

**Oral Health Commission Safety Net Workgroup  
Patient Centered Medical-Dental Home Initiatives:  
A Survey of Current and Future Strategies to Coordinate Care in Rhode Island  
September 2011**

## **Executive Summary**

Traditionally, medical and dental care have been two separate streams of health care services in the American healthcare system. The current patient-centered medical home movement in the healthcare field presents an unprecedented opportunity for the integration of medical and dental care. While there have been many initiatives to implement the patient-centered medical home in Rhode Island and some work around building dental homes, there has so far been limited integration between the two.

The Oral Health Commission Safety Net Workgroup, as part of the RI Oral Health Plan 2011-2016, has been tasked with expanding the medical home model to include oral health and increasing knowledge of the medical-dental home model among dental practices in Rhode Island.<sup>1</sup> As a result of ongoing meetings, this workgroup decided to produce this paper as a first attempt to 1. Gather information regarding dental homes and medical/dental integration on the national scene; 2. Survey the medical/dental landscape in the state of Rhode Island; and 3. Disseminate information and continue the conversation around the integration of dental and medical care in Rhode Island.

After reviewing the results of this report, the Safety Net Workgroup makes the following recommendations for next steps in Rhode Island:

- Facilitate the learning, exploration and implementation of emerging best practices around the integration of medical and dental care, including some of those listed on pages 10-11 of this report.
- Disseminate information about integration strategies in medical and dental settings to continue the conversation around coordination of care.
- Commit to reassessing the progress of integration efforts in Rhode Island in one year.

## **Background**

### **Patient-Centered Medical Homes and Dental Homes Defined**

The Patient-Centered Medical Home (PCMH) is an approach to providing comprehensive primary care services for children, youth, and adults.<sup>2</sup> The model involves patients as active participants in their health and uses a physician-led medical team to coordinate all aspects of a patient's care. Common features of medical homes include a team-based approach at medical

offices to provide for all the patient's healthcare needs at all stages of life; care coordinators at health centers to help patients schedule and keep appointments with specialists; evidence-based medicine and clinical decision-making tools; and electronic medical records to improve efficiency and clinical outcomes, increase the quality of care, and streamline resource management.<sup>3</sup>

The American Academy of Pediatric Dentistry first issued its support of the dental home concept in 2001 after evaluating the success of the medical home policy put forth by the American Academy of Pediatrics in 1992.<sup>4</sup> The dental home model follows many of the same principles of the patient-centered medical home model. There is strong clinical evidence for the efficacy of dental care early on in a child's life coupled with caries-risk assessment, anticipatory guidance, and periodic supervision.<sup>5</sup> It has been demonstrated that children who have a dental home are more likely to receive preventive and routine oral health care.<sup>6</sup> Associations have also been found between adults having natural teeth and dental care utilization and less dental caries.<sup>7</sup>

### **Medical Homes in Rhode Island**

There have been a number of initiatives to advance the medical home movement in Rhode Island. The Chronic Care Sustainability Initiative for Rhode Island (CSI) and the Rhode Island Beacon Community Program are just two of the many initiatives. CSI was established as a multi-payer demonstration of the patient-centered medical home model and currently includes

### **Figure 1. AAPD Dental Home Guidelines**

#### **The Dental Home Model of Care (AAPD Guidelines)**

**According to the American Academy of Pediatric Dentistry (AAPD), a dental home should provide:**

- **comprehensive oral health care, including acute and preventive care in line with the AAPD periodicity schedules**
- **comprehensive assessment of oral diseases and conditions**
- **individualized preventive dental health programs based on caries and periodontal disease risk assessments**
- **plan for acute dental trauma**
- **guidance about growth and development issues**
- **information about care for the child's teeth and gingivae**
- **dietary counseling as appropriate**
- **referrals to dental specialists when the level of care exceeds that of the dental home**
- **education regarding future referrals to adult dental providers**

13 practices, as well as all Rhode Island payers (including Medicaid, Medicare, and Rhode Island private insurers).<sup>8</sup> The Beacon Community Program was created to provide Rhode Island with funding to build and strengthen the health information technology (HIT) infrastructure within the PCMH model of healthcare delivery.<sup>9</sup> Some commercial insurers, including Blue Cross Blue Shield of Rhode Island, have PCMH programs, as well. Legislation recently passed to expand PCMH implementation and development efforts to primary care practices across Rhode Island.<sup>10</sup> There are also payer-specific incentive initiatives, as well as support and incentives for establish Electronic Medical Records (EMR) from a number of sources. (EMRs are a critical component of the PCMH model and facilitate coordinated care.)

Despite all of these strides to implement medical homes that address all of a patient's health needs, there has been very little effort to include oral health care in these pilot projects. Incorporating the dental home into the patient-centered medical home movement will ensure better coordination and integration of health care services that will benefit the overall health and well-being of the patient.

### **Relationship Between Oral and Physical Health**

There is an incontrovertible link between oral health and physical health. Evidence of many systemic diseases and conditions can be found in the mouth. Oral examinations can signal

*Dental caries is the most common preventable chronic childhood disease.*

the presence of disease, disease progression, or exposure to risk factors. For example, changes in pigmentation of soft and hard tissue can signal the presence of

diseases like cystic fibrosis and Addison's disease, or exposure to tetracycline in childhood. Nutritional status and tobacco exposure can also be assessed through the oral examinations. Furthermore, there have been numerous studies that have found associations between oral disease and diabetes, heart disease and stroke, and adverse pregnancy outcomes.<sup>11</sup>

In 2000, the Surgeon General, in his landmark Report *Oral Health in America*, emphasized that oral health is integral to overall health, and advised that oral health and general health should not be treated as separate entities.<sup>12</sup> This inextricable link between oral health and physical health signals the need for increased coordination of care between oral health providers and primary care providers.

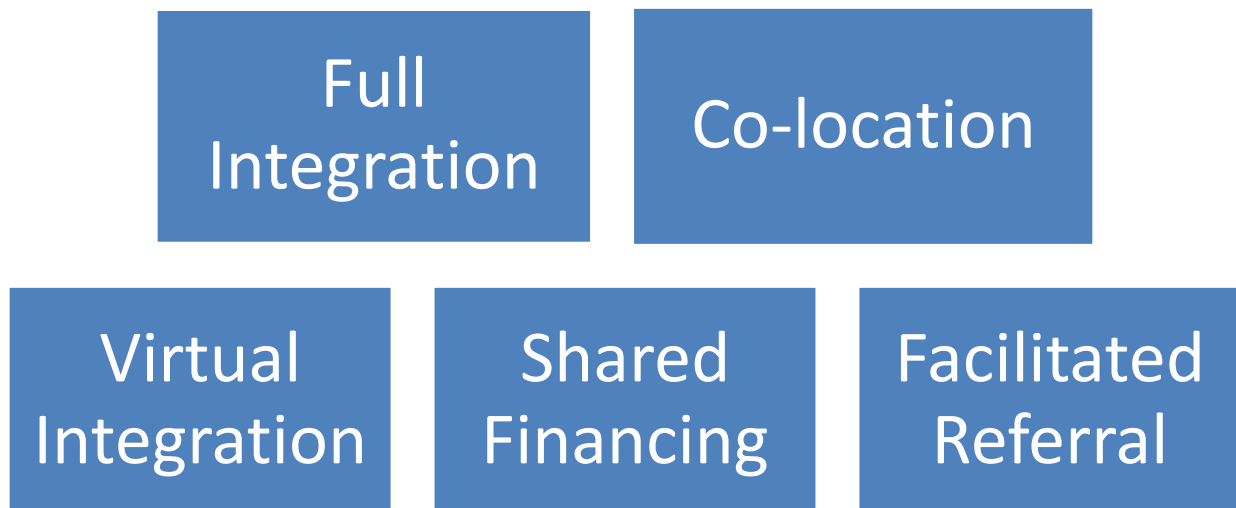
This paper is a first attempt to 1. gather information regarding dental homes and medical/dental integration in the national arena; 2. survey the medical/dental landscape in the

state of Rhode Island; and 3. disseminate information and continue the conversation around the integration of dental and medical care in Rhode Island.

## National Integration Initiatives

The National Maternal and Child Oral Health Policy Center has outlined five approaches and strategies for implementing health homes that include both comprehensive medical and dental care.<sup>13</sup> These approaches are not necessarily mutually exclusive, but all allow for greater coordination between medical and dental care than the current setup of two independent care systems.

**Figure 1. Approaches to Medical/Dental Integration**



**Facilitated Referral and Follow-up.** This approach formalizes the process of referral, referral tracking, and follow-up between medical and dental providers to ensure the provision of dental care by both providers. Examples of this model include health centers that have formal contracts with dental providers for the provision of dental services.<sup>14</sup>

**Virtual Integration.** This strategy emphasizes the coordination that can occur through shared information provided through a common electronic health record that is visible and accessible by both medical and dental providers, such as that provided by health information

exchanges. The integrated medical-dental records used by the Veteran's Administration would be an example of this type of coordinated care.<sup>15</sup>

Shared health records and the creation of a Virtual Dental Home can significantly increase access to oral health care in the community. The Pacific Center for Special Care at the University of Pacific, Arthur A. Dugoni School of Dentistry in California has used the concept of a Virtual Dental Home to support a community-based oral health delivery system where children and adults can receive preventive and basic therapeutic services in community settings. Dental hygienists collect electronic dental records, including X-rays, photographs, charts of dental findings, and dental and medical histories, and upload the information to a secure database where a collaborating dentist can review them and put together an initial treatment plan. If the treatment plan requires the skills of a dentist, the hygienist easily makes the referral. When the patient arrives at the dentist's office for the visit, the patient's dental records and images have already been reviewed and the diagnosis and treatment plan has been pre-determined.<sup>16</sup>

**Shared Financing.** This approach brings medical and dental providers together to share the financial risk and opportunity in ways that allow for greater access to dental care services for children and families. These strategies include performance payments for primary care providers who successfully refer patients to dental providers and joint financing arrangements through global capitation.

United Healthcare launched a pilot program in New Jersey that uses financial incentives to increase the number of dental referrals from primary care providers. The goal of the program is to identify children who are at risk for Early Childhood Caries as early as possible. In New Jersey, AmeriChoice, United Healthcare's Medicaid managed care product, reimburses primary care medical providers for oral health screenings, preventive counseling, and fluoride varnish services to young children. Due to the legal restraints of being unable to directly reimburse for a referral, this program uses reimbursement for fluoride varnish as a vehicle to incentivize physicians to get them to make a referral to a dentist.

The initial response among primary care providers has been mixed. Representatives from AmeriChoice advised others interested in setting up similar programs to (1) Be persistent in talking with primary care offices, and continue working with PCPs to make the logistics run smoothly; and (2) Identify key allies in the community, especially large practices who can have their mid-level personnel trained to apply the varnish and may not experience as big of a disruption in their practice.

**Co-location.** In this approach, dental professionals deliver care in the same location as primary care providers. Working in the same location facilitates communication and referrals.

Federally Qualified Health Centers (FQHCs) that provide dental services at the same location as medical services are examples of this model of coordinated care.<sup>17</sup>

Another example is Colorado's Dental Hygienist Co-location Project. The Colorado Delta Dental Foundation has sponsored the co-location of dental hygienists in primary care settings with the goal of creating a true health home for children and changing the practice culture. "Our goal is to change the culture so it becomes standard for oral health preventive care to be part of primary care practices," says Patty Braun, MD, MPH, a pediatrician and the program director for the

*"Our goal is to change the culture so it becomes standard for oral health preventive care to be part of primary care practices," says Patty Braun, MD, MPH, a pediatrician and the program director for the Colorado Dental Hygienist Co-Location Project.*

Colorado Dental Hygienist Co-Location Project.<sup>18</sup> Most of the hygienists also practice part-time in a dental office, which helps create a natural referral system to help ensure continued access to care. The project's directors are currently exploring public financing strategies to improve its sustainability. Such strategies include negotiations with Medicaid and CHIP regarding reimbursement of dental hygienists in these primary care settings.

**Full Integration.** In this model, dental care providers who offer comprehensive preventive and restorative care become full members of inter-professional group practices that provide a single location for patients to receive comprehensive primary and specialty care. Dental professionals actively contribute to care teams; provide primary dental services to children; deliver specialty-level dental care to children with special or advanced needs; and involve primary care physicians in oral health promotion, screening, and prevention.<sup>19</sup>

The Health Resources and Services Administration (HRSA) has published preliminary guidelines for medical practices who aspire to integrate oral health care fully into their primary care setting. The Oral Health Disparities Pilot began in August of 2005 with the goal of developing intervention strategies to generate improvements in perinatal oral health and the prevention and treatment of early childhood caries. One of the goals of the HRSA Oral Health Disparities Pilot was to explore ways to integrate dental and medical primary care. Through their work in this pilot program, the four pilot centers developed an in-depth understanding of what true medical/dental integration would involve. They have assembled a list, categorized by groupings outlined in the Care Model, of structures, systems, and characteristics that would support an integrated model of care. Their recommendations can be seen in Table 1.

**Table 1. HRSA Dental and Medical Primary Care Integration Guidelines<sup>20</sup>**

<b>Clinical Information Systems</b>	<ul style="list-style-type: none"> <li>• Integrated health record and scheduling system (ideally electronic)</li> <li>• Close the information loop on referrals and ensure that providers report back to medical with the date patient was seen, what treatment was received and future treatment plan</li> </ul>
<b>Decision Support</b>	<ul style="list-style-type: none"> <li>• Greater understanding among medical staff of dental practices</li> <li>• Understanding of the importance of oral health for children 0-5 years of age and pregnant women</li> <li>• Referral mechanism are in place from medical to dental with access ensured</li> </ul>
<b>Delivery System Design</b>	<ul style="list-style-type: none"> <li>• Integrated care team pods</li> <li>• Shared support staff</li> <li>• Open access for children 0-5 years of age and pregnant women when seen in the medical clinic</li> <li>• Dental liaison in medical department (dental packets created and ready to distribute to patients and staff)</li> <li>• Dental screenings during well child visits</li> <li>• Medical providers discuss the importance of oral health visits with pregnant women and young mothers</li> <li>• Oral health considerations are integrated into every appropriate medical visit</li> <li>• Dental presence in medical clinic (i.e. a dental hygienist is present to provide screening during a health maintenance or sports physical exam)</li> <li>• “Patient navigator” to perform medical, dental and mental health risk assessment</li> </ul>
<b>Self-Management</b>	<ul style="list-style-type: none"> <li>• Patient education materials co-located</li> <li>• Integrated self-management goal sheet</li> <li>• Shared self-management “message” and interview techniques across departments</li> </ul>
<b>Organization of Healthcare</b>	<ul style="list-style-type: none"> <li>• Co-location</li> <li>• Increased respect and understanding of roles and contributions of medical and dental staff</li> <li>• Measurements within medical primary care that address oral health</li> <li>• System of care coordinated to address medical, dental, and mental health needs at each patient visit</li> <li>• Integrated case management</li> <li>• Shared language and understanding between medical and dental (cultural competency)</li> <li>• Structural parity for dental (dental is viewed as having the same level of importance as medical)</li> </ul>
<b>Community Resources</b>	<ul style="list-style-type: none"> <li>• Creating patient and community awareness that oral health is an integral part of overall health</li> <li>• Insurance and reimbursement structures adjusted to encompass oral health as part of comprehensive health care</li> <li>• Dental screenings are incorporated into WIC, Head Start, and Early Head Start visits</li> </ul>

## **Current Initiatives in Rhode Island to Integrate Care**

To get a better understanding of what is happening in Rhode Island to improve the coordination of medical and dental care, a survey was conducted of all dental centers affiliated with a medical center in the state of Rhode Island in July of 2011. The goal of this survey was to determine where Rhode Island was in the process of integrating primary care and dental care, and what strategies dental centers and medical centers were employing to facilitate the coordination of care. In most cases, respondents were the dental managers at each organization, but executive directors were asked to designate who would be best to speak about the integration process within their organization.

The dental safety net is currently the locus of co-located or otherwise integrated medical and dental facilities in Rhode Island. Eight community health centers and two hospital-based dental centers were surveyed. There are no other known locations of co-located or integrated medical and dental care at this time. These sites are listed in Appendix B.

The survey asked centers if they operated using a dental home model of care, if the model of care included any kind of coordination with or integration of medical care, and if the center had any future plans for improving integration. There was also an opportunity for centers to share what had been and continue to be the biggest challenges they had faced in trying to integrate dental care and medical care, and if they had any other thoughts on how to facilitate the integration process. The survey questions are attached at the end of this report for review.

As part of the survey, we also contacted payers of both medical and dental services to investigate whether they do anything to coordinate, track, or encourage care of the services for which they do not directly provide coverage. They were also asked if they saw any opportunities to increase integration in the future.

There is some discrepancy among dental managers about what is considered a dental home, but all representatives affirmed that their center is a dental home and elaborated to describe how they had interpreted the model at their center. Every dental center interviewed met the qualitative criteria of the dental home. Though responses varied, overall respondents linked the dental home concept with continuous care delivered by the same dental provider whenever possible, an emphasis on preventative care, and coordination of any treatment or services that need to be referred out. As discussed above, these are all components of the AAPD guidelines for establishing dental homes.

Ten medical-dental centers in Rhode Island have some kind of system in place to encourage coordination between dental care and primary care. These systems vary from facilitated referrals and follow-up between providers to systems that are nearly completely integrated.

**Table 2. Rhode Island Oral Health Integration Survey Results July 2011**

	A	B	C	D	E	F	G	H	I	J
<b>Co-located Centers</b>	✓	✓	✓ <sup>1</sup>	✓		✓	✓ <sup>1</sup>	✓ <sup>1</sup>	✓	✓
<b>Integrated Referral System</b>	✓	✓	✓	✓	✓	✓	✓	✓		
<b>Open to All Community Members</b>	✓	✓	✓	✓		✓	✓	✓	✓	Children only
<b>Patients Shared with Medical Center</b>	Mixed	~20%	Most, but not all.	~10%	All	N/A	N/A	Approx. 80%	Not many	Mixed
<b>Joint Staff Meetings</b>		✓	✓	All staff	All staff	✓		✓		✓
<b>Medical provider screens all patients for dental provider</b>	Unsure	✓	✓	✓	✓	✓	N/A	✓	✓	
<b>Dental provider screens all patients for primary care provider</b>	✓	✓	✓	✓	---	✓	N/A	✓	✓	
<b>Electronic Medical Records</b>	✓	✓	✓	2 of 3 sites have EMR	✓	✓	✓	In process	In process	✓
<b>Electronic Dental Records</b>	✓	✓		✓	✓	✓	✓	In process	In process	✓
<b>Shared Medical and Dental Records</b>	✓	✓	✓ <sup>*</sup>		✓	✓		In process		

\*= Currently only dental has access to medical records; medical does not have access to dental records.

1= Only one center is co-located with medical center

N/A = Unknown

where a full-time dentist is on staff and participates fully as a member of the care team. Below is a summary of emerging best practices, persistent challenges, and innovations.

### **Emerging Best Practices in Rhode Island**

#### ✓ Shared Medical and Dental Records

Ensuring shared access to medical and dental records allows each care provider to view the patient's complete history, including the patient's problem list and current medications, and creates a more accurate snapshot of the patient's overall health. Shared records also allow PCPs and dental providers to view each other's prescriptions and can allow for electronic communication between providers in addition to the in-person case discussions.

#### ✓ Patient Orientation to Health Services

Many centers have found that providing all new patients with an "orientation visit" that fully describes all of the health services an organization provides for patients increases the number of referrals to dental providers. This visit serves as a patient activation tool and inspires patients to ask their medical providers for referrals to dental services.

#### ✓ Routine Screenings on Both Ends

Incorporating questions related to a patient's dental care into the routine medical screening has resulted in an increased number of referrals to dental providers at many health centers. Asking if a patient has a regular primary care physician in the dental exam room has had a similar effect. Furthermore, asking these cross-discipline questions of the patient further emphasizes that oral health and general health are intimately related and can begin to link the two disciplines together in the patient's mind.

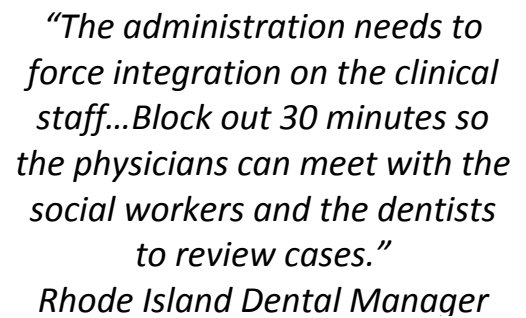
---

*"Dental is a required part of the conversation at all well-child visits. It's a required loop that dental then closes."*  
*Rhode Island Dental Manager*

---

## ✓ Closing the Loop

After receiving dental referrals from medical providers, consistently closing the loop with the medical provider has been shown to increase communication and coordination of care. This communication could take the form of a written provider update form detailing the procedures performed, additional treatment needed, date of the next appointment, and contact information of the provider. An example can be seen in Appendix C.



*“The administration needs to force integration on the clinical staff...Block out 30 minutes so the physicians can meet with the social workers and the dentists to review cases.”*  
*Rhode Island Dental Manager*

## ✓ Joint Staff Meetings

Bringing together medical and dental providers through regular joint staff meetings has been found to increase communication and collaboration between the two disciplines. Creating a designated time for medical and dental clinicians to discuss specific cases, practice logistics, and best practices facilitates communication and strengthens a center’s commitment to integrated care. Holding joint staff meetings can also help ensure medical and dental professionals are treated equally in the health center, and also that they know each other and begin to form collaborative relationships.

## ✓ Co-location and Shared Office Space

Co-locating medical and dental services can facilitate communication and interactions between medical and dental providers. It also can allow for easier referrals and can potentially make it easier for patients to access services. Co-location alone, though, is not sufficient for integration of care. Without concerted efforts to increase communication and collaboration, co-existing in the same building does not itself lead to integrated care. Some dental centers in Rhode Island have found that having medical and dental providers share the same office space pushes the co-location model to a point where integration can happen more organically. Dental centers that share office space with medical providers and have exam rooms down the hall from medical exam rooms have reported increased integration and collaboration among the care providers.

## Challenges

**Patient Education.** The most frequently identified challenge was changing the mindset of patients to think of dental care as integral to their overall health. Many centers have made

progress by increasing educational opportunities for patients, but the process is complicated by cultural and language barriers. Furthermore, many families facing financial hardship either continue to consider dental care a discretionary service or are forced to go without dental care services in favor of other, more pressing needs. It is important to make sure patients are aware of low-cost, sliding scale dental options in the dental safety net.

**Provider Education.** Another challenge to integrated care has been convincing medical providers of the importance of dental care and the relevance of dental care to overall health. There is a tremendous need to make physicians aware of the importance of dental care to overall health and to convince physicians to discuss oral health with their patients.

**Practice Changes.** Many sites cited the challenge of changing the way their practice works. Some centers described how difficult it was to make the initial change of asking the key questions in the exam room, both on the medical and dental side. Some providers would simply forget to ask if their patient had a dental home or a regular primary care physician. Though many noted the difficulty of inserting these questions into the routine screening process at each center, implementing these screening tools seemed to significantly improve collaboration and increase referrals at many sites.

**Staff Dynamics.** A few centers identified some tension between the medical and dental staffs that inhibited full cooperation between the two centers. Where there is not resistance to integration, there is still often a period of transition while providers adjust to being able to call on their medical or dental partner for consults.

**Coordination with Private Practices.** Centers have found coordination and communication with private medical and dental practices to be more difficult than coordination and communication within safety net organizations. Many noted that without direction from a higher authority, such as a professional association, state department, or payer, private practices may not choose to devote resources to coordinating care.

## **Innovations**

### **Training PCP to Apply Fluoride Varnish**

One health center has applied for a grant to pay the salary for a dental hygienist to train the medical providers on how to recognize dental problems and determine when it is appropriate to refer to a dentist, as well as possibly how to apply fluoride varnish. Another center conducts numerous trainings in caries risk assessment, oral disease prevention, and fluoride varnish application for interdisciplinary medical/dental staff throughout the greater Providence area.

## Stronger Efforts for At-Risk Populations

Many centers have focused their efforts on specific at-risk populations, such as pregnant women and patients with diabetes, and have found ways to strongly coordinate care for them. For diabetes patients, entering dental information into electronic registries has allowed dental and medical providers of diabetes patients to better coordinate care. Many health centers also hold educational seminars directed towards these at-risk populations focused on preventative dental care.

## Involving Dental Residents

One center exposes their dental residents to increased communication and coordination with medical staff. As part of their series of internal/external rotations, dental residents regularly interact and coordinate care with their medical colleagues.

## Additional Suggestions for Future Medical/Dental Integration Efforts

When asked what might facilitate the integration process, the most popular responses were increasing the number of shared staff meetings and case reviews where medical and dental providers can talk directly about process issues, as well as specific patients, and ensuring that dental providers are treated equally as members of the professional team. Other ideas for increasing coordination between medical and dental staffs include exploring whether and how mid-level dental providers can be used to triage dental problems for medical providers, similar to how medical nurses triage medical problems and assess the level of urgency before the medical provider intervenes, and coordinating medical and dental provider's on-call schedules.

Many centers also stressed the value of supportive, visionary administrative and clinical leadership that is committed to seeing true integration of care realized at the health center. Respondents noted that integration requires a conscious effort on the part of all providers and staff, and a strong leadership team that makes time for providers to discuss best-practices and review cases ensures that the whole care team is consistently making that effort.

Some respondents also questioned how further integration could occur without a stronger mandate from a higher authority, either from an association of professionals or the state. Although strong leadership within the organization has allowed for an increasing level of coordination between providers within the organization, some who have expressed difficulty in connecting with medical providers outside of their center cited this as a possible solution. Some respondents also called for oral health to be explicitly included in state evaluation criteria of the patient-centered medical home.

### **The Payers: Dental Insurance Plans**

Delta Dental of Rhode Island is the state's largest private dental insurance provider. Currently, Delta Dental does not do anything to explicitly encourage or track medical care for their patients. They are, however, interested in exploring opportunities for increased collaboration. Recently they have funded a study to determine if the dental office was an appropriate location to diagnose pre-diabetes and diabetes given the connection between elevated glucose levels and periodontal disease. They collaborated with Dr. Robert Genco from the University of Buffalo School of Dentistry and Blackstone Valley Community Health Centers for this project. The study is in its final stages and a report is set to be issued in September 2011.

The RIte Smiles program, started in 2006, provides dental coverage to all children in Rhode Island who have medical assistance coverage and were born on or after May 1, 2000. This dental coverage is provided through UnitedHealthcare Dental. The goal of this program is to increase overall access to dental services for children at-risk of developing early childhood caries. RIte Smiles is only just beginning to develop a fluoride varnish program to train primary care providers in Rhode Island. The program has previously been almost exclusively focused on dental access issues and working around service shortage areas in Rhode Island.

### **The Payers: Medical Insurance Plans**

Neighborhood Health Plan of Rhode Island (NHPRI) administers health benefits to more than 83,000 Rhode Islanders, including families with low to moderate income, children with special health care needs, children in the Rhode Island foster care system, and Medicaid-only adults.<sup>21</sup> NHPRI does not manage dental coverage, only medical coverage. Because of this, NHPRI cannot be billed for dental claims. They will, however, pay for fluoride varnish applied by a primary care provider's office if the right code is billed. This is the only dental code NHPRI accepts. They are also responsible for hospital charges if dental care is done under anesthesia.

Recently, NHPRI has been developing a pilot program for training primary care providers to apply fluoride varnish. They have found a dental hygienist who will provide this

---

*"We definitely have a financial incentive to encourage dental care."*

*NHP Representative*

---

training and are offering to cover the cost for providers if they agree to participate. They are looking to pilot this program in the next couple of months. This initiative has partly stemmed from a lack of primary care providers billing for fluoride varnish application. NHP noted that the cost of applying varnish is about \$1-2 per

application and the reimbursement is currently set at about \$18. The goal of this project is to increase the number of providers who are trained in applying fluoride varnish and convince providers this is a worthwhile service that is easy to provide to their patients.

NHPRI is very interested in discussing other ways to convince their beneficiaries to seek routine dental care. They have a financial incentive to encourage dental care because of their share in the cost of outpatient oral surgery. It is difficult to show empirically, however, that providing beneficiaries with fluoride varnish does reduce the number of children who end up in the OR because even the application of fluoride varnish does not have an immediate return on investment. It is especially difficult to track the effects of fluoride varnish application and show the value of this investment because of the transient nature of their members' lives. Despite these challenges, they are hoping to see a decrease in OR visits as a result of this fluoride varnish initiative within the next 2-4 years.

Blue Cross Blue Shield of Rhode Island reported that they currently do not have any focused program to encourage medical/dental collaboration, but they do see the value to coordinated care and would potentially be interested in learning more about how to incentivize coordination efforts among their providers.

## **Next Steps for Rhode Island**

Rhode Island's dental safety net has devoted significant resources to encouraging coordination and incorporating integration efforts into their system of care. Despite these efforts, there are still areas in which improvements in coordination and cooperation can be improved. After reviewing the results of this report, the Safety Net Workgroup recommends that the following next steps to promote the integration of medical and dental care:

- Facilitate the learning, exploration and implementation of emerging best practices around the integration of medical and dental care, including some of those listed above.
- Disseminate information about integration strategies in medical and dental settings to continue the conversation around coordination of care.
- Commit to reassessing the progress of integration efforts in Rhode Island in one year.

## **Acknowledgements**

Prepared by: Amy Traver, Rhode Island Health Center Association; Rebecca Kislak, Rhode Island Health Center Association

Jennifer Bowdoin, Chronic Care Sustainability Initiative; Darby Buroker, Rhode Island Quality Institute; Cameron Chrystal, Providence Community Health Centers; Nancy Coburn, Neighborhood Health Plan Rhode Island; Betsy Doucette, Well One Primary Medical and Dental Care; Jerry Fingerut, Blackstone Valley Community Health Centers; Monica Gallo, Wood River Community Health Centers; William Hochstrasser-Walsh, Comprehensive Community Action Program Health Services; James Hosmer, St. Joseph Pediatric Dental Centers; Daniel Kane, St. Joseph Pediatric Dental Centers; Stephanie Ledoux, Blue Cross Blue Shield Rhode Island; John Luther, United Healthcare Dental/AmeriChoice New Jersey; Matt Roman, Tri-town Community Health Centers; Maureen Ross, St. Joseph Pediatric Dental Center; Kathryn Shanley, Delta Dental Rhode Island; Shirley Spater Freedman, Samuel Sinclair Dental Clinic; Colleen St. John, Thundermist Community Health Centers; Michael Weisner, AmeriChoice New Jersey.

## **Appendix A: Survey Questions**

### **Oral Health Commission Safety Net Workgroup Patient Centered Medical-Dental Home Initiative June 2011**

#### **Questions for Medical Homes:**

1. Are you implementing/have you implemented a patient-centered medical home model of care?
2. Does your model of care include any kind of coordination with or integration of dental care?
3. Do you have any plans for improving integration?
4. What are some challenges that you have run into in trying to integrate medical care and dental care?
5. Do you have any thoughts on how to facilitate integration?

#### **Questions for Dental Centers:**

1. Do you operate your dental center using a dental home model of care? If so, what does that model mean to you?
2. Does your model of care include any kind of coordination with or integration of medical care?
3. Do you have any future plans for improving integration?
4. What are some challenges that you have run into in trying to integrate dental care and medical care?
5. Do you have any thoughts on how to facilitate integration?

#### **Questions for Insurance Reps/Payers:**

1. If you provide medical and dental coverage, do you do anything to integrate, track or encourage care?
2. If you do not provide both, do you do anything to coordinate, track or encourage care?
3. Do you see opportunities to increase integration? Do you have plans to increase integration/coordination?

## **Appendix B: Rhode Island Medical-Dental Centers Contacted**

Blackstone Valley Community Health Centers

Comprehensive Community Action Program Family Health Services

East Bay Community Action Program Health Services

Providence Community Health Centers

Samuel Sinclair Dental Center, Hasbro Children's Hospital

St. Joseph Pediatric Dental Centers, Center for Health and Human Services, St. Joseph Health Services of RI

Thundermist Health Center

Tri-town Community Health Centers

Well One Primary Medical and Dental Care

Wood River Health Services

## Appendix C: Sample Provider Update Report

Patient Name: \_\_\_\_\_

Chart #: \_\_\_\_\_

Date: \_\_\_\_\_

Dear \_\_\_\_\_,

Physician

The above-mentioned patient was seen for dental treatment at \_\_\_\_\_. The following procedures were completed:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Your patient:

Requires additional treatment. Next visit scheduled \_\_\_\_\_

All required treatment has been completed. Next visit should be in \_\_\_\_\_ months for preventative maintenance..

If you have any questions, please do not hesitate to call XXX-XXXX.

Respectfully Submitted,

\_\_\_\_\_

Dentist Signature

- 
- <sup>1</sup> Rhode Island Oral Health Commission, Rhode Island Department of Health. “Rhode Island Oral Health Plan, 2011-2016.” (January 2011.)
- <sup>2</sup> American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association. “Joint Principles of the Patient-Centered Medical Home.” (March 2007.) Available at [www.pcpcc.net](http://www.pcpcc.net).
- <sup>3</sup> Ibid.
- <sup>4</sup> American Academy of Pediatric Dentistry. “Policy on the Dental Home”. Reaffirmed 2010.
- <sup>5</sup> Nowak, Arthur J and P Casamassimo. “The dental home: A primary care oral health concept”. Paul S. *Journal of the American Dental Association*. (January 2002.) 133: 93-98.
- <sup>6</sup> American Academy of Pediatric Dentistry. “Policy on the Dental Home”. Reaffirmed 2010.
- <sup>7</sup> Nowak, Arthur J and Casamassimo. “The dental home: A primary care oral health concept”. Paul S. *Journal of the American Dental Association*. 2002. 133: 93-98.
- <sup>8</sup> Patient-Centered Primary Care Collaborative, Rhode Island Chronic Care Sustainability Initiative. Available at [www.pcpcc.net](http://www.pcpcc.net).
- <sup>9</sup> Rhode Island Quality Institute, Rhode Island Beacon Community Program. Available at [www.rigi.org](http://www.rigi.org).
- <sup>10</sup> Rhode Island Senate Bill 770. (Signed by governor 7/9/2011).
- <sup>11</sup> U.S. Department of Health and Human Services. “Oral Health in America: A report of the Surgeon General.” (May 2000).
- <sup>12</sup> Ibid.
- <sup>13</sup> National Maternal and Oral Health Policy Center, *TrendNotes*. (May 2011). <http://nmcohpc.net/>.
- <sup>14</sup> Ibid.
- <sup>15</sup> Ibid.
- <sup>16</sup> Pacific Center for Special Care, Dugoni School of Dentistry. “Community Involvement: Virtual Home Demonstration Project.” Available at: <http://www.dental.pacific.edu/>.
- <sup>17</sup> National Maternal and Oral Health Policy Center, *TrendNotes*. (May 2011). <http://nmcohpc.net/>.
- <sup>18</sup> Delta Dental Colorado Annual Report 2010, available at: <http://annualreport.deltadentalco.com/dentalHygienistCoLocation.html>
- <sup>19</sup> National Maternal and Oral Health Policy Center, *TrendNotes*. (May 2011). <http://nmcohpc.net/>.
- <sup>20</sup> Health Resources and Services Administration, *Oral Health Disparities Collaborative Implementation Manual*. (February 2008.)
- <sup>21</sup> Neighborhood Health Plan of Rhode Island Website. “Fact Sheet,” available at [www.nhpri.org](http://www.nhpri.org).