CHCANYS DEFINING NEW DIRECTIONS
Community Health Care Association of New York State

CHCANYS' Clinical Committee's Sub-committee on Oral Health

Pediatric Oral Health in Primary Care

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AAP NY Chapter 1 COHA
December 1, 2015

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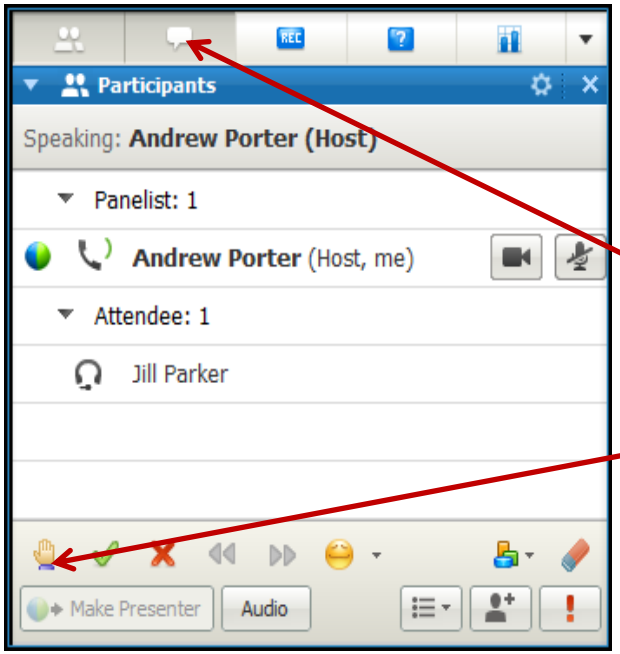

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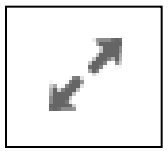

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Pediatric Oral Health in Primary Care

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Learning Objectives

- Understand the impact of oral health on the overall well-being of children
- Explain the nature of early childhood caries (ECC), risk factors, prevention methods, and consequences of untreated caries
- Review national recommendations for fluoride varnish use in the medical home
- Increase familiarity with oral health resources available to primary care providers
- Discuss integration of oral health prevention services and fluoride varnish in the primary care setting

Are We Doing All That We Can For Our Children?

Impetus for the Question

- Surgeon General's report on oral health
  - "Silent Epidemic"
  - Prevalence: Most common unmet health need
  - Oral-systemic health connections
  - Access to care
  - Cost
  - Oral health disease is largely preventable

Oral Health in America. A Report of the Surgeon General; 2000.

Periodontal Disease and Heart Health

Brushing and flossing may actually save your life.

By R. Morgan Griffin
WebMD Feature
Reviewed by Louise Chang, MD

WebMD

The Journal of the American Dental Association

Volume 139, Supplement 5, October 2008, Pages 19S–24S

The Relationship Between Oral Health and Diabetes Mellitus

Hospitalizations And Medical Care Costs In Diabetics Reduced By Periodontal Therapy

MNT SINCE 2003

Beyond tooth decay: why good dental hygiene is important

Published: Wednesday 8 October 2014 at 8am PST

Dentistry
Alzheimer's / Dementia
Pancreatic Cancer
Heart Disease

MNT featured

Most of us are aware that poor dental hygiene can lead to tooth decay, gum disease and bad breath - but not brushing your teeth could also have consequences for more serious illnesses.

Oral-Systemic Health Connections

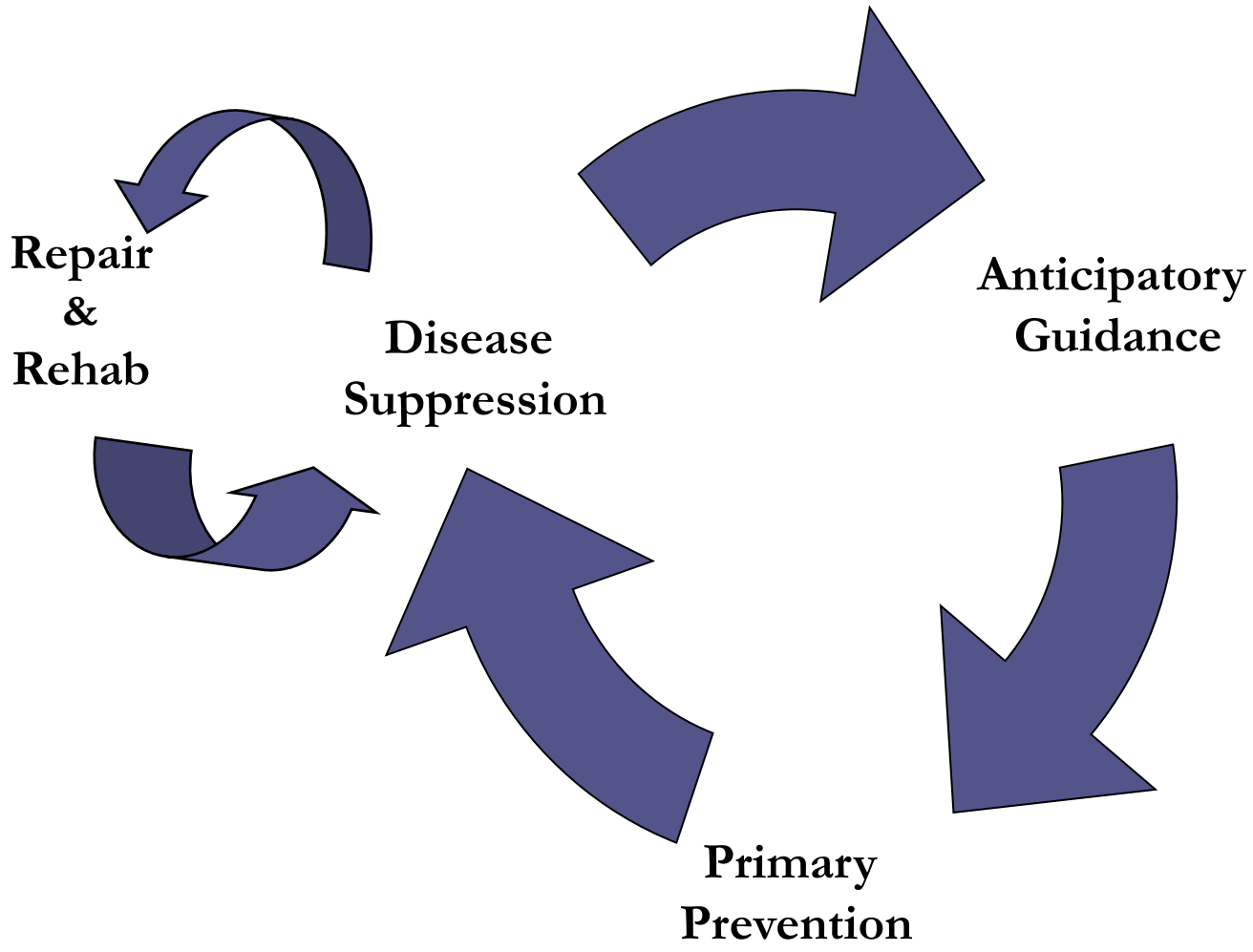
- Periodontal disease and diabetes
  - Diabetes increases the risk for periodontitis and uncontrolled periodontitis worsens glycemic control
  - Systematic reviews show periodontal treatment improves A1c by ~0.4%
- Cancer
- Xerostomia
- Coronary artery disease
- Obesity
- Pneumonia
- Pregnancy outcomes

The Big Picture

"You are not healthy without a healthy mouth…"

David Satcher, Surgeon General 2000

Medical Prevention Paradigm



Is a systems shift necessary?

- 50 million Americans live in rural or poor areas where dentists do not practice
- Senior centers – 89% of participants in NYC needed some form of dental treatment
  - 6-12 weeks following screening exams, 48% unable to access dental services
- 23% of poor children do not see a dentist by age 5
- 56% of women do not receive dental care during pregnancy
  - 76% of black non-Hispanic women & 75% Hispanic women

Courtesy of Qualis Health

Why is a systems shift necessary?

- Preventable dental conditions account for 4 million ED visits 2008-2010, total cost $2.7 billion
  - Uninsured patients account for >40 % of dental ED visits
- Dental ED visits in the U.S. increased from 1.1 to 2.1 million from 2000 to 2010 (NHAMC)
  - Dental ED visits increased from 1.06% to 1.65% of total ED visits from 2000 to 2010
  - Estimated cost of $867 million to $2.1 billion
- 2000 to 2008 - Hospitalization costs for abscessed teeth complications = $858.9 million

The Medical Home is often the default Dental Home

Existing Prevention Paradigm

- Initiate oral health preventive services in the medical home
- Referral to establish dental home by age 1
- Seems ideal…

- But is it working?

The Disconnect

- ECC remains the most common unmet health need
- 23% of poor children do not see a dentist by age 5
  - 2010 - 20% of Medicaid-enrolled children under age 3 received dental care
- Coverage gap - 108 million people in the U.S. (40% pop) has no dental insurance
  - Children are 2.5 times more likely to lack dental than medical coverage
- Public health safety nets are disappearing
- 50% of primary care providers have little or no oral health training
- Poor communication and referral from medical and dental providers

The Dentist Challenge

- Relatively few see young children
- Predominant reasons general dentists report for not seeing 0-2 yr-olds:
  - Do not believe in young dental visit necessary
  - Too young to cooperate
  - Refer children this young
  - Not trained
  - Uncomfortable with young children
  - Crying disrupts office
  - Insufficient reimbursement

Caries rates

- ~ 50% of 5-9 year olds
- 78% of 17 year-olds
- 85% of adults
- Most common chronic disease of childhood
  - 5x more common than asthma

Early Childhood Caries (ECC)

- ECC: ≥ 1 decayed, missing, or filled tooth surfaces in a primary tooth from birth through age 5

Courtesy of Dr. Martha Ann Keels, DDS

Courtesy of Dr. Rocio Quinonez

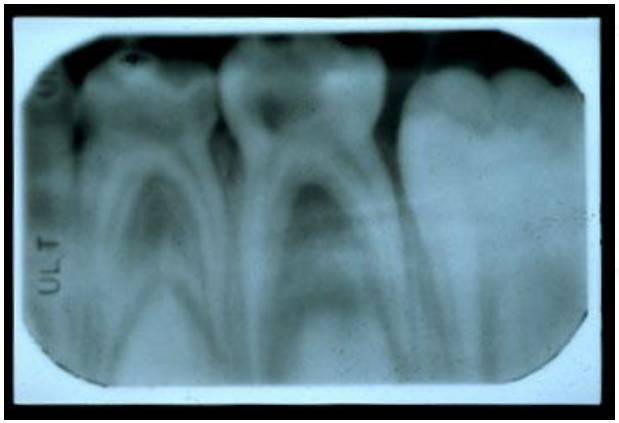
Early Childhood Caries (ECC)

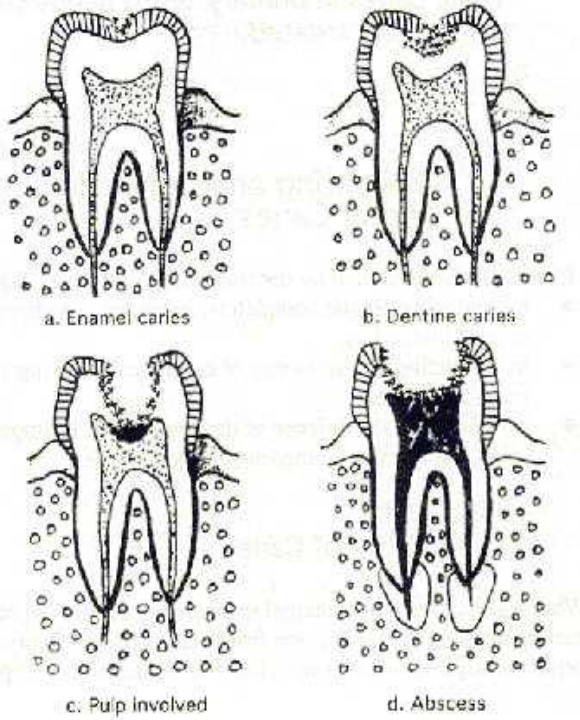
- Affects children under age 5
- Destroys tooth structure
- Infectious and transmissible
- Previously called “Baby Bottle Tooth Decay” or “Nursing Caries”
- Affected by oral and dietary habits

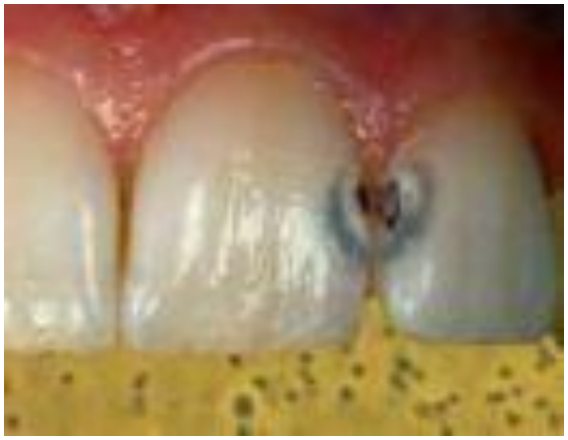
Epidemic of ECC

- ECC Prevalence
  - ~ 25% of all U.S. children
  - 30-50% of children in low income pop
  - ~70% in some Hispanic and Native American populations
- 80% of decay occurs in 20% of children

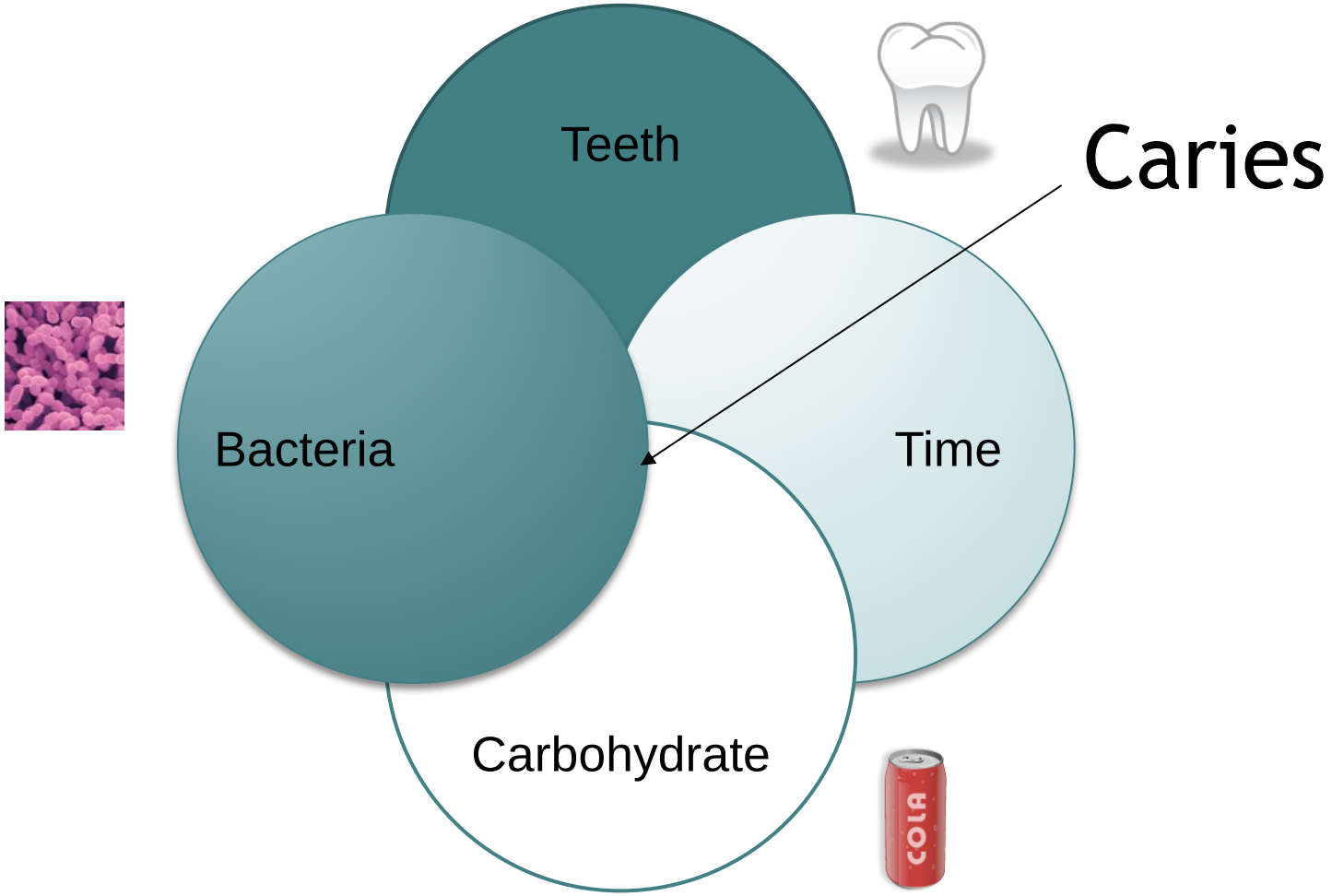
ECC Stages







Pathogenesis of Caries



What if…

we don't address ECC?

Consequences of ECC

- Pain
- Tooth loss
- Impaired chewing and nutrition
- Below average weight gain
- Infection
- Poor self esteem
- Difficulty sleeping

- Increased caries in permanent dentition
- Future dental work
  - Pain and $$$
- School/work absences:
  - 51 million school hours per year
  - Missed learning opportunities

Poor Performance

Miss School

Jackson SL, Vann WF Jr, Kotch JB, Pahel BT, Lee JY. Am J Public Health. 2011 Feb 17. Impact of Poor Oral Health on Children's School Attendance and Performance.

Slide courtesy of Dr. Rocio Quinonez

Human and Economic Costs

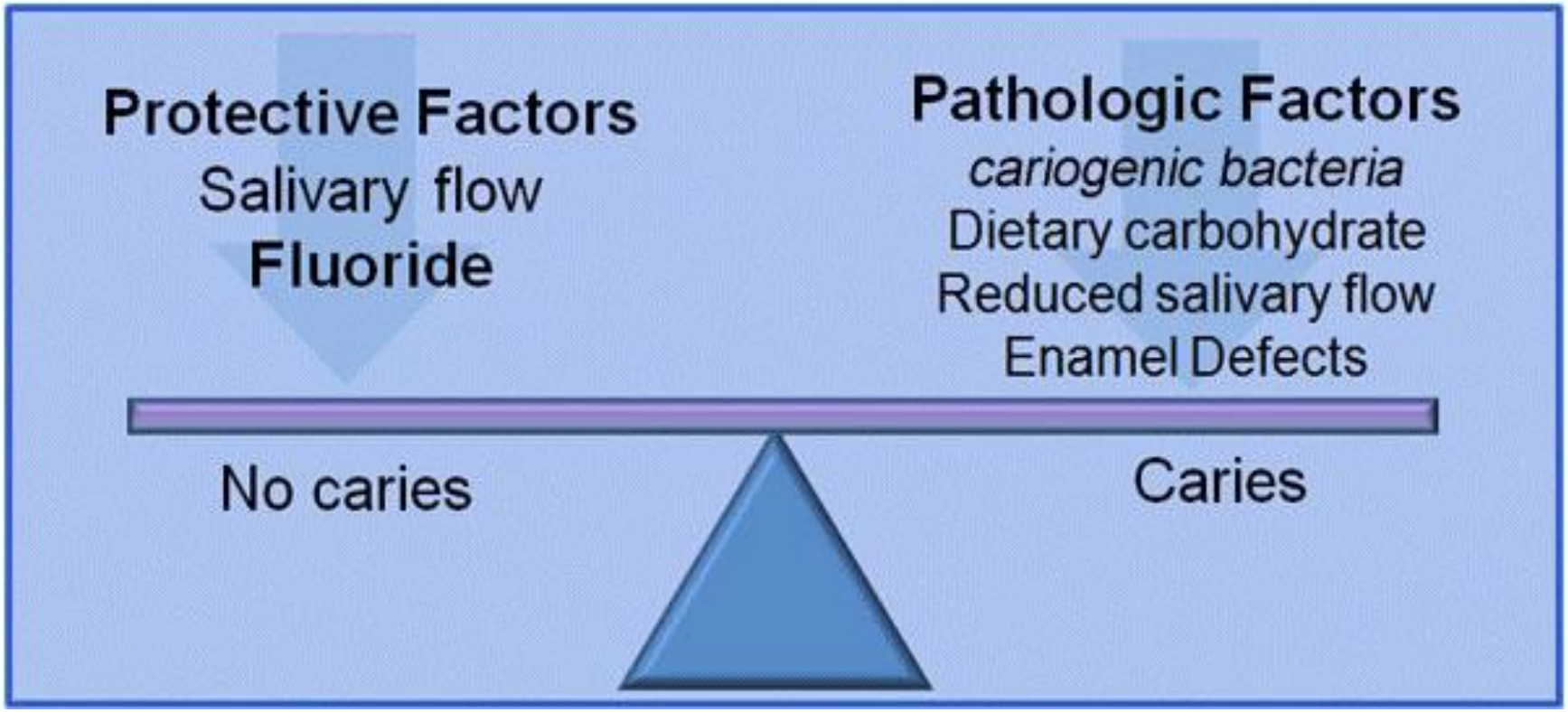
Casamassimo PS et al. JADA. 2009.

Casamassimo PS et al. JADA. 2009.

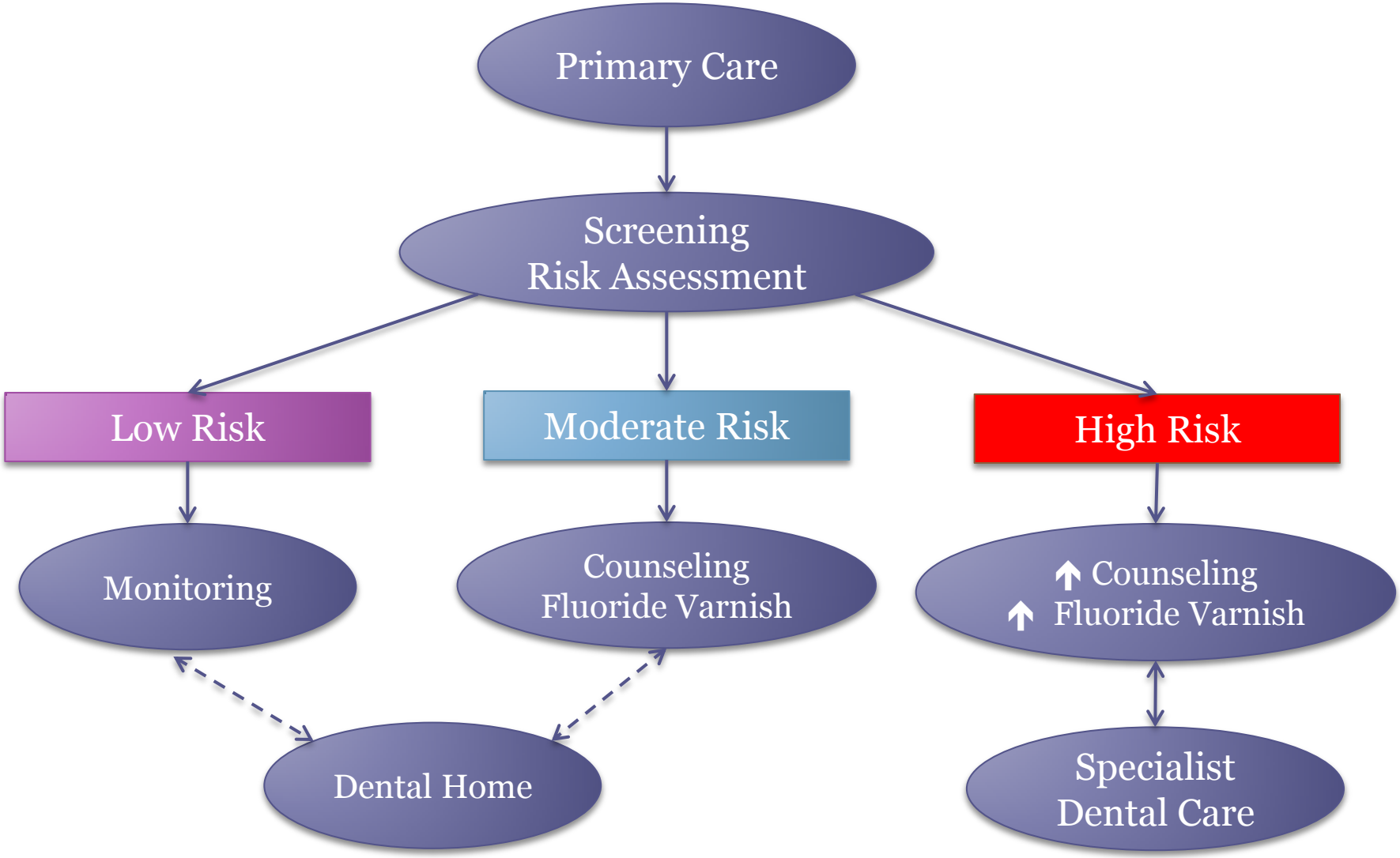
Prevention of ECC

- Tooth brushing
- Dietary counseling
- Delay Colonization
- Dental sealants
- Fluoride
- Professional consultation/referral

Balancing Act



Limited Resources - ? New Paradigm



Why PCP's?

- Primary Prevention – all of our goal
- Access
- Child has contact with a primary care provider 13 times in the first 36 months
- Familiar with implementation of risk-based care
- Expertise in education and counseling
- Engaged in overall health of the child patient, not just one facet of care
  - Oral health links to systemic disease

Screening and Risk Assessment

- PCPs can successfully identify children with ECC and those in need of referral
- Caregivers satisfied with PCP involvement
  - 92% approved of provider explanations
  - 84% reported provider spent adequate time with the child
- Risk assessment
  - No published studies examine the reliability of PCPs to detect white spots or properly use risk assessment tools
  - No studies examining whether oral screening by PCPs results in decreased caries rate
- Oral health integration into the primary care setting does not result in decreased dental visits

Pierce & Rozier. Pediatrics. 2002 Rozier, Slade et al. Pediatr Dent 2005.

Oral Health Natural Fit for PCMH

- Patient-centered
  - Whole human – mouth back in the body
  - Self management – diet and hygiene under pt control
  - Cost impact of oral health interventions limited because segregated
- Comprehensive care – eliminate silos
- Coordinated care
  - Team-based care (silo integration)
  - True integration requires:
    - Focus on counseling
    - Utilization of supporting health professionals (CHW)
- Accessibility
  - Oral health in medical home (screening, education, tx)
- Systems-based approach to quality and safety
  - Evidence-based
    - ECC and sequelae
    - Periodontal disease and chronic (e.g. diabetes)

Fluoride Varnish: A Proven Intervention

Fluoride Varnish

- Most extensive literature of PCP based preventive strategies
- Nearly all studies include oral health education
- Majority of studies emanate from “Into the Mouth of Babes” in NC

Effectiveness of Preventive Dental Treatments by Physicians for Young Medicaid Enrollees

WHAT'S KNOWN ON THIS SUBJECT: Mixed evidence exists regarding the effectiveness of preventive dental services in medical settings. Physicians and nurses are willing to provide preventive dental services, parents are satisfied with the services their children receive, and programs that encourage physician participation increase access.

WHAT THIS STUDY ADDS: Despite declines in effectiveness since fluoride treatment and referrals to dentists to treat existing disease, this study reports that oral health services by non-dental health care providers for Medicaid preschool-aged children lead to reductions in caries-related treatments.

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KEY WORDS
dental caries, Medicaid, fluoride varnish, dental treatment, preschool children, physicians

ABBREVIATIONS
ECC—early childhood caries
IMB—Into the Mouths of Babes

The content of this article is solely the responsibility of the authors and does not necessarily represent the official views of the National Institute of Dental and Craniofacial Research or the National Institutes of Health.

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abstract

OBJECTIVE: To estimate the effectiveness of a medical office–based preventive dental program (Into the Mouths of Babes [IMB]), which included fluoride varnish application, in reducing treatments related to dental caries

Effect of IMB on Dental Caries-related Treatment per 1,000 Medicaid-enrolled Children

Number of IMB Visits	Age in Months at IMB Visit	Change in CRTs (95% CI)	% Change
1	12	-7 (-85, 84)	-0.3%
2	12, 24	19 (-82, 124)	0.7%
3	12, 15, 18	49 (-88, 163)	2.9%
4	12, 18, 24, 35	-281 (-469, -58)	-10.9%
≥4	12, 15, 18, 24, 35	-458 (-623,-204)	-17.7%

Courtesy of Dr. Rocio Quinonez

Into the Mouths of Babes (IMB)

- Children with ≥ 4 visits:
  - 17% reduction in dental-caries-related treatments up to 6 yrs compared with children with no IMB visits.
  - Multiple treatments at tooth emergence most effective
- Data Simulation for initial IMB visits at 12 and 15 mths:
  - Cumulative 49% reduction in caries treatments at 17 mths
- Statewide survey:

Year	Mean dmft for kindergartners	Mean IMB visits for 0-4-yr-olds
1989	1.53	
2001		0.01
2004	1.84	
2009	1.59	0.22

  - 1-unit increase in IMB visits resulted in a 0.25 decrease in dmft per student.

Courtesy of Dr. Rocio Quinonez

Fluoride Varnish

- Topical 5% sodium fluoride lacquer professionally applied to tooth surfaces
- Resin matrix releases fluoride over 1 to 7 days (versus 10-15 min for gels/foams)
- Helps prevent new cavities and halts cavities that have already started
- Strengthens teeth and reduces decay - average 40%
  - Caries reduction range 30-63.2%
  - Dose responsive, effectiveness enhanced by counseling
  - Greatest effect when applied before onset of caries
  - Slows progression of shallow carious lesion

Rozier RG et al. *Am J Prev Med*. 2004;26:315-325.

Fluoride Varnish

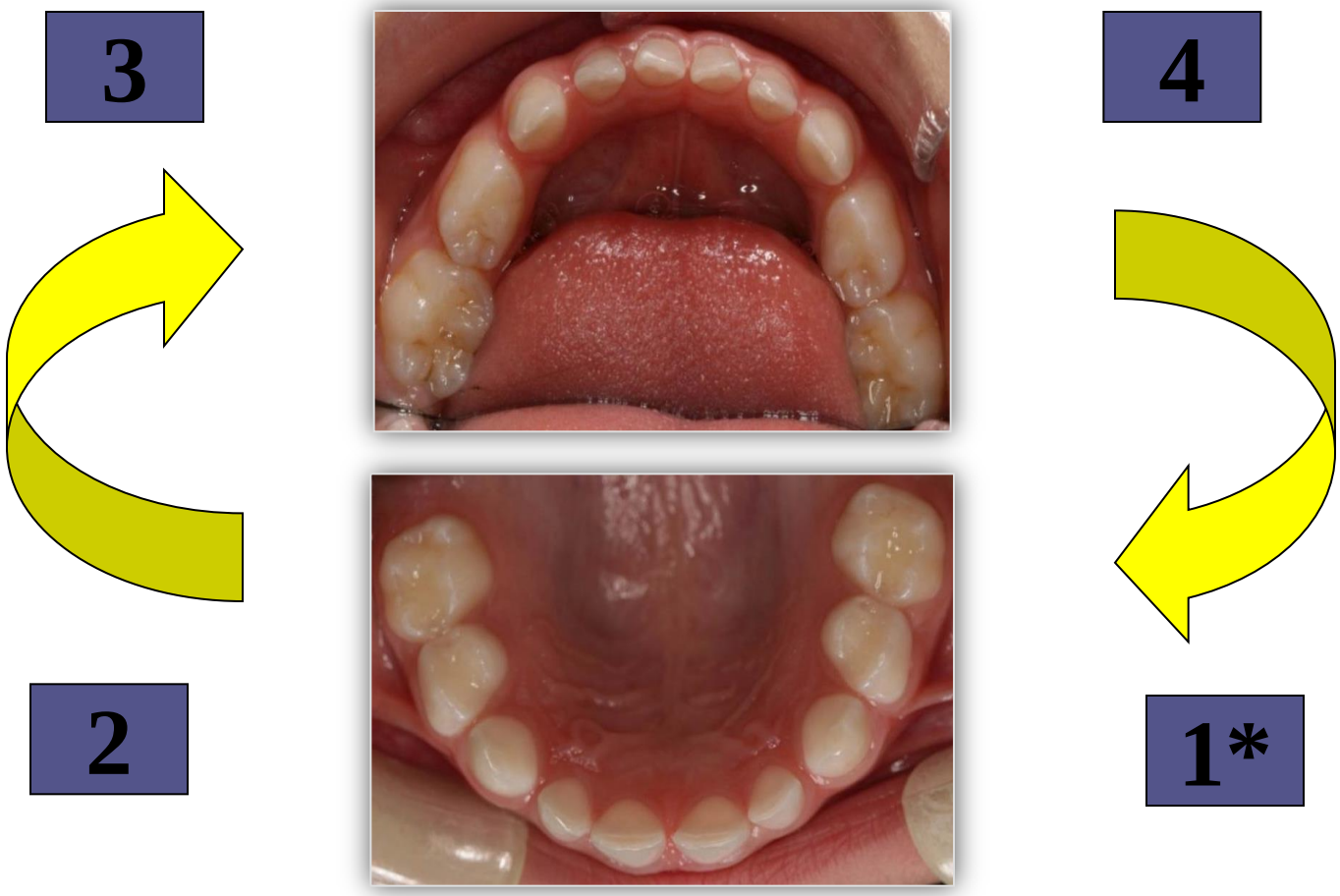
- Used in Scandinavia for >30 years
- Over 110 studies and 40 clinical trials have documented effectiveness
- Available in the U.S. for years. FDA has approved fluoride varnish as a cavity liner
- Contains 22,600 ppm, only 2.5-5 mg applied

Knee-To-Knee Exam

- **Mirror & Direct light source**
  - Otoscope, Pen light, Head lamp, Floor lamp
- **Be systematic**

Courtesy of Dr. Rocio Quinonez

Systematic Exam



Takes less than 1 minute

“Lift the lip” exam

Application

- Get everything ready (gloves, tongue blade, applicator)
- Dry the teeth with 2 x 2 gauze and apply varnish
- Dental mirror increases visibility (optional)
- Toothbrush optional
- Apply varnish on top teeth then bottom teeth, 1 dab per arch
- Lift the lip- focus on upper 4 incisor
  - Most disease in young children occurs here

Safety

- No acute toxic effects
- Plasma fluoride varnish application levels
  - Small rise in plasma fluoride levels = Comparable to ingesting 1 mg fluoride tablet or brushing with a fluoridated dentifrice
  - Low rise in urinary excretion returns to normal in 24 hours
- Use sparingly to prevent children from swallowing excess product
- Contains alcohol – vaporizes upon application
- Contraindications:
  - Ulcerative gingivitis/stomatitis, Aphthous ulcers, open lesions
  - Allergy to colophony/rosin*
  - Allergy to pine or pine nuts*
  - 3 cases in literature: 1 contact dermatitis and 2 stomatitis

Primary Care Provider Challenges

- Parents:
  - Get information outside of the health care setting
- PCPs:
  - Education re: importance
  - Recognize normal vs abnormal
  - Time and resource allocation
  - Payment
  - Consultation and referrals
    - Less likely to engage in oral health activities if feel there is nowhere to refer
  - Norm is to engage specialists when cannot manage in primary care setting

Potential Change Drivers

- Education
  - Accreditation Standards
- Policy
- Practice Guidelines
- Reimbursement
- Stakeholders (e.g. Accountable care organizations)
- Parallel systems changes
  - PCMH expansion
  - Integration momentum
    - Team-based care
    - HRSA Core Clinical Competencies
- External encouragement

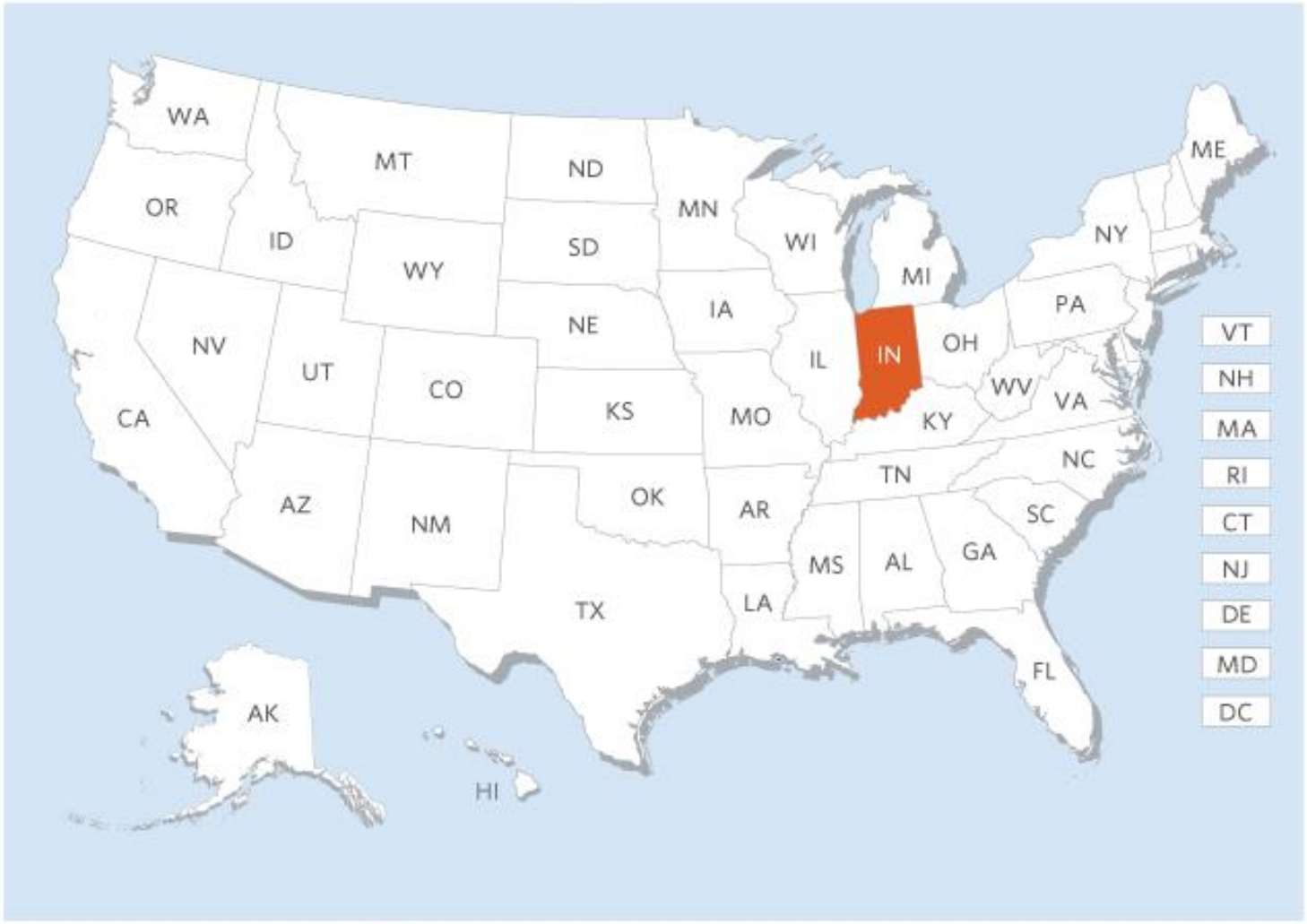
Reimbursement

- PCP reimbursement for risk assessment & fluoride varnish application has dramatically shifted in a decade
  - 46 states reimburse for preventive services including fluoride varnish; range $4 to $85.
- Several studies examined the effect of reimbursement and PCP participation in fluoride varnish application
  - Wisconsin: Fl Varnish Medicaid reimbursement claims for ages 1-3 increased from baseline 557 to 9,053 in two-year period after reimbursement introduced
    - PCPs provided majority of varnish treatments ages 1 to 2
  - Washington reported similar findings; increase from 145 (2000) to 9,098 (2007) applications
- Reimbursement is necessary, but insufficient

Dental Update: Fluoride Varnish Applications Covered for Children up to Seven Years of Age

- October 1, 2009
- Maximum of four (4) annual fluoride varnish applications covered for children from birth until 7 years of age
- Physicians, Dentists, and Nurse Practitioners treating Medicaid fee-for-service beneficiaries will be reimbursed up to $30.00 per application.
- www.health.state.ny.us/health_care/medicaid/program/update/2009/2009-09.htm#den

States with Medicaid funding for physician oral health screening and fluoride varnish



U.S. Preventive Services TASK FORCE

SPECIAL ARTICLE

Prevention of Dental Caries in Children From Birth Through Age 5 Years: US Preventive Services Task Force Recommendation Statement

AUTHORS: Virginia A. Moyer, MD, MPH, on behalf of the US Preventive Services Task Force

KEY WORDS
dentistry/oral health, preventive medicine

ABBREVIATIONS
AAP—American Academy of Pediatrics
ADA—American Dental Association
NHANES—National Health and Nutrition Examination Survey
USPSTF—US Preventive Services Task Force

Recommendations made by the US Preventive Services Task Force are independent of the US government. They should not be construed as an official position of the Agency for Healthcare Research and Quality or the US Department of Health and Human Services.

The US Preventive Services Task Force (USPSTF) makes recommendations about the effectiveness of specific preventive care services for patients without related signs or symptoms.

It bases its recommendations on the evidence of both the benefits and harms of the service and an assessment of the balance. The USPSTF does not consider the costs of providing a service in this assessment.

The USPSTF recognizes that clinical decisions involve more considerations than evidence alone. Clinicians should understand the evidence but individualize decision making to the specific patient or situation. Similarly, the USPSTF notes that policy and coverage decisions involve considerations in addition to the evidence of clinical benefits and harms.

abstract

DESCRIPTION: Update of the 2004 US Preventive Services Task Force (USPSTF) recommendation on prevention of dental caries in preschool-aged children.

METHODS: The USPSTF reviewed the evidence on prevention of dental caries by primary care clinicians in children 5 years and younger, focusing on screening for caries, assessment of risk for future caries, and the effectiveness of various interventions that have possible benefits in preventing caries.

POPULATION: This recommendation applies to children age 5 years and younger.

RECOMMENDATION: The USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride. (B recommendation) The USPSTF recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption. (B recommendation) The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of routine screening examinations for dental caries performed by primary care clinicians in children from birth to age 5 years. (I Statement) *Pediatrics* 2014;133:1–10

Primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption (B rec).

AAP FLUORIDE STATEMENT

- Pediatrics September 2014
- Fluoride Use in Caries Prevention in the Primary Care Setting
- Recommendations:
  - Fluoride varnish recommended in the primary care setting every 3–6 months starting at tooth emergence
  - Fluoridated toothpaste is recommended for all children starting at tooth eruption, regardless of caries risk
  - Fluoride supplements for children 6 months to 16 years living in non-fluoridated communities

Bright Futures™

prevention and health promotion for infants, children, adolescents, and their families™

- Fluoride Varnish added to Periodicity Schedule Sept 2015
  - www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity%20Schedule_FINAL.pdf
- Patient Protection and Affordable Care Act provision ensures children enrolled in all health care plans receive gold standard preventive care
  - Insurance plans must cover all Bright Futures preventive screenings/services recommended by the AAP/Bright Futures
  - No cost-sharing

Recommended Varnish Frequency

- ADA recommends application every 3-6 months
- AAPD every 3-6 months
- USPSTF 2014 Recommendations
- AAP 2-4 times per year
- Minimum 6 month intervals
  - 3 month interval for high-risk children

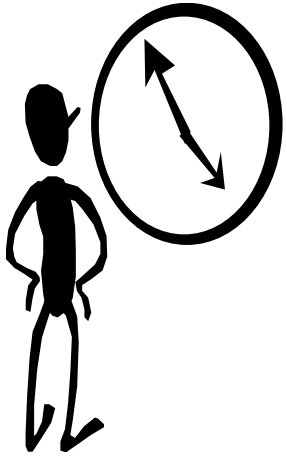
Implementation Timeline

- Varnish can be applied maximum 4x/yr
  - 6-9 months
  - 12 months
  - 15 months
  - 18 months
  - 21 months (nurse or imms visit)
  - 24 months
  - 30 months (WCC, developmental screen, ASQ)
  - 36 months
  - Thereafter, provider discretion

Billing

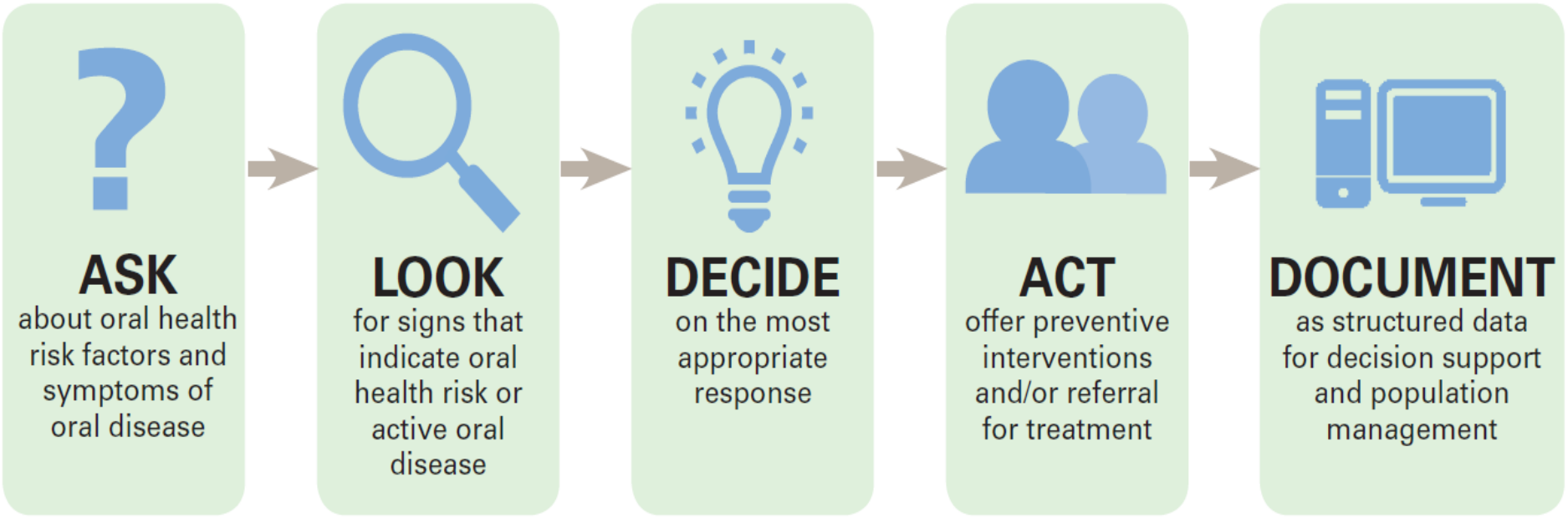
- OH assessment, anticipatory guidance, and fluoride varnish application
- Some states specify provider education and some insurers require prior approval
- CPT Codes: 99188
- ICD 10
  - V modifier Z41.8 (prophylactic fluoride administration)
  - Can use dental caries codes if disease visible
  - D1206 with V modifier (previous Medicaid code)
- Info at AAP Children's Oral Health Home www2.aap.org/oralhealth/index.html

Barriers



- Time
  - Fast
  - Important: Most common chronic disease
- Disinterest
  - Immediate and future impact of neglect
  - Obesity message and caries nutrition messages parallel
- Someone else's job
  - USPSTF, AAP, Bright Futures
- Not getting paid
  - Start billing
- Will it matter?
  - Burden of disease and relative impact of interventions
- Families do not want to hear it - messaging

Oral Health Delivery Framework



Preventive interventions may include: Fluoride therapy; dietary counseling to protect teeth and gums; oral hygiene training; therapy for substance use; medication changes to address dry mouth; chlorhexidine rinse

Hummel J et al. Oral Health: An Essential Component of Primary Care. Qualis Health; June 2015

Conclusions

- Oral health/Fluoride varnish in the primary care setting can:
  - Be successfully incorporated
  - Be cost-effective
  - Improve oral health outcomes

- How can we reach primary care providers with the message?

Stimulating PCP Oral Health Interest

- Gold standard of care
- Reimbursement available for select office services
- Health care reform – cost savings
  - Cost impact of OH interventions limited because segregated
- PCMH application
- Oral health as QI project
- Engagement with public health

Lessons Learned

- Cultivate champions
- Focus on “Why” - Gap between what we know is important and what we are actually doing
- Incremental “pilot” approach
  - One team, department, or patient type
- Balance standardization and flexibility - Oral health needs to be done, flexibility on how to operationalize
- Recruit partners: Dental insurance, FQHC, private practice dentists

Thoughts on next steps

- Access to Care
- Collaboration
  - Inter-professional focus, Bridge silos, Bidirectional communication
- Education
  - Health Professionals, families, children
- Integrate OH into EMR
- Case management and referral process reform
- Support for Integrated Service Programs
  - Community Pilot Projects
- Advocacy
- School focus on oral health
  - Dental health certificates
- Public health efforts
  - Media messaging

Resources

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Children's Oral Health

PRINT

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- EVENT CALENDAR
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How do I order, apply, and get reimbursed for fluoride varnish?

Join the Section on Oral Health

Find your state's Oral Health Advocate

Where can I get training? Protecting All Children's Teeth

Oral Health and Children

- Early childhood caries (cavities) is the number 1 chronic disease affecting young children.
- Early childhood caries is 5 times more common than asthma and 7 times more common than hay fever.
- Tooth pain keeps many children home from school or distracted from learning.
- Children are recommended to have their first dental visit by age 1.

Yet many children and their families have trouble accessing oral health care and pediatricians may not know where to turn to help them.

The American Academy of Pediatrics Section on Oral Health and Chapter Oral Health Advocates provide education, training, and advocacy for pediatricians, dentists, other health professionals, and families.

The importance of improving children's oral health and strategies to do so are included in the **Academic Pediatrics Special Issue on Children's Oral Health**.

Together we can make a difference by improving communication and collaboration between the medical and dental homes and making pediatricians and other health professionals an essential part of the oral health team!

NEWS AND HIGHLIGHTS

- **AAP receives funding from the Dental Trade Alliance Foundation to support the work of the Chapter Oral Health Advocates**
- **New AAP/Bright Futures Oral Health Risk Assessment Tool**
- **AAP updates the Protecting All Children's Teeth curriculum with new resources for teaching medical students and residents.**
- **AAP endorses the child-focused modules of the Smiles for Life National Oral Health Curriculum.**

American Academy of Pediatrics, 141 Northwest Point Blvd., Elk Grove Village, IL, 60007, 847-434-4000

Smiles for Life
A national oral health curriculum

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Module 2: Child Oral Health

Description

This module addresses the prevalence, etiology, and consequences of early childhood caries (ECC). Clinicians will learn to assess risk factors, recognize the various stages of ECC, and counsel patients on preventative techniques. Additionally, this module will discuss common oral developmental issues in children such as teething, eruption hematomas, and non-nutritive sucking.

Register to Download

Module 2: Child Oral Health

Last Modified: May, 2014

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COURSES COMPLETED:

EQIPP: Oral Health in Primary Care

Fluoride Varnish APPLICATION DEMONSTRATION

www.youtube.com/watch?v=zfdcjZ3ht9M

Courtesy of: Dr. Joanna Douglass

Questions?

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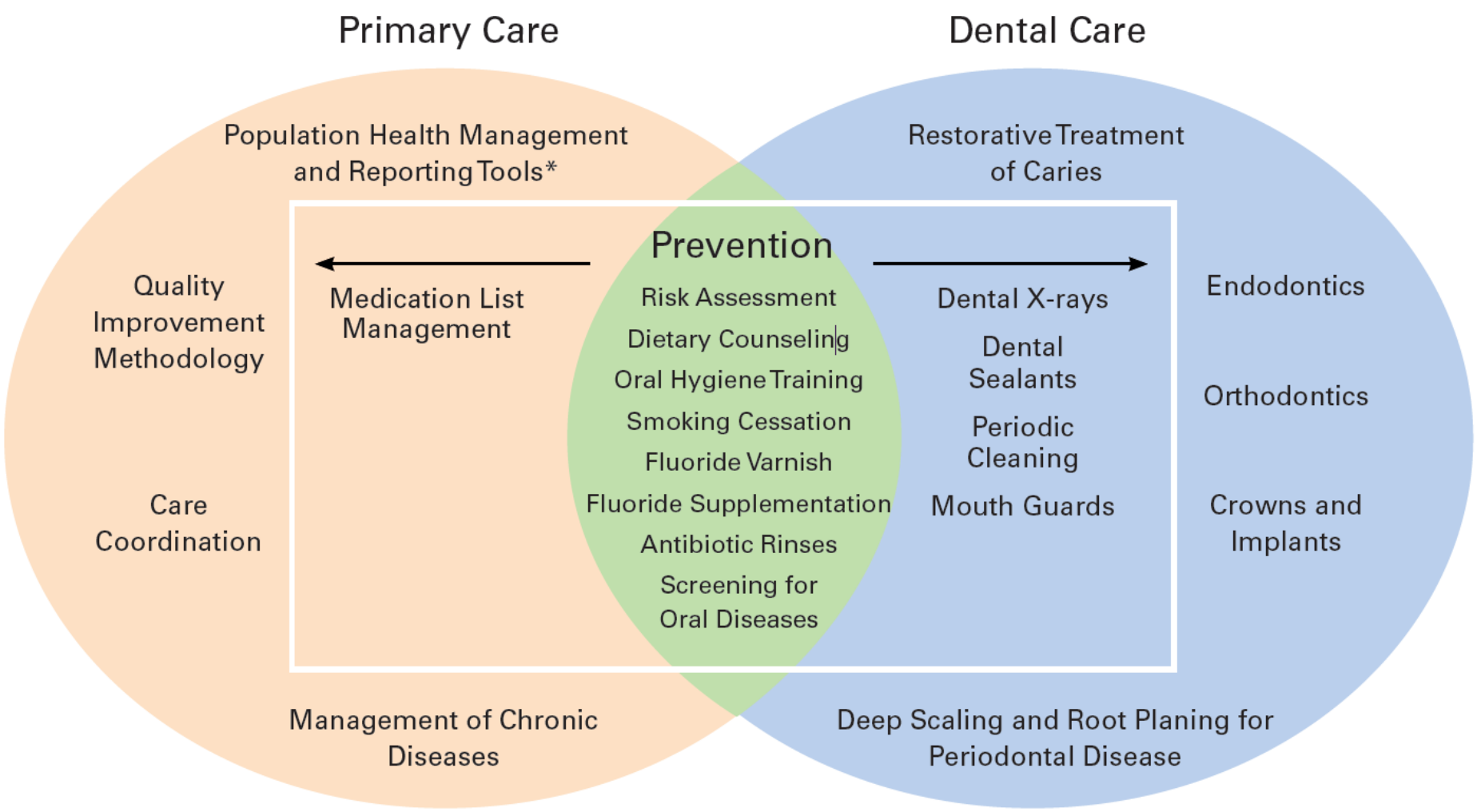

*Including structured EHR data and diagnostic codes, disease registries, and other tools