to selling MDI to FQHC leadership, what were the barriers to getting started. Recommendations for Best Practices**
- **3. A day in the life of a dental hygienist in a primary care pediatric setting.**
- **5. Outcome measures and evaluation**
- **6. Audience participation Questions and answers.**

What is Medical Dental Integration?

- 1. Coordinating dental and medical care for improved outcomes and lower costs.
- 2. Integration of oral health into medical care expands the potential for high-risk individuals to have access to care that halts and even reverses dental disease, avoiding or reducing the need for expensive treatment,
- 3. The Institute of Medicine and others have proposed integrating oral health into primary care as a way to expand access to recommended treatments and promote better health overall.
- 4. Systems of care in which teams are currently practicing integrated oral health care delivery
- 5. Health insurance providers have taken note of the connection and are investing in programs that integrate medical and dental care.

Some examples

- **1. Placement of a dental hygienist in a primary care family physician or an internist/general medicine office.**
- **2. Placement of a dental hygienist in a primary care pediatric office**
- **3. Placement of a dental hygienist in an obstetrics office.**
- **4. Interprofessional educational programs for health professionals.**
- **5. Colocation of health professionals in an integrated hospital clinic to prevent "frequent visitors" to ED department or hospital admissions.**

Dental Hygienist in a primary care pediatric office in an FQHC

- **Florida dental practice laws recently changed, allowing a dental hygienist to work under general supervision in designated health access settings, i.e., an FQHC.**
- **Our next speaker, Kim Herremans saw the potential for doing this in Florida, building on national models in other states. She got this started in several FQHCs.**
- **We joined forces in 2018 in response to the HRSA Oral Health Workforce grants call for applications, and working with Florida Department of Health, were awarded a grant to examine best practices and evaluation of outcomes of this model. We will use this funding to start MDI at a new site and do an evaluation of outcomes.**

About the Greater Tampa Bay Oral Health Coalition

501 c 3 Nonprofit

Mission: To improve the oral health of residents living in the Greater Tampa Bay Area

Vision: To advocate for evidence based oral health practices and research, increase oral health literacy and provide support for direct dental services.

What is Medical Dental Integration?

- **Early Intervention To Improve Oral Health Outcomes**
  A paradigm shift in the Pediatric Medical Visit

Integration = Oral health care provided **within** and/or **embedded** in the primary care medical team

vs.

Collaboration = primary care and oral health working with one another

Creating a Vision for Integration

- How can we create effective population-based integration?
- The strategic planning process - vision to reality
- Who are the key stakeholders?
- What populations do we serve?
- What populations will we focus on?
- What financial models fit best?
- Where are the opportunities?
- Where are the gaps?

In the beginning:

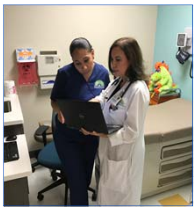
Build a relationship of trust, common ground and mutual understanding
Outline a clear plan – start small
Determine model and cost associated with model
- Dental provider in Medical Exam Room
- Portable dental equipment in Medical Clinic
- Permanent Dental Operatory in Medical Clinic

Inventory space, resources and opportunities
- Is medical and dental co-located or stand alones
- Does the medical clinic have any available or underused floor space
- How many children enrolled at CHC medical clinic received prior dental care at clinic?

Make a clear a 'specific' ask to CEO CHC leadership
- How is change beneficial to them? Their patients and community?

Create the Integration Plan

- Create a budget
- Staffing (Must love kids)
- Create action steps and timeline
- Strategic plan
- Business plan- operations and systems
- Policies, procedures, and workflow
- Set Goals (monthly, quarterly, yearly)
- Evaluation plan



Medical Dental Integration Goals and Objectives

- Prevent and control oral and craniofacial diseases, conditions and injuries
- Improve access to preventive oral health services
- Lower overall health care costs
- Improve overall health outcomes
- Improve health care quality
- Provide direct access to a Dental Home
- Increase referrals to Dental Clinic

Using Quality Management Principles to launch model

- Customer/Patient focus – increase customer value
- Leadership – leaders in all levels must establish a unity of purpose and direction
- Engagement of Staff – engage, empower and recognize all people essential to create and deliver change (anticipate co-learning)
- Plan, Do, Study, Act Cycle approach- predict results achieved
- Improvements – Refine and modify successful interventions
- Evidence based decision making – build sustainable models

- **Create Actionable Items:** Timeline, Expected Outcomes, Data Source and Evaluation Methodology
- **Determine Person(s) respons**ible for each action item and provide multiple resources for study/homework
- **Provide training** to build Oral Health Knowledge: Smiles for Life curriculum, Motivational Interviewing Skills, GI Sealant and SDF placement and essential communication between MDI RDH, medical team and patient.
- **Facilitate communication** among team members @ patient care. Develop DHR tools to talk to EMR
- **Account for Oral Health Services** delivered on Medical Team – adopt processes to account for delivery of care
- **Survey patients** to get feedback on oral health knowledge and skills obtained at medical visit, as well as, determine if needed follow up dental treatment was competed.

Primary Care Referrals for Oral Health Care

- Encourage patients to see a dental professional regularly for oral health intervention and preventive care
- Patients with signs of disease and risk behaviors need to be evaluated by a dental professional
- Understand patients may have health insurance but still be uninsured or underinsured for dental care (potential barrier to care)
- Full integration between medical and dental technology will promote referrals and sharing pertinent information

Dental Hygienist: Part of the CHC Pediatric Team

- Review history and complete oral health risk assessment
- Screen for oral disease
- Engage patients/parents on the nature of dental disease and self-care strategies to prevent/reverse disease
- Recommend 'therapies' and behavioral practices to maintain optimum oral pH levels, reduce unhealthy bacteria and remineralize teeth
- Make appropriate referrals for dental care

Benefits of Integration

- Referring to oral health providers by medical providers and referring to medical providers by oral health providers.
- Quick access for medical patients with acute oral health situations and for dental patients with potential medical issues
- Warm hand-offs and curbside consults
- More effective early and chronic disease management
- Preventive oral health care and effective self-care strategies extended to medical settings

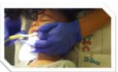
Barriers to Integration

- PCPs traditionally see the mouth as the property of dentists
- Sharing of health information rarely occurs between medical and dental
- Medical and dental care are seen by the public/patients as separate
- Limited oral health training for health professionals
- Time
- Comfort
- Reimbursement
- Referrals
- Medical and dental services not co-located
- Dentists and Dental Hygienists have limited experience with working with young parents and their babies/toddlers
- Buy in of Dental Director to support RDH under general supervision

Everyday Reality:

- People who are at highest risk for dental disease have the greatest difficulty in accessing care (lack of access points, lack of insurance, out-of-pocket costs, time, lost wages, transportation, fear, etc.)
- Integration of oral health into medical care expands the potential for high-risk individuals to have access to care that halts and even reverses dental disease, avoiding or reducing the need for expensive treatment
- The state of Florida is facing a shortage of dentists to the under served and rural areas.
- Children seen for oral health care in 2nd grade is far to late.
  - We have too many referrals for restorative care in second graders as observed from our Hillsborough County School Based Dental Sealant Program. 50-50% untreated decay

Role of the Primary Care Leadership Team



- Ensure workforce is oral health literate
- Develop work flow processes to support integration:
  - include feedback from users of the CHC,
  -include CHC staff: Marketing, IT, HR, Clinic Administrator, Facilities, Training, Front Desk, MA, Nurse, ARNP, Supervising Dentist, Pediatrician, RDH, Patient Navigator and Finance staff.
- Identify factors that put patients at high risk for future dental problems
- Adopt a system to track outcomes (# of children who received oral health services at medical visit, # of children who received sealants, SDF, etc.)
- # of children who completed referral to dentist within CHC

Promising Practices of MDI

- Staff training (primary care providers and dental professionals)
- Hiring 'right' kind of dental hygienist – positive attitude, dependable, willingness and flexible (Must love kids!)
- Develop space for DH equipment/chair in medical setting
- Adopt Caries Risk Assessment - CAMBRA
- Assure EMR/EDR Interfaces/Information sharing among all Providers
- Patient/Caregiver Educational Materials
- Utilize all Preventive Therapies
- Referral Process (medical to dental and dental to medical)
- Warm-Handoff process
- Designated Dental Access Appointments
- Measure and Report

Reimbursement/Payment for Services

CHC's receives regular Medicaid Encounter Rate, if:

- Dental Provider and facility are credentialed and recognized as a CHC site
- No dental services have been provided within the last 6 months

AND

- If screening/risk assessment, oral hygiene instructions, and Fluoride were administered

OR

- If dental sealants were placed on permanent molars

More Fully Integrated Model Features

- Primary care team has comfort level with oral health
- Patient experiences oral health as a key component of a routine medical visit
- Primary care team incorporates oral health into the care of patients with chronic diseases
- Primary care team treats ordinary oral health conditions; consult with dentist if patient does not improve; refers patients with treatment needs to dentists; retains responsibility for routine care
- For patients at high risk, primary care team follows clinical protocols designed to lower risk factors

Surveys:

- Families surveyed liked the convenience of dental visit at medical visit
- Medical providers liked the idea
- Dental Hygienists liked the idea
- MDI CHC Clinics are on track to be financially sustainable and are considering expansion.

Resources:

- Health Resources and Services Administration www.hrsa.gov
- National Network of Oral Health Access www.NNOHA.org
- Adv Dent Res. 2018, Featherstone, JDB, Chaffee BW 'Evidence for Caries Risk Assessment' (CAMBRA)
- Delta Dental Foundation, Colorado MDI Project
- American Academy of Pediatrics, Oral Health Integration Project
- Smiles for Life – A National and Oral Health Curriculum www.Smilesforlifeoralhealth.org
- LifeStrategies, Miller and Rollnick, 2013 and Dr. Rebecca Long, 2017.

MDI Model in partnership with:

Gulfcoast North Area Health Education Center
Florida Department of Health
Central Florida Health Care CHC
Suncoast Community Health Center CHC
Pinellas Community Health Center CHC
Premier Community Health Center CHC

Medical Dental Integration Registered Dental Hygienist

JENNY RUFFI, RDH

Central Florida Health Care
Health Care With a Heart

History

- Winter Haven, Polk County. Born and raised in rural Florida. Daughter of farming family, 1st to attend and graduate from college. Single mother of 2 smart, beautiful girls.

Dental Hygienist for:

- Private practice – both general and periodontics
- Corporate Dentistry

While in the heart of our states citrus industry, I opted to jump out of corporate dentistry and into community dental health at Central Florida Health Care CHC.

Since DH's can now work under general supervision, new dental hygiene opportunities are opening for employment in health access settings.

As they say, when life hands you lemons, make lemonade.

Leap of faith: humble beginnings

- As a new staff member, I was hired at CFHC to work within their pediatric medical practice in Lakeland Florida.
- MDI, a first at Central Florida Health Care and second CHC in the state to adopt a MDI model
- The pediatric clinic at CFHC houses 1 Pediatrician, 4 ARNP's, ___ Nurses, ___ Medical Assistants, ___ Front Desk, 1 patient navigator and a clinic supervisor.
- At the time, no dental clinic in Lakeland at CFHC.

- A former medical exam room was converted into a dental operatory

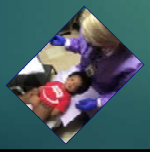
Developing patient engagement strategies:

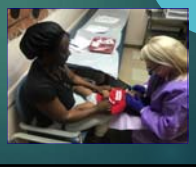
From front desk, medical assistants and nurses, all support is welcomed!

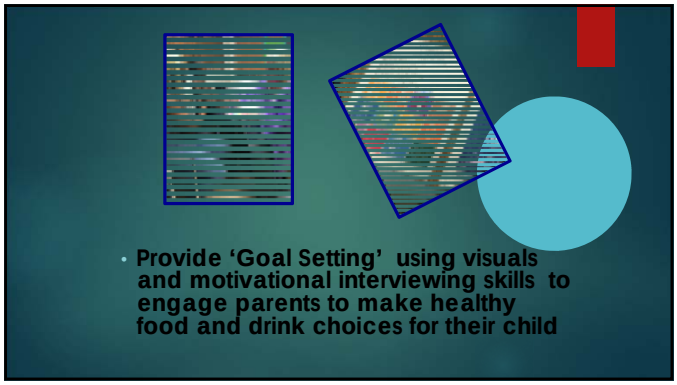
All written materials are offered in Spanish and English

Life in the day of a MDI RDH

- Job requirement: Must Love Kids!!!
- Following doctor visit, warm hand off for oral health services
- Provide oral risk assessment and demonstrate home care aka 'Lift the Lip'







- Provide 'Goal Setting' using visuals and motivational interviewing skills to engage parents to make healthy food and drink choices for their child

Teach backs and home care

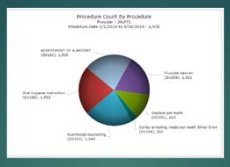
Every new Mom enjoys learning how to care for her child's teeth.

FQHC QI Measure:
Dental Sealants at first CHC visit

Always prepared with sealant trays made readily available to do sealants

Co-location of office space

Helpful hint: Having a desk located with medical providers improves formal and Informal communication and acceptance on team.



- **End of the day, complete records and review medical provider schedules to create list of next day potential patients.**
- **Acquire medical clearance for patients prior to visit**
- **Do not see patients who are scheduled for a sick visit aka infectious**
- **To avoid any infractions of FL practice act, (13 month exam required) do not provide prophy's or scaling in health access medical setting.**

Challenges and Successes

- **Educating support staff to embrace oral health services offered in medical visit.**
- **Collaborated with medical providers to develop warm hand off following medical visit.**
- **Developed age specific protocol to see toddlers and babies in medical exam room.**
- **Developed RDH schedule to attain medical clearance by physician.**
- **Developed policy to assure ever**y child receives oral health services at medical visit. (no matter of inability to pay)

Best things about being a MDI RDH

- Being a part of the healthcare team at CFHC.
- Now Parents are asking if their child can get a oral screening at their medical visit
- Making a difference in the diet and behavioral changes of young patients
- Helping children prepare for dentist visit.
- Share story

OUTCOME MEASURES AND EVALUATION

- Based upon our subcontract with FDOH related to the Oral Health Workforce Grant.
- Number of patients actually seen by the dental hygienist in the pediatric office.
- Number of patients who actually attend at least one dental visit after MDI visit, or maybe a recall visit.
- Number and variety of procedures done by dental hygienist at MDI visit.
- Cost effectiveness- does the dental hygienist break even financially.
- Compare dental visits of MDI patients to dental visits of other FQHC patients who are seen in normal primary care settings without MDI intervention.

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Notes

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