Bridging the gap in medical and oral health care - the past and the future

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Chief Dental Officer, Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services

 Programs like Piedmont Health Services, where dental services for children are integrated into WIC and medical departments, can maximize their impacts through collaboration.

Why is oral health care usually viewed as separate from traditional medical care? For reasons not easily understood, oral health care and medical care are not thought of as connected. Think about “health” insurance and you will probably find that everything above the hyoid bone has not necessarily been included. Other than the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit for children and adolescents in Medicaid and CHIP which provides dental, vision, hearing and mental health, the majority of private insurance usually offered these as optional benefits, at additional cost.

The reason may be based in the founding, in 1840, of the first dental school, The Baltimore College of Dental Surgery. Prior to the founding of the dental school, dentistry was considered a specialty of medicine, with students first completing medical education, and then specializing in dentistry, sometimes referred to as “stomatology.” Separating dental education from medical education may have led, in part, to separating the mouth from the rest of the body.

Fortunately, in recent years the medical and dental community are building bridges across these two important fields – and noting that this bridge should be a two-way street. Our medical colleagues usually see infants in their offices well before the recommended age one dental visit. This provides a perfect opportunity to assess oral health as a routine part of the infant’s or child’s physical exam.

Our medical colleagues understand that

NOTE: The NNOHA newsletter is for information sharing & discussion purposes. NNOHA does not endorse all included viewpoints or authors.
Our medical colleagues understand that the mouth and teeth are a fundamental part of keeping their patients healthy. New billing codes (CDT 0190 and 0191) allow reimbursement for screenings and assessments when performed by physicians or other non-dental professionals. It is our hope that states will use these procedure codes in various settings to go beyond the oral assessment that is part of the well-child exam and conduct a risk assessment on children at risk of dental caries, and more importantly, refer them to dental providers for dental care.

In addition to screening for oral health status, medical providers can also apply fluoride varnish to a child’s teeth, as appropriate, and many state Medicaid and CHIP programs will train and reimburse physicians for this service. As dental providers, we should support these collaborative efforts that lead to healthier mouths and better health for children.

Dental-medical collaboration also occurs when dental professionals work with our medical colleagues for consultation and care coordination. Dentistry does not presume to treat diabetes or hypertension, but we must work with our patients’ other health care professionals to ensure that the patient is receiving the most appropriate care – care that moves the patient toward better health. Careful review of the patient’s health history and medications will help us understand how dental care can be tailored to specific chronic, as well as acute conditions, without compromising medical treatment.

We and our many health provider partners across the country have the opportunity to improve health every day – and yes, that does include oral health.

Editor’s Note: This article was originally written in February 2014 as part of a series on the National Children’s Dental Health Month. Dr. Mouden, with almost 40 years of background in private practice and dental public health, now serves as Chief Dental Officer for the Centers for Medicare & Medicaid Services.

Advocacy

Early experience of a dental therapist employed by an FQHC

Jane Koppleman, Senior Officer
Pew Children’s Dental Campaign

How can FQHCs make use of dental therapists, an emerging workforce addition to the traditional dental team, and does it make good business sense to hire them? The Pew Charitable Trusts addresses these questions in a report, to be released in May that chronicles the experience of the People’s Center FQHC in Minneapolis, MN, the first FQHC in the nation to hire a dental therapist.

Dental therapists are midlevel providers who deliver preventive and routine restorative care, including fillings. Currently, dental therapists are operating in two states in the U.S., Alaska and Minnesota, and an additional 15 states are considering their utilization. Compared to dentists, dental therapists require less education, perform fewer procedures, and command lower salaries. Research has confirmed that they provide high-quality, cost-effective routine care.¹

The Minnesota legislature authorized dental therapists in 2009 to help address significant

gaps in access to dental care, particularly in rural areas of the state. People’s Center is located in Minneapolis, Minnesota and had over 34,000 patient visits in 2012, 8,906 of which were dental. According to the FQHC staff, 24 percent of patients are uninsured and 62 percent are on publicly-subsidized insurance. Eighty-two percent of the clinic’s patients are from communities of color and 22 percent are not native English speakers.

Peggy Metzer, CEO at the time of the study, described why People’s Center became the first FQHC to hire a dental therapist. Faced with a high demand for dental care, the clinic needed to find a way to serve more patients within its limited budget. Additionally, the clinic wanted to offer extended hours to meet the needs of its working-poor population, but in the local area it was difficult to find enough available dentists to work those hours. According to Ms. Metzer, “it’s becoming more and more difficult to recruit and retain dentists. We find that our dentists don’t want to spend all their time doing fillings, extractions and periodontal work. But routine restorative services are high in demand.”

The People’s Center dental director during this study recalled that initially, he was unsure about bringing a dental therapist into the practice. “I was a little hesitant about their training and I wasn’t sure what kind of treatment dental therapists would be able to provide and what they would be able to do,” he said. “Basically I had no idea what their place in a dental office [was] until we had one. It turned out that it’s been a great help… if I can put all my filling patients on the side, then I have more freedom. I can pick up more crown and bridge cases or root canal cases.”

In her first year at the FQHC, the dental therapist conducted 1,756 patient visits, seeing an average of seven patients per day, without the help of a dental assistant. She spent most of her time providing fillings, fluoride rinses, placing sealants, and performing some primary teeth extractions. She assessed new patients and saw walk-ins with urgent needs, in both scenarios describing the patient’s circumstances to a supervising dentist who then developed a treatment plan for her to implement.

In terms of her contribution to the clinic’s bottom line, the dental therapist more than covered her costs of employment through revenues generated. In one year, her employment costs (salary, benefits, taxes, dentist supervisory time, and supplies) came to about $137,000. Factoring in that 65 percent of her visits were paid for by Medicaid with a 25 percent Medicaid collection failure rate, the Health Center collected an estimated $167,000 in Medicaid revenues alone based on its PPS encounter rate. Even before factoring in the revenues generated from the remaining 35 percent of her patient visits, the dental therapist generated about $30,000 more in revenue than her employment costs.

An estimated 1,198 FQHCs across the United States operate a dental program and are the centerpiece of the nation’s oral health care safety net. With more states considering dental therapists to help expand access to dental care, FQHCs may consider using these midlevel providers to help them provide care to more people in a sustainable manner. For more information on Pew’s case studies or on dental therapists, please visit, [http://www.pewstates.org/projects/childrens-dental-policy-328060](http://www.pewstates.org/projects/childrens-dental-policy-328060).

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Editor’s Note: NNOHA supports development and evaluation of workforce innovations that expand access to oral health care. The newsletter has continued to explore different workforce models to highlight different perspectives. Read the NNOHA policy statement on workforce, approved by our Board of Directors, for more information.

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2 Estimate based on 2012 UDS Data. Health Centers were assumed to have an onsite or internal dental program if they provided over 500 dental visits annual or employed at least .5 FTE dental providers.
NNOHA’s National Primary Oral Health Conference
Disney's Coronado Springs Resort, Lake Buena Vista, FL
August 17-20, 2014

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For additional information, please visit:  http://www.nnoha.org/events/npohc/
Public-private partnerships: A model that benefits all

Jason M. Roush, DDS
Dentist, Jason M. Roush D.D.S., Inc

I am a private practice dentist and have owned my own practice for over 14 years. During that time, I have had the pleasure of meeting and treating a variety of patients from all walks of life. In 2004, I was approached by a local Federally-Qualified Health Center (FQHC) in West Virginia to develop a partnership that would provide preventive dental services in the public school setting. Initially, I was apprehensive due to my unfamiliarity with school-based services, but I decided to give it a try.

Once I began working in the schools I noticed that this decision was professionally beneficial to me and my practice as a whole. I provided services coordinated through the FQHC on Fridays and operated my private office Monday through Thursday. The FQHC handled all of the administrative work, including contacting the schools, scheduling the visits, obtaining parental consent, arranging support staff, and billing. My only responsibility was providing much-needed professional dental services to children at school.

In my experience, this set up can benefit not only the provider, but also the community and the FQHC. For a private dentist who partners with an FQHC the benefits include: increasing revenue, acquiring new patients, and creating a sense of gratification through increased access to dental care in my local community.

The community benefits because barriers for children who may not otherwise receive care are reduced, and there is a decreased loss of valuable student instructional time due to dental pain and/or travel off-site to receive dental care.

The FQHC’s benefits can include: immediate access to an experienced community dental provider, creation of an automatic dental referral network, bypassing the hiring process of a full-time staff member, and fostering improved health outcomes for patients.

There are different options for partnering for both for private dentists and the FQHC. The arrangements between FQHCs and dentists can vary on a contract by contract basis. Dentists can be paid hourly, a base rate, or per diem – it just depends on the needs of the area and works best for all involved.

The concept is innovative, leaving room for both entities to customize the partnership to fit their individual needs, as well as the needs of their community. Working together, the private dentist and the FQHC can provide comprehensive health care and improve the health of all patients served.

Editor’s Note: In January 2014, NNOHA conducted a webinar, “Contracting with Private Practice Dentists: Partnerships for Access.” The recording of the webinar, as well as the PowerPoint slides, are available on the website at: http://www.nnoha.org/resources/access-to-care/partnerships/.
The National Primary Oral Health Conference, August 17-20, 2014, in Lake Buena Vista, Florida, offers several special sessions and networking opportunities that require pre-registration. The titles below will take you to a description of the session and a full listing of all sessions requiring pre-registration.

- Intensive Clinical Learning Session: Cariology 101
- Fundamentals of Leading a Health Center Oral Health Program
- Digging Deeper: Staff Motivation
- Digging Deeper: Maximizing the Impact of Your Dental Program
- And many more!

Visit the [conference website](#) to see a full list of sessions to pre-register for, view the draft agenda, information on hotel and travel, and to register. Early bird rates end July 18th, so register today!

Don’t forget that NNOHA members get a $50 registration discount and you can add your membership to your conference registration. [Click here](#) to learn about all the benefits of a NNOHA membership.

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**Member Spotlight**

**North East Medical Services (San Francisco, Calif)**

Cordelia Achuck-Saito, DDS, Dental Director, North East Medical Services
Maria Smith, MPA, Project Coordinator, National Network for Oral Health Access

For this article, NNOHA interviewed Cordelia Achuck-Saito, DDS, the Dental Director at North East Medical Services, a Health Center serving medically underserved populations in the San Francisco Bay Area, Calif.

**When did your Health Center start?**
North East Medical Services opened its doors in 1971 in response to the lack of adequate, culturally competent health care services for the underprivileged and uninsured Asian community. Our mission is to provide affordable, comprehensive, compassionate, and quality health care services in a linguistically competent and culturally sensitive manner to improve the health and well being of our community. The Health Center has a “one stop shop” health care delivery approach; our services include primary medical care, outpatient medical specialties, ancillary services, and patient eligibility assistance. We have ten clinics in the San Francisco Bay Area: seven sites in the City and County of San Francisco, two in Santa Clara County, and one in San Mateo County.

The dental department has been serving patients since January 1971. Currently, we offer dental services at two sites, one in San Francisco and the other in San Jose. Our seven dentists and one dental hygienist provide preventive and emergency services, oral exams, prophylaxis, sealants, fluoride treatment, restorative services, oral surgery, and rehabilitative services.

**What is your community like?**
The San Francisco Bay Area is home to a large number of foreign-born individuals and diverse ethnic groups. At 34 percent, Asians
are the second largest ethnic group in San Francisco, and this percentage is growing every year. This urban population usually requires health care that meets their cultural and linguistic needs, and we at North East Medical Services do our best to meet those needs. Our patient population is 90 percent Asian, 53 percent uninsured, 51 percent have incomes below the Federal Poverty Level, and 14 percent are over the age of 65.

What challenges do you face that might be different from other Health Centers and safety-net clinics?
One of the largest obstacles faced by our patients in accessing health care is a language barrier. About 85 percent of our patients are best served in a language other than English. When patients do not receive health services in their language, it can lead to an increased risk of non-adherence to treatment and follow-up care. To tackle this challenge, the Health Center hires dental providers and dental assistants who are bilingual in Cantonese or Mandarin. In addition, some staff speak two or three Chinese dialects.

Moreover, the majority of our patients are recent Asian immigrants who may not be aware of the value of preventive oral health care. For example, many patients believe that the best or only way to eliminate a toothache is to pull the tooth. Our goal is to gradually change this belief by providing linguistically and culturally appropriate oral health education through outreach to the community and in-reach to existing patients.

What are you doing well that you would like to share with us?
We have developed flexible and creative scheduling to accommodate both scheduled appointments and walk-ins. Our no-show rate is only 10-12 percent. Some of the strategies we use to keep a low no-show rate include sending an automated reminder two days in advance so patients can confirm or cancel appointments, manually calling patients a day in advance if they do not respond to the automated reminder, and generating a list of patients who have flexible scheduling for on-call appointments.

Do you have any strong partnerships in the community?
In-kind contributions from community agencies and health organizations have been of great assistance to us. Thanks to donations from the California Dental Association Foundation and the Henry Schein Cares Foundation we have reduced overall spending on dental supplies, which has freed up additional funds for direct patient services and patient education to promote oral health in the community.

We are in our third year of partnering with Lutheran Medical Center’s Dental Medicine Residency Program to serve as a host site for residents. We have also served as a training site for City College of San Francisco dental assisting students. We hope that by partaking in these programs, we can increase interest in serving the oral health needs of underserved communities.

How do you interface with the medical department?
We work with the pediatrics and OB/GYN departments to make sure they refer pregnant patients, infants and children to our dental department. We also collaborate with the Health Education department to host interactive oral health education programs for young children on-site at the Health Center. Our staff uses fun activities and story time to encourage good oral health habits and proper oral health care, and to provide free screenings.

Why did you join NNOHA?
When I assumed the role of Dental Director at North East Medical Services in 2005 I knew only a few other dentists working in the public health arena. NNOHA connected me to other Health Center dental providers with similar backgrounds and interests. NNOHA is where I first found a reliable forum to seek answers and advice on Health Center dental operations.
I wish my dental school had offered courses in dental program operations for me to have been better equipped to run my dental program from the beginning of my career.

What would you like decision makers in DC to know about Health Centers and safety-net clinics?

Good oral health is an essential component to maintaining overall health. Poor oral health has been linked to increased risk for cardiovascular disease, diabetes, and other chronic conditions. Many patients understand the importance of choosing a primary care provider to manage their medical health; however, it is equally important to choose a primary dental provider who can follow through with their oral health needs. I hope that Health Centers and the federal government can work together to raise awareness of the importance of oral health care.

What is on your wish list for the future?

My goal for the future is to add several satellite dental clinics so that patients have shorter travel times to the clinics. I also hope to work more closely with our pediatrics department to strengthen our existing referral process so that we can ensure that 100 percent of pediatric patients have a dental home. Ultimately, my wish is that all children within our population service area have a dental home, not just those being served by North East Medical Services.

A special thank you to Cordelia Achuck-Saito, DDS and Anh La at North East Medical Services for contributing to this article.
NNOHA Updates

NNOHA President named WCN Clinician of the Year:
Huong Le, DDS, MA, Dental Director of Asian Health Services and NNOHA President, has been selected by the Western Clinician’s Network Board of Directors for the 2013 Clinician of the Year Award. As the recipient of that award, she was recognized at the Annual Awards Luncheon on Tuesday, April 29th at the Arizona Grand Hotel in conjunction with the Region IX Clinic Leadership Institute. For more information on the award see the Western Clinicians Network website.

Staff Change:
NNOHA said goodbye to Marija Osborn, NNOHA’s former Policy Analyst, at the end of April. Marija made significant contributions in expanding NNOHA’s policy and advocacy activities, reviving the Advocacy and Strategic Partnerships Committee, and implementing NNOHA’s communication strategies, such as launching the new website. We wish her the best of luck in her future endeavors as she moves on to the next steps in her career at the Colorado Community Health Network.

News Alerts

Health Center Expanded Services Supplemental Funding:
The FY 2014 Affordable Care Act Health Center Expanded Services supplemental funding opportunity will be open to current Health Center Program grantees and will support increased access to comprehensive primary health care services, including oral health, behavioral health, pharmacy, and/or vision services, at existing health center sites. BPHC expects to open the supplemental funding applications in May 2014. For more information, visit: http://www.hrsa.gov/grants/apply/assistance/es/.

National Maternal and Child Oral Health Resource Center Warehouse:
The contract for HRSA’s warehouse will end on June 2, 2014. This news significantly impacts the distribution of materials produced by the National Maternal and Child Oral Health Resource Center (OHRC). Although they hope to maintain limited warehouse and distribution capacity, the future of such service is uncertain. We encourage you to order printed OHRC materials as soon as possible using the online order form. You may order single or bulk copies and there is no charge for the publications. If you have questions about placing an order, please contact Sarah Kolo.
Upcoming Conferences & Events

Register today for NNOHA’s 2014 National Primary Oral Health Conference, August 17-20, 2014 at Disney’s Coronado Springs Resort, Lake Buena Vista, FL!

- Early Bird Rates (through July 18th):
  - NNOHA member - $449
  - Non-NNOHA member - $499
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  - NNOHA member - $499
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2014 National Medicaid and CHIP Oral Health Symposium
Hosted by the Medicaid-CHIP State Dental Association
June 8-10, 2014
Washington, DC

2014 USPHS Scientific and Training Symposium
June 10-12, 2014
Raleigh, NC

American Dental Hygienists’ Association’s 91st Annual Session
June 18-24, 2014
Las Vegas, NV

Association of Clinicians for the Underserved Annual Conference and Health IT Forum
June 25-27, 2014
Alexandria, VA

Academy of General Dentistry Annual Meeting & Exhibits
June 26-29, 2014
Detroit, MI

2014 National School-Based Health Care Convention
June 29-July 2, 2014
Seattle, WA

National Dental Association Convention
July 25-29, 2014
New Orleans, LA

Henry Schein Business of Dentistry Conference
August 7-9, 2014
Las Vegas, NV

Hispanic Dental Association Conference & Expo
August 22-23, 2014
Las Vegas, NV

2014 Community Health Institute & Expo
Hosted by the National Association of Community Health Centers
August 22-26, 2014
San Diego, CA
Organizational/University & Association Members
The following have initiated or renewed their membership with NNOHA between February 1, 2014 and May 1, 2014.

We recognize their commitment to supporting NNOHA and improving access to oral health services for the underserved.

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- Christ Community Health Services Memphis
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- Community Healthcare Network
- Community University Health Care Center
- Denver Health Medical Center
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- El Pueblo Health Services
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- La Clinica de los Campesinos, Inc.
- Lakeland Immediate Care Center
- Legacy Community Health Services
- Minnesota Association of Community Health Centers
- Missouri Highlands Health Care
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- Salina Family Healthcare Center
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