North Carolina Institute of Medicine
2020 Update on Implementation of Recommendations from the 2013 North Carolina Oral Health Action Plan for Children Enrolled in Medicaid and NC Health Choice

Introduction

Dental caries, also called "tooth decay" or "cavities," is the most prevalent chronic infectious disease among children in the United States (1). Tooth decay, which can lead to pain and swelling, can limit a child's ability to eat and speak, create problems that distract their ability to learn, and impact a child's quality of life (2, 3). Fortunately, dental caries is both preventable and manageable. With proper dental care and dietary choices, dental caries could almost be eliminated among children (1).

In 2011, In North Carolina, 14% of children in kindergarten (ages 5-6) had untreated dental decay in at least one primary tooth.[a] National data show that 40% of 2-8 year old children have dental caries in their primary teeth and 21% of 6-11 year old children have dental caries in their permanent teeth. A number of factors put some children at greater risk of developing dental caries, particularly low socioeconomic status and minority race/ethnicity (4). In North Carolina, children with family incomes below 200% of the federal poverty level qualify for health care coverage, including dental services, through Medicaid or NC Health Choice, North Carolina's State Child Health Insurance Program (5-7).

In the fall of 2012, the Centers for Medicare and Medicaid Services (CMS) asked states to develop a plan to increase the proportion of children ages 1-20[a] enrolled in Medicaid or Children's Health Insurance Programs (CHIP) who receive any preventive dental services, and the proportion of children ages 6-9 who receive a dental sealant on a permanent molar tooth by 10 percentage points over five years.[b] The North Carolina Institute of Medicine Task Force on Children's Preventive Oral Health Services was convened to help the North Carolina Division of Medical Assistance (DMA)[c] develop its dental action plan to improve access to preventive oral health services for all children in response to the request from CMS.

[a] In this report, we will use the term children to refer to the population ages 1 to 20 unless otherwise noted.
[b] In 2013, the federal poverty level for a family of four is $23,550. 200% of the federal poverty level is $47,100. http://aspe.hhs.gov/poverty/13poverty.cfm.
[c] NC Medicaid is now run through the NC DHHS Division of Health Benefits. Throughout this update, we have left "Division of Medical Assistance" in recommendations; in the text describing implementation activities, we use "NC Medicaid" to capture implementation activities conducted under both Division names.

The Task Force on Children's Preventive Oral Health Services was chaired by Mark Casey, DDS, MPH, dental director, DMA; Frank Courts, DDS, chair, Physicians Advisory Group Dental Committee, DMA and dental practitioner; and Marian Earls, MD, FAAP, lead pediatric consultant, Community Care of North Carolina (CCNC). The task force included 35 task force and steering committee members representing dental health professionals, state policymakers, public health and other health professionals, researchers, consumer representatives, and others. The task force met monthly from December 2012 to May 2013.

The task force developed three goals. The first two were expected to be required by CMS and focus on preventive dental services provided by dental providers:

1. Increasing the proportion of children ages 1-20 enrolled in Medicaid or NC Health Choice[d] (enrolled for at least 90 days) who received any preventive dental services from dental providers by 10 percentage points, from 45% to 55% for children enrolled in Medicaid and 42% to 52% for children enrolled in NC Health Choice, over a five-year period from FFY 2011 to FFY 2015.

2. Increasing the proportion of children ages 6-9 enrolled in Medicaid or NC Health Choice (enrolled for at least 90 days) who receive a dental sealant on a permanent molar tooth by 10 percentage points, from 17% to 27% for children enrolled in Medicaid and 25% to 35% for children enrolled in NC Health Choice, over a five-year period from FFY 2012[e] to FFY 2017.

In addition to these goals set by CMS, the task force felt it was important to include a goal looking at the role primary care providers serve in providing preventive oral health care. Therefore, the task force set a third goal to:

3. Increase the utilization of preventive oral health services among children ages 6 months-20 years 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 to FFY 2015.

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[d] NC Health Choice is North Carolina's CHIP program.
[e] For the purposes of this report we are using FFY 2012 as the baseline year. CMS has not yet defined the baseline year for this measure for their requirements; therefore, the baseline year may need to be changed once CMS has decided on a baseline year.

The task force examined the main barriers to the utilization of preventive oral health services for children enrolled in Medicaid and NC Health Choice and developed recommendations to address these barriers. Low-income children enrolled in Medicaid or NC Health Choice are at much higher risk of developing caries than are children with higher incomes and are also more likely to have untreated caries (8).

The *North Carolina Oral Health Action Plan for Children Enrolled in Medicaid and NC Health Choice* includes a wide variety of recommendations that could be pursued and promoted by both public and private stakeholders. The report outlines a multifaceted approach that, if implemented, would significantly improve access to and utilization of preventive oral health services among children enrolled in Medicaid and NC Health Choice.

The following document describes the progress that has been made toward implementing the recommendations of the NCIOM Task Force on Children's Preventive Oral Health Services. The original recommendations are provided in bold, along with a description of progress to date. For the purposes of this update, progress is defined as movement toward the goals of the recommendation, regardless of whether the recommendation was followed directly or advancement was achieved through other means. Likewise, progress is evaluated based on the intent of the recommendation.

Acknowledgements

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Total Recommendations: 14

Fully Implemented: 2
Partially Implemented: 11
Not Implemented: 1

Recommendation 3.1 Partially Implemented

Increase Outreach and Education to Families of Young Children about the Importance of Oral Health Services

The Division of Medical Assistance (DMA) and the Oral Health Section of the Division of Public Health (OHS) should:

a) Educate agencies and organizations that interact with pregnant women and young children and their families about how to maintain good oral health for infants and young children, the importance of seeking dental services for children beginning at age 1, and to help link young children, particularly those at high risk, to dental homes. Outreach efforts should include the following agencies and organizations:

1) Programs serving young children and their parents including local Departments of Social Services, Community Care of North Carolina, local health departments, early care and education providers, Head Start, SmartStart, the North Carolina PTA, the faith community, and others.

2) Programs serving pregnant women and their partners, including WIC and prenatal/birth education classes, offered through health departments, hospitals, local Departments of Social Services, and others.

3) Health care professionals serving pregnant women and their partners and young children, including OB-GYNs, family physicians, pediatricians, certified nurse midwives, physician assistants, and nurse practitioners.

The OHS created a Perinatal Oral Health Workgroup in 2016 to educate agencies and organizations within the state that work with pregnant women and families with young children about maintaining good oral health and seeking dental services for young children. The workgroup adopted and disseminated guidelines at the 2018 North Carolina Public Health Association (NCPHA) Fall Conference. The guidelines provide six goals designed to promote oral health during pregnancy. The goals include 1) assess pregnant women's oral health status, 2) advise pregnant women about oral health care, 3) work in collaboration with prenatal and oral health professionals, 4) provide oral disease management and treatment to pregnant women, 5) provide support services and case management to pregnant women, and 6) improve health services in the community.[f] The workgroup goals have been aligned with the work of WIC,

[f] https://publichealth.nc.gov/oralhealth/docs/NCOH-PracticeGuidelines-Revised120618-WEB.PDF

HeadStart, and Smart Start, but there is still room for partnerships with the Division of Social Services (DSS).

The OHS staff offers early childhood oral health training to child care providers, health care professionals, parents, and community groups across the state. The Section also has worked with the state WIC program to develop a flier to teach parents about the importance of early oral health care for children, and Section staff offer community activities that educate the public about pediatric oral health. Finally, primary care providers are provided with information and resources for counseling parents of small children about the importance of oral health care during Into the Mouths of Babes (IMB) training.

b) DMA should develop a one-page document that summarizes the major Medicaid and NC Health Choice dental benefits and information on how young children can receive oral care. DMA should partner with other organizations and agencies to distribute this information to families. Partnering organizations should include those listed above as well as schools, community-based organizations, and others.

NC Medicaid provides information to the public summarizing dental benefits available through Medicaid and NC Health Choice and enumerating other resources for dental care for young children. The agency has also advocated for the extension of coverage for women on Medicaid for Pregnant Women (MPW) to 60 days postpartum to increase access to covered dental services. Additional information provided by NC Medicaid includes: a one-page document distributed to Community Care of North Carolina (CCNC) primary care providers who treat children emphasizing the importance of sealants to prevent tooth decay in children at risk for caries and encouraging providers to discuss the benefits of sealants with parents/caregivers; direct mail letters sent to the parents/caregivers of Medicaid/Health Choice-enrolled children containing information about the importance of establishing a dental home by age 1 and follow-up with routine care every 6 months.

Although some gains have been made, there is room for more collaboration among other agencies and organizations within the state to further spread information about available pediatric and perinatal dental services. A partnership with the DSS could help NC Medicaid expand its communication reach, both for dissemination of educational information about oral health and access to dental services and about NC Families Accessing Services Through Technology (NC FAST) eligibility for mothers.

Additionally, while information about coverage options through Medicaid and NC Health Choice is available on the NC Department of Health and Human Services (NC DHHS) website, the

information may not be accessible to many North Carolinians. Lack of computer access and low health literacy may prevent parents and expectant mothers from understanding eligibility and coverage options to ensure that oral health needs are met. Therefore, greater tailoring of information delivery to the target population could increase public awareness of preventive oral health services and coverage opportunities for young children.

Recommendation 3.2 — Partially Implemented

Support Dental Care Coordination by North Carolina Community Care Networks

> **The Division of Medical Assistance and the North Carolina Community Care Networks should examine whether an additional per member per month (pmpm) payment is needed to expand the capacity of Health Check Coordinators to help families with children enrolled in Medicaid or NC Health Choice understand the importance of oral health and connection to a dental home. The pmpm payment should be increased accordingly if additional resources are warranted.**

The pmpm payment has not been increased to expand the reach of health check coordinators. Nonetheless, Community Care of North Carolina (CCNC) has overseen continued operation of health check coordinators who work with case managers to ensure patients receive care alerts for necessary checkups, including dental care. CCNC also encourages primary care providers to ask patients if they have a dental home during routine visits, and if they do not, connect the patient with a dentist.

In October of 2018, North Carolina's Medicaid Innovations Waiver was approved by the Center for Medicaid and Medicare Services (CMS). In accordance with the approved waiver, the state is undergoing Medicaid transformation and has accepted bids from five companies to provide Prepaid Health Plans (PHPs) within the state. These companies are BlueCross BlueShield of North Carolina, AmeriHealth Caritas NC, WellCare NC, United Healthcare, and Carolina Complete Health Network, which is a partnership between Centene Corporation, the North Carolina Community Health Center Association, and the North Carolina Medical Society (9).

Although dental services are carved out of the new managed care system, CCNC is currently working to make contracts with the five PHP providers to establish the future roles of health check coordinators and how patient health reminders will work under Medicaid transformation. As of October 2020, implementation of Medicaid transformation is scheduled to begin no later than July 1, 2021.

There has also been some development in the academic training of dental health coordinators. In early 2018, Alamance Community College became the first school in the state to offer a Community Dental Health Coordinator Certificate (CDHC). The one-year online program, developed in partnership with the American Dental Association (ADA), was designed to help dental assistants and hygienists gain public and dental health advocacy skills. These skills can be used to bridge the gap between patient and provider, and position dental assistants and hygienists as patient educators who can explain procedures and the importance of preventive services to patients and parents of young children. The NC Department of Health and Human Services (NC DHHS) has applied for grant funding to support the hiring of community dental health coordinators, but no partnership between NC DHHS and the Alamance Community College program has been established. As of 2019, Catawba Valley Community College had also developed an online Dental Health Coordinator program. The Catawba program may also be working with Alamance to continue their program.[g]

Recommendation 3.3 — Partially Implemented

Increase the Participation of Dentists in Medicaid and NC Health Choice

The North Carolina Dental Society (NCDS) should:

a) **Partner with the Division of Medical Assistance (DMA) to encourage more dentists to participate in Medicaid and NC Health Choice by:**

   1) **Providing information in the NCDS Gazette about the importance of treating patients enrolled in Medicaid and NC Health Choice.**

   2) **Highlighting dental champions that actively participate in Medicaid and NC Health Choice who can make the business case for participation.**

   3) **Identifying NCDS leaders who can encourage other dentists to participate in Medicaid and NC Health Choice.**

NC Medicaid has undertaken outreach efforts to encourage dentists to participate in Medicaid and NC Health Choice. Although industry champions and leaders have not yet been incorporated into outreach initiatives, NC Medicaid has operated a booth at the annual NCDS meeting and attended interprofessional meetings hosted by NCDS to educate and recruit providers into Medicaid and NC Health Choice networks. Additionally, NC Medicaid has sent representatives

[g] http://www.cvcc.edu/CCE/Health_Services/Community-Dental-Health-Coordinator.cfm

to industry forums and has responded to referrals from NCDS to address concerns that providers have with participation in the program.

At the time of publication of the original task force report, an obstacle to recruitment of providers in the state was the stagnation of Medicaid and NC Health Choice reimbursement rates, which had remained at 30% for some time. In May 2019, the NC Medicaid received permission from the Centers for Medicaid and Medicare Services (CMS) to increase the Medicaid reimbursement rate for dental services by 10%, from 30% to 40%.[h]

b) Partner with DMA to increase the willingness of general dentists to treat young patients. The NCDS can help by:

1) Conducting focus groups or otherwise seeking information from dentists about barriers to treating young children.

The NCDS maintains an Access to Care Committee that conducts focus groups with dental providers, and otherwise solicits information from dentists in the state about barriers to treating young children. While the number of NC Medicaid-enrolled young children receiving dental services slightly increased from 2011 to 2019, there has been no real increase in the number of dentists treating this population.

2) Identifying local dental champions that can encourage other general dentists in their area to treat young children enrolled in Medicaid and NC Health Choice.

The NCDS intends to use pilot studies to identify dental champions who are willing to treat young patients who are enrolled in Medicaid and NC Health Choice. A larger workgroup has also been organized with providers and NCDS members to develop strategies for encouraging the treatment of young patients. However, this recommendation has not yet been met.

3) Creating a referral system of pediatric dentists willing to take referrals of children with more complex dental needs and/or more difficult behavioral problems.

[h] https://medicaid.ncdhhs.gov/blog/2019/05/02/special-bulletin-dental-reimbursement-rate-increase

Dental providers in the state have not faced difficulties referring children to pediatric dentists. However, there is still a need for a referral system for other dental subspecialties, especially for periodontal care and endodontics.

4) **Encouraging dentists to reach out to pediatricians and family physicians in their community to encourage them to use the Priority Oral Health Risk Assessment and Referral Tool (PORRT), and to create referral networks into dental homes.**

The Division of Public Health (DPH) continues to advocate for the Priority Oral Health Risk Assessment and Referral Tool (PORRT) as a simple and accurate means of assessing and referring patients. Additionally, the Carolina Dental Home pilot project is being used to develop a model system for pediatricians and family physicians.

Recommendation 3.4 — Partially Implemented

Reduce Barriers to Participating in Medicaid and NC Health Choice

a) **The Division of Medical Assistance (DMA) should encourage more dentists to participate in Medicaid by reducing administrative barriers, including conducting outreach to dentists to help them understand the enrollment, certification, and other administrative processes involved with Medicaid.**

NC Medicaid has worked to streamline enrollment for dentists by improving the background and accreditation check process.

b) **The North Carolina General Assembly should modify Session Law 2011-399 to change the classification of dentists from moderate to low categorical risk providers.**

The session law has not yet been amended, and dentists remain "limited" categorical risk providers.[i]

c) **DMA should revise their policies so that solo incorporated dentists and group dental practices are not charged the federal application fee.**

[i] https://www.ncleg.gov/EnactedLegislation/Statutes/PDF/BySection/Chapter_108C/GS_108C-3.pdf

NC Medicaid has revised its regulatory policies to ensure that solo incorporated dentists and group dental practices are no longer charged the federal application fee (Public Facing Provider Permission Matrix, 2019).

d) **DMA should study the likely impact on dental participation, before making any changes to the Medicaid and NC Health Choice payment structure for dentists, including, but not limited to, moving from fee-for-service to capitation. DMA should not take any steps that would adversely impact participation.**

Despite sweeping changes to Medicaid in the state, oral health was carved out of North Carolina's Medicaid transformation plan. Therefore, dental service payment structures for Medicaid and NC Health Choice patients remain fee-for-service and have not been converted into a capitation model (10).

Recommendation 4.1 — Implemented
Increase Reimbursement for Dental Sealants

The Division of Medical Assistance (DMA) should explore changes in Medicaid payment policies to increase reimbursement to the 75th percentile of a commercial dental benchmark for dental sealants. DMA should explore the possibility of increasing payments for sealants using a pay-for-performance model or other reimbursement strategy that is based, in part, on the number of children eligible for Medicaid or NC Health Choice ages 6 through 9 who receive a sealant on a permanent molar.

Effective January 1, 2019, overall reimbursement rates for dental services, including sealants for children, were increased 10%. In response to the COVID-19 pandemic, NC Medicaid also retroactively implemented a temporary 5% reimbursement rate increase for all fee-for-service providers, effective March 1, 2020.

Recommendation 4.2 — Partially Implemented
Allow Reapplication of Sealants When Medically Necessary

a) **The North Carolina Dental Society should educate dentists about EPSDT and the ability to seek an exception from regular coverage policy to obtain reimbursement for the reapplication of sealants when medically necessary.**

This recommendation has not yet been fully implemented. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) has been included in NCTracks training programs and

pediatric dentists are generally more aware of EPSDT and prior approval procedure for services that exceed clinical coverage limits.[j]

b) **The Division of Medical Assistance Physician Advisory Group should create new coverage policies for Medicaid and NC Health Choice to allow reapplication of sealants on the same tooth when medically appropriate.**

The Physician Advisory Group Dental Subcommittee continues to meet on this issue. At present, reapplication when medically appropriate is reimbursed on a case-by-case basis when requested by a provider and family member of the patient (NC DHHS, Medicaid's Benefit for Children and Adolescents Under 21).

Recommendation 4.3 Partially Implemented

Increase Private Sector Efforts to Encourage Dentists to Provide Sealants for Medicaid and NC Health Choice Participants

a) **The North Carolina Dental Society (NCDS) should promote the use of dental sealants and disseminate information about the efficacy of sealants by:**

1) **Including periodic articles in the gazette and in their electronic communications about sealant research. These communications should also highlight dentists who have placed sealants on a high proportion of Medicaid and NC Health Choice children. These stories should highlight the use of dental hygienists and dental assistant IIs in placing sealants, and show how these practices can generate profits even with relatively low Medicaid reimbursement rates.**

2) **Identifying dental opinion leaders who can help promote the use of sealants. This may include members of the NCDS Board of Directors or other dental opinion leaders who can help sway the opinions of general practitioners. These leaders can attend local dental society meetings and promote the use of dental sealants. The NCDS or local dental societies should offer continuing education (CE) credits to encourage dentists to attend these meetings.**

3) **Creating a dental video, hosted on the NCDS website, about the science behind sealants and information about how to properly place sealants. NCDS**

[j] https://www.nctracks.nc.gov/content/public/es/providers/prior-approval/PA-announcements/EPSDT-Policy-Update.html

should seek continuing education (CE) credits for the video so that dentists and dental hygienists could view the video as part of their CE requirements.

The NCDS has published a series of articles in the gazette and electronic communications to provide its members with information about sealant research and financially beneficial means of providing sealant services. Dental opinion leaders have not yet been identified to promote the use of sealants. The NCDS has begun production of a video designed to educate dental providers about sealants.

b) NCDS, in partnership with Old North State Dental Society and the North Carolina Dental Hygiene Association (NCDHA), should expand existing efforts to provide sealants to children through the Give Kids A Smile/MOMs effort.

The Give Kids A Smile program has now expanded to almost every county in the state. The MOMs effort had a brief expansion after the publication of the 2013 report but has lost some ground due to increased insurance costs.

c) To assist NCDS in identifying dental champions, as well as communities where greater outreach and education is needed, the North Carolina Division of Medical Assistance should provide data to the NCDS about:

1) Pediatric and general dental practices that have placed sealants on a high percentage of their young (child) patients eligible for Medicaid or NC Health Choice

2) Counties that have a very low percentage of children eligible for Medicaid or NC Health Choice who have received sealants

3) Other organizations, such as the North Carolina Area Health Education Centers and NCDHA, that provide continuing education for dental professionals, should increase their focus on sealants.

The North Carolina Area Health Education Centers (NC AHEC) have offered some continuing education courses focused on the application of sealants and topical fluoride.[k]

[k] https://www.ncahec.net/courses-and-events/55709/application-of-dental-sealants-and-topical-fluoride

Recommendation 4.4 **Partially Implemented**

Educate Primary Care Providers about Sealants

The Division of Medical Assistance, Oral Health Section of the Division of Public Health, North Carolina Dental Society, Old North State Dental Society, North Carolina Academy of Pediatric Dentists, North Carolina Pediatric Society, North Carolina Academy of Family Physicians, the North Carolina Medical Society, Old North State Medical Society, Area Health Education Centers, and North Carolina Community Care Network should expand or create continuing education opportunities for primary care professionals to educate them on sealants. To accomplish this, these organizations should:

a) **Develop a one-page primer on sealants for primary care providers.**

A one-page primer on sealants, available in both English and Spanish, has been created and disseminated to primary care providers across the state. Community Care of North Carolina (CCNC) also provides a poster on sealant use designed to educate both providers and patients.

b) **Conduct outreach to primary care providers who are involved in the Into the Mouths of Babes program (IMB) and other primary care professionals, to educate them about the importance of sealants, and encourage them to educate the parents or caretakers of the children in their practice about the importance of having sealants placed on their children's permanent molars.**

The Division of Public Health (DPH) created and disseminated a webinar to educate providers about the importance of fluoride varnish and help with referrals, while also developing educational materials related to sealants to educate parents or caretakers about the importance of having sealants placed on their children's permanent molars.

Other work continues to be done in the state to improve sealant use and preventive dental treatments. The North Carolina Academy of Family Physicians (NCAFP) participates in the Early Childhood Oral Health Collaborative, which works to encourage provider participation in the Into the Mouths of Babes (IMB) program and educate providers about sealants. The NCAFP also promotes the IMB program and sealant use in its e-newsletter and magazine, and through presentations at continuing medical education (CME) events that it hosts. Despite support for the IMB program, utilization and provider participation rates have been stagnant in recent years. In response, the NCAFP, North Carolina Dental Society (NCDS), and North Carolina Pediatric Society (NCPeds), as well as other partners have been discussing opportunities to reinvigorate

the IMB program, which has been identified as an important consideration in the context of the transition to managed care.

Task force member Dr. Frank Courts, DDS, is exploring the use of lower-cost cavity preventive treatments such as fluoride varnish, silver diamine fluoride, and other new techniques.

c) Expand the role of the CHIPRA quality improvement specialists who are promoting oral health among CCNC practices to also promote the use of sealants.

There is no longer funding available for Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) quality improvement specialists, and as such, there has been no expansion of their role in promoting sealants among CCNC practices. However, pediatric quality improvement specialists still operate in CCNC networks, and will continue to do so in regional structures to provide practice support in the community.

d) Encourage pediatric dentists to reach out to primary care providers to educate them about the importance of dental sealants.

The NCAFP has attended regional meetings about the importance of communication between primary care providers and dental providers, and has used its e-newsletter to promote and encourage cross-communication between the two provider fields to promote child oral health. However, there is more work to be done to encourage communication between these two provider groups.

e) Develop one-page educational materials about dental sealants that can be given to parents in pediatric or family practices, and/or create posters that could be posted in exam rooms.

The DPH developed a series of brochures and posters in 2016 designed to educate parents and families about the benefits of dental sealants. CCNC also produced a poster for pediatric offices to educate the parents of young children.

Recommendation 5.1 — Partially Implemented

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.

The Oral Health Section of the Division of Public Health (OHS) partnered with NCCCN during the 3-year CHIPRA grant project to increase the utilization of the Into the Mouths of Babes (IMB) program and dental referrals. The quality improvement specialists involved received the IMB "train the trainer" training and credentials so that they were able to award providers who participated in the training AAFP-CME credit as an incentive. The training sessions for providers included education about the Priority Oral Health Risk Assessment and Referral Tool (PORRT), which serves as a standardized evaluation form for providers to use.

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.**

Community Care of North Carolina (CCNC) has distributed an educational poster, developed by NC Medicaid, to pediatrics and family medicine practices across the state to provide parents with comprehensive information about oral health and sealants. Providers have also been encouraged to document a dental home, or a referral to a dental home, in all patient charts to ensure that families are being consulted about oral health care during well-child visits.

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

CCNC has developed a quality measure to determine if a child has made it to a dentist. This program can be used to identify and provide services to families to ensure that children are connected to a dental home from a young age. CCNC partner providers are encouraged to ask parents of all patients if the child has a dental home. In the absence of a dental home, the provider is to refer the patient to an appropriate practice. There is some concern that this quality measure may not accurately capture all children enrolled in Medicaid (due to timing of enrollment and measurement), which may impact measurement of numbers of enrollees who are connected to oral health services.

   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).**

CCNC promotes the use of the PORRT tool or the AAP Risk Assessment to evaluate the oral health of pediatric patients. Although the initial intent was to focus referrals on high-risk patients, CCNC now recommends that all children be referred to a dentist, regardless of risk, by age 1 in accordance with NC Medicaid requirements. Although referral to a dental home is the goal, some practices are unable to connect children with a dental home by that time, due to lack of enrolled providers, and aim to have the referral completed by age 3.

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.**

Parents of children of all ages are asked if they have an established dental home and are referred to one if necessary. The PORRT tool or AAP Risk Assessment are also conducted on all children, regardless of age. Additionally, utilizing CHIPRA grant funding, CCNC conducted a Maintenance of Certification (MOC) Part IV project in which providers could receive continuing education credits through the American Board of Pediatrics or Family Medicine for auditing

their practice charts for 6 months. Audits specifically focused on completion of scheduled dental varnishing, designation of a dental home, or indication of referral to dental home if necessary. During the course of the MOC project, approximately 100 physician practices across the state participated. Since the end of the project due to cessation of funding, CCNC has allowed Mission Children's Hospital to use the structure of the MOC to help practices within its network evaluate and establish oral health quality standards. CCNC also continues to compile claims data to determine the number of children on Medicaid receiving four or more dental varnish treatments before the age of 3 1/2. Data is then sent out to practices across the state. Last year, 46.8% of children continuously enrolled on NC Health Choice and Medicaid received the service.

b) Support ongoing efforts to expand outreach and education for primary care providers to encourage them to participate in the Into the Mouths of Babes program.

The North Carolina Association of Family Physicians (NCAFP) supports the work of the Early Childhood Oral Health Collaborative, which promotes the IMB program, and has also publicized the program and its benefits through the NCAFP e-newsletter. Under the 2015 CHIPRA grant for improving pediatric oral health, 130 practices were educated about the IMB program and were provided with one-pagers about billing for oral health services.

c) As part of the pregnancy medical home,

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

No care alert for dental visits during pregnancy has been developed.

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.

In 2016, Randall Williams, MD, convened a Perinatal Oral Health Task Force, comprised of representatives from schools, local health departments, and community provider groups to form a medical-dental collaborative to focus on the importance of oral health in pregnancy. This task force is still active.[1]

[1] https://publichealth.nc.gov/docs/2016-NCMS-AnnualReport-WEB-20160914.pdf

Recommendation 5.2 — Partially Implemented

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.

The Division of Public Health (DPH) is providing technical assistance to primary care providers and helping find referral providers in the system. The North Carolina Academy of Family Physicians (NCAFP) and Community Care of North Carolina (CCNC) encourage the use of the Priority Oral Health Risk Assessment and Referral Tool (PORRT) tool for referrals, and CCNC has used its e-newsletter to publicize local discussions about improving the process through which infants and young children are referred to dental homes. Other than the PORRT tool, no formal referral system has been established, nor is there a system for dental records to be sent to primary care physicians, which may represent a barrier to achieving continuity of care.

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

This recommendation has not been met.

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

The NCAFP has attended and publicized regional meetings and oral health policy discussions designed to promote cross-communication between dental and primary care providers. CCNC has also promoted social events organized to bring primary care providers and dentists together to discuss referrals and other collaborative practices to address the oral health needs of pediatric

patients. However, it is unclear if these events have led to any increased dental-medical collaboration.

Recommendation 6.1 — Partially Implemented

Maintain the Structure of the Oral Health Section and Increase Funding for Public Health Dental Hygienists

a) **The North Carolina General Assembly should maintain the structure of the Oral Health Section of the Division of Public Health (OHS), including dental hygienists, in order to meet the Centers for Medicaid and Medicare Services goals of increasing preventive dental services and increasing utilization of sealants among children ages 6 to 9.**

The structure has not been maintained as envisioned by this recommendation. Since the publication of the 2013 report, the OHS has been reorganized. The section now operates as a regional model with staff in each region to serve residents across the state, rather than just in high-need areas. Perinatal and early childhood oral health guidelines are now modeled after the Into the Mouths of Babes (IMB) program. The section has also broadened its focus from school-age children to include early childhood and adult populations in accordance with a new strategic plan that was developed with mandated implementation of adult programs.

b) **The North Carolina General Assembly should increase funding to OHS, in order to hire additional dental hygienists who can provide preventive oral health services in schools, help link children with oral health problems to a dental home, participate in oral health surveillance activities, and otherwise promote oral health among children.**

The NC General Assembly did allocate additional funding for oral health services, and the funding was used to purchase additional dental equipment and fund two staff positions. The two positions, a western region dental technician and a western region dental epidemiologist, are now approved as full-time positions and are funded by the Preventive Block Grant.

Recommendation 6.2 — Not Implemented

Require Limited Service Dental Providers to Provide Comprehensive Dental Services

The Division of Medical Assistance and the Physician Advisory Group should examine current dental payment policies to support dental homes that provide continuity of care and comprehensive oral health services. Payment policies should ensure that dental

providers who offer diagnostic and preventive services, but not comprehensive restorative care:

a) **Have referral systems to refer patients to dental homes that can offer comprehensive oral health services.**

The development of referral systems has been complicated by the existence of mobile providers in the state. These providers are enrolled with NC Medicaid but generally only offer preventative and diagnostic services and have weak referral systems overall, which shifts the burden of expensive treatments to private providers with fixed sites. The largest mobile practice that was only providing diagnostic and preventive services has expanded its range of services to include restorative and simple extractions of primary teeth, which may be indicative of trends toward inclusion of more comprehensive services.

Work remains to be done to build a concrete referral system that links mobile and fixed-site providers. This could be achieved by requiring a comprehensive referral system for NC Medicaid accreditation, which may be feasible under the forthcoming transition to managed care.

Another opportunity for development in this area is a revision of state policies that requires that children be seen by a dentist for a full exam before they can receive care in schools. Presently the only exception to this rule is for the sealant pilot program underway in Edgecombe and Halifax counties.

b) **Transfer the appropriate diagnostic records, including oral health images, to the dental home in a timely manner.**

There is no evidence that this recommendation has been met; however, NC Medicaid is limited in its ability to systematically collect and track information related to all transfers of records, representing a barrier to evaluation in this area.

Recommendation 6.3 — Implemented (In Progress)
Pilot Private Dental Practice School-Based Programs

a) **The North Carolina Dental Society, Oral Health Section of the Division of Public Health, and Division of Medical Assistance should seek funding to create school-based pilot programs to provide screenings, preventive services, and sealants. For this pilot:**

1) Dental practice would serve as the dental home.

This program began in 2016 utilizing funding from a Duke Endowment grant. Each child at the participating schools receives a full dental exam, effectively establishing the dental practice as the dental home. After the initial exam, preventive services are provided within the schools to maintain oral hygiene. In addition, participating practices receive assistance in improving school-based programs.

2) Dental hygienists would need additional training and to be certified to provide reversible preventive procedures under general supervision (without having a dentist physically present at the schools or requiring prior exam from a dentist).

The pilot organizers received special exemption from the North Carolina State Board of Dental Examiners (NCSBDE) to allow dental hygienists to apply sealants and provide other preventive services without the direct oversight of a dentist.

3) Dental hygienists and dental assistants employed by the dental office would provide the dental services in schools, and would be supervised, remotely by participating dentist.

This is how the pilot has operated, and although concerns have been expressed that expanding the capacity of dental hygienists to perform services on patients may compromise the quality of dental services, early results from the pilot have not shown this to be a valid concern. Results from the 2016-2017 school year show an increase in the number of children who have received sealants at the pilot elementary schools. As such, the North Carolina Dental Society (NCDS) has convened the Prevention and Oral Health Council of NC to study capacity issues and advocate with the NCSBDE for an amendment to the Dental Practice Act to expand the practicing role of hygienists.

4) Participating practices should work with appropriate partners, such as the Oral Health Section, school nurses, and school-based and school-linked health centers, to help identify appropriate schools with high numbers of at-risk children, obtain parental consent, and create a system of care.

The pilot program selected four schools in Edgecombe and Halifax counties where the entire student body was receiving free or reduced-price lunch. These schools were selected because

eligibility for free or reduced-price lunch was treated as a proxy for financial need and Medicaid enrollment or eligibility.

5) **Participating practices and local health departments should work with local school nurses, and, if available, school-based and school-linked health centers, to promote services.**

The pilot has not yet been rolled out statewide, but has an ultimate goal of involving local health departments (LHDs) as contract-holders for private dental practices that participate in the program.

6) **The model should be evaluated after three years. Evaluation should include an assessment of unmet treatment needs. If successful and financially viable, the model should be expanded across the state, and should be tested for viability in other settings, such as Head Start, child care centers, primary care offices, etc.**

The pilot program began in 2016 utilizing funding from a Duke Endowment grant. As the program wrapped up its third year, the NCDS was evaluating data that has already been collected and determining unmet treatment needs. The pilot has not yet been rolled out statewide. In 2018, the BlueCross BlueShield Foundation announced a $30,000 grant for the continuation of the program at the four participating schools in Edgecombe and Halifax counties.

b) **The North Carolina Board of Dental Examiners should allow dental hygienists and dental assistants to provide reversible preventive procedures under general supervision (without having a dentist physically present at the schools or requiring prior exam from a dentist) for this pilot.**

This recommendation has been met. For the first few years of the pilot, hygienists and dental assistants within the program were permitted to provide sealants and other reversible preventive procedures without a dentist physically present at the school, but a prior exam by a dentist was still required for a child to participate in the program. As of February 2020, the rules governing public health hygienists have been changed to allow hygienists to apply preventive oral health treatments under the direction of a dentist based on a written standing order, but without a prior exam by a dentist in dental access shortage areas. Additionally, the rules now allow dentists to supervise more than two public health hygienists at a time.[m]

[m] https://files.nc.gov/ncoah/documents/Rules/RRC/01162020-Dental-Examiners-Technical-Changes.pdf

Recommendation 6.4 **Partially Implemented**

Reduce Barriers for Qualified Out-of-State Dentists

The North Carolina State Board of Dental Examiners (NCSBDE) is charged with regulating dentists in the public interest. Given the relative lack of dental professionals in North Carolina as compared to other states and the ongoing dental shortages in some areas of the state, the NCSBDE should consider opportunities to increase the supply of high quality providers practicing in North Carolina, with special attention to underserved areas and populations. Such opportunities could include, but are not limited, to the following:

a) Reducing or eliminating the current five years required practice in another state in order to qualify for a provisional license if the provider is willing to serve underserved populations for that portion of the five years that is waived.

In 2018, North Carolina amended the state statutes governing licensure of dentists from other states. Although amendments were made to facilitate easier licensure of dentists from states that border North Carolina, no changes were made to the required practice term of five years. The amendment also eliminated license-lapse exceptions for those dentists who receive a provisional license to practice in North Carolina but perform out-of-state dental work for underserved populations.[n]

b) Creating reciprocity arrangements with other states.

The 2018 amendments to the dental statutes created the framework for a reciprocity program with states that border North Carolina. Under the newly amended statute, the NCSBDE must license dentists from border states who meet the five-year practice requirement and are in good standing in their prior state of residence, as long as the prior state of residence would also accept a North Carolina dentist with similar qualifications. This effectively exempts qualifying dentists from border states from the examination and evaluation requirements imposed on those dentists seeking licensure in North Carolina from non-bordering states.

c) Accepting more regional dental examinations.

The NCSBDE now accepts two regional examinations: The Council of Interstate Testing Agencies (CITA) exam and the Commission on Dental Competency Assessments (CDCA) exam

[n] https://www.ncleg.gov/EnactedLegislation/Statutes/PDF/BySection/Chapter_90/GS_90-36.pdf

(formerly known as the North East Regional Board of Dental Examiners). However, North Carolina still does not accept scores from the Central Regional Dental Testing Service (CRDTS), the Southern Regional Testing Agency (SRTA), or the Western Regional Examining Board (WREB).

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