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CME

Health problems of the mouth can affect the whole patient, making primary care physicians a natural ally.

OFFERING Oral Health Services IN YOUR OFFICE

Evidence that poor oral health is connected to poor systemic health has grown over the last decade. Children with dental caries often face pain and nutritional problems, and caries build the foundation for adult dental disease. In adults, periodontitis, or deep inflammation of the gingiva, is strongly linked to poor diabetes control and is associated with vascular disease, arthritis, obesity, and adverse pregnancy outcomes. These connections underscore the value of addressing this major area of patient care in primary care practices.

Offering these services might be not only effective preventive care but also remunerative depending on the makeup of a physician's pediatric population. Although payer policies limit physicians' ability to be reimbursed for oral health services, four-fifths of state Medicaid programs reimburse for child oral health care.

The Institute of Medicine has defined roles for family physicians and other non-dental health care professionals in two reports on advancing oral health care.[1,2] Also, Healthy People 2020 made oral health one of its top nine health indicators. While bold in mission, none of these documents provide detailed guidelines for medical clinicians, so this article will try to help prepare physicians to incorporate oral health services in their practices.

The family doctor and early childhood caries

Treating children and early childhood caries from birth through age 5 has generated the most evidence of beneficial intervention. Recently, the U.S. Preventive Services Task Force (USPSTF) recommended (level "B" – "moderate certainty that the net benefit is moderate to substantial") that primary care providers apply fluoride varnish to the primary teeth of children.[3]

Many family doctors have been addressing the oral health of children for years. Researchers have shown that primary care doctors can apply fluoride varnish and examine the mouth accurately to identify caries.[4] Moreover, they can do this work efficiently in their offices, enjoy tackling this problem, and find that the efforts result in fewer cavities.[5,6]

The American Academy of Pediatrics (AAP) suggests that primary care physicians should discuss oral health with parents starting when children are 6 months of age, which coincides with when primary teeth erupt. Such visits should include a risk history for caries, an oral exam, dental hygiene and diet advice, an assessment of the need for systemic fluoride, and a referral to a dentist with the first dental visit before the child's first birthday. Family physicians can start this discussion even earlier with women of childbearing age, as maternal oral health is a strong predictor of a child's oral health. Dietary patterns, oral hygiene practices, and oral flora that cause tooth decay are all passed along from the primary caregiver to the child.

Getting started

In order to make providing oral health services easier and less time-consuming, we have involved the entire staff in

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Children with dental caries often face pain and nutritional problems, and caries build the foundation for adult dental disease.

Physicians should discuss oral health with parents starting when a child's teeth erupt at six months.

Adding oral exams and fluoride varnish application to well-child visits is relatively simple and most likely to be reimbursed.

Practices should add oral health care information to their documentation, website, and patient education materials.

the process. For example, consider the steps taken to assess and manage the oral health of a 1-year-old patient in the context of a well-child visit:

First, the front-desk staff determines whether the child is covered by Medicaid or another payer that pays for oral health screens and fluoride varnish or whose family wants to pay out-of-pocket for these services. If so, staff can communicate this information by adding a tooth-shaped sticker or other marker to the patient's paperwork for the visit. As part of the intake process, the medical assistant or nurse can help parents complete a caries risk assessment verbally or by questionnaire. The AAP has an easy-to-use risk assessment tool, which can be downloaded at https://www2.aap.org/oralhealth/RiskAssessmentTool.html.

During the visit, the family physician or midlevel provider can perform the oral exam using the knee-to-knee approach (sit facing the parent/guardian with knees touching, sit the child in the parent/guardian's lap, and lay the child's head back into the examiner's lap) and offer dietary and hygiene advice. Providing this exam and oral health advice can be learned easily online while earning free CME credit through the American Academy of Family Physicians (AAFP)-endorsed Smiles for Life curriculum. (See "Features of Smiles for Life.")

After the oral exam, the medical assistant or nurse can apply fluoride varnish as well as provide any necessary vaccinations, patient education, or other services required in follow up to the exam. This arrangement allows the physician or midlevel provider to move more quickly on to the next patient and helps to preserve productivity. Applying varnish takes less than a minute and is easily learned. Many states have free training programs that are grant funded. Check out the AAP state information and resource map for details (http://www2.aap.org/oralhealth/State.html) or seek out your state's oral health programs (http://www.astdd.org/state-programs/). The varnish costs about $1 an application, has a pleasant flavor for children, and is not contraindicated in patients' whose community water supply is fluorinated. The child can eat or drink immediately after treatment (although it's advisable to wait at least one hour before tooth brushing). To maintain an efficient flow in the office, practices should keep fluoride varnish supplies in the exam rooms or in an easy-to-carry toolbox that can be transported from a central location into the exam room. To minimize documentation fatigue, staff members should share this responsibility, with each documenting the portion of the service he or she provided.

Keep the documentation simple whether you use paper charts or an electronic health record (EHR). For example, add prompts to your EHR for well visits to include oral health findings, advice, and referrals. In the exam section of the record, add a check box to indicate whether teeth and gums are normal or abnormal. In the advice section, add check boxes to indicate whether nutrition and dental hygiene advice are given, as well as whether a dental referral is made. Other ideas include loading patient education about oral health into your EHR for easy printing or keeping paper information sheets in exam rooms. You might also add advice on oral health to your practice website. You can find high-quality resources on the patient-oriented websites of the American Dental Association (www.mouthhealthy.org) and the American Academy of Pediatric Dentistry (www.mychildrensteeth.org). Incorporating oral health into your office as a quality improvement project could easily be used as Part IV of your American Board of Family Medicine (ABFM) Maintenance of Certification (MOC) requirement. This can be a self-initiated MOC project; the ABFM is working with the AAP to add a new oral health option for Part IV in the future.

Getting paid

Forty-three states pay medical providers through their Medicaid programs for address-

ing child oral health, including those services provided in the context of a well-child visit. These programs pay between $11 and $78 when provided between the time a patient's teeth erupt up to age 21, depending on the state and whether reimbursement is offered for screenings, fluoride varnish application, or both.[7] Most states pay for the service two to four times per year based upon the child's risk. For example, an office in Nevada applying fluoride varnish for 20 eligible children per week would increase its revenue by $55,432 annually at that state's reimbursement rate of $53.30. In Washington state, where Medicaid reimburses for fluoride varnish plus two additional oral health services, the same provider is paid $13.25 for the fluoride varnish application, $29.46 for the oral exam, and $27.58 for the oral health risk assessment. This would generate $73,102 annually for 20 children a week in addition to reimbursement for the well-child visits themselves (see "Example of dental care reimbursement"). To explore reimbursement rates for your state, go to http://www2.aap.org/oralhealth/State.html.

For children not covered by Medicaid, offices could offer the fluoride varnish application to patients' families for an out-of-pocket cost equal to what Medicaid would pay. Note that the USPSTF recommends fluoride varnish for all children under 6 years, but most patients not on Medicaid are at lower risk for caries.[8] Of course all children should be given an oral health screening, their caregivers should be advised about nutrition and oral hygiene, and the patient should be referred to a dentist, regardless of reimbursement, as part of comprehensive well-child care.

Oral health for all ages

Oral health affects individuals in different ways across the life cycle. While there is no specific Medicaid reimbursement available at this time for patients other than children, addressing oral health will improve the overall health in other age groups as well.

For example, gum disease may flare during pregnancy, particularly in women with poor oral hygiene. Periodontitis has been associated with preterm labor and low infant birth weight, and family physicians can screen prenatal patients at the intake visit with a few questions and a quick exam. Some state Medicaid programs include dental benefits for pregnant women. Physicians are encouraged to record their findings and refer pregnant patients to a dentist, an approach promoted by the American College of Obstetrics and Gynecology. The National Maternal and Child Oral Health Resource Center has developed some handouts that patients can take to their dentist explaining what dental care prenatal patients can receive (http://www.mchoralhealth.org/PDFs/OralHealthPregnancyResGuide.pdf) and what dental treatment is safe during pregnancy (http://www.mchoralhealth.org/PDFs/OralHealthPregnancyConsensus.pdf).

Adolescents benefit from basic oral care advice, including caution about oral piercings, which can lead to gum erosion, intraoral infections, and fractured teeth. Physicians can make this a part of these patients' annual visits, remembering to document the discussion and providing handouts. Sports clearance visits should include discussion of dental injury prevention, such as using mouth guards.

Family physicians should address periodontitis during chronic care visits for patients with diabetes, vascular disease, and arthritis. In addition to checking blood pressure and doing foot exams, oral health can become part of the protocol for diabetes visits. It's also an easy topic to cover during group visits. Recent studies have reported that addressing periodontitis can save a patient with diabetes an average of $2,840 in avoided hospitalizations and office visits and can save a patient with cerebral vascular disease $5,681.[9]

Many geriatric patients are on far too many medications. Some of the common medications prescribed can cause a decrease in saliva flow, exacerbating gum disease and increasing adult cavities, particularly in teeth

- Forty-three states pay primary care providers for child oral health care through Medicaid.
- Offer oral health care to non-Medicaid families with out-of-pocket costs equal to what Medicaid would pay.
- Patients of all ages and health status can benefit from oral health care services.

FEATURES OF SMILES FOR LIFE

www.smilesforlifeoralhealth.org

Six hours of free web-based CME training are available through a downloadable iOS application suitable for physicians, nurses, physician assistants, medical assistants, students, pharmacists, and dental professionals. The eight modules, which take about 45 minutes each to complete, cover the relationship between oral and systemic health, child oral health, adult oral health, geriatric oral health, acute dental problems, oral health for pregnant patients, the oral examination, the use of fluoride varnish, caries risk assessment, and counseling.

with exposed roots not protected by enamel. Patients on antihistamines, anticholinergics, antidepressants, and some antihypertensives should be particularly counseled about the importance of oral hygiene and the need to avoid sucking on sugary candy to relieve dry mouth. The anticipatory guidance that physicians provide for a multitude of health behaviors can readily include an oral health component. The power of this guidance is increased if patients hear the same message from both their physician and their dentist.

Treating oral health problems in chronically ill patients can help them avoid significant future care costs.

Oral health care guidance gains credibility when it comes from both the patient's physician and dentist.

Physicians are a natural fit to provide oral health care services.

Why the family doctor?

Some will ask, "But why the family doctor? Shouldn't dentists be doing all of this?" In fact, there are many barriers to accessing dental care, including transportation, lack of Medicaid dental providers, lack of dental coverage in general and among Medicare patients in particular, and a lack of awareness by individuals about the importance of oral health. Only 43 percent of people age 2 years and older had a dental visit in the past 12 months.[10] For those older than age 65, only 30 percent[11] have dental insurance. And even among those with full dental coverage under Medicaid, only 35 percent had a dental visit last year.[12]

Although patients may not be seeing the dentist, they are seeing their personal physician. Based on immunization schedules and standard well-child visit intervals, family doctors see children an average of 11 times by the age of three, and many adults see their physician every one or two years for periodic checkups. We provide a home for these patients' total health, which includes oral health. In many geographic areas with limited access to dentists who are willing to see young children, prenatal patients, or those with special needs, primary care physicians remain the major or only source of oral health care and advice.

Offering oral health screens and dental hygiene advice is not difficult nor is it time consuming. In addition to adding fluoride varnish applications to well-child exams, offering oral health care services to your patients is meaningful and adds reimbursement dollars to the office. FPM

EXAMPLE OF DENTAL CARE REIMBURSEMENT

Here's a breakdown of what a practice could receive from Medicaid in Washington state for a well-child visit with an established patient:

Well-child visit (V20.2, 9938x or 9939x)	$56.40-$108.65
Fluoride varnish application (D1206)	$13.25
Oral exam	$29.46
Oral health risk assessment	$27.58
Total	**$126.69-$178.94**

Source: Washington Health Care Authority; American Academy of Pediatrics.

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