

## Oral Health Care Coordination and Effectuated Referrals

**Recorded October 27, 2020**

**Stephanie Kelly:**

Hello, everyone. We are thrilled to welcome you to today's event, Oral Health Care Coordination and Effectuated Referrals. My name is Stephanie Kelly, and I'm a program analyst at Mathematica. Mathematica is supporting CMCS with the Oral Health Learning Collaborative and Affinity Group. Next slide, please.

To start us off today, I'd like to hand it over to my colleague, Derek, to cover a few housekeeping items. Next slide.

**Derek Mitchell:**

Thank you, Stephanie. Again, welcome and thank you for attending today's information session. My name is Derek Mitchell and I will be the technical host for today's event. Before we begin, we wanted to cover a few housekeeping items. All participants logged into our session currently have their phone lines muted. We welcome audience questions throughout today's event through the Q&A pod. We will have a dedicated time at the end of this webinar to respond to any questions you might have for our presenters.

If you have technical difficulties, please use the chat pod on the right-hand side of your console to contact us for assistance. Please select "Host" in the "Send to" field when sending the chat. Finally, this meeting is being recorded and will be posted on the Medicaid.gov after the event. Now, I would like to turn it back to Stephanie. Stephanie, you now have the floor.

**Stephanie Kelly:**

Thanks, Derek. Next slide.

Before we begin today's event, we'd like to learn a little bit about who you, our webinar participants, are. You will see a poll open on the right-hand side of your screen above the Q&A pod. You will have 30 seconds to respond. Please let us know which type of organization that you represent. You can select all that apply. The poll should now be open. Your choices are; A, state Medicaid or CHIP agencies; B, health or dental plan or health system administrator; C, dental provider; D, other health care providers; E, community or advocacy organization; F, other state or local agency; G, federal agency; or H, other. When you make your selection, please be sure to hit the "submit" button on the lower-right hand corner of your polling pod.

Thanks everyone. The result of today's poll indicates that we are joined largely by our state Medicaid and CHIP colleagues. We also have a number of other state and local agencies represented, as well as health or dental plans and community or advocacy organizations, and a few others. It's so great to see such a variety of participants in today's event. Next slide, please.

I will now turn it over to Andy Snyder from CMCS to take us through some introductory remarks and walk through the agenda. Andy?

## Andy Snyder:

Thanks so much, Stephanie, and thank you all for making the time to be with us today. This is our last kind of run-up webinar before the expressions of interest are due for our learning collaborative, and I'm very excited that we have been able to share some information with you in advance of that offering, and I'm hopeful that all of the Medicaid and CHIP state folks that are on are having their interest peaked and will join us for the learning collaborative.

So, I'm Andy Snyder. I am the lead for CMS's Oral Health Initiative work, which has the goal of increasing the percentage of Medicaid-enrolled kids that are receiving appropriate preventive dental care. My colleague, Dr. Natalia Chalmers, dental officer with CMS, sends her regards. She's not able to be with us today due to another commitment with the American Public Health Association. But, we do have a great set of presentations for you to lay out a couple of different approaches to the question of if you are working on early prevention for kids, especially related to fluoride varnish programs, what do you do to assure that kids with identified needs are able to be referred effectively for dental care to have those needs tended to?

So, first, we're going to hear from New Jersey about New Jersey Smiles, expanding access to preventive dental care in New Jersey FamilyCare, and we are joined by Dr. Bonnie Stanley, who is the dental director for the New Jersey FamilyCare Program that includes the Medicaid, CHIP and Medicaid Expansion Program for the state. In her position, she administers and manages the comprehensive dental program, and works with and monitors the activities of the five New Jersey FamilyCare MCOs. Prior to that position, Dr. Stanley was a clinical dentist, working in private practice, hospital-based clinics, FQHCs, and at the Community College of Baltimore's Dental Hygiene Program. Following that, we are going to hear about medical and dental care coordination in Colorado, from the FQHC context, from Dr. Patty Braun.

Dr. Braun is a professor of pediatrics, public health, and dental medicine at the University of Colorado and has practiced pediatrics at Denver Health, a large safety-net healthcare system for over 25 years. She's the chair of the American Academy of Pediatrics, Section of Oral Health Executive Committee and project director for the HRSA-funded Rocky Mountain Network of Oral Health Integration.

Following that, we'll have a discussion and Q&A session that will be facilitated by Stacey Chazin with our Mathematica team, and then we'll have a wrap-up, where Stephanie will share some next steps and reminders for you. Next slide.

So, this webinar, as I stated, is part of a larger series. Our previous events included events on silver diamine fluoride, fluoride varnish in non-dental settings, and information about the upcoming affinity group offering. Webinar materials such as slides, transcripts, and recordings are available on demand at [Medicaid.gov](https://www.Medicaid.gov), at the same link that that you probably used to register for this event.

As I mentioned, the affinity group expression of interest forms for our state Medicaid and CHIP teams who would like to apply for our affinity group offering, those are due on November 18th, 2020. We will then review those applications and will notify successful applicants of their acceptance to the affinity group in December, and we are planning to begin those affinity group activities in January of 2021. If you've got any questions about the Advancing Prevention and Reducing Childhood Caries in Medicaid and CHIP Learning Collaborative or the affinity group, please e-mail the TA mailbox at [MACQQualityimprovement@mathematica-mpr.com](mailto:MACQQualityimprovement@mathematica-mpr.com). We want to make sure that we address any of those questions in advance of the expression of interest submission deadline. Next slide.

And just as a reminder, the goal for our affinity group is to support state Medicaid oral health teams over two years to improve the use of fluoride treatments. Participating state teams will have the opportunity to expand their knowledge of oral health policies, programs, and practices; develop, implement, and assess a data-driven quality improvement project; network with your peers; and advance your knowledge and skills in quality improvement methodologies. We're really hopeful that a lot of states will be interested and submit those expression of interest forms, and we are really looking forward to working with a group of you on that. But now, next slide.

Let me go ahead and turn things over to Dr. Stanley to talk about New Jersey's experience in Expanding Access to Preventive Dental Care in New Jersey FamilyCare. Dr. Stanley.

### Dr. Bonnie Stanley:

Thank you, and hello to everyone. I would like to thank CMS and Mathematica for the opportunity to share the work we're doing in New Jersey as our New Jersey Smiles programs to reduce the incidence of caries early in the life of a child through access to preventive dental services by primary care practices or PCPs. And when I say that, I'm referring to both pediatric and family medical practices. Next slide, please.

As of July 2020, the total population in New Jersey was 8.9 million. There were 1.8 million residents enrolled in New Jersey FamilyCare Program, which represents 20.3 percent of the population, and of those enrolled, 813,000 were children. Next slide, please.

In 2010, New Jersey began investigating the opportunity to increase access to preventive oral health care by allowing PCPs to apply fluoride varnish on the teeth of young children enrolled in New Jersey FamilyCare Managed Care Plans. Our reasons for considering this were based on several things. There is limited access to publicly fluoridated water in New Jersey. PCPs have the opportunity to provide fluoride varnish early in a child's life, because they see children up to 12 times between birth and the age of three years old for well child visits. This is both earlier and more frequently than children this age are seen by a dentist. As a result, this allows PCPs to begin early intervention and prevention soon after the eruption of the first tooth.

Additionally, during the well child visit, the PCP has the opportunity to begin the conversation with parents and caregivers on the importance of oral health for overall health, to educate families on the role and importance of the dentist as a member of the health team for comprehensive oral care that includes comprehensive oral evaluation to assess oral development and disease, as well as to provide needed dental care. Based on that established relationship of trust between the family and their PCP, the parent and caregiver is more likely to follow that recommendation and take their child at an early age for a dental visit, and it allows a child to become comfortable with having oral assessments and receiving preventative care.

Internal meetings were held concerning the benefit and policy to allow non-dentists to apply fluoride varnish. Once these were established, they were shared with our New Jersey FamilyCare MCOs, followed by external meetings to obtain buy-in and support from the dental community. During these meetings, our reasons, as previously mentioned, were explained, along with our goals, which were to provide access to preventive oral care for infants and toddlers, and to improve direct referrals of these young children to a dentist to establish a dental home. Next slide.

New Jersey Smiles, as a program in New Jersey FamilyCare, began January 1st of 2013, with the policies and requirements of the program being included under the EPSDT services and that year's MCO contract. Allowing PCPs to apply fluoride varnish was another step towards improving access to dental care for young children and was considered an expansion of the New Jersey Smiles Quality Collaborative to improve oral health for kids.

The collaborative started in September of 2007, and had the goal of improving oral health of young children enrolled in Early Head Start and Head Start programs by increasing access to quality dental care and establishing a dental home. While the Quality Collaborative ended in 2009, the work in New Jersey continued. So, keeping the name, New Jersey Smiles, for the next phase of our program kept the familiar name and expanded the program's purpose and goals.

A valuable outcome of New Jersey Smiles Quality Collaborative was the development of our New Jersey Smiles Directory of dentists seeing young children under the age of six. It started as a paper document, but because of this, it was only updated annually, which was problematic. To correct this, a change was made to require each MCO to post their New Jersey Smiles Directory on their website and update it as needed, and, at a minimum, annually. The New Jersey Smiles Directory continues to be a valuable resource tool for referrals. Next slide.

The Oral Health Services in the New Jersey Smiles program requires a non-dentist to provide the following five services at well child visits: oral screening assessment, completion of the American Academy of Pediatrics Caries Risk Assessment form, anticipatory guidance with the family, application of fluoride varnish, and referral to a dentist by the age of one, with follow-up at subsequent visits to determine that the dental visit occurred. Next slide, please.

The five bundled services are submitted for payment using CPT code 99188. The frequency for the combined services is, at a minimum, twice a year, and up to four times a year based on medical necessity. So, examples of this could be children with special needs or children that have been diagnosed with early childhood caries. There are no conflicts with these services between the PCP and the dentist or vice versa. The age limit for the service is through the age of three. Originally, the training for application of a fluoride varnish was limited to physicians, physician assistants, and nurse practitioners. But feedback from both the MCO dental directors and the New Jersey Academy of Pediatrics, let us know that there were practices that did not have physician assistants and nurse practitioners and as a result, this was limiting participation. So, based on this input, the revision was made to allow any licensed medical provider to complete the fluoride varnish training.

The predominant method of training on fluoride varnish application continues to be Smiles for Life, a national oral health curriculum that is online and includes training on using the caries risk assessment form, fluoride varnish use and application, and counseling with the family. The other option that we had in New Jersey was for in-person training offered by the New Jersey Chapter of the American Academy of Pediatrics that provided similar information and included but was not limited to demonstration of fluoride varnish application, assistance with incorporating the service into the practice, and assistance with billing. Following the completion of either training, a letter of attestation is submitted to the MCO to allow billing and reimbursement. Next slide.

Collaborating with the New Jersey Chapter of the American Academy of Pediatrics Oral Health Unit continues to be an asset for not only the New Jersey Smiles Program but for the New Jersey FamilyCare Program. They facilitated meetings to discuss application of fluoride varnish by PCPs as early as 2009. Those in attendance at those meetings included State New Jersey FamilyCare staff, as well as our New Jersey FamilyCare MCOs, dentists, physicians, and other community stakeholders. During these meetings we discuss medical and dental collaboration, developing policy to support non-dentists providing fluoride varnish, as well as reimbursement and community outreach.

The New Jersey Chapter of the AAP also shared the AAPs activities on a national level to support application of fluoride varnish by PCPs, as well as developing best practices from the AAP and the American Association of Pediatric Dentistry. They actively sought out physicians as oral health champions, and dentists as dental champions, with both participating in the in-person training. They provided outreach and engagement to PCPs to promote the inclusion of fluoride varnish application with the other required services, and once a PCP practice implemented the program, they continued to provide support and assistance as needed.

As partners, the AAP also provided useful feedback to the states and to the MCOs on the PCP experience that included successes, as well as identified challenges, which allowed us to know what was working and to address and resolve areas of concern in a timely manner.

Some examples of these that I would like to share are as follows: They advised us of frustration that the PCPs was experiencing because each of our MCOs had their own requirements for submitting claims. The solution was each MCO had to develop a factsheet to serve as a single source for their New Jersey Smiles information. The factsheet included the CPT code for billing, as well as required oral health services, the process for claim submission and the requirements, as well as listing the dental vendors for ordering the fluoride varnish. They also provided us with feedback on providers that were experiencing problems with billing so that we could follow up with the MCOs to address and resolve this.

The AAP also expressed the need for consistent communication through bidirectional referrals, and communication between the providers. This resulted in us reviewing and modifying an existing bidirectional form, which is now in draft. It's a one-page document and consists of two sections. The top section is information that the PCP completes regarding the patient information and their oral assessment findings, and the bottom half is to allow the dentist to indicate the treatment that was provided, a check-off area where treatment was completed or additional treatment is needed, as well as a section for comment. The draft is going to be a PDF fillable electronic document, because we had concerns about the referral actually being delivered to the dentist, as well as returned to the PCP.

Other areas that are being considered when we look at this bidirectional referral is the need for provider review so that we can get their input and buy-in. Also, we need to determine the level of training that is needed and how to facilitate it to support acceptance and widespread use of the form. We need to consider ways to encourage bidirectional communication between the PCP and the dental practice so that we can actually have peer coordination, and to also understand the role and responsibilities of the state, the MCOs, and the providers in making this work. Next slide, please.

While we've met challenges and work to address them, implementing any new program brings opportunities to continually grow, learn, and make needed adjustments. Let's look at some of the lessons that we've learned. The New Jersey Smiles Directory of dentists treating children under the age of six is available on the website of each MCO, but a direct referral and subsequent dental visit still do not always occur. When we talk about direct referrals, we know that they're linked to relationships between PCPs and the community dentist. This is because referrals are based on knowing the expected patient experience, the quality of care, along with the treatment outcomes. The relationship between PCPs and the community dentist need to be evaluated and ways to improve them considered and encouraged so that referrals occur.

Referrals are also affected by having the needed dental workforce. We know that both pediatric and general dentists are necessary to serve the pediatric population, but there are limited number of pediatric dentists, which means general dentists are needed to serve these young children. Ways to monitor and maintain the workforce of general dentists are being considered to ensure that dental homes are being established. System changes to integrate medical and dental claims is also needed.

Currently, we have two claim systems, one to pay services by PCP, and another one to pay services by the dentist. As a result, it's cumbersome to use claims data to report our preventive oral services received. We are also not able to identify referrals or associate them with the subsequent dental visit. Knowing this would allow us to identify health outcomes and care coordination resulting from referral and bidirectional communication between these two practices.

New Jersey will continue to work with the MCOs and network providers and the New Jersey Academy of Pediatrics to address these challenges, lessons learned, as well as to increase the workforce of PCPs offering this early intervention and preventive care, and dentists, both pediatric and general practitioners, establishing a dental home for our youngest members, because we want to improve the oral health of our children by establishing a preventive model of care early in their life. We want to continue to expand the workforce, and we want to lower the cost of care by establishing a dental home and reducing the need for dental treatment services through early prevention and intervention. Next slide.

I would like to thank everyone. Please feel free to contact me should you have questions after the webinar or just to share a story on how you've made it work in your state. I would now like to hand it back over to Andy. Thank you.

**Andy Snyder:**

Great. Thank you so much, Dr. Stanley, and I think that really highlights a lot of the areas that states need to think through carefully about engagement of your providers, thinking about your provider work force beyond the pool of pediatric specialists and the systems that need to support effective referral, and those are all things that we are going to be thinking about in our affinity group and learning collaborative. But right now, let's go ahead to the next slide.

I'm going to turn things over to Dr. Patricia Braun to talk about medical/dental care coordination in the Colorado context. Dr. Braun.

## Dr. Patty Braun:

Thank you very much. Thank you for the opportunity to present some of my work to you today. I know that this session is competing with the National Network of Oral Health conference and the American Public Health Association conference, so we really appreciate all of you who are taking the time to be on this particular webinar today.

And thank you to Dr. Stanley for a great presentation. Her presentation is music to my ears. As the AAP chair of the section on oral health, we work hard at getting medical providers to engage in providing preventive oral health services. In our last AAP periodic survey of pediatricians, only 18 percent responded that they apply for a varnish to children at well child care visits, so, we need all the help we can get to increase that number, and it's very much appreciated. Next slide.

So, the AAP, the American Academy of Pediatrics, produces the Bright Futures guidelines. Many of you are familiar with this. This is the established standard of care that pediatric medical providers are expected to follow and strongly influences the EPSDT recommendations. The Bright Futures guidelines state that the pediatric medical providers should apply fluoride varnish to children after the eruption of their first tooth and until the establishment of the dental home. Medical and dental professionals shall work in collaboration to provide fluoride varnish every six months to children at low risk for caries, and every three months for children at high risk for caries. This is really the standard of care for what medical providers are expected to do. Next slide, please.

So, to help medical providers incorporate preventive oral health services into their care, we're seeing innovations at the educational level, practice level, payment, and cultural level. Today, I'm going to briefly present some of the innovations we have been doing here in Colorado and beyond in the frame of practice. Next slide.

So, as we heard in the New Jersey FamilyCare presentation, we're leveraging those many medical visits that patients attend to try to address oral health. Per the Medical Expenditure Panel Survey, 111 million Americans visited a medical provider in the year and not a dental provider, compared to 25 million who had a dental visit but no medical visit, so we want to try to promote that medical/dental collaboration at those many medical visit opportunities. Next slide.

So, here in Colorado we're looking for opportunities to coordinate, co-locate, and integrate oral health promotion in a professional collaboration. Next slide. Across this continuum, we're finding ways to implement HRSA's five oral health clinical core competencies, very similar to what we heard from Dr. Stanley, these include caries risk assessment, which includes that clinical evaluation as part of the assessment; preventive interventions, such as fluoride varnish; or patient engagement to try to improve their oral health behaviors; bidirectional open communication with patients and patient education, and interprofessional collaborative practice with coordinated dental referrals. Next slide.

I'll give you an example of our experience here in Colorado. So, we implemented something very similar to Dr. Stanley at our large federally qualified health care system in Colorado, which is Denver Health. Denver Health has over 175,000 unique unduplicated patients, so we're quite big. In 2009, we worked with our State Health Department to implement our in our state program called "Cavity-Free at Three." The medical teams received oral health education and were coached to complete a risk assessment, apply fluoride varnish, place a referral to a dental provider, and provide oral health instruction.

On our Denver Health Quality Improvement dashboard, we tracked the number of fluoride varnishes received at visits in the individual clinic's population, and teams used this monthly quality improvement measures in that data-driven continuous quality improvement approach. We used these oral health kits, as you see here, as part of our workflow. One kit was placed with a patient or on the door of all well child care visits, and we found that it really nicely paired with the Reach Out and Read program, which promotes literacy at well child care visits and is very common and well known to pediatricians and pediatric providers who serve patients with Medicaid. Next slide, please.

So, we wanted to see if this work reduced dental decay. Bear with me on this slide. As part of the evaluation of the program, we invited a random sample of three-year-olds who were regular patients of Denver Health to come in for a dental exam by a calibrated dental examiner and complete an oral health behavioral survey in 2009, before the program started, again in 2011, when the program had been implemented in half of the community health centers within the system, and then again in 2015, when all of the health centers had received the oral health education.

In this graph, time is on the x-axis and the percent of children receiving services is on the y-axis. Looking at the green line, it took us about five years to get over 75 percent of our three-year-olds at least three fluoride varnish applications. If you look at the blue line, after two years, we maxed out our dental capacity and were able to get 30 percent of our children into a dental visit, but it was hard to get beyond that. We have a lot of patients, and we have about ten times more medical providers than we have dental providers, and this unbalanced medical to dental provider ratio is really common across many federally qualified health centers. Next slide.

So, at baseline, 46 percent of our three-year-old population had dental disease, and this number was about the same in 2011 when we had only trained half of our health centers, and the main number of fluoride varnish applications was just barely over one by age three years. We enhanced the program, and in 2015, we called in a new group of kids. Children who had received at least three fluoride varnish doses had 20 percent less dental caries than their previous cohorts, which is 11 percentage points lower. Our program is still going strong, and now almost all of the Denver Health kids are getting at least four fluoride varnishes by age three, yet, we still don't have enough dental capacity to meet our patients' needs. So, this got worse when Colorado approved a very needed adult dental Medicaid benefit in 2014, and the dentists were busy taking care of our immediate adult population. Next slide, please.

So, I'd like to tell you about our Medical-Dental Integration Project, which aims to expand access to dental services for patients who traditionally struggle to get traditional dental care, such as those that we see in our federally qualified health centers. Next slide, please.

As many of you know, in 42 states, patients can directly access a dental hygienist. Next slide.

In 2011, the Delta Dental of Colorado Foundation implemented the Colorado Medical-Dental Integration Project. We have implemented two waves of this project, and have integrated dental hygienists into medical teams into over 30 medical practices across Colorado, most of which are federally qualified health centers. Next slide.

The model extends the dental clinic into the medical clinic by promoting full-scope dental hygiene services in medical settings. These are integrated services, not co-located. For young children, the dental hygienist provides care in the same room as the medical provider, and for older patients, they are taken to the dental room, which is right in the medical clinic where they will receive services, such as dental sealants. Next slide.

The work has been supported with a learning collaborative, where peers can share experiences and best practices, and practice improvement coaches use quality improvement metrics to help build efficient workflows and meet project goals. Next slide.

Briefly, so far, our dental hygienists have provided more than 70,000 visits to a broad range of patients across all ages. Most of the patients are insured with Medicaid or uninsured, and are the patients that are traditionally most challenged with accessing regular dental care. And these patients carry the burden of dental disease. Next slide, please.

So, the hygienists have spent a lot of time and effort coordinating care to dentists. For almost half the patient visits, the patient had not seen a dental provider in more than a year, and the patients served have a lot of dental disease. Of all of these more than 70,000 visits, over half had untreated dental decay. These patient visits were navigated to a dentist for restorative care in many ways, which included a direct phone call to a dental provider who was known to the practice, a paper referral with the location and address of the dentist. In some of our health-care systems, they had the capacity to directly put a dental referral into the electronic health record. There were a few sites who got the text with the dentist and were able to text and get patients in, and then within systems where there were dentists onsite, lots of internal warm handoffs.

The dental hygienists have been tracking the referrals to see if the patient made it to the dentist. What I mean by "tracking the referrals," is that a list is kept of all the referrals and followed for up to six months, giving patients six months to receive that dental care. In systems that have integrated dental records, they can look and see if the patient attended, but, otherwise, there's a lot of manual labor put to closing that referral. This includes calling the patient to see if they were able to get in, calling the dental practice to find if the patient presented, looking into the Medicaid portal to see if a patient had attended a dental visit, and other ways to track closed referrals -- to end close referrals. Of the referrals they were able to track, 57 percent were completed for at least 18,900 referrals, and these are the ones we were able to directly track. Next slide.

Switching gears a little bit -- I'd like talk to you next about the RoMoNOH Project. So, HRSA has funded three networks of oral health within the maternal and child health safety net. The networks are supported by the National Maternal and Child Health Resource Center run by Katrina Wolf at Georgetown University, the ASTDD, the Association of State and Territorial Dental Directors, and the Frame Shift Group, which is a practice transformation group working out of Arizona. Next slide, please.

We are called the Rocky Mountain Network of Oral Health, and we're working with up to 30 federally qualified health centers across Montana, Wyoming, Colorado, and Arizona, and our focus is on young children and pregnant women. We are in year two of this five-year cooperative agreement and if any of your federally qualified health centers would like to participate in any of these three networks and aren't already, please don't hesitate to reach out to me. Next slide.

So, in summary, we've learned that the HRSA five oral health clinical core competencies can be integrated in the medical visits across the continuum of coordinated, co-located, and integrated care, and all of these models give examples of care coordination. We've also learned that one model does not fit all and that completing a needs and capacity assessment is important before you launch the work, understand which model fits and meets the patients' needs or the patient populations within the health center or clinic. We attest that these models expand access to model services, and we also attest that there is potential to improve the oral health of patient populations. Thank you.

**Andy Snyder:**

I was double muted. I apologize for that. Thank you so much, Dr. Braun. I think that was a great presentation. I think, also, it's important to note that we are well aware that there's a lot of work going on across multiple actors related to medical and dental integration out in the field, and our goal in our affinity group and learning collaborative is to coordinate with those efforts in states that apply and that are working with us over the next couple of years, and really just want to make sure that everyone is pulling in the same direction and that there's not unnecessary duplication of that effort. But that's some great experience from Colorado in the FQHC context, and the point is well taken that one model doesn't fit all cases, and we hope to be working with a group of states to help figure out how they each can make some progress, of the sort that you described here.

So, let's go ahead to the next slide, and then one more, and I will ask Stacey Chazin with our Mathematica team to take us through our discussion and Q&A section. Stacey.

**Stacey Chazin:**

Thanks so much Andy, and thank you to Dr. Stanley and Dr. Braun for your fantastic presentations. We already have a number of questions coming in. I'll remind folks to use the Q&A box toward the right-hand of their screen to add any more. Please select "All Panelists" in the "Ask" field before submitting your question or comment.

So, our first question is for Dr. Stanley. Since a referral is one of the five tasks pediatricians must provide for payment and the administrative data can't confirm whether a referral occurred, how does New Jersey confirm referral to a dentist to ensure payment?

**Dr. Bonnie Stanley:**

Well, in our program, your payment is not contingent on the referral. Your payment is based on providing those five services. Does that answer the question?

**Stacey Chazin:**

So, if the referral is one of the five, I guess the question is, how does the provider prove that the referral was made?

**Dr. Bonnie Stanley:**

That currently is not a requirement. That is something that is being considered as we look at using that bidirectional referral.

**Stacey Chazin:**

Okay. Thank you. Our next question is for Dr. Braun. Have you considered having RDHs provide comprehensive prevention utilizing SMART, SDF and ART to treat all asymptomatic tooth decay and make referrals for all other care that falls outside of the RDH's scope?

**Dr. Patty Braun:**

Thank you for that question. Yes. So, in Colorado, dental hygienists are allowed to apply silver diamine fluoride and treatment plan silver diamine fluoride, so they're able to do that at a medical visit or at a visit within a medical setting. For ART in Colorado, a dentist has to treatment plan an ART, so hygienists can do it, but they can't treatment plan that ART. So that's a bit of an obstacle that delays care in some situations. But there are models in our state where images are taken at a visit, and then the dentist virtually reviews those and can treatment plan. We are eager for our hygienists to provide more of these noninvasive dental services. We interviewed families who were receiving SDF and ART and they strongly endorsed it. They felt they were very much in favor of the services, so we were wondering how patients would feel about that. But, largely, they endorsed the services, so that's encouraging.

Interesting, I'll mention across the RoMoNOH Project, one of the things that we're learning is just the difference in scope across all states, and as you can imagine, the scope of dental hygienists does vary state to state. But in any state where it is within their scope, we strongly support it. Not all hygienists are doing it yet, but they're gaining confidence.

**Stacey Chazin:**

Thanks, Dr. Braun. And I want to make sure that our audience is familiar with all of the acronyms that we just threw at them. So, SDF is silver diamine fluoride, RDH is a registered dental hygienist, and I'm stumped with ART. Could you tell us what that is? Go ahead.

**Andy Snyder:**

Atraumatic restorative technique, so it's glass ionomer filling materials and kind of removal of decayed tooth matter without using a high-speed hand piece. Dr. Braun, make sure I got that right.

**Dr. Patty Braun:**

Yes, that's right. I will just mention, in pediatrics -- and I'm going to mention the Covid word -- as many of you all know, dental visits were shut down earlier in the spring, but the AAP has strongly supported children coming in for their well child care visits to get those essential preventive services, like vaccines, but also, fluoride varnish. And so, our hygienists have been able to access kids at their well child care visits, which has been really, really great. In some of our settings, where there are co-located dentists, the dentists are also then called up to visit if there isn't an integrated hygienist, and, often, they are applying silver diamine fluoride, and some are doing ART, because they can do that without generating aerosol, so that's been a really valuable during this unique time.

**Stacey Chazin:**

Thank you, both. Another question, Dr. Braun, perhaps you can answer, can you share any good examples of closed-loop referrals between primary care and dental offices?

**Dr. Patty Braun:**

Thank you for that question. Well, closed-loop referrals are really important, but they are challenging. So, if there is a system that's electronic, then someone can help manage those referrals and give an update on their status. So, if the patient attended or didn't attend, if you want to call them back in, those kinds of actions. So, when you have an integrated health record, that facilitates that closure of the loop, and it also facilitates the way you can pull a registry or track your referrals to see if they have been attended or not, and then use that population health approach to identify the folks that didn't get to the dentist and have a patient navigator or somebody on your staff call them up and navigate them back in again, or that also could be navigated at a well child care visit.

In systems that don't have an integrated electronic record, it becomes more challenging, but it's absolutely doable. So, as an example, if you entered in a referral in some discreet data field in your health record, you could pull a monthly report of the patients who had received a referral and of those who had attended it, either within your system or, theoretically, outside of the system, and then focus the navigation of those folks who either were high-risk, had high level of disease, and/or didn't make it in and focus your phone calls to help navigate them into the system and try to identify the barriers. If their insurance had lapsed, they have fear, they have Covid concerns, and so then the navigator can walk through some of the barriers and help relieve them and hope that gets them in. So, it's hard to do without some human touch, but that's a really important part of closing referrals, and we do that very commonly on the medical side with the referrals that we make to a host of specialists.

**Stacey Chazin:**

Thank you, Dr. Braun. Dr. Stanley, is there anything that you'd like to add to that?

**Dr. Bonnie Stanley:**

I would add that I do know that that is occurring more within our federally qualified health centers, because they do have the electronic health record. But as Dr. Braun noted, it's really challenging when you don't have that electronic process to monitor it, and to go back retrospectively and do a chart review is also challenging. But I do like that she kept referring to health navigators and seeing that they can play a role in that closing the loop.

**Dr. Patty Braun:**

And Dr. Stanley, this is Dr. Braun, I also wanted to highlight the importance of having personal relationship with the dentist or dental provider. And so, generally, referrals are more likely to be bidirectional and you get feedback back if you have some connection with that provider, that you've got your office staff to know each other, you've got their fax number, you've got some process to actualize that bidirectional referral, and it always goes better if you've got some essence of a relationship between the two sides. The hardest referrals are when you're referring to black box, and you may not actually have met that person.

**Dr. Bonnie Stanley:**

Yes.

**Dr. Patty Braun:**

And the chapters, AAP chapters can do a really great job at bringing medical and dental providers together and just getting them to know each other. We work a lot of trying to bring those two professions together so that they can collaborate.

**Dr. Bonnie Stanley:**

Thank you. I agree.

**Stacey Chazin:**

Thank you both. Another question for either of you. How often are case managers or care coordinators utilized for outreach services and following-up with referrals?

**Dr. Patty Braun:**

I can respond to that. As much as possible. You know, it takes a staff person to fill that position, but more and more and more in medical sides, there is somebody who is helping navigate people into visits or to referrals, and so I'm finding more and more that there is somebody who is dedicated to that role in the health center or in the practice. We have, for instance, been interviewing the health centers who will be providing care who are participating in the RoMoNOH Project and asking about that, and I'm surprised that even in the smallest clinics, with very few providers, that they more commonly have someone in that role, so I think it's becoming more and more common. We always hope that there's reimbursement for those services, just a shout out for that, but that is a critical position.

I'll also just mentioned that we are encouraging our dental hygienists to go through the ADA CDHC program, the American Dental Association Coordinated Dental Health –

**Andy Snyder:**

I got this one too, yeah, Community Dental Health Coordinator.

**Dr. Patty Braun:**

Oh, thank you so much. And a lot of the things that they learn in that curriculum is how to navigate these referrals. It takes work, but it really is part of care, and it is very patient centric.

**Stacey Chazin:**

That's great. And I think you've preempted another question we got for you, Dr. Braun, which was whether Colorado has any CDHCs. So, thanks for anticipating that.

**Dr. Patty Braun:**

You bet. We don't have many, but we have some, and the number is growing.

**Stacey Chazin:**

Great. Another question we received -- and Andy, I think this one might best be answered by you -- please discuss any best practices for a dental MCO to work with local Medicaid programs that have self-administered medical coverage for beneficiaries.

### Andy Snyder:

Thanks, Stacey. Yeah, I'm not sure how applicable this is going to be to most states, since most states have most of their populations in managed care for medical services. But if you are in a situation where you've got fee for service or primary care case management on the medical side and managed care for dental, we don't have many kind of specific best practices to point to. But I imagine that the building blocks would be about the same from a dental managed care organization's perspective, you know, the other kinds of coordination we talked about here today. So, the dental MCO should be thinking about coordinating with the state Medicaid agencies throughout the whole process, work with their network dentists to make sure that those dentists are willing and able to take referrals for young kids, especially thinking about curriculum that are out there to train general dentists to treat kids under the age of five, collect and disseminate contact information for those dentists to pediatric providers. There's a possibility that the dental MCO could work with the state Medicaid agency to be an avenue for training medical practices on how to apply for fluoride varnish or do oral screenings and, of course, connecting with the state's Beneficiary Services Unit to coordinate at that level as well. I recognize that it may be a little bit more of a challenge with systems that are not integrated under the same roof or under the same managed care contract, but I think the sort of basic activities to do probably falls under the same baskets.

### Stacey Chazin:

Thanks, Andy. Do we have any other questions? Okay. Then I am going to turn it back to my colleague, Stephanie Kelly, to wrap us up.

### Stephanie Kelly:

Thanks so much, Stacey. Next slide, please. To wrap us up, one more thing. Just as a reminder, Andy went through some of this content earlier in the presentation, but today's event is part of a larger series that includes prior events on silver diamine fluoride, fluoride varnish in non-dental settings, and information about our upcoming affinity group. If you missed any of these webinars, or attended but would like to refresh your memory, materials from those events are all available on the Oral Health Learning Collaborative webpage on Medicaid.gov. And then also listed below are a few key dates related to our upcoming affinity group, most notably the due date for the expression interest form of November 18th. Next slide, please.

We did want to let everyone know about the quality improvement resources that are available through the Medicaid and CHIP Quality Improvement Open School. Open School online courses provide an overview of QI building blocks. Courses are free, and continuing education credit is available. As part of our upcoming affinity group offering, we will be strongly encouraging participating state team members to take the online courses available through Open School to prepare for and complement affinity group work. However, you can also take advantage of the Open School curriculum as a refresher or to improve your QI skills for any other project. For more information, you can visit the Open School website link at the bottom of the slide. Next slide.

Please reach out to the technical assistance mailbox, listed here, with any questions or feedback related to the Oral Health Learning Collaborative or affinity group. Next slide.

And thanks so much to our speakers, and thank you to all of our attendees for taking the time to listen in to today's event. Your feedback is very important to us, so please complete the evaluation as you exit the webinar today. Thank you.