TASK FORCE ON CHILDREN'S PREVENTIVE ORAL HEALTH SERVICES
Friday, March 22, 2013
North Carolina Institute of Medicine, Morrisville
10:00am - 3:00pm
Meeting Summary

Attendees

Members: Mark Casey (co-chair), Frank Courts (co-chair), Marian Earls (co-chair), Sam Bowman Furhmann, Joseph Crocker, Rob Doherty, Sharon Nicholson Harrell, Rebecca King, Thomas Koinis, Jasper Lewis, Linda Moore, Rafael Rivera, Caroline Rodier, Gary Rozier, Michael Scholtz, Linda Swarts, Tom Vitaglione, Lisa Ward

Steering Committee and NCIOM Staff: Krutika Amin, Katie Eyes, Pam Silberman, Anne Williams, Berkeley Yorkery

Other Interested people: Danielle Breslin, Shawn Henderson, Michael Ignelzi, Jessica Riley, Darryl Smith

WELCOME AND INTRODUCTIONS

Mark Casey, DDS, MPH
Dental Director, Division of Medical Assistance
North Carolina Department of Human Services

Frank Courts, DDS
Chair, Physicians Advisory Group Dental Committee

Marian Earls, MD
Lead Pediatric Consultant
Community Care of North Carolina

Berkeley Yorkery,MPP
Project Director and Research Associate
North Carolina Institute of Medicine

The co-chairs welcomed everyone to the meeting and asked attendees to introduce themselves. Ms. Yorkery, reviewed the results of the survey members completed prioritizing the strategies brainstormed at the February meeting.

MOBILE CLINICS: AN OUT OF OFFICE ALTERNATIVE

Shawn Henderson, MBA

Practice Manager II
Mission Children's Hospital

Ms. Henderson gave the Task Force an overview of the operations of the Mission Children's Dental Program which addresses the oral health needs of "at-risk" children in Western North Carolina. The program treats NC Medicaid, Health Choice, uninsured and undocumented patients from birth to age 18 and offers a sliding fee scale (0-100%). The program sees patients either in one of its two mobile dental clinics—The ToothBuses®—or under general anesthesia in an operating room. In 2012, there were 1,164 visits on The ToothBus®, and 1,071 children treated in the operating room. The ToothBus® goes to schools in 5 counties and offer full restorative care to children on site with parent permission. Ms. Henderson concluded with a summary of the oral health care status of children in lower socioeconomic status.

Ms. Henderson's presentation is available here: Mission Children's Dental Program.

Selected Questions and Comments:

- Q: How many of your dentists are pediatric dentists?
  A: Our dentists are surgical dentists, not pediatric dentists. They are not pediatric board certified, they are surgical dentists, did general residencies.
- Q: How involved are parents when the children are seen at school? Do you run into legal problems?
  A: The parents sign consent forms prior to the visit of the ToothBus® and information about the devised plan of care is communicated to the parents. The program office staff call parents to discuss any planned procedures, and if something unusual arises, dentists will also stop and call the parents. About 10-25% of parents consent for children to be treated. Typical patients are children of families who can't or don't take time off work to take kids to the dentist's office.
- Q: Does the program act as patients' dental home or refer patients to dental homes? How does the program handle subsequent patient needs?
  A: The program will try to refer patients to dental homes, but for many of the kids the program acts as their dental home through 5th or 6th grade and then works with parents to transition kids to a community dentist. The bus returns to the school each year and when necessary, the program will transport kids to the school the bus is visiting or send the bus back to a school to address a child's needs. During the summer both buses park in Transylvania and have 100% of the slots filled.
- Q: What percent of the program is funded through patient services?
  A: The program funding breaks down to 12% by the hospital system, and 88% patient revenue. The operating room part of the program helps, but there's no reason a bus program couldn't be self-sufficient.

CCNC EFFORTS TO INCREASE ACCESS TO DENTAL CARE
Marian Earls, MD
Lead Pediatric Consultant
Community Care of North Carolina

Dr. Earls gave the Task Force a summary of the work being done by CCNC around pediatric oral health. She outlined the three main oral health objectives:

(1) Increase the awareness of families for the need of all children to be linked to a dental home and engage primary care providers to reinforce this message.
(2) Expand the efforts of the Into the Mouths of Babes (IMB) dental varnish project.
(3) Routine use of an Oral Health Screening tool by primary care providers.

Dr. Earls presented some of the claims data collected by CCNC that networks and practices can access quarterly to check the rates of EPSDT Annual Dental visits and applications of fluoride varnish. Under CHIPRA, CCNC networks have been conducting quality work in one of three categories. Category A Networks have pediatric QI specialists and have identified fluoride varnishing as a top priority for improvement and expansion. The QI specialists are assisting with practice trainings using the IMB/PORRT (Priority Oral Risk Assessment and Referral Tool) Toolkit. Category C "CHIPRA Connect" Networks have been using a learning collaborative model and hosting mixers with pediatricians and dentists to change referral patterns and focus on building community relationships for more coordinated care. And Category D Networks have been using PORRT to develop and improve pediatric EHR measures.

Dr. Earls presentation is available here: CHIPRA & CCNC.

Selected Questions and Comments:

- C: It would be good to bring up the importance of preventive oral health care and having a dental home in prenatal education.

THE SCIENCE OF SEALANTS
Michael Ignelzi, DDS, PhD
Lake Jeanette Orthodontics and Pediatrics Dentistry

Dr. Ignelzi presented an overview of the science of pit and fissure sealants to the task force. He outlined some of the data regarding sealants and common dentist concerns. 90% of caries in permanent teeth found in pits and fissures but in 2011, less than 40% of dentists indicated they sealed non-cavitated carious lesions. Many dentists are concerned that they will inadvertently seal over caries and that the caries will progress. However, research shows that the probability for progression for non-cavitated carious lesions that have been sealed is very low. Dr. Ignelzi argued that dentists should restore cavitated lesions, but seal the majority of non-cavitated lesions, and commit to the maintenance of selants because they must remain intact to protect the tooth.

Dr. Ignelzi summarized the American Dental Association Council of Scientific Affairs' evidence-based clinical recommendations for the use of pit-and-fissure sealants. The recommendations include sealing primary teeth if the tooth is at risk of caries, placing pit-and-fissure sealants on non-cavitated carious lesions, using resin-based sealants, and techniques for improved retention and effectiveness of sealants.

Dr. Ignelzi's presentation is available here: The Science of Sealants.

Selected Questions and Comments:

- C: When dentists say that they don't place sealants it may be a result of a lot of patients presenting with active decay or cavitated lesions. Transporation also becomes an issue if dentists recommend sealants but kids don't come back to the office.
- Q: What are your thoughts on flouride varnish?
- A: Dr. Ignelzi is a big fan of fluoride varnish and said that the data to support the use of fluoride varnish is very strong. Flouride varnish protects the smooth surfaces of teeth while sealants protect the pit-and-fissure grooves.
- C: Pit-and-Fissure caries are 90% of the caries seen in permanent teeth in part because the prevalence of smooth surface caries has decreased over the last few decades.

TASK FORCE DISCUSSION AND POTENTIAL RECOMMENDATIONS

The task force discussed the barriers and root causes of underutilization of sealants due to both dental provider behaviors and issues of Medicaid policy. The task force discussed more effective ways to approach dentists about placing sealants and referring children to dental homes. One method discussed was a learning collaborative model with key early adopters in the dental community.

NEXT STEPS

The upcoming task force meetings are scheduled for Friday, April 26th and Friday, May 31st. For a summary of the planned discussion topics by month see this task force update: Task Force Update.