Most oral health services are provided by dental professionals. However, primary care professionals also have a responsibility and ability to support children's oral health. Primary care providers play a critical role in helping increase access to preventive oral health care. Primary care providers can educate children and their families about the importance of oral health care, the need for all children ages 1 and older to have a dental home, and the impact of nutrition on children's teeth; refer children to the dentist for care; and, in North Carolina, provide some basic preventive oral health care to high-risk young children. In North Carolina there are many efforts underway within the primary care setting to improve children's oral health.

Current Efforts in Primary Care Practices to Improve Children's Oral Health

Primary care providers play a critical role in helping increase access to preventive oral health care.

The North Carolina Division of Medical Assistance (DMA), Community Care of North Carolina (CCNC), Oral Health Section (OHS) of the Division of Public Health, the Gillings School of Global Public Health at the University of North Carolina at Chapel Hill, and other partners have several initiatives aimed at using primary care professionals to help improve oral health of children. For example, several of the partnering organizations helped create the Priority Oral Health Risk Assessment and Referral Tool (PORRT) to promote referrals from primary care professionals to dentists. CCNC is also promoting oral health quality improvement efforts, as part of its Child Health Insurance Program Reauthorization Act (CHIPRA) Quality Improvement Initiative. Several local communities are working to increase collaboration between primary care professionals and dentists as well. Each of these initiatives is described in more depth below.

Into the Mouths of Babes

North Carolina has a statewide Medicaid program to increase access to preventive dental care for young children called Into the Mouths of Babes (IMB). IMB serves children 0-3.5 years enrolled in Medicaid. IMB aims to reduce the incidence of early childhood tooth decay among low-income young children by providing preventive oral health care in a medical setting. IMB also aims to reduce the burden of treating very young children on a statewide dental system that currently does not have enough dentists willing to treat these children.[1] Recognizing that accessing dental care can be a challenge for families, the IMB program capitalizes on the fact that almost 90% of infants and one-year-olds visit a physician at least once a year compared to less than 2% of infants and one-year-olds who visit a dentist at least once a year.[2]

The IMB program in North Carolina began training primary care providers to deliver preventive oral health services to high-risk children enrolled in Medicaid in 2000. Primary care providers can be reimbursed for services provided from tooth eruption through 3.5 years. To be reimbursed by Medicaid through IMB, a physician must do an oral evaluation, and the physician, nurse practitioner,

physician assistant, or nurse must provide oral health education to parent or caregiver and apply fluoride varnish.[3] Fluoride varnish treatment is recommended every three to six months for up to six applications between tooth eruption and age 3.5.[4] Medicaid policy requires 60 days between applications and reimburses health professionals $52 for completing the full IMB oral preventive procedure.[4]

More than 450 physician practices, residency programs, and local health departments have been trained and provide IMB services.[1] Evaluations of the IMB program show that IMB has helped to increase access to preventive dental services, reduced billing for treatment services among very young children, increased dental visits through referrals, and reduced hospitalization due to dental causes.[5-7]

In North Carolina there are many efforts underway within the primary care setting to improve children's oral health.

Zero Out Early Childhood Tooth Decay

Zero Out Early Childhood Tooth Decay (ZOE) is a 5-year joint effort among the Gillings School of Global Public Health at the University of North Carolina at Chapel Hill, OHS, Early Head Start and others.[8] Funding for ZOE comes from the National Institutes for Health. ZOE's goal is to zero out early tooth decay among children enrolled in Early Head Start, which serves children ages 0-3. ZOE has trained Early Head Start staff in 25 sites across the state on pediatric oral health issues and motivational interviewing. Early Head Start staff in turn promote preventive services in the classroom, use motivational interviewing in parent education, and link early head start children with primary care providers who participate in the IMB program.[1] The impact of this intervention on parents and children is being evaluated through baseline and follow-up interviews of parents and clinical dental examinations of children at age 3.[a]

Carolina Dental Home

Carolina Dental Home is a pilot project to increase collaboration among primary care and dental providers in Craven, Jones, and Pamlico counties with the goal of preventing tooth decay before it starts among young children ages 0-3.[9] Primary care providers use the North Carolina Priority Oral Health Risk Assessment and Referral Tool (PORRT) (see below for more information) to screen very young children for risk factors and dental problems. The PORRT is used to refer children with multiple risk factors or dental problems to dentists. The emphasis is on increasing collaboration and establishing best practices for preventing and treating tooth decay among very young children.[9] Funding for the pilot program is provided by a Health Resources and Services Administration (HRSA) Access to Dental Care Grant.

a Rozier, Gary. Professor, Health Policy and Management, Director, Dental Public Health & Residency Training Program, University of North Carolina at Chapel Hill. Written communication May 31, 2013.

North Carolina Priority Oral Health Risk Assessment and Referral Tool

The North Carolina Priority Oral Health Risk Assessment and Referral Tool (PORRT) is a risk assessment tool that was developed jointly by the Gillings School of Global Public Health at the University of North Carolina at Chapel Hill, the University of North Carolina at Chapel Hill School of Dentistry, DMA, OHS, and privately practicing pediatricians and dentists who tested the tool.[10] PORRT is a short risk assessment tool for primary care providers to use to determine which children ages 0-3.5 years are most in need of a referral to a dentist.[b] The PORRT also includes a section to provide the referral, a section with instructions to notify the dental office of the referral, and a section for the dental office to provide follow up information to the referring professional on whether the patient showed up for the dental appointment and the dental findings. The PORRT aims to increase primary care referrals to dentists for young children and increase communication between primary care and dental professionals.

CHIPRA

Funding from the Centers for Medicaid and Medicare Services (CMS) is supporting a number of initiatives within Community Care of North Carolina (CCNC) that include improving children's oral health as one of their objectives. The NC CHIPRA Quality Demonstration Grant is supporting efforts to: experiment with and evaluate the use of new and existing measures of quality for children, including oral health quality measures; evaluate provider-based models to improve the delivery of care; and demonstrate the impact of model pediatric electronic health records.[11]

Oral health quality measures: Each CCNC Network has a pediatric quality improvement specialist (QIS) responsible for working with providers to improve the quality of care provided. CCNC maintains data on whether children seen in its practices have received a dental topical fluoride varnishing, the number of varnishings, and if they have had an annual dental visit. For the year ending September 2012, 62% of children enrolled in Medicaid and NC Health Choice had an annual dental visit,[c] 57% of eligible children ages 0-3.5 years of age had received 3 or more dental varnishes, and 42% had received 4 or more varnishings.[11] These data can be further broken down by age and network. QISs review this data and work with practices to improve their performance on a number of quality indicators. The QISs have begun working with practices to train them in the use of the PORRT. The QISs also provide training on the IMB program and encourage practices to become IMB providers.[11]

The Task Force identified a third goal to "increase the utilization of preventive oral health services among children ages 6 months-20 years old enrolled in Medicaid and NC Health Choice by any appropriate health professional by 10 percentage points, from FFY 2011-FFY 2015.

b King, Rebecca. Section Chief, Oral Health Section, Division of Public Health, North Carolina Department of Health and Human Services. Written communication May 24, 2013.

c Data do not capture whether the annual visit was for preventive services or treatment.

Provider-lead quality improvement initiatives: CCNC is using a learning collaborative model which provides in-depth, long-term training and coaching to a smaller number of practices. Eight of the CCNC networks and 26 practices are participating in the learning collaborative (called CHIPRA-Connect). The learning collaborative is focusing on four objectives, one of which is oral health. Each of the eight networks received a full-time QIS to focus only on CHIPRA Connect practices. Each month these QISs review charts for the practices involved in the learning collaborative and provide feedback to the practices about how they can improve screening, referral, and documentation.[11] QISs do a monthly quality chart review that includes an indicator that looks for documentation that the child has a dental home at every well visit from age 1-20. In addition, another focus of the CHIPRA Connect effort has been to build community relationships, including between primary care providers and dentists, in order to provide comprehensive and coordinated care.[11] As part of this work, practices have had "mixers" where primary care providers in the community and dental professionals in the community have been invited to network in informal settings in an effort to increase communication, particularly around referrals and feedback, and understanding between the two.

The Task Force made two recommendations to increase the utilization of preventive oral health care among children enrolled in Medicaid and NC Health Choice within the primary care setting.

Pediatric electronic health records: CCNC is working with CMS, Agency for Healthcare Research and Quality, the American Academy of Pediatrics, and other organizations on implementing and evaluating a Pediatric Electronic Health Record format.[12] CCNC is working with practices to increase their understanding and knowledge of the role of electronic health records (EHR); improve the pediatric content and functionality of EHR; and knowledge on how to use EHR to improve the quality of care provided to children. Dental indicators, including evidence of a dental home, varnishing rates, and oral health screening and counseling, are among the key measures included in the pediatric EHRs.[11]

Promoting Oral Health in the Primary Care Setting

In addition to the two goals identified by the CMS, the Task Force on Children's Preventive Oral Health Services identified a third goal to "increase the utilization of preventive oral health services among children ages 6 months-20 years old enrolled in Medicaid and NC Health Choice (enrolled for at least 90 days) by any appropriate health professional by 10 percentage points, from 55% to 65% for children enrolled in Medicaid and 42% to 52% for children enrolled in NC Health Choice, over a five-year period from FFY 2011-FFY 2015" as being critical to achieving the two goals set by CMS. The Task Force identified existing access barriers and the root causes of these barriers as the first step to identify strategies the state could undertake to achieve the this goal. The Task Force focused on primary care providers and Medicaid and NC Health Choice policies.

Primary Care Providers

- Primary care providers may not be talking to families about dental care and/or referring families for dental care.[7]
- Primary care providers may not be talking to families about the importance of oral health for overall health and well-being or the impact of diet on oral health.
- Primary care providers often lack training on what to look for when doing an oral screening and what action to take based on the screening.
- There is not widespread use of PORRT, the standard risk assessment or screening tool for primary care providers to use to assess and refer children to dental providers.[11]

The Task Force developed recommendations to address these barriers. The Task Force prioritized the initial list of potential recommendations based on their potential impact and whether they are actionable and achievable (both politically and financially). Based on this process, the Task Force made two recommendations to increase the utilization of preventive oral health care among children enrolled in Medicaid and NC Health Choice within the primary care setting:

Recommendation 5.1: Encourage Primary Care Providers to Promote Oral Health

Recommendation 5.2: Create Systems for Greater Collaboration between Primary Care Providers and Dental Professionals

Raising the Profile of Oral Health during Primary Care Visits

The group recognized the importance of educating other health care professionals, including but not limited to pediatricians, family physicians, nurse practitioners, physician assistants, nurses, and others who are providing health care services to children. If health care professionals are educated about the importance of preventive oral health services (in general) and sealants (in particular), they can help educate parents about the importance of obtaining these services for their children.

If health care professionals are educated about the importance of preventive oral health services (in general) and sealants (in particular), they can help educate parents about the importance of obtaining these services for their children.

The American Dental Association and the American Academy of Pediatric Dentistry recommend that children see a dental provider "at the time of the eruption of the first tooth and no later than 12 months of age.[13]" This standard is incorporated into the North Carolina Oral Health Periodicity Schedule for children enrolled in Medicaid and NC Health Choice, as well as the Bright Futures guidelines, which are used by the Divisions of Medical Assistance

(DMA) to establish required preventive services during children's well child visits.[d,14,15] (See Appendix E.) The Bright Futures guidelines for oral health preventive care as part of periodic primary preventive care visits recommend that an oral health risk assessment be performed at 6 months, 9 months, 12 months, 18 months, 24 months, and 30 months. Bright Futures recommends referral to a dental home at the 12 month, 18 month, 24 month, 30 month, 3 year, and 6 year visits. Bright Futures does not have any recommendations for preventive oral health during primary care visits after age 6. However, Bright Futures does recommend that the primary care provider assure that the patient has a dental home and, if not, to refer to a dentist. In addition to these recommendations, through the IMB program, DMA provides reimbursement to primary care providers for additional oral health care services (IMB includes an oral evaluation, the provision of oral health education to parent or caregiver, and fluoride varnish application) up to six times between tooth eruption and 3.5 years.

The North Carolina Oral Health Periodicity Schedule for children enrolled in Medicaid and NC Health Choice states that "promotion of oral health care is considered a joint responsibility between oral health professionals and other health care professionals.[14]" While most of the services outlined in the North Carolina Oral Health Periodicity Schedule refer to services that should be performed by a dental health professional, the schedule does not explicitly state what type of health professional should perform each of the services, "particularly for Medicaid eligible infants and toddlers under age 3.[14]" The reason for this is because the type of health professional delivering services "will be determined by other factors including local community capacity to provide care to preschool Medicaid children.[14]" The low overall number of dentists in North Carolina, the fact that many general dentists do not treat infants and toddlers ages 0-3 in their practices, the low number of pediatric dentists in North Carolina, and the maldistribution of dentists across the state all factor into this recommendation.[16] (See chapter 6 for more information on the dentist population in North Carolina.) The North Carolina Oral Health Periodicity Schedule further states that "An oral evaluation should be done by the Primary Care Physician/Pediatrician/Dentist up to age 3.[14]" However, the North Carolina Oral Health Periodicity Schedule provides no further guidance for primary care professionals on how to determine whose oral health can be safely cared for by a primary care provider for the first three years versus who needs to absolutely be referred to a dentist.

d All of the child health services that can be covered through Medicaid are outlined in federal legislation (42 U. S.C.§ 1396d(r) [1905(r) of the Social Security Act: "Early and Periodic Screening, Diagnosis and Treatment Services", or EPSDT)…In North Carolina the preventive health services/periodic screening portion of Medicaid (EPSDT) program for children from birth to 21 years of age is known as Health Check. Health Check screening services are performed during Well Child visits and are reimbursed by the North Carolina Medicaid program…The components of periodic preventive health screening assessments required by the NC Health Check program are based on the American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Care…as set forth in the Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents." (cite http://www.ncdhhs.gov/dma/healthcheck/FINAL_Health_Check_Billing_Guide.pdf)

The PORRT is a solid step towards guiding primary care providers' decision making around children's oral health care for young children. If a primary care provider in an area without sufficient dentists to see all young children uses the PORRT and a referral to a dentist is not recommended, then that child may be one whose oral health can be safely cared for by a primary care provider until age 3, although the PORRT should be re-administered at every well visit to make sure the child's oral health needs have not changed. The PORRT can also help identify children with significant oral health needs who should be referred to a pediatric dentist, rather than to a general dentist who sees children. Other behavioral health assessments used by primary care providers may also be a useful tool to determine if a child needs to be referred to a pediatric dentist with training in child behavior management techniques rather than to a general dentist. The North Carolina Oral Health Periodicity Schedule calls for oral hygiene, dietary counseling, and other counseling to improve oral health to be provided throughout childhood with the parent and the patient.[14] The guidelines do not specify what type of health professional should provide the counseling. Ideally, the Task Force would like to see such counseling coming from both primary care providers and dental health professionals.

The North Carolina Oral Health Periodicity Schedule calls for oral hygiene, dietary counseling, and other counseling to improve oral health to be provided throughout childhood with the parent and the patient.

There is a broad need for education and counseling as well as a need to screen young children for oral health needs, and, in some cases, fluoride supplementation may be needed to prevent dental caries in young children. Fluoride, a naturally occurring mineral, is effective at preventing and reversing the early signs of dental caries.[17] Fluoride has been added to community water supplies since 1949 and is the most cost-effective method for preventing caries.[18] Eighty-seven percent of North Carolinians have fluoridated water available in their homes while 13% do not.[18] Because of the effectiveness of fluoride at preventing dental caries, the US Preventive Services Task Force recommends that primary care providers prescribe oral fluoride supplementation "at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride.[19]" Before prescribing any type of fluoride supplementation, a water sample from the child's home should be analyzed to find out exactly what level of fluoride is in their water.[17] Local and state health departments conduct fluoride testing. The American Dental Association (ADA) provides details on the proper dosage for fluoride supplementation based on an individuals' age and the fluoride ion level in the drinking water in their home.[17] The ADA recommends fluoride supplementation for children ages 6 months-16 years if the fluoride levels in their drinking water do not meet recommended levels.[17]

In addition to working with children and their families, it is important to educate pregnant women about the importance of their oral health and that of their baby. (See Recommendation 3.1.) In North Carolina, pregnant women with family incomes up to 185% of the federal poverty guideline (FPG) may be eligible for Medicaid for Pregnant Women (MPW). In North Carolina, individuals receiving MPW services receive comprehensive, coordinated maternity care through

CCNC. Preconception care is an essential first building block for a healthy mother and her child. During the preconception period, the main goals of care are to: 1) screen for risks, 2) offer health promotion and education, and 3) provide interventions or referrals to address identified risks.[20] The oral health of pregnant women can influence the health of their developing babies.[21] After a child is born, caregivers can transfer mutans streptococci, the primary bacteria which cause tooth caries, to young children, therefore reduction of maternal dental disease and instruction of oral hygiene are particularly important.[22] Thus, the ADA and the American Academy of Pediatric Dentistry recommend oral health education and professional oral health care for pregnant women to improve their oral health and the oral health of their children.[22]

The guidelines provided by DMA for primary care providers around the oral health of children are quite broad. The Task Force would like to see more explicit guidelines for primary care providers to help clarify the expectations for oral health care provided during medical visits. Additionally, providing education to pregnant women about their own oral health and the oral health of their infants is important to improve young children's oral health. Therefore the Task Force recommends:

Recommendation 5.1: Encourage Primary Care Providers to Promote Oral Health

The Division of Medical Assistance (DMA) and the North Carolina Community Care Network (NCCCN), including the CHIPRA quality improvement specialists, should continue to work with primary care providers (PCPs) who treat children and pregnant women and their partners to help them further encourage families with children to obtain oral health services.

a) DMA and NCCCN should develop and disseminate guidelines that specify oral health expectations for primary care professionals. These guidelines should encourage PCPs to:

1) Provide families with education and counseling about the importance of oral health, including preventive oral health visits for all children, and sealants for children starting with the emergence of molars.

2) Help link children to a dental home beginning at age 1.

3) If there are not sufficient dentists available in the community who see very young children, then :

i) Refer children at higher risk, as determined by the Priority Oral Health Risk Assessment and Referral Tool (PORRT) or similar tool, to a dentist at age 1;

ii) Manage children identified as lower risk , as determined by the PORRT or similar tool, through routine risk assessment, counseling, and application of varnish, and then refer them to a dental home no later than age three.

iii) Refer young children with significant oral health problems or behavioral health problems to pediatric dentists or other appropriately trained dentists (if available).

4) For children ages 4 and older:

i) Conduct an oral evaluation and oral health counseling, as part of a complete physical examination.

ii) Assure a dental home. If the child does not have a dental home, refer to a dentist.

iii) Prescribe fluoride supplementation when appropriate as specified by the US Preventive Services Task Force and the American Dental Association.

a) Support on-going efforts to expand outreach and education for primary care providers to encourage them to participate in the Into the Mouths of Babes program.

b) As part of the pregnancy medical home,

1) NCCCN should develop a care alert to trigger a dental visit during pregnancy.

2) OB-GYNs and family physicians should be educated about the importance of educating pregnant women and their partners about the connection between the caregivers' oral health and that of the child, as well as the importance of establishing a dental home.

Increase Collaboration between Primary Care Providers and Dental Professionals

Although oral health is integral to the overall health and well-being of children, the health care systems for primary care and oral health are not well integrated, nor are they designed to encourage collaboration. Currently there is little professional interaction between primary care providers and dentists. Additionally, the Task Force identified common misconceptions between the two professions including many primary care providers thinking that dentists

in their community do not take Medicaid and NC Health Choice patients or are not accepting new patients, and many dentists thinking that primary care providers are not engaging in enough oral health promotion or strongly encouraging children to have a dental home. Efforts that have been piloted in some communities show promise for improving collaboration between primary care providers and dentists.

The PORRT aims to increase primary care dental referrals and increase communication between primary care and dental providers. QIS specialists are working with CCNC primary care practices to increase the use of the PORRT through trainings and other activities. These efforts are increasing the use of PORRT by primary care providers. A common, formal referral system is the first step towards increasing the rate of successful referrals to dentists. However, one challenge has been getting dentists to return the follow-up portion of the PORRT to primary care providers. This step is critical because without follow-up from the dentist, primary care providers do not know if patients received needed dental care.

The health care systems for primary care and oral health are not well integrated, nor are they designed to encourage collaboration.

The community mixers that are part of the CHIPRA Connect initiative have also helped promote communication and collaboration between primary care and dental health professionals.[11] This type of interaction is a way to share information, dispel common misperceptions, and open lines of communication between primary care providers and dental professionals in a community.

Electronic means of exchanging information also holds promise for improving care coordination and communication between different types of providers. CCNC practices use an electronic provider portal so that health professionals can securely access specific types of Medicaid and NC Health Choice health information. The CCNC provider portal includes information about patients' visit history (including inpatient, emergency department, office visit, and imaging history), claims data, medication list and other information.[23] Currently primary care and specialty professionals, Health Check coordinators, and pharmacists can access this data. Dentists do not currently have access to the portal. One of the primary goals of the provider portal is to foster better care coordination between providers. The use of electronic health records (EHRs) is another means of securely sharing patient information. Certain types of health professionals, including pediatricians, family physicians, and dentists can qualify for incentive payments from the Centers for Medicaid and Medicare Services if they adopt and use certified electronic health records. As a result, more health professionals have begun to adopt electronic health records,[e] although, the use of electronic health records is not universal. Over time, as more professionals adopt and use EHRs, they should be able to share patient health information electronically (when necessary for the treatment of a particular patient). The

e Williams, Rachael. Assistant Program Manager, Medicaid HIT, Division of Medical Assistance, North Carolina Department of Health and Human Services. Written (email) communication, May 24, 2013

North Carolina Health Information Exchange (NC HIE) is the state designated entity for health information exchange. Over the next several years, the goal is to connect as many EHRs to the NC HIE to enable the sharing of patient health information across North Carolina's provider community. However, it may take several more years before the use of EHRs and connection to the NC HIE is so prevalent to make it easy to share patient-level data across health professionals. The lack of communication between primary care providers and dental professionals impedes efforts to improve the oral health of children. Therefore, the Task Force recommends:

Recommendation 5.2: Create Systems for Greater Collaboration between Primary Care Providers and Dental Professionals

The Division of Medical Assistance, Oral Health Section of the Division of Public Health, North Carolina Community Care Network (NCCCN), North Carolina Dental Society, North Carolina Academy of Pediatric Dentists, Old North State Dental Society, North Carolina Pediatric Society, North Carolina Academy of Family Physicians, and North Carolina Area Health Education Centers Program, should create systems for greater collaboration between professionals. These organizations, and other appropriate partners, should work together to:

a) Create a formal referral system, encouraging primary care providers to send a referral to the child's dental home, and encouraging dentists to send treatment records back to the PCP.

b) Explore ways to open up the NCCCN provider portal or other mechanisms to exchange clinical information such as shared electronic health records.

c) Encourage "mixers," video webinars, or joint local meetings or educational opportunities to create opportunities for collaboration between dental professionals and medical professionals.

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