Dental Sealants on Permanent Molars for Children – Guidance Document

The purpose of this document is to provide Coordinated Care Organizations (CCOs), Dental Care Organizations (DCOs) and dental sub-contractors, Oregon medical and dental providers, and administrative staff with information on improving dental sealant rates for children. This document will be updated as appropriate to reflect any changes in policy, regulation, or measure specifications.

This document was updated November 2015 to reflect the 2016 measure specifications and recent legislation.

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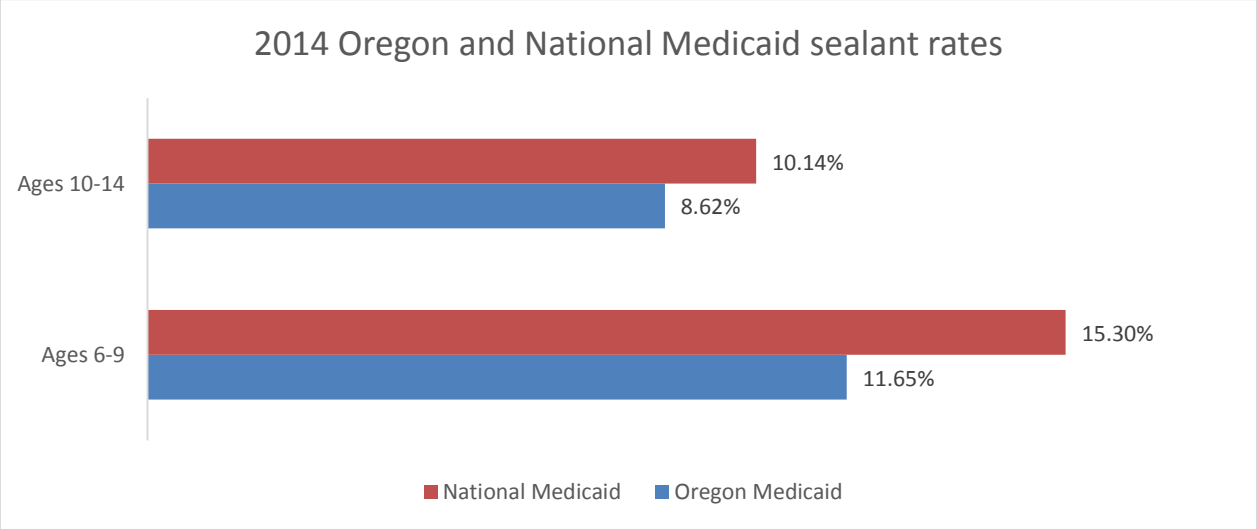
Introduction

Childhood tooth decay causes needless pain and infection, and can affect a child's academic performance and nutrition. According to the 2012 Smile Survey[1], half of children in Oregon ages 6-9 have had at least one cavity, and at least one in five has untreated decay. Children from lower-income households have substantially higher rates of cavities and untreated decay, and more than twice the rate of rampant decay (seven or more teeth with decay) than children from higher-income households.

Dental sealants are a widely recognized tool used to prevent tooth decay. A dental sealant is a white or clear liquid coating applied to the chewing surfaces of a child's permanent molars. The coating flows into the pits and grooves where decay is most likely to occur, and seals out decay-causing bacteria. Sealants are easy to apply and can be provided in many settings. Applied and cared for properly, sealants can prevent tooth decay for up to nine years.

According to the 2012 Oregon Smile Survey, 38 percent of children in Oregon ages 6-9 have received a sealant on a permanent molar.[2] Although this exceeds the Healthy People 2020 goal of 28 percent, a considerable number of Oregon children are still not benefiting from a simple and effective preventive measure against dental decay.

In 2014, among Oregon children covered by Medicaid, the dental sealant rates for ages 6-9 and 10-14 were only 11.7 and 8.6 percent, respectively. This is lower than the national Medicaid rates of 15.3 percent and 10.4 percent. Note that compared to prior years, the number of eligible children in Oregon in 2014 went up considerably compared to national, which resulted in Oregon's lower rate. See below.[3]



[1] https://public.health.oregon.gov/PreventionWellness/oralhealth/Documents/smile-survey2012.pdf
[2] ibid
[3] These data come from EPSDT reports, which use a slightly different methodology than the CCO incentive measure for dental sealants (e.g., different continous enrollment criteria, etc). These EPSDT data will not match 2014 baseline data reported for the CCO metric. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html

What is a dental sealant?

Dental sealants, also referred to as pit and fissure sealants, are a white or clear liquid coating applied to the chewing surfaces of a child's permanent molars. The coating flows into the pits and grooves where decay is most likely to occur, and seals out decay-causing bacteria.

Dental sealants do not require drilling or removing tooth structure to apply. The teeth that will be sealed are cleaned and the sealant liquid is painted in the grooves of the chewing surfaces. The sealant bonds directly to the tooth and hardens in one minute.

Sealants are not the same as fluoride varnish, or preventive resin restoration. Preventive resin restoration (PRR) are minimally invasive fillings that are placed when very early cavities infiltrate the grooves of chewing surfaces, but only on teeth already affected with decay processes. PRR should be coded with D1352, which could include the placement of a sealant. However, PRR does not count toward the CCO incentive measure, and if PRR is performed, the code for sealants alone (D1351) should not be used.

Dental sealants are an evidence-based clinical practice and are recommended by federal agencies (Centers for Medicare and Medicaid Services; Centers for Disease Control and Prevention; U.S. Department of Health and Human Services) as well as by professional organizations (American Dental Association; American Academy for Pediatric Dentistry) as an effective preventive method to avoid decay in permanent teeth in children.

- See the ADA's evidence-based clinical recommendations for the use of pit and fissure sealants online at: http://www.ada.org/en/member-center/oral-health-topics/dental-sealants

- See the Cochrane review of the evidence for pit-and-fissure sealants online at: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003067.pub3/abstract

Who can apply dental sealants?

In Oregon, the following provider types can apply sealants:

- Dental hygienists can determine the need for and apply sealants in certain locations and for certain populations without the supervision of a dentist. See ORS 680.205(1) and (2) for specific locations and populations.

  Outside of these locations and populations, dental hygienists require direct supervision by a dentist to determine the need for and apply sealants.[4]

[4] https://www.oregonlegislature.gov/bills_laws/lawsstatutes/2013ors680.html [see ORS 680.150 and 680.205] and OAR 818-035-0030. http://arcweb.sos.state.or.us/pages/rules/oars_800/oar_818/818_035.html

- Expanded Practice Dental Hygienists (EPDH), those hygienists with permits to practice independently, can determine the need for and apply sealants, without the supervision of a dentist in the locations and for the populations specified.[5]

- Dental assistants, who hold a valid Expanded Function Dental Assistant (EFDA) certificates, can also obtain certification in a Board-approved program to place sealants under the indirect supervision of a dentist or an EPDH, provided the patient is examined by the dentist or EPDH before the sealants are placed and prior to the patient's dismissal.[6]

Note applying sealants via 4-handed dentistry (i.e., two providers) is a best practice.[7] In school-based settings, 4-handed dentistry is required to ensure quality.

Barriers to Sealants

Nationally, there are a number of barriers to children receiving adequate dental care, including dental sealants.[8] These include:

- Provider reluctance to provide sealants;[9]
- Limited availability of dental providers;
- Low reimbursement rates;
- Lack of clear information for beneficiaries about dental benefits;
- Missed dental appointments;
- Transportation and child care;
- Cultural and language competency; and
- Need for consumer education about the benefits of dental care.

To improve oral health care for low-income children, a combination of these barriers must be addressed.

[5] Ibid.

[6] http://www.oregon.gov/dentistry/Pages/d_assist.aspx#Additional_Functions_of_EFDA

[7] Exploring Four-Handed Delivery and Retention of Resin-Based Sealants. Journal of the American Dental Association, March 2008. http://jada-plus.com/content/139/3/281.full

[8] CMS review of states with low dental utilization rates http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/2008-national-dental-sum-report.pdf

[9] Sealants and dental caries: insight into dentists' behaviors regarding implementation of clinical practice recommendations. JADA 2013;144(4):e24-e30 http://www.ncbi.nlm.nih.gov/pubmed/23543700

Measure Specifications

The Oregon Health Authority has developed specifications based on the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Report Form CMS-416, and on the NQF-endorsed Dental Quality Alliance (DQA) measures *Dental Sealants for 6-9 Year Old Children* / *10-14 Year Old Children at Elevated Caries Risk*. Modifications have been made to enable CCO-level reporting, and to accommodate the lack of risk assessment data available for measurement.

This measure is based on administrative (billing) data. There is only one billing code for sealants: HCPCS (or equivalent CDT) Code D1351.

Sealants provided by OHA's Oral Health Program's School-Based Sealant Program are not encountered and are not currently counted as part of this measure. OHA is exploring options to develop a state registry that will combine school-based sealant program data with Medicaid claims data for a more representative sealant rate that may be used in future years.

In the meantime, the benchmark for this measure has been set deliberately low to account for these data challenges, as well as the fact that not all children need sealants.

2016 Benchmark: 20 percent, or a 3 percentage point improvement target.

Numerator: Unduplicated number of children ages 6-14 who received a sealant on a permanent molar tooth, as defined by HCPCS code D1351 (CDT code D1351) with teeth numbered 1, 2, 3, 14, 15, 16, 17, 18, 19, 30, 31, and 32.

Note: for dental sealant services submitted through medical professional or facility claims, the tooth number information is not available on the claim form and therefore not required for inclusion in the numerator; any sealant code D1351 submitted through medical professional or facility claims will be included in the numerator.

Sealants can be placed in any clinical setting and by any dental professional for whom placing a sealant is within his or her scope of practice (see above).

Denominator: Unduplicated number of children ages 6-14 who are continuously enrolled in a Coordinated Care Organization for the 12-month measurement year (with no more than one gap in continuous enrollment of up to 45 days) counted as part of the denominator.

Age is determined as of December 31 of the measurement year; thus, a child may have been 5 years of age at the time of sealant placement.

Note: OHA will stratify measurement and reporting by two separate age ranges (6-9, and 10-14), but the rates will be combined for comparison to the benchmark and for calculating the incentive payment.

Strategies for Improvement

This section provides a number of evidence-based strategies and promising practices for improving sealant rates at both the population and individual practice level. Strategies include integration of medical and dental care, improving access to dental care, outreach to members, coordinating with school-based and other community programs, and provider-focused strategies. These strategies are intended for Coordinated Care Organizations, Dental Care Organizations, and Oregon medical and dental providers to implement within their own organizations and networks.

Note that school-based dental sealant programs are the only evidence-based approach at the population level. Information about coordinating with school-based dental sealant programs is provided as part of the access strategy section below.

Integration Strategies

Dental professionals, including dental hygienists, can be incorporated into physical health or physical and mental health co-located settings. When children are seen by a primary care provider for routine vaccinations and well-child or adolescent well visits, oral health assessments, cleanings, oral health education and nutrition education, fluoride varnish, and sealants can be provided.

One strategy to make best use of embedded dental professionals in medical settings is to schedule them consistently and advertise their availability so patients know when they can see both a medical provider and a dental professional. One recommended approach is holding "Tooth Tuesdays" or other dedicated day(s) for dental services to be offered on-site.[10]

Note that sealants are technique sensitive and do require specialized equipment. Sealants are more expensive than varnish and it may not be cost-effective to embed these services in medical offices, depending on volume of patients served and economies of scale. Note also that medical providers cannot supervise auxiliary dental staff; expanded function dental assistants with additional certification (see pages 3-4 above) require dentist or dental hygienist supervision to place sealants.

Another integration option is to establish dental clinics in conjunction with medical clinics. One federally qualified health center in Boston built a pediatric dental suite in their pediatric clinic, providing more direct and effective access to dental care.[11] The FEARsome clinic, within the Waterfall Community Health Center in Coos Bay, Oregon is staffed by a pediatrician, a mental health therapist, and a dentist to provide one-stop care for children in foster care.[12] However, housing medical and dental services in the

[10] Webinar: strategies to increase oral health care access to children in Medicaid: lessons from pioneering states. Center for Health Care Strategies, Inc. Dec 2014. http://www.chcs.org/media/OHLC-Webinar-Slides_12.18.14.pdf

[11] Oral Health Integration in the Patient-Centered Medical Home Environment: Case Studies from Community Health Centers, Qualis Health, 2012. http://dentaquestfoundation.org/sites/default/files/resources/Oral%20Health%20Integration%20in%20the%20Patient-Centered%20Medical%20Home,%202012.pdf

[12] http://www.oregonhealthstories.com/coos-bay-clinic-one-stop-shop-foster-kids/

same physical structure does not assure integration of services. Co-location requires much planning to achieve fully integrated services, with well-coordinated care and bi-directional referral systems.

A recent study on integrating oral health in primary care found the drivers of successful implementation were:

- ✓ Oral health champion(s) present, defined as someone motivated to make a change within the primary care site and willing to work toward sustainability.
- ✓ Oral health activities delegated throughout the health care team.
- ✓ Oral health activities formally integrated into the work flow.
- ✓ Oral health prompts and questions included in the electronic health record.[13]

Additional integration strategies include:

- Medical and dental providers can both promote services and schedule according to the Oregon Health Plan's Recommended Periodicity Schedule, available online at: http://www.oregon.gov/oha/healthplan/tools/Dental%20Services%20Provider%20Guide,%2012-19-2014.pdf.

  Note the Recommended Periodicity Schedule is under review to ensure the schedule provides the appropriate level of flexibility while ensuring access to needed dental services.

- Establishing bi-directional referral and follow-up systems. If a medical provider refers a child to a dentist, structures should be in place to follow-up on the referral. Dental clinics may need to revise scheduling templates or workflows to accommodate referrals from medical clinics.

  It is particularly important in co-located settings or with embedded dental providers for the medical provider to utilize "warm handoffs" to the dental provider to ensure children are actually seen by the dental provider.

- Exploring incentive programs for medical providers to refer children for sealants, or provide resources such as sealant prescription pads, to facilitate referrals. The Connecticut Dental Health Partnership provided prescription pads to hospital emergency departments, primary care physicians, and community agencies to facilitate referrals to dental care.[14]

  New Jersey Smiles, a Robert Wood Johnson Foundation funded Medicaid quality collaborative to improve oral health in young children also utilized referral forms to provide families with contact

[13] Interprofessional Study of Oral Health in Primary Care, Final Report. American Academy of Pediatric Dentistry, Pediatric Oral Health Research & Policy Center, May 2014. http://www.aapd.org/assets/1/7/Dentaquest_Year_1_Final_Report.pdf

[14] Oral Health: Fighting the Number One Chronic Infectious Disease among Children. Connecticut Dental Health Partnership. May 2011. http://ct-aap.org/110505/18-Dental%20CTDHP%20Presentation%20for%20AAP%205-2011_db_mm.pdf

information for recommended dental providers.[15]

- Identifying roles for case managers, care coordinators, or health navigators in ensuring referred children are able to make appointments and successfully see dental providers.

- Coordinating joint staff or provider meetings, or hosting retreats for medical and dental providers across the network to strengthen collaboration and facilitate shared learning.

[15] http://www.chcs.org/resource/child-oral-health-resources-for-primary-care-providers/

Access Strategies

Access to dental care is a critical barrier. CCOs and DCOs should explore opportunities to provide sealants in non-traditional settings, partner with OHA's school-based sealant program, and adopt strategies to address appointment adherence.

Non-Traditional Settings

Non-traditional settings could include providing sealants in combination with winter flu shot clinics, or utilizing mobile sealant clinics.[16] Mobile clinics can visit schools, neighborhoods, summer programs, Boys & Girls Clubs, Head Starts, and other non-traditional settings. Mobile clinics can also be a successful strategy for reaching rural areas, where access to dental providers may be limited.

- See the National Maternal & Child Oral Health Resource Center's Mobile-Portable Dental Manual for additional information on creating mobile / portable systems of care to serve populations in need of oral health care. http://www.mobile-portabledentalmanual.com/

Other non-traditional settings could include non-profit organizations, hospitals, group homes or state operated facilities serving youth, and WIC clinics. Medical settings that do not provide dental services (see integration strategies above) could include community health centers, Indian Health Centers or tribal health clinics, and public health departments.

School-Based Sealant Programs

School-based dental sealant programs are an evidence-based practice recommended by the Association of State and Territorial Dental Directors, the Centers for Disease Control and Prevention, and Healthy People 2020.[17] School-based sealant programs can effectively reach children from low-income families who are less likely to receive care at a dental office.

Oregon's School-Based Dental Sealant Program services 1st and 2nd graders (all grades in small schools) or 6th and 7th graders (all grades in small schools). Schools are eligible if 40 percent of the students are eligible for free-and reduced-price lunches. A dental team brings portable equipment to the school, screens the participating children, and applies dental sealants as appropriate.

Additional information about the program is available online:
https://public.health.oregon.gov/PreventionWellness/oralhealth/School/Pages/SchoolDentalSealantProgram.aspx

OHA's School-Based Dental Sealant Program provides a valuable service to low-income children and can be a valuable partner for CCOs and DCOs; however it is not the only school-based dental sealant

[16] To read more about best practices for mobile clinics based on school-based programs, see http://www.astdd.org/state-and-community-practice-examples/?bpareport=School-based%20Dental%20Sealant%20Programs

[17] http://www.astdd.org/school-based-dental-sealant-programs/, http://www.thecommunityguide.org/oral/schoolsealants.html, and http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=32

program! OHA is currently aware of school-based dental sealant programs operating in 35 of Oregon's 36 counties, for example:

- Ready to Smile in Coos and Curry Counties
- Kemple Memorial Children's Dental Clinic in Deschutes County
- Multnomah County Dental Sealants Program

OHA does not maintain a central database of all school oral health programs operating in Oregon, but the School-Based Dental Sealant Program is willing to share any collected information. To see if any school-based sealant programs are operating in your area, please contact the School Oral Health Programs Coordinator, Laurie Johnson, DHSc, MA, RDH at laurie.johnson@state.or.us or 971.673.0339.

Organizations interested in school-based oral health programs should focus on collaboration. Multiple organizations attempting to administer programs in the same school can be confusing and disruptive. OHA recommends conducting an environmental scan, contacting OHA's Oral Health Program, and collaborating with community partners to learn more about what programs are offered where before beginning conversations with schools about new programs.

School-based strategies:

- Research supports implementing school-based oral health programs in schools where 40 percent or more of the students are eligible for free and reduced price lunches. If there are school-based programs already serving schools where 50 percent of more students are eligible, consider ways to bring these programs to other schools (between 40 – 50 percent of eligible students).

- While many school-based oral health programs are serving 1st and 2nd graders (sealing first molars), there are many opportunities to serve 6th and 7th graders (sealing first and second molars). If there are school-based programs in your region, consider partnering with them to increase capacity.

- Note school-based oral health services should be offered to all students in eligible grades regardless of race, ethnicity, insurance status, or socio-economic status.

- Organizations should base programs on evidence-based practices. Dental sealant programs can produce a 50 percent reduction in cavities.[18] Other services, such as fluoride varnish and oral health education, can be beneficial additions to a sealant program, but should not replace or interfere with the provision of sealants.

[18] The Community Guide, 2013. Preventing dental caries: school-based dental sealant delivery programs. http://www.thecommunityguide.org/oral/supportingmaterials/RRschoolsealant.html

Training

- Organizations interested in starting a school-based oral health program must be trained in the evidence-based protocols established by the Association for State and Territorial Dental Directors (ASTDD) and the American Dental Association (ADA).[19]

- OHA's Oral Health Program currently offers a voluntary certification program where dental sealant programs / organizations can be certified in providing school-based oral health services after receiving training and signing a Memorandum of Agreement (MOA). Certification provides schools with assurance that a minimum set of standards will be met while delivering services.

  For more information about the certification process, the MOA, or to register for an upcoming training, visit: www.healthoregon.org/schooloralhealth/

Changes for the 2016-17 School Year

Senate Bill 660, which passed during the 2015 legislative session, requires local school dental sealant programs to be certified by the OHA Oral Health Program before dental sealants can be provided in a school setting. Mandatory certification will be required beginning for the 2016-17 school year.

- The OHA Oral Health Program has convened a Rules Advisory Committee (RAC) to develop the proposed rules providing guidance for local school dental sealant programs on the requirements for certification; application process for certification and recertification; monitoring of local school dental sealant program; and decertification or provisional certification for programs out of compliance.

- A public comment period on the proposed rules will be available in mid-November 2015 and posted online at: www.healthoregon.org/sealantcert/.

- The rules should be finalized in late January 2016. The OHA Oral Health Program will conduct certification trainings from February – August 2016.

[19] http://www.astdd.org/school-based-dental-sealant-programs/, http://www.thecommunityguide.org/oral/schoolsealants.html, and http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=32

Billing and Contracting

There are multiple strategies for contracting with school-based oral health programs and billing for services. Examples include:

- CCO / DCO contracts with a local school-based sealant program to provide services, paying a fixed amount for each Medicaid child served (fee-for-service), regardless of enrollment in CCO. The CCO / DCO then bills other CCOs / DCOs for their enrolled members. This approach adds administrative burden on the primary CCO / DCO, but reduces burden on the local sealant program.

- Local school-based sealant program contracts with each of the CCOs / DCOs in the region, billing each CCO / DCO separately. This approach reduces administrative burden on the CCOs / DCOs but increases burden on the local sealant programs, especially small programs, which may not have a billing specialist.

- CCO / DCO contracts with OHA's School-Based Dental Sealant Program to provide services for their enrolled children, paying per school served. The state program cannot bill the CCO / DCO for these services directly, but contracts can be established.

An example of a successful collaboration, leading to the transition of schools previously served by OHA's School-Based Dental Sealant Program to a DCO comes from Capitol Dental.

Capitol Dental hygienists and administrative staff attended a training conducted by OHA, which included information regarding evidence-based practices, school protocols, and templates for school forms. Capitol Dental later contacted OHA's School-Based Dental Sealant Program to express an interest in transitioning the nine schools in Yamhill County currently served by OHA to Capitol Dental.

A letter explaining the transition was approved by both organizations and was sent to the schools late in the school year. A Memorandum of Agreement was completed. Capitol Dental hired an OHA expanded practice dental hygienist already serving these schools received technical assistance from OHA throughout the transition, and began serving the schools directly the following school year.

Capitol Dental then transitioned five schools previously served by OHA in Lincoln County. Throughout the transitions, Capitol continues to communicate with OHA and local programs to ensure that services are not duplicated and resources are used wisely.

Data

Ideally, school-based dental sealant programs throughout Oregon will be standardized to ensure all programs are evidence-based, schools are satisfied, and data and encounters are captured to meet all

reporting requirements. *Note that any sealants provided through school-based programs that are not encountered through Medicaid will not count toward the CCO incentive measure.*

One example of integrating community and clinical dental data comes from Advantage Dental:

Advantage Dental has developed the Advanced Dental Information Network (ADIN) to integrate organizations providing dental sealants and other preventive services in the community. ADIN is a cloud-based practice management system that allows data to be entered real time using a laptop computer or tablet with Wi-Fi capability. The community outreach function of this platform is available at no cost to organizations that wish to use it. The only requirements are a connectivity agreement and Business Associate Agreement in order to be compliant with HIPAA rules.

ADIN has been used by Advantage Dental for over three years to allow Expanded Practice Permit (EPP) dental hygienists to record preventive services done in the community into an electronic health record as encounter data. At the same time, services done by the EPP hygienist are communicated real-time with the patient's primary care dentist and the Advantage Case Management Department if follow-up for care is required for urgent needs.

ADIN was piloted in Coos, Curry and Douglas counties where independently-funded community-based dental sealant programs have been operating for several years. Business Associate Agreements were negotiated with the organizations so ADIN could be used to input sealant data when done by non-Advantage dental hygienists. The purpose of the pilot was to measure the system's effectiveness in capturing sealants done by organizations other than the responsible dental organization. Results of this pilot showed the percentage of additional data capture ranged from 25% to 57% when ADIN was used to integrate and connect the different organizations doing sealants.

ADIN is a promising practice in integrating preventive services done in communities by various organizations that heretofore have been working in independent silos to provide services to children. Adoption of a system such as ADIN allows capture of all encounter data regardless of the organization providing the services, improves the opportunity for follow-up care for urgent conditions and reduces the likelihood of redundant services being provided by separate organizations.

For more information about ADIN, please contact Jeanne Dysert at jeanned@advantagedental.com or Gary Allen at garya@advantagedental.com. A presentation on ADIN is also available in the February 2015 meeting materials online at: http://www.oregon.gov/oha/healthplan/Pages/CCO-Quality-and-Health-Outcomes-Committee.aspx

Improve Appointment Adherence

One barrier to accessing dental care is low rates of dental provider participation in Medicaid, which is part driven by high no-show rates. In order to ensure a high degree of adherence to dental visits, especially for hygiene and preventive services, some strategies to address appointment adherence include:

- Utilizing the Oregon Health Plan Dental Benefits brochure (form 7224) on how to access dental services for member education.[20] CCOs, DCOs, and medical providers can distribute these, or other in-house created materials.

- Confirming appointments with all patients prior to the day of the appointment. Confirmation can include face-to-face communication, postcards or other mailed materials, calls to landlines or mobile phones, and mobile phone voice and text messaging.

  Pilot projects in other states have found mailing combined with phone effective, particularly when the message offers help with transportation. Other studies have found that telephone reminders were most effective, then text messages and postal reminders, with text messages being the most cost-effective. [21]

- Ensure that lists of dental providers and any information provided online is kept updated on a regular basis, so members are able to find available dentists and are not relying on outdated information.

- Counseling members on how to successfully access dental services (see below for outreach strategies), which could include helping members find dental homes, or providing a central point of contact for members to identify available dentists and make appointments.

  Any counseling on access should also include information on canceling with at least 24 hours' notice.

- Utilizing dental case managers or care coordinators to assist families in overcoming barriers to accessing dental care.

  One pilot program in New York utilized a dedicated dental case manager to alleviate administrative burden on providers and maintain a communication portal for families. The case manager helped resolve billing problems, educated patients, and assisted with patient transportation to appointments. This program showed an increase in access to dental care for

[20] See Forms section http://www.oregon.gov/oha/healthplan/Pages/dental.aspx

[21] Stubbs ND, Geraci SA, Stephenson PL, Jones DB, Sanders S. Methods to reduce outpatient non-attendance. The American journal of the medical sciences. Sep 2012;344(3):211-219 http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0053298/

Medicaid-enrolled families from 9 percent to 41 percent, and the case manager was also able to increase oral health literacy and treatment compliance among patients.[22, 23]

A program in Seattle found that when dental clinics partnered with community organizations and provided case management, they achieved a 108 percent increase in the number of children who received a dental visit. Case managers facilitated the first appointments, ensured follow-up and helped address other barriers to care.[24]

Patient navigators or other care coordinators can also be utilized to follow up with patients who miss their dental appointments.

- Develop cultures of patient-centered care and mutual respect.[25] One federally qualified health center in St Louis reported a very low rate of patients missing scheduled dental appointments which correlated with their increased attention to this culture and high expectations placed on clinic staff to maintain mutual respect between patients and staff. This FQHC also reserves Saturdays and once weekly evening appointments for working parents with school-aged children to help decrease the potential for missed appointments.[26]

  Patient and family-centered care, as adopted by the American Academy of Pediatrics, is an approach grounded in collaborative decision-making among patients, families, dentists, physicians, nurses, and other health care providers. The approach acknowledges that care should be planned not only around the individual child, but also around and in partnership with the family.

  Mutual respect can include:

  - Cultural sensitivity towards the patient / family, which includes, but is not limited to, socioeconomic status, race, religion, ethnicity, and perception of care;
  - Respectfully considering the family's needs and preferences in making decisions to ensure flexibility in practices; and

[22] Greenberg BJ, Kumar JV, Stevenson H. Dental Case Management Increasing Access to Oral Health Care for Families and Children With Low Incomes. J Am Dent Assoc. 2008;139:1114–21.

[23] The Use of Case Management to Improve Dental Health in High Risk Populations, American Academy of Pediatric Dentistry, Pediatric Oral Health Research & Policy Center, June 2013. http://www.aapd.org/assets/1/7/POHRPC-TR3-2013-Final.1.pdf

[24] Wysen KH, Hennessy PM, Lieberman MI, Garland TE, Johnson SM. Kids get care: integrating preventive dental and medical care using a public health case management model. Journal of dental education. 2004;68(5):522-530.

[25] Patient Centered Care Brief, American Academy of Pediatric Dentistry, Pediatric Oral Health Research & Policy Center. August 2013. http://www.aapd.org/assets/1/7/PatientCenteredCarePolicyBrief.pdf

[26] Missouri's Early Periodic Screening and Diagnosis and Treatment Program Dental Services Management Review. 2008 Individual State Reports. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Dental-Care.html

- Advocating services with the purpose of building on the family's strengths and tailored to the needs, beliefs, and cultural values of the family.

Outreach Strategies

Coordinated Care Organizations and Dental Care Organizations can identify children that have not had a dental visit in the past year and/or who have not had any billing claims for sealants. Searches for these children should be focused on those ages 6 and 12, as this is typically around the time new sets of teeth erupt.

Once identified, outreach efforts can be directed towards these children. Potential strategies include:

- Providing gifts or other financial incentives. One CCO has experimented with providing gift cards for adolescents who complete their well child visits – a similar approach could be used for dental visits.

- Sending 'birthday card' reminders with information for parents on dental benefits and how to make an appointment. Note one CDC birthday program focused on sealants was unsuccessful; however including dental anticipatory guidance into a birthday card with overall age appropriate guidance distributed by a CCO may be more successful.

- Sending tailored mailings to parents of children with low dental utilization, or those missing preventive services that may include sealants. A 2012 project in Virginia found approximately 25-30 percent of members with low utilization accessed services after receiving just one postcard.[27]

- If able to integrate dental professionals in pediatric settings (see above), consider combining this outreach with recommended well-child visits or back-to-school checkups.

- Identifying adult patients with eligible children. If these adult patients make appointments for dental visits, encourage them to schedule a visit for their children at the same time to avoid issues with transportation or child care.

- Identifying children with siblings and scheduling appointments at the same time to avoid issues with transportation or child care.

  Note: dental providers may be reluctant to schedule family visits due to high no-show rates. See above for strategies on improving access and reducing no-show rates.

- Medical providers can incorporate questions into visits on whether a child has a dentist and whether the child has had sealants. If no, the medical office can help coordinate access to a dentist (see strategies above).

[27] DentaQuest: Repeatable Success Implementing Outreach Strategies. CMS Learning Lab: Improving Oral Health through Access. 2012. http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/learninglabslides2.pdf

Members may not know what dental benefits are available to them or their children. Outreach strategies focused on raising awareness of benefits include:

- Providing new patients with an "orientation visit" to the system that describes all available services and how to access them.

- Ensuring information on dental benefits and the importance of preventive oral health care is included in member handbooks and other eligibility / enrollment materials that may be provided by the CCOs or DCOs.

- Ensuring information is made available on CCO websites, not just in written form, but in video or other media formats. Ensure information is made available in multiple languages to reach all audiences.

- Using patient navigators to inform CCO members of their dental benefits, including dental sealants. Patient navigators can also assist members with finding a dentist and making the first appointment.

There may be other opportunities to provide educational messages to parents about the importance of oral health care and encourage them to talk to their child's provider about dental sealants. Dental care may not be a priority for many families given the variety of social and economic issues they face daily. In addition, parents may not fully understand the need for good preventive oral health care, particularly if they were not a recipient of dental care growing up.

Other opportunities to reinforce the importance of dental care may include:

- Placing anticipatory guidance on sealants on phone system hold messages;

- Placing posters on the back of exam room doors in medical and dental settings;

- Utilizing social media at the CCO, DCO, or provider level. Suggestions include:
    - Texting educational messages to parents or children on sealants.
    - Promoting oral health messages on CCO's Facebook or other social media accounts.
    - Downloadable puzzles, games and coloring pages on oral health.[28]
    - Show the "Seal in a Smile" or other video promoting sealants in waiting rooms, or on websites.[29]

[28] Recommendations include the American Dental Association's Mouth Healthy™ Kids website. http://www.mouthhealthykids.org/en/

[29] Carter NL, with the American Association for Community Dental Programs and the National Maternal and Child Oral Health Resource Center. 2011. Seal America: The Prevention Invention (2nd ed., rev.). Washington, DC: National Maternal and Child Oral Health Resource Center. http://www.mchoralhealth.org/seal/video.html

In general, messages regarding sealants should highlight that sealants are painless and do not require any drilling. Some parents may avoid dental care for their children for fear it will hurt.

Provider Strategies

A recent study found that personal clinical experience is the determining factor in dentists' treatment decisions, regardless of the dentists' knowledge of clinical recommendations. Ingrained practice behavior based on personal clinical experience can differ substantially from evidence-based recommendations, such as providing dental sealants.[30]

While it is important to promote evidence-based best practices regarding dental sealants, education-only strategies for dental providers may not be sufficient to improve sealant rates and other strategies such as provider incentives or more systemic changes may be required.

Provider Education

- Iterate to providers that sealants are easy to apply and only take a few minutes for each tooth, following a thorough cleaning of the tooth surface. Communicate with dental providers about the efficacy of dental sealants in preventing tooth decay, and develop processes to routinely assess for risk and apply sealants during regular dental visits.

- If pursuing integrated / embedded strategies, ensure medical providers receive training and are comfortable with any new referral systems or new workflows. Cross-training may help support provider buy-in for integrated models.

  One federally qualified health center in Idaho had dental professionals make presentations to medical staff, to help raise awareness of the links between oral health and chronic disease, and help medical providers see oral health as an integral part of their job.[31]

- Ensure providers are aware that varnishes or PRRs (protective resin restoration) are separate procedures from dental sealants.

- Be prepared to provide existing evidenced-based literature and clinical practice guidelines. Make resources available to providers, such as informational brochures and facts sheets. For examples, see: http://www.nidcr.nih.gov/oralhealth/Topics/ToothDecay/Documents/Sealants_Eng.pdf http://www.doh.wa.gov/Portals/1/Documents/Pubs/160-145_SealantInfoParent.pdf

- Ensure any provider manuals and relevant provider updates are available to dental providers online. This type of information should be as convenient, timely, and easily accessible as possible.

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[30] Sealants and dental caries: insight into dentists' behaviors regarding implementation of clinical practice recommendations. JADA 2013;144(4):e24-e30 http://www.ncbi.nlm.nih.gov/pubmed/23543700

[31] Oral Health Integration in the Patient-Centered Medical Home Environment: Case Studies from Community Health Centers, Qualis Health, 2012. http://dentaquestfoundation.org/sites/default/files/resources/Oral%20Health%20Integration%20in%20the%20Patient-Centered%20Medical%20Home,%202012.pdf

Monitoring

- CCOs should share sealant data with providers – it is important for DCOs and providers to monitor sealant rates among other oral health services and regular, actionable, data will help identify children in need of services.

Workforce Development

In 2013, 17.3 percent of Oregonians were considered underserved and living in a dental shortage area.[32]

- Foster workforce development: for example, encourage dental assistants to obtain EFDA certification so that they can apply sealants, or advocate for hygienists to practice part-time in a dental office within your network (this may also help create a cohesive referral system).[33]

- Increase the number of dentists serving Medicaid patients. In 2000, Georgia dentists launched their "Take 5" campaign, asking all Georgia dentists to register as Medicaid providers and to voluntarily take on five of more new Medicaid patients into each practice. After one year of the program, dental participation increased by 23 percent.[34]

- Utilize Collaborative Practice Expanded Practice Dental Hygienists (EPDH). These are EPDHs that have entered into a written collaborative agreement with a licensed dentist. The agreement must be in a format approved by the Board of Dentistry and must set forth an agreed-upon scope of the EPDH's practice regarding specific procedures. A collaborative agreement is not required to apply for an expanded practice permit, but EPDHs who have collaborative practice agreements are better positioned to make referrals to a particular dentist.

  EPDHs with collaborative practice agreements are being identified in Oregon's Medicaid Management Information System (MMIS).

[32] U.S. Department of Health and Human Services, Health Resources and Services Administration, Jan. 9, 2013. Designated HPSA Statistics Report, State Population and Health Professional Shortage Areas Designation Population Statistics, data as of Jan. 9, 2013. Analysis by The Pew Charitable Trusts.

[33] http://www.oralhealth.ri.gov/documents/PatientCenteredMedicalDentalHomeSurveyReportOHCSafetyNetWorkgroupReportAugustDraft.pdf

[34] http://www.ahrq.gov/cpi/initiatives/chiri/Briefs/brief2/index.html

Community Coordination Strategies

Community-based approaches require coordination across CCOs, DCOs, and community partners. Strategies include:

- Consider hosting a local sealant summit to bring everyone together and identify shared strategies for improving sealant rates in the region.

- If not already completed as part of community health assessment work, conduct an inventory of what partners and local organizations are already doing around sealants.

- Identify ways to capture data on sealants provided to Medicaid children in the community, such as through school-based sealant programs. Note the Centers for Medicare and Medicaid Services recently issued guidance to states regarding Medicaid payment for services covered under a state's Medicaid plan to an eligible Medicaid beneficiary that are available without charge to the beneficiary (including services that are available without charge to the community at large, or "free care").[35]

- Reach out to minority populations by partnering with culturally-specific community groups to help distribute language-appropriate informational brochures about dental sealants.

- Consider partnering with local businesses or community organizations to develop a media campaign.

For More Information

For questions about School-Based Oral Health Programs, please contact Laurie Johnson, DHSc, MA, RDH at laurie.johnson@state.or.us or 971.673.0339.

For questions related to the CCO incentive measure, please contact metrics.questions@state.or.us.

For questions related to Medicaid billing, please contact Provider Services at 1.800.336.6019.

[35] http://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf