

TRENDNOTES

May 2011



ABOUT TRENDNOTES

TRENDNOTES, published semi-annually by The National Maternal and Child Oral Health Policy Center, is designed to highlight emerging trends in children's oral health and promote policies and programmatic solutions that are grounded in evidence-based research and practice. It focuses policymakers' attention on the trends, opportunities and options to improve oral health for all children at lower cost through the best use of prevention, disease management, care coordination, and maximized resources.

This issue of TRENDNOTES discusses the overall importance of a patient-centered health home that includes medical, dental and mental health care to improving children's health and explores key considerations related to integrating dental care with medical care. Additionally, it discusses federal opportunities, particularly those under ACA, to promoting a health home for children and their families.

Future TRENDNOTES:

Because TrendNotes is a publication that strives to be relevant to current policy issues, we welcome your comments, feedback, and suggestions for future issues.

Contact us at (202) 833-8388 or send us a comment through the Policy Center website: www.nmcohpc.org.

Children's Oral Health in the Health Home

Trend

Policymakers are placing greater focus on health homes in an effort to improve health outcomes, lower health care costs and improve health care quality. More than 30 states have initiated efforts to advance such homes through improvements to Medicaid and CHIP. Additionally, the Affordable Care Act (ACA) includes key provisions to support further development and implementation of such homes at the state and local levels.

Health homes coordinate medical, behavioral, and dental service systems through a variety of approaches including full integration, co-location, shared financing, virtual linkages and facilitated referral and follow-up. Such health homes are an important approach for helping to ensure that children and their families, particularly those who are low-income, have access to comprehensive health care services, including dental care. Currently, there are few health home models that fully integrate dental care. However, policymakers can promote children's oral health through prevention by engaging a variety of strategies and practice options described in detail in this TrendNote.

Policy Solutions

1. Establish state and local health home initiatives that include dental care.
2. Integrate health home strategies into statewide oral health planning and integrate dental home strategies into health home planning.
3. Collaborate with existing dental home initiatives at the national, state and local level.
4. Interpret the concept of health home to include oral health care wherever relevant.
5. Model comprehensive health homes on the experience of safety-net providers that offer integrated team-based care.
6. Assure that new initiatives and innovations from the Center for Medicare and Medicaid Innovation (CMMI) in the Centers for Medicare and Medicaid Services (CMS), particularly those focused on development of health homes, consider and include dental care.
7. Promote financing strategies in private and public (e.g., Medicaid, CHIP) insurance that support dental care within health homes.
8. Integrate oral health information within electronic health records and ensure that dental providers are included in health information exchanges.
9. Leverage dental training programs at all levels to promote interdisciplinary, holistic health care that includes oral health services.

Health Home: A Concept Whose Time Has Arrived

The idea of children benefiting from a consistent and regular source of comprehensive primary health care from infancy through young adulthood and beyond is not new. First described in the late 1960s by the American Academy of Pediatrics, “medical home” refers to an approach to providing primary care that is “accessible, continuous, comprehensive, family-centered, coordinated, compassionate and culturally effective.”¹ In parallel fashion, the concept of a dental home has been promoted since the early 2000s by the American Academy of Pediatric Dentistry as a means to promote oral health and prevent early childhood dental caries by enhancing access to dental care at an early age. More recently, policymakers and other leaders have been exploring the concept of a health home² wherein children receive integrated, comprehensive medical, dental and mental health care focused on prevention and early intervention with reliance on specialists to help with disease management and provide more intensive care as needed.³

While these concepts are not new, multiple factors affect whether a regular source of comprehensive health care,⁴ including dental care, is a reality for all children particularly those children who are low-income or have special health care needs (e.g., diabetes, spina bifida). Low-income children experience greater health problems, including oral health problems, than their higher income counterparts, yet are least likely to obtain regular medical and dental care including preventive care. Dental care is among the top unmet health care needs for children with special health care needs (CSHCN).⁵ Many children also remain uninsured⁶ despite federal coverage expansions under Medicaid and the Children’s Health Insurance Program (CHIP) – a situation that clearly limits their access to care.

The potential benefit of health homes has gained further interest and attention as state policymakers and health care purchasers have struggled to control escalating health care costs while questioning return on investment in healthcare.⁷ The U.S. health system spends a higher proportion of its gross domestic product on health care than any other country but ranks 37th among 191 countries – between Costa Rica and Slovenia – in the World Health Organization’s ranking of health system effectiveness.⁸ U.S. healthcare resources are disproportionately focused on treatment services for more advanced stages of diseases and on tests and procedures of uncertain utility, while an estimated two-to-three percent are spent on preventing the diseases that drive this spending.⁹ Investments in enhanced models of primary care, including health homes, may lead to lower health care costs, greater equity in health care spending, and improved health outcomes.¹⁰ As further evidence of policymaker interest, more than 30 states have initiated efforts to advance medical homes through Medicaid and CHIP.¹¹

These trends taken together with new opportunities presented by the Affordable Care Act make advancing the health home a timely concept for state policymakers and others to be examining, particularly leaders interested in promoting children’s oral health and preventing early childhood dental caries. This Trend Note discusses the opportunities, options and policy implications for advancing a health home that includes oral health care. It is part of the National Maternal and Child Oral Health Policy Center’s (Policy Center) ongoing work to improve children’s oral health by promoting dental care that is coordinated with primary care and focused on prevention.

Medical, Dental and Health Home Definitions

Medical Home: Numerous groups including the American Academy of Pediatrics have defined this term. According to the Patient Centered Primary Care Collaborative, a medical home is a physician-directed medical practice that provides point-of-entry, enhanced primary care in a continuous fashion, across the health care spectrum, and is comprehensive, coordinated and delivered in the context of family and community.

Dental Home: Dental home refers to the ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated and family-centered way. Establishment of a dental home begins no later than 12 months of age and includes referral to dental specialists when appropriate.

Health Home: Health home refers to an approach to providing primary care where children receive integrated, comprehensive medical, dental and mental health care that is focused on prevention and early intervention with reliance on specialists to help with disease management and provide more intensive care (e.g., treatment procedures and therapies).

Sources:

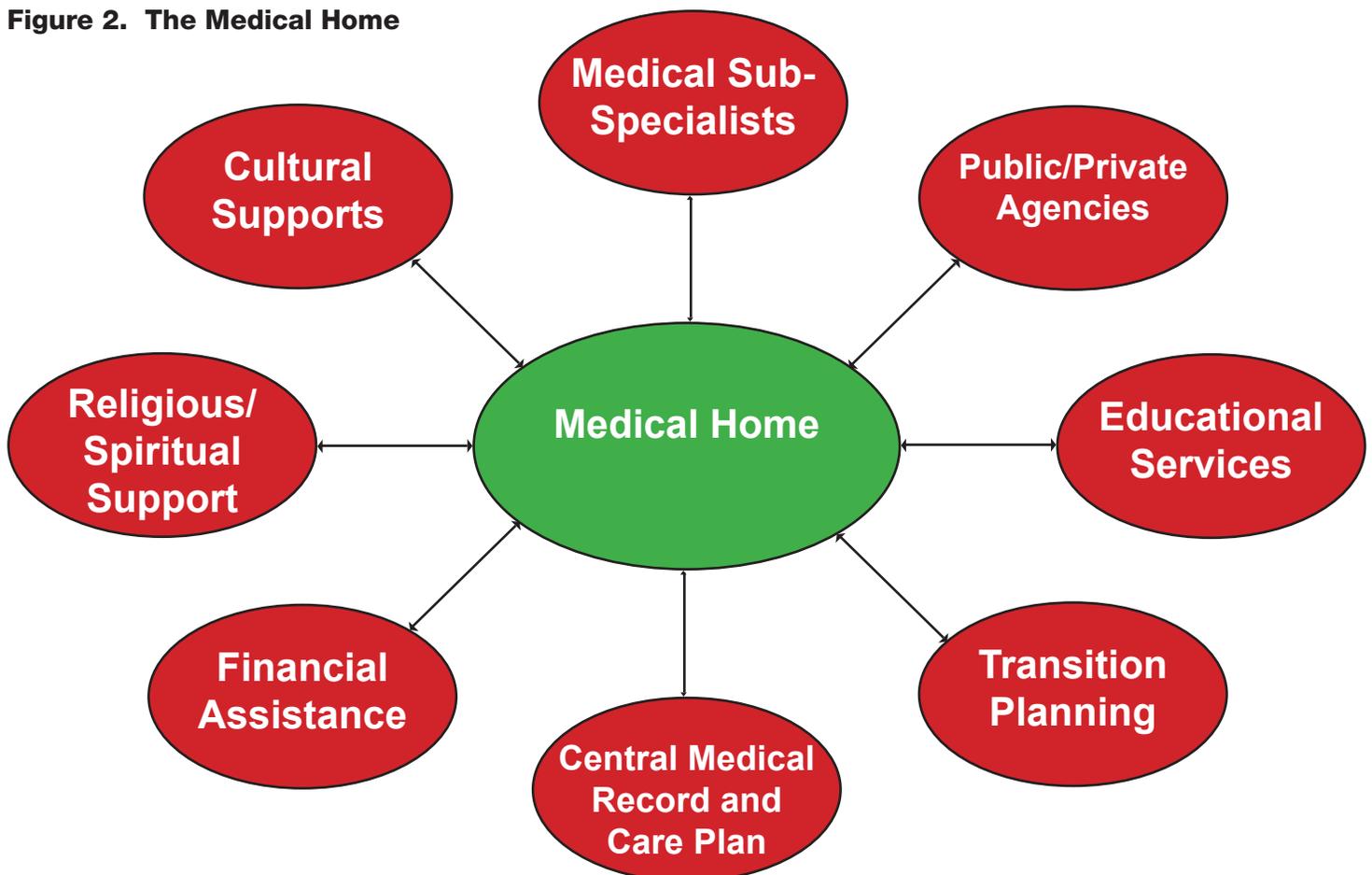
Patient-Centered Primary Care Collaborative. Patient Centered Medical Home. Accessed 2/1/11 at: <http://www.pcpcc.net/patient-centered-medical-home>.
Definition of a Dental Home. Policy Statement. 2010. American Academy of Pediatric Dentistry. Reference Manual. Vol 32; No. 36.
Edelstein, BE. Environmental factors in implementing the dental home for all young children. National Oral Health Policy Center, November 2009.
American Academy of Pediatric Dentistry. Toward a Health Home. December 2010

Why Health Homes are Critical to Children's Oral Health

Tooth decay is the most prevalent chronic disease of childhood in the U.S. and despite being overwhelmingly preventable is on the rise among young children for the first time in 40 years.¹² Dental caries – the disease process leading to cavities – is established in the first few years of a child's life, with some children being susceptible to decay soon after their teeth first appear. The occurrence of tooth decay before the age of six years – known as Early Childhood Caries (ECC) – is of particular concern both because of its prevalence (affecting 44% of five year olds)¹³ and because past caries experience is the best predictor of tooth decay across the lifespan. The younger a child is when they experience their first cavity, the more likely they will experience more cavities in both their baby and permanent teeth. Effective prevention requires early intervention, risk-adjusted care, and parental engagement and education. Both the American Academy of Pediatric Dentistry and the American Academy of Pediatrics

agree that a dental home be established by one year of age, particularly for young children deemed at high-risk for ECC.^{14,15} By establishing a health home early in life, children and their families can be provided with oral health counseling and primary prevention services at a time when interventions can make the most difference – before dental caries is established in a child's mouth. Early dental care may also reduce dental care costs while improving health outcomes^{16,17,18} and has been associated with reduced costs in tooth repair. Primary care providers (e.g., pediatricians, family physicians) have a unique opportunity to address a full range of health issues including oral health with children and their families. Many children visit these providers on a regular basis -- an average of 10 - 12 visits in the first year of life, alone. -- for well-child visits and other routine primary care (e.g., school physicals). In 2007, 88.5 percent of children ages 0-17 received at least one or more well-child visits in the past year.¹⁹

Figure 2. The Medical Home



Source: Alden, ER, Executive Director and CEO, AAP. PowerPoint Presentation entitled, "The American Academy of Pediatrics and the Medical Home: A Long-Standing Relationship" April 25, 2008.

What Could a Health Home Look Like?

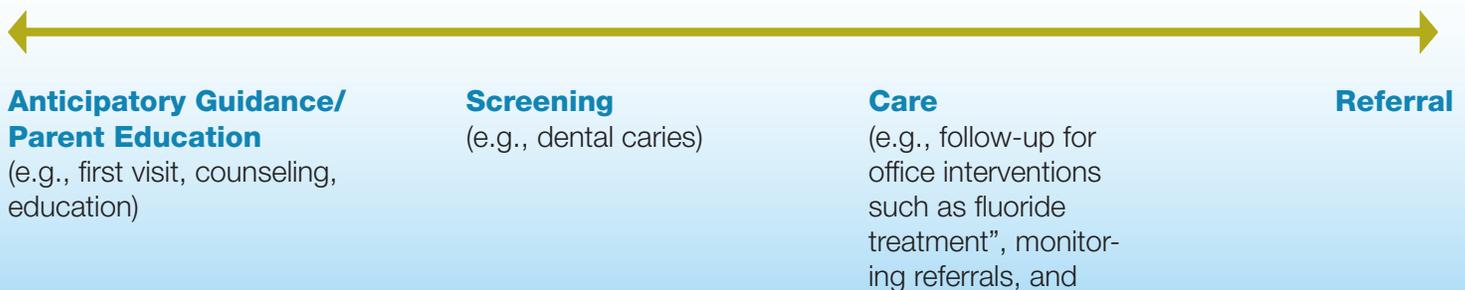
In a system that addressed dental caries common yet preventable and manageable chronic disease, universal, well-established public health strategies (e.g., community water fluoridation) designed to promote the importance of oral health and prevent dental caries transmission would be provided to all children. For children deemed to be at high risk for dental caries, more individualized and family-centered interventions including counseling, risk management and topical fluoride application would further reduce risk for dental caries progression. Finally, children at high risk and those with early or advanced cavities would be provided intensive and ongoing services to treat and arrest the disease. These practices would be embedded in a comprehensive system of care that recognizes the importance of childhood health on health outcomes throughout the lifespan²⁰ and includes the following key components:

- comprehensive public and private dental coverage,
- comprehensive dental care services provided as part of a health home,
- linkages with child-serving programs and systems (e.g., child care, schools, Head Start, WIC),

- workforce development,
- dental tracking and monitoring, and
- quality improvement efforts.

In a health home that is part of this overall system of care, primary care providers (e.g., pediatricians, family physicians) would provide initial, early and proactive anticipatory oral health guidance (e.g., counseling and education about oral health), screen for dental caries, make timely referrals for a dental visit, and where appropriate given a child's risk for tooth decay, provide individualized fluoride management. Dentists would be readily available to all children starting at birth for any and all oral health concerns identified by primary care providers and families. They would provide oral health supervision, either individually or as part of a health home team, that includes caries prevention and treatment, ongoing monitoring of a child's oro-facial growth and development including bite development, and reparative treatment as necessary.

Figure 2. Roles of Pediatric Primary Care Providers in Children's Oral Health



System Considerations to Advancing the Health Home

Primary care providers and dental care professionals each recognize the importance of children's oral health and the need for increasing access to dental care services, particularly for low-income children.^{21,22} Yet, significant challenges to creating and implementing health homes exist, perhaps the most important being the lack of an accepted health home definition and related models.. These barriers include but are not limited to the following.

- Lack of primary care provider training: Primary medical care providers receive minimal training in oral health, which can affect their willingness to address oral health topics in a well-child visit. Physicians may feel ill prepared to engage in oral health as medical schools²³ and residencies²⁴ offer little education in oral health supervision of children.
- Lack of dental care provider training: Dentists receive limited training that prepares them for engagement with multidisciplinary coordinated healthcare teams in health homes. Three-quarters of recently graduating dental students report feeling "less than well prepared" to integrate oral health with medical care.²⁵ Two-in-five graduates also felt "less than well prepared" to treat children. Perhaps reflecting this discomfort, general dentists—who comprise more than three quarters of all US dentists – care for a disproportionately small number of children. (Children comprise 26% of US population²⁶ but only 17% of general dentists' patients.)²⁷
- Lack of primary care provider time in well-child visits to provide services beyond those focused on physical health: Primary care providers have limited time during a well-child visit – an average of 18 minutes per child for children under age three²⁸ – to cover numerous health topics and parental concerns.
- Separate medical and dental financing strategies that impede paying for dental services in the health home: Coordination or integration of medical and dental financing is critical to the successful development, implementation and sustainability of comprehensive health homes of all types. Currently, grant funds (e.g., foundations, state general revenue) are common sources of funding that have been used to initiate, develop, and implement integrated co-located models. Public insurance (e.g., Medicaid) is a primary

source of funding for primary care and dental services for low-income children. However, financing strategies are needed to support the range of approaches and strategies for providing dental care services within a health home.

- Administrative barriers including sharing of health information (e.g., electronic health records) between providers. Fully integrated medical-dental electronic health records can help promote and facilitate sharing of health information between medical and dental care providers if included within health information exchanges. Historically, however, dental and medical records have not been linked. Many medical and dental providers continue to use paper records, and barriers to sharing information (e.g., HIPAA confidentiality laws) between providers – whether real or perceived – still exist.



Approaches and Strategies for Implementing Health Homes

Policymakers and others interested in health homes can consider a range of options for integrating dental care into a health home. Each approach provides greater coordination between medical and dental care for children and their families than does the current independent medical and dental systems. The following information outlines a range of approaches and strategies – not all mutually exclusive – that states, communities and providers might implement and/or adapt to increase access to dental care services for children with a focus on health homes.

Full Integration

Under this approach, dental care professionals who provide a full spectrum of preventive and restorative care are full members of inter-professional group practices that provide a “one stop shop” to deliver comprehensive primary and specialty care to children. Pediatric clinics in children’s hospitals that thoroughly integrate oral health into their service systems reflect this option. In this arrangement, dental professionals actively participate in care teams (e.g., craniofacial teams, transplant teams, rehabilitative teams); provide primary dental services to children who use the hospital for primary medical care; deliver specialty-level dental care to children with special or advanced needs; and involve medical care providers in oral health promotion, screening, and prevention.

Co-location

Under this option, dental professionals deliver services in the same location as pediatric primary care providers. This arrangement facilitates communication, transfer of patients between providers, and typically, shared health records. Examples of this approach include primary care providers that co-locate dental providers in their primary care practice and Federally Qualified Health Centers (FQHC) that include dental care services at the same location as medical services.

The **Colorado Delta Dental Foundation** sponsors the co-location of dental hygienists in primary care settings in an effort to create a health home for children, particularly those children at high risk for dental caries.

The Dental Hygienist Co-Location Project supports hygienists in five primary care sites across the state including private family practice and pediatric offices and public community health centers. Practices were selected because they have a significant proportion of patients at risk for dental caries and tooth decay. The integration of an oral health practitioner into the medical clinic varies from site to site: it ranges from building a multi-use operatory on-site that can be used for dental or medical care, to locating a hygienist in an independent office located across the hall from the medical clinic.

Most of the hygienists practice part-time in the medical setting and part-time in a dental office, creating a natural referral system and helping to assure continuity of care. The average age of children who are seen by the hygienists is 18 months, allowing a strong focus on timely prevention and parent education. Dental treatment, when necessary, is provided by dentists who are part of a comprehensive referral network – a top priority of the project from its inception.

The project is currently exploring development of public financing strategies to assure its sustainability. These efforts include promoting policies and mechanisms that would enable dental hygienists to bill Medicaid and CHIP for their services as currently, billing is done separately for medical and dental care. Additionally, the Project continues to engage dentists in the community to inform them about the underlying need for the Project and its non-traditional approach and to engage their support. For more information contact: Patricia Braun, MD, MPH, Department of Pediatrics, Denver Health, Patricia.Braun@dhha.org.

Michigan has invested in efforts to increase dental student participation in underserved communities. In 2000, the **Michigan Department of Community Health (MDCH)** awarded 22 local agencies oral health access grants. Five grantees elected to subcontract with the University of Michigan Dental School (UMDS) to rotate dental students at five community health centers where they treat Medicaid beneficiaries. The program’s dual goals are to increase dental access while also increasing students’ knowledge and skills in caring for the underserved.

As a result of these initial grants more than 140 dental students, dental hygiene students, and dental residents have rotated to five community health centers averaging two weeks of service and learning experience. More than 8,600 additional Medicaid beneficiaries have been treated. Perhaps most significantly, all five community health clinics have hired dentists who were former students of the program.²⁹ The program has remained sustainable due to negotiated different payment mechanisms, including cost-based reimbursement and an administrative contract between the MDCH and UMSD.

Shared Financing

Using this strategy, medical and dental providers may be located in physical space that is independent from one another, but they share financial risk and opportunity in a variety of ways that can promote greater access to dental care services for children and their families. These financing strategies range from performance payments for primary care providers who successfully make a dental referral such as United Healthcare's pilot AmeriChoice Program in New Jersey to a joint financing arrangement through global capitation.

AmeriChoice in New Jersey reimburses primary care medical providers for oral health screening, preventive counseling, and fluoride varnish services to young children and provides a financial incentive for completing a timely referral (within 120 days) to a pediatric dentist. AmeriChoice prepares these primary care medical providers through an on-line distance learning program, which then qualifies them for dental service reimbursement. Through this program, the company reports that more than half of young children were successfully referred for ongoing primary dental care. For more information contact John Luther at: John.Luther@optumhealth.com.

Virtual

Under this option, medical and dental providers are linked through shared information provided through a common electronic health record that is visible and accessible to both medical and dental providers, also commonly known as health information exchanges. Examples of this approach include integrated medical-dental records in use by the Veteran's Administration and the Marshfield Clinic of Wisconsin. In other cases, children in FQHCs, elementary schools and Head Start

programs receive dental services virtually through links to dentists and other dental care providers.

The **Pacific Center for Special Care at the University of the Pacific, Arthur A. Dugoni School of Dentistry** in collaboration with state agencies, private foundations and other key groups have developed the Virtual Dental Home to increase access to dental services for underserved children and adults in key settings (e.g., elementary schools, Head Start programs, FQHCs) across California. The Virtual Dental Home constitutes a community-based oral health delivery system in which children and adults receive preventive and basic therapeutic and services in community settings where they live or receive educational, social or general health services. It utilizes the latest technology to link practitioners in the community with dentists at remote office sites.³⁰ Registered dental hygienists in alternative practice (RDHAP), registered dental hygienists working in public health programs (RDH) and registered dental assistants (RDA), equipped with portable imaging equipment and an internet-based dental record system, collect electronic dental records (e.g., X-rays, charts, dental and medical histories) and upload the information to a secure website where they are reviewed by a collaborating dentist. The dentist reviews the patient's information and creates an initial plan. The RDHAP, RDH or RDA then carries out the aspects of the treatment plan that can be conducted in the community setting. This includes aspects of the health home concept including health promotion, preventive procedures, and placement of Interim Therapeutic Restorations (ITR). The majority of people can be kept healthy in the community setting using these procedures. For those who require additional treatment, they are referred to a dental office for procedures that require the skills of a dentist. For more information visit the project website at: [http://www.dental.pacific.edu/Community_Involvement/Pacific_Center_for_Special_Care_\(PCSC\)/Projects/Virtual_Dental_Home_Demonstration_Project.html](http://www.dental.pacific.edu/Community_Involvement/Pacific_Center_for_Special_Care_(PCSC)/Projects/Virtual_Dental_Home_Demonstration_Project.html).

Facilitated Referral and Follow-up

Under this approach, referral, referral tracking and follow-up between medical and dental providers is formalized and implemented in ways that ensure provision of dental care by both types of providers. Examples of this approach include FQHCs that have formal contracts with dental providers for the provision of dental care services.

Federal and National Opportunities to Implement Health Homes

Multiple federal training programs administered by the Health Resources and Services Administration (HRSA) promote enhancements in medical and/or dental training that may advance greater integration between primary care and dental care providers to serve underserved children. HRSA's HIV/AIDS Bureau sponsors the Community Based Dental Partnership Program at twelve dental schools across the country. This program prepares dental students and advanced practice general dentistry trainees to care for socially vulnerable and HIV-impacted populations.³¹ HRSA's Bureau of Health Professions sponsors training programs for primary care medical providers as well as general dentists, pediatric dentists, public health dentists, and dental hygienists with a focus on care of underserved populations. The Affordable Care Act (ACA) expanded this program's size and scope beyond dental residency training to include training of dentists already in practice, pre-doctoral dental students and dental hygienist. ACA emphasized the training programs role in care of underserved children by authorizing technical assistance to pediatric dental training programs "in developing and implementing instruction regarding the oral health status, dental care needs, and risk-based clinical disease management of all pediatric populations with an emphasis on underserved children."³² Additionally, HRSA's Maternal and Child Health Bureau sponsors three Leadership Training in Pediatric Dentistry programs combining pediatric dental and public health education. The Bureau's Leadership Training in Adolescent Health specifically promotes inter-disciplinary training, although not all grantees involve oral health professionals.

Health Home Opportunities under The Affordable Care Act

States have several opportunities under the Affordable Care Act to advance health homes. In particular, the Center for Medicare and Medicaid Innovation (CMMI), which was established under Section 3021 of ACA, is designed to test innovative payment and service delivery models for Medicare, Medicaid, and CHIP programs. Established in November 2010 as part of the Centers for Medicare

and Medicaid Services (CMS), the mission of CMMI is to "produce better experiences of care and better health outcomes for all Americans and at lower costs through improvements." CMMI has a mandatory appropriation under ACA of \$10 billion over the next ten years. The Center is designed to be a public/private/consumer partnership to explore new payment and service delivery models in three main areas³³:

- Improved Care for Individuals: Focusing on patients in traditional care settings (e.g., hospitals, doctor's offices, etc.), CMMI seeks improvements to care safety, efficiency, effectiveness, affordability, and making care more patient-centered. CMMI also plans to promote "bundled payments," a collaborated care effort wherein multiple providers bundle multiple procedures for one medical episode into a single payment, eliminating the need for traditional fee-for-service's multiple billing submissions.
- Coordinating Care to Improve Health Outcomes for Patients: CMMI seeks to develop new care models that make it easier for providers in different settings to coordinate care efforts for a single patient. New health home models and Accountable Care Organizations will be a major focus.
- Community Care Models: Focusing on improvements to public health, CMMI will examine how to best identify health potential crises as well as innovations in interventions for prevalent chronic diseases and conditions.

A number of CMMI initiatives are in development or underway. One of the most relevant initiatives to advancing health homes in states is the Medicaid Health Home State Plan Option, mandated by Section 2703 of ACA.³⁴ Under this option, states have the option to allow Medicaid beneficiaries with "at least two chronic conditions, one chronic condition and the risk of developing a second, or one serious and persistent mental health condition" to select a specific provider as a "health home" to help coordinate their treatments. Services under the

health home as defined by CMS are: comprehensive care management, care coordination and health promotion, comprehensive transitional care from inpatient to other settings, individual and family support, referral to community and social support services, and the use of HIT. Participating states receive an enhanced FMAP rate of 90% for the first eight quarters that the option is in effect. Other health care services for program participants will continue to be matched at the state's regular matching rate. CMS released its initial guidance to states on Section 2703 in a November 2010 State Medicaid Director letter along with a draft template for states to use in designing and developing health home State Plan Amendments (SPAs).

The National Maternal and Child Oral Health Policy Center, its partners and other key stakeholders interested in children's oral health are actively pursuing opportunities to integrate oral health in the Medicaid Health Home State Plan Option. At the same time, other ACA provisions such as the preventive services requirement may prove promising for advancing health homes.

The ACA defines the Essential Benefits Package that will be required of Qualified Health Plans offered by the federal and/or state-based Exchanges (the administrative body that will facilitate access to health coverage).³⁵ Pediatric dental benefits are included as an "essential benefits" within the larger pediatric health benefit as Section 1302(a) of the law requires "pediatric services, including oral and vision care." This definition provides an important opportunity for states to use the pediatric benefit to assure that dental benefits are an integral part of pediatric services, further underscoring the important link between medical and dental care. The details of how this benefit will be implemented in 2014 are still unspecified, but may represent an opportunity to structure payment, health services delivery, and health records in ways that integrate medical and dental care in a health home setting.



Implications for Policy and Practice

State and local level policymakers, program administrators, children's advocates, and others interested in promoting children's oral health and preventing dental caries can advance health homes using a variety of strategies, many of which are outlined below.³⁶ The National Maternal and Child Oral Health Policy Center will continue to monitor, track and advance these and other opportunities, particularly the ACA provisions and their implications for promoting a health home.

- **Establish state and local health home initiatives that include dental care.** States can establish health or medical home initiatives to include dental services by explicitly referencing dental care in these initiatives and related efforts (e.g., pilot projects, grant guidance, performance measures). In Texas, the Medicaid Health Home Request for Proposals (RFP) language stipulates that the mission of the pilot initiative is partly “to encourage innovative approaches to the delivery of primary medical and dental care to children and adolescents enrolled in Texas Medicaid.”^{37,38} Evaluation criteria for applications includes evidence of a plan to integrate dental services into the medical home. An increase in dental care utilization is one of the performance measures listed in the RFP.
- **Integrate health home strategies into statewide oral health planning and integrate dental home strategies into health home planning.** In February 2011, the Minnesota Department of Health, Oral Health Unit released a draft state oral health plan that calls for collaboration with the state's health home initiative.³⁹ The plan proposes health home collaboration as a component of broad efforts to, for example, improve “professional integration” between dental and other providers, use school-based programs to promote the health home concept, and develop a coordinated plan for fluoride varnish programs.
- **Collaborate with existing dental home initiatives.** Iowa is developing a statewide, multi-payer health home and is in the early stages of determining how to ensure that it includes a strong dental component. In doing so, the state

is collaborating with I-Smile™, which is a dental home project focused on primary prevention and care coordination that is rooted in the state's public health network and designed to provide optimal dental care to children.⁴⁰

- **Interpret the concept of health home to include oral health care wherever relevant.** For example, while neither Nebraska's health home legislation nor its grant guidance reference dental or oral health, yet the state's medical home initiative emphasizes the concept of “whole person” care, which the State interprets to include dental care. Participating pilot programs enter into agreements that require them to coordinate with and provide access to “specialty care” and “community services”. The state and its technical assistance contractors use dental care as one example of meeting these requirements.
- **Model comprehensive health homes on the experience of safety-net providers that offer integrated team-based care.** States may have a free clinic or community health center that effectively integrates medical and dental care services in a primary care setting. West Virginia, for example, has a free clinic in the capital city of Charleston that introduces patients to “total health care” including dental, behavioral, pharmaceutical and other services. A community health center in the northern area of the State ensures that every patient is asked about his or her last visit to a dentist and is scheduled for a follow-up appointment with a dentist. Lessons from safety net providers in a state may help inform the integration of dental care into a medical or health home initiative.
- **Assure that new initiatives and innovations from the Center for Medicare and Medicaid Innovation, particularly those focused on development of health homes, consider and include prevention of dental caries in children wherever relevant.** These initiatives include implementation of the Medicaid Health Home State Plan Option (Section 2703) and other efforts such as the development of Accountable Care Organizations.

Implications for Policy and Practice, Continued

- **Promote financing strategies in private and public (e.g., Medicaid, CHIP) insurance that support dental care within health homes.** These strategies include but are not limited to payment to medical personnel for dental care services such as providing fluoride varnish application. Currently, 40 states allow primary care providers to apply fluoride varnish.⁴¹
- **Integrate oral health information within electronic health records and ensure that dentists are included in health information exchanges.** For example, Marshfield Clinic in Wisconsin was an early adopter of health information technology and integrated medical and dental records that includes information on medications, appointments, diagnoses, and health histories. Marshfield Clinic also utilizes tele-dentistry when needed to share visual images.⁴²
- **Leverage dental training programs at all levels to promote interdisciplinary, holistic health care that includes oral health services.** Dental training programs at all levels provide multiple options to expand workforce and facilities while potentially attracting permanent caregivers for the underserved.



TRENDNOTES

About the National Maternal and Child Oral Health Policy Center

The National Maternal and Child Oral Health Policy Center was created in 2008 with support from the Maternal and Child Health Bureau as a collaborative effort of the Association of Maternal and Child Health Programs (AMCHP), Association of State and Territorial Dental Directors (ASTDD), Children's Dental Health Project (CDHP), Medicaid/SCHIP Dental Association (MSDA), and National Academy for State Health Policy (NASHP). The Policy Center, which is housed at CDHP, promotes the understanding of effective policy options to address ongoing disparities in children's oral health. The three-year initiative has set out to map a course for improving family oral health by building knowledge and skills of professionals with the ability to steer systems changes. Please visit the Policy Center website at <http://nmcohpc.org>.

Acknowledgements

This TRENDNOTE was written by Karen VanLandeghem, MPH, Health Policy and Program Consultant. Children's Dental Health Project (CDHP) Chair and Founding Director, Burton Edelstein, and CDHP staff provided invaluable content, guidance and support in the development of this TRENDNOTE. Special thanks also go to Carrie Hanlon and Larry Hinkle at the National Academy for State Health Policy (NASHP) as well as Amy Gibson at the Patient-Centered Primary Care Collaborative (PCPCC) for providing valuable research and information.

The National Maternal and Child Oral Health Policy Center would also like to thank our partners at AMCHP, ASTDD, MSDA, and NASHP for their thoughtful input



Feedback for Future TRENDNOTES Topics:

The National Maternal and Child Oral Health Policy Center covers emergent and emerging trends in children's oral health to educate policymakers and to advance policies and practices that improve oral health for all children, including those with physical and social vulnerabilities. To provide your feedback to this publication and submit ideas for future TRENDNOTES please go to: <http://www.nmcohpc.org/feedback>.

For Further Information:

The Policy Center would like to know how policymakers are using TRENDNOTES and hear about additional topics of interest. To help inform future TRENDNOTES topics and for more information about children's oral health or this TRENDNOTE please contact: Meg Booth, Deputy Executive Director, Children's Dental Health Project, at (202) 833-8288 mbooth@cdhp.org.

Endnotes

1. American Academy of Pediatrics. Children and the Medical Home. 2011.
2. The term “health home” is used throughout this TrendNote to refer to approaches whereby children have access to comprehensive, integrated medical and dental care.
3. Edelstein BL. Environmental Factors in Implementing the Dental Home for All Young Children. Washington, DC: National Oral Health Policy Center. 2010.
4. The term “comprehensive health care” is used throughout this TrendNote to refer to comprehensive medical, dental and mental health care.
5. The National Survey of Children with Special Health Care Needs. U.S. Department of Health and Human Services, Health Resources and Services Administration. Accessed 4/25/11 at: <http://mchb.hrsa.gov/cshcn05/NF/4healthcna/services.htm>.
6. Cover the Uninsured. Child Health Fact Sheet. Robert Wood Johnson Foundation. Accessed 2/1/11 at: <http://covertheuninsured.org/content/overview>.
7. The PCPCC was created in late 2006, when approached by several large national employers with the objective of reaching out to the American College of Physicians, the Academy of Family Physicians, and other primary care physician groups in order to (1) facilitate improvements in patient-physician relations, and (2) create a more effective and efficient model of healthcare delivery. Patient Centered Primary Care Collaborative. History of the Collaborative. Accessed 2/1/11 at: <http://www.pcpcc.net/content/history-collaborative>.
8. The World Health Report 2000. Health Systems: Improving Performance. 2000.
9. Stange KC and Woolf SH. Policy options in support of high-value preventive care. Washington, DC: Partnership for Prevention. December 2008.
10. Kaye N and Takach M. Building Medical Homes in State Medicaid and CHIP Programs. Washington, DC: National Academy for State Health Policy. June 2009.
11. Ibid
12. Dye BA, Tan S, Smith V, Lewis BG, Barker LK, Thornton-Evans G, et al. Trends in oral health status: United States, 1988-1994 and 1999-2004. National Center for Health Statistics. Vital Health Stat 11(248) 2007.
13. Iida H, Auinger P, Billings RJ, Weitzman M. Association between infant breastfeeding and early childhood caries in the United States. Pediatrics. 2007; 120(4): e944-52.
14. Oral Health Risk Assessment Timing and Establishment of the Dental Home. Pediatrics; 111 (5); May 2003; 1113 – 16.
15. American Academy of Pediatric Dentistry. Policy on the Dental Home. Oral Health Policies. 2010.
16. Weintraub JA. Prevention of early childhood caries: a public health perspective. Community Dent Oral Epidemiol. 1998; 26(1 Suppl): 62-6.
17. Zavras AI, Edelstein BL, Vamvakidis A. Health care savings from microbiological caries risk screening of toddlers: A cost estimation model. J. Public Health Dent. 2000 Summer; 60(3): 182-88.
18. Ramos-Gomez FJ, Shepard DS. Cost-effectiveness model for prevention of early childhood caries. J Calif Dent Assoc. 1999 Jul;27(7):539-44.
19. Savage Matthew, Lee Jessica, Kotch Jonathan, and Vann Jr. William. “Early Preventive Dental Visits: Effects on Subsequent Utilization and Costs”. Pediatrics 2004; 114 pp.418-423.
20. Forrest CB, Riley AW. Childhood origins of adult health: a basis for life-course health policy. Health Affairs 2004; 23 (5): 155-65.
21. Edelstein B. Barriers to Medicaid Dental Care. Washington, DC: Children’s Dental Health Project. 2000.
22. Krol DM and Wolf JC. Physicians and dentists attitudes toward Medicaid and Medicaid patients: review of the literature. Columbia University. 2009.
23. Ferullo A, Silk H, Savageau JA. Teaching oral health in U.S. medical schools: results of a national survey. Acad Med 2011; 88(2): 226-30.
24. Krol DM. Educating pediatricians on children’s oral health: past, present, and future. Pediatrics 2004; 113(5): e487-92.
25. Okwuie I, Anderson E, Valochovic RW. Annual ADEA survey of dental school seniors: 2008 graduating class. J Dent Educ 2009; 73(8):1009-32.
26. Nationalatlas.gov. Accessed 3/5/11 at http://www.nationalatlas.gov/articles/people/a_age2000.html.
27. American Dental Association. 2009 Survey of Dental Practice: Characteristics of US Dentists and Their Patients. American Dental Association, Chicago IL, 2009.
28. American Academy of Pediatrics, Periodic Survey of Fellows 46. Elk Grove Village, IL: American Academy of Pediatrics; 2001.
29. Association of State and Territorial Dental Directors (ASTDD). Dental Public Health Activities and Practices, Practice #25002: University of Michigan Dental School’s Partnership with Community Health Centers. ASTDD. Washington, DC, June 2010. Accessed 2/8/11 at <http://www.astdd.org/bestpractices/pdf/DES25002Mldentalschool.pdf>.
30. Virtual Dental Home Demonstration Project. San Francisco, CA: University of the Pacific, Arthur A. Dugoni School of Dentistry. Accessed 4/15/11 at: [http://www.dental.pacific.edu/Community_Involvement/Pacific_Center_for_Special_Care_\(PCSC\)/Projects/Virtual_Dental_Home_Demonstration_Project.html](http://www.dental.pacific.edu/Community_Involvement/Pacific_Center_for_Special_Care_(PCSC)/Projects/Virtual_Dental_Home_Demonstration_Project.html).
31. The HIV/AIDS Program: Community-Based Dental Partnership Program. Health Resources and Services Administration. Accessed on 4/15/11 at: <http://hab.hrsa.gov/publications/cbdpp08>.
32. Patient Protection and Affordable Care Act, P.L. 111-48.
33. US Department of Health and Human Services, Centers for Medicare and Medicaid Services, Center for Medicare and Medicaid Innovation. About Us. Accessed 3/5/11 at <http://innovations.cms.gov/about-us>.
34. Patient Protection and Affordable Care Act, P.L. 111-48.
35. Ibid
36. Several of these strategies were provided by the National Academy for State Health Policy and obtained as part of their ongoing work to advance medical homes in state Medicaid and CHIP programs.
37. Texas Health and Human Services Commission. Medicaid Health Home Pilot Project RFP # 529-10-0057. Accessed 3/5/11 at <http://www.hhsc.state.tx.us/contract/529100057/Docs/RFP529100057.pdf>.
38. As of February 2011, funding for Texas’ Health Home pilot initiative is pending legislative approval.
39. Minnesota Plan to Reduce Oral Disease and Achieve Optimal Oral Health for All Minnesotans: 2011-2020 (Draft).
40. I-Smile™ Page. Iowa Department of Public Health Oral Health Bureau. http://www.idph.state.ia.us/hpcdp/oral_health_ismile.asp.
41. Deinard A., Chris Contrell, et al. Caries Prevention Service Reimbursement Table. American Academy of Pediatrics Oral Health Initiative, Medicaid/SCHIP Dental Association and Nation Academy for State Health Policy. Updated 4/6/11. Accessed on 4/20/11 at <http://www.aap.org/commpecds/dochcs/oralhealth/pdf/Caries-Prevention-Chart.pdf>.
42. Acharya A. Improving the Quality of Oral Health Care for Child and Adults through Health Information Technology and Informatics: Initiatives at Marshfield Clinic/Family Health Center of Marshfield, Inc. Expert Panel meeting on Quality Oral Health Care in Medicaid through Health Information Technology. January 19, 2011.