This material is provided by the Idaho Oral Health Alliance and was compiled in May 2016 from recognized industry professionals. For current IOHA contact information, visit www.idahooralhealth.org

Oral Health Position Statements & References
for SHIP Regional Health Collaborative Oral Health Representatives

The Idaho Oral Health Alliance (IOHA) and its Oral Health Advisory Group of industry professionals presents the following information as reference materials in support of integrating oral health preventive practices into the primary care setting. Additional resources for each topic can be accessed via the electronic links embedded into this document.

American Academy of Pediatrics (AAP)-

Website: http://www2.aap.org/commpeds/dochs/oralhealth/index.html

The AAP Children's Oral Health effort is committed to the following goals:

- To promote oral health care in primary pediatric settings by giving anticipatory guidance to families about oral hygiene, diet, fluoride, and the importance of the first dental visit at 1 year of age.
- To educate and advocate for primary pediatric care professionals to apply fluoride varnish.
- To educate policy makers and payers about the importance of reimbursement for pediatric oral health care.

Policy Statements- The following policy statements and supporting resources can be found at http://www.aappublications.org/

Oral Health Risk Assessment Timing and Establishment of the Dental Home (2003, reaffirmed in 2009)
Pediatricians and pediatric health care professionals should develop the knowledge base to perform oral health risk assessments on all patients beginning at 6 months of age. Patients who have been determined to be at risk of development of dental caries or who fall into recognized risk groups should be directed to establish a dental home 6 months after the first tooth erupts or by 1 year of age (whichever comes first).

Fluoride Use in Caries Prevention in the Primary Care Setting (2014)
This succinct report will help to guide pediatricians and other health professionals regarding the use of fluoride as a caries prevention agent in the primary care setting. It covers the use of fluoride toothpaste in young children, fluoride varnish application in the primary care setting, fluoride supplements for children living in non-fluoridated areas, and facts about community water fluoridation.

Maintaining and Improving the Oral Health of Young Children (2014)

Oral health is an integral part of the overall health of children. Dental caries is a common and chronic disease process with significant short- and long-term consequences. The prevalence of dental caries for the youngest of children has not decreased over the past decade, despite improvements for older children. As health care professionals responsible for the overall health of children, pediatricians frequently confront morbidity associated with dental caries. Because the youngest children visit the pediatrician more often than they visit the dentist, it is important that pediatricians be knowledgeable about the disease process of dental caries, prevention of the disease, and interventions available to the pediatrician and the family to maintain and restore health.

United States Preventive Services Task Force Recommendation Statement (UPSPSTF)-

Website: http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/dental-caries-in-children-from-birth-through-age-5-years-screening

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 (*Grade 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 (*Grade 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.

***Definition of Grade B Recommendation:** The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.

Oral Health: An Essential Component of Primary Care- A Whitepaper by Qualis Health

Website: http://www.safetynetmedicalhome.org/sites/default/files/White-Paper-Oral-Health-Primary-Care.pdf

Americans are more likely to visit a primary care provider than a dentist, making the primary care setting a more reliable source of preventive oral health care. In 2012, 82% of adults and 93% of children made at least one visit to a physician or other ambulatory care provider. By comparison, only 61% of adults visited a dentist, with significantly lower visit rates for uninsured, unemployed, low-income, Hispanic, and African-American adults, as well as adults with Medicare or Medicaid coverage. Among children with commercial insurance, 58% received dental care at least once per year. Rates were lower for

children with Medicaid coverage (44%), particularly for the very young. The regularity and frequency of contact with primary care offers particular benefits for at least three high-risk/high-need groups: children, pregnant women, and people with diabetes.

- **Children:** The vast majority of children, especially young children, see their primary care provider on a routine basis for well-child care visits and other preventive services, such as immunizations. Offering preventive oral health care as a standard component of routine well-child care expands access, including the opportunity for referral, for nearly all children and adolescents.

- **Pregnant women** face barriers to accessing dental care, regardless of income or insurance status. Only 50% of pregnant women with a dental problem visit a dentist during their pregnancy. Many dentists mistakenly believe that dental care could put pregnant patients at risk, and convey the message that dental care should be delayed until after delivery; despite evidence showing that dental care, including radiographs, local anesthesia, and oral pain medication is safe throughout pregnancy. Nearly 75% of pregnant women receive prenatal care in the first trimester of pregnancy (and an additional 20% receive prenatal care beginning in the second trimester) from a primary care provider, midwife, or physician specialist, yielding an important access opportunity.

- **People with diabetes** are at high risk for oral health complications, and untreated oral disease may complicate diabetes. Most patients with diabetes see their primary care team on a regular basis for chronic illness care, including screening, self-management support (e.g., goal setting for diet and exercise), and medication management. Preventive oral health care fits squarely within chronic illness care for diabetes, and oral health self-care messages reinforce those already addressed in diabetes care; for example, the importance of reducing sugary beverages.

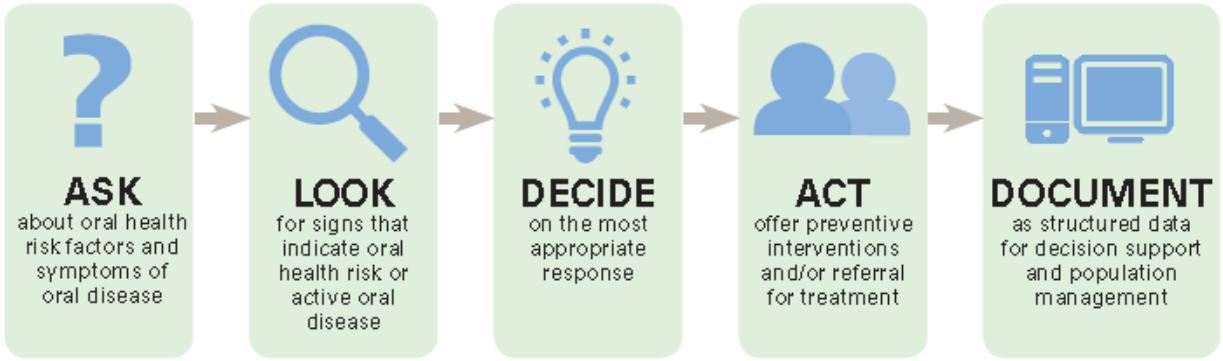
The American Academy of Pediatrics recommends that oral health risk assessment begin before the first tooth erupts, i.e., prior to 6 months of age. A primary preventive intervention for children is fluoride to protect the teeth. In 2014, the U.S. Preventive Services Task Force (USPSTF) recommended that primary care clinicians prescribe fluoride supplementation for children aged 6 months to five years whose water supply is deficient in fluoride, and provide fluoride vanish for all children from the time their first tooth erupts through age 5.

The Oral Health Delivery Framework

The *Oral Health Delivery Framework* delineates the activities for which a primary care team can take accountability to protect and promote oral health. These activities are within the scope of practice for primary care; and if organized efficiently, can be integrated into the office workflow of diverse practice

settings. Activities are grouped into five action categories: Ask, Look, Decide, Act, and Document & Follow Up.

Figure 2: Oral Health Delivery Framework



1. **Ask about symptoms that suggest oral disease and factors that place patients at increased risk for oral disease.** Two or three simple questions can be asked to elicit symptoms of oral dryness, pain or bleeding in the mouth, oral hygiene and dietary habits, and length of time since the patient last saw a dentist. These questions can be asked verbally or included in a written health risk assessment.
2. **Look for signs that indicate oral health risk or active oral disease.** Assess the adequacy of salivary flow; look for signs of poor oral hygiene, white spots or cavities, gum recession or periodontal inflammation; and conduct examination of the oral mucosa and tongue for signs of disease.
3. **Decide on the most appropriate response.** Review information gathered and share results with patients and families. Determine a course of action using standardized criteria based on the answers to the screening and risk assessment questions; findings of the oral exam; and the values, preferences, and goals of the patient and family.
4. **Act by delivering preventive interventions and/or placing an order for a referral to a dentist or medical specialist.** Preventive interventions delivered in the primary care setting may include: 1) changes in the medication list to protect the saliva, teeth, and gums; 2) fluoride therapy; 3) dietary counseling to protect the teeth and gums, and to promote glycemic control for patients with diabetes; 4) oral hygiene training; and, 5) therapy for tobacco, alcohol, or drug addiction.
5. **Document the findings as structured data to organize information for decision support, measure care processes, and monitor clinical outcomes so that quality of care can be managed. (Follow Up).**

Integration of Oral Health and Primary Care Practice Crosswalk with the Oral Health Delivery Framework

HRSA Core Clinical Domains	Oral Health Delivery Framework Actions
Risk Assessment • Conduct patient-specific oral health risk assessments on all patients. • Identify patient-specific conditions and medical treatments that impact oral health. • Identify patient-specific, oral conditions and diseases that impact overall health. • Integrate epidemiology of caries, periodontal diseases, oral cancer, and common oral trauma into the risk assessment.	**Ask about symptoms that suggest oral disease and factors that place patients at increased risk for oral disease.** Two or three simple questions can be asked to elicit symptoms of oral dryness, pain or bleeding in the mouth, oral hygiene and dietary habits, and length of time since the patient last saw a dentist. These questions can be asked verbally or included in a written health risk assessment.
Oral Health • Perform oral health evaluations linking patient history, risk assessment, and clinical presentation. • Identify and prioritize strategies to prevent or mitigate risk impact for oral and systemic diseases. • Stratify interventions in accordance with evaluation findings.	**Look for signs that indicate oral health risk or active oral disease.** Assess the adequacy of salivary flow; look for signs of poor oral hygiene, white spots or cavities, gum recession or periodontal inflammation; and conduct examination of the oral mucosa and tongue for signs of disease (HEENOT Exam). **Decide on the most appropriate response.** Review information gathered and share results with patients and families. Determine course of action using standardized criteria based on the answers to the screening and risk assessment questions; findings of the oral exam; and the values, preferences, and goals of the patient and family.

HRSA Core Clinical Domains	Oral Health Delivery Framework Actions
Preventive Interventions • Implement appropriate patient-centered preventive oral health interventions and strategies. • Introduce strategies to mitigate risk factors when identified.	**Act by delivering preventive interventions and/or placing an order for a referral to a dentist or medical specialist.** Preventive interventions delivered in the primary care setting may include: 1) changes in the medication list to protect the saliva, teeth, and gums; 2) fluoride therapy; 3) dietary counseling to protect the teeth and gums, and to promote glycemic control for patients with diabetes; 4) oral hygiene training; and, 5) therapy for tobacco, alcohol, or drug addiction.
Communication and Education • Provide targeted patient education about importance of oral health and how to maintain good oral health, which considers oral health literacy, nutrition, and patients' perceived oral health barriers.	
Interprofessional Collaborative Practice • Exchange meaningful information among healthcare providers to identify and implement appropriate, high-quality care for patients, based on comprehensive evaluations and options available within the local health delivery and referral system. • Apply interprofessional practice principles that lead to safe, timely, efficient, effective, equitable planning and delivery of patient- and population-centered oral health care. • Facilitate patient navigation in the oral health care delivery system through collaboration and communication with oral health care providers, and provide appropriate referrals.	**Document the findings as structured data to organize information for decisions support, measure care processes, and monitor clinical outcomes so that quality of care can be managed (Follow Up)**

Quality Improvement: The Importance of Measurement

To monitor the effectiveness of an oral health integration effort and understand its impact on patients, families, and the practice as a whole, we recommend that practices track a set of measures similar to those identified in Table 1 (see below). Ideally, these measures are incorporated into the primary care practice's existing quality improvement dashboard and presented transparently alongside other clinical quality data for staff, patients, and other stakeholders to see.

Table 1: Sample Measures to Understand Impact of Oral Health Integration Efforts

Clinical Process Measures	Percentage of patients given: • A written or verbal risk assessment or screening questions • An oral exam • A referral to a dentist, if indicated based on findings
Intervention Measures	Percentage of patients in need given: • Dietary counseling • Oral hygiene training • Risk behavior education • Fluoride varnish and/or other fluoride supplement therapy • Medication adjustment to address dry mouth
Care Coordination and Referral Process Measures	• Number of referral agreements in place with local dental partners • Percentage of referred patients with a completed dental referral
Patient Experience Measures	• Percentage of patients satisfied with the preventive oral health care offered or coordinated by primary care • Percentage of patients who received useful oral health information, dietary counseling, or oral hygiene training
Practice Experience Measures	• Percentage of staff trained to deliver oral health preventive services • Percentage of staff with demonstrated knowledge of oral health clinical content • Percentage of staff satisfied with dental referral process

ICD 10 Codes: Oral Health in Primary Care

ICD10 Code	Condition
K02.9	Dental caries, unspecified
K02.7	Dental root caries
K05.0	Acute gingivitis
K05.6	Periodontal disease, unspecified
K03.2	Erosion of teeth
K08.1	Complete loss of teeth
K11.7	Disturbances of salivary secretion
K13.2	Leukoplakia of oral mucosa
K14.0	Glossitis