

## Chapter Oral Health Advocate Models

Submitted by:

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As a general pediatrician, I often feel overwhelmed by the multitude of clinical areas I need to be aware of and master. Oral health certainly wasn't on my radar before I became involved with the efforts at the AAP. I had a good residency training program with pediatric dental residents working with us in the ER and a pediatric dentist located in our continuity clinic. I was aware that children needed to have a dental home by age 1, but not much beyond that recommendation. Until my COHA training and interest in oral health, I had never really seriously looked (mirror, lights, etc) at teeth! We look to the tonsils, the pharynx, but teeth are for the dentist. I began to notice how many 2 and 3 year old patients we were seeing for clearance for operative dentistry and really wished we could PREVENT this problem.

When our state Medicaid program introduced payment and education for providers on the data that fluoride varnish coupled with anticipatory guidance about dental care showed reductions in operative dentistry - I was hooked. We as pediatricians can make a huge difference in the lives of children: less pain from caries, less dental work, and in conjunction with advice about good dental care comes good nutrition. With the last point, we can also make inroads on the obesity problem of many of our patients. Parents want the best for their children, and the active care we provide for their children's teeth helps them to get the message to take care at home too. As a COHA, I am happy to spread the word about how this can function in the office setting, get education for staff set up, and help billing staff with payment issues. Our patients love it, our providers love it, and it is good care!

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I began my oral health experience sharing an Oral Health Risk Assessment Preceptorship Grant with Leslie Carroll, MD, FAAP, at Sacred Heart Hospital in Allentown. Dr. Norman Tinanoff, a pediatric dentist from the University of Maryland Department of Preventive Dentistry served as our preceptor and spent a half day in each of our practices, did a grand rounds in each hospital, and spent an evening with pediatric dentists and family dentists who see children in each of our areas. He also met with the PA State Medicaid

dental consultant and health officer for a long lunch that I was privileged to attend and "listen".

The luncheon was very helpful to me in understanding the Pennsylvania State Medicaid oral health landscape. Although the visit to the office was so helpful in teaching staff, and the grand rounds was well attended, reimbursement didn't arrive for two years so training will likely need to be repeated. The meeting with the local dentists facilitated our practice getting to know them and them us. They are now available to us as consultants 24/7! Four months later, I was privileged to receive COHA training and, in retrospect, I wish that it had come first so that I would have been more informed!

My ability to impact oral health risk assessment and fluoride varnish application by pediatricians in Pennsylvania was limited to lobbying along with my state AAP Chapter Executive Committee for Medicaid payment. I got to know the Medicaid Medical Consultant (but more importantly he knew of me and that oral health was important) who was very much in favor of our proposal. He navigated the state politics and got it in 18 month later (April 2010) so we are now able to recruit practices and get out and teach.

In November 2010 Dr. Tinanoff and I set up a "Let's Talk", a teleconference series, on oral health. About 150 listeners participated on the call with good interest, but it seems that the recommendations for lowering the fluoride levels in drinking water may become a barrier for pediatricians and family physicians related to fluorosis.

As a COHA, here is how I approach teaching others about oral health:

- Oral health risk assessment is mostly already part of what we do with children and families.
- Linking with private and university dentists (pediatric and family dentists who provide care to kids) is a resource that enables us to access needed care for our patients with caries urgently without waiting 3-6 months. They know that we will screen and care for the "healthy" ones until they are three and can establish a dental home.
- Applying fluoride varnish is something that we can do when we see the first signs of Early Childhood Caries (ECC) to stave off progression of disease until the dentist can see the child, as well as preventing the development of ECC in the first place.
- Enabling us to tackle two epidemics at the same time - caries and obesity. Emphasizing water in sippy cups instead of juice.
- Providing reimbursement for a "procedure" to supplement dwindling office visit income.
- Ways to make the procedure cost effective. We keep zip-lock sandwich bags holding 2 gloves, mirror, fluoride varnish and brush, and gauze in the exam room cabinets. Utilizing this, the procedure, including history, takes less than 60 seconds extra in the visit if the clinician (MD, DO, NP) applies the varnish while we are examining the child. I take a bag as an example to give to each attendee to my talks.
- Providing templates for risk assessment, office policy, and billing information. Also resources and how to order varnish.

- Parent gratitude. Varnish application in the pediatric office saves children with healthy teeth additional visits to the dentist and it utilizes valuable and scarce pediatric dentist time more effectively. We give parents a list of dentists that we know provide quality dental care to children and encourage them to interview each provider prior to taking their children.

In summary, my performance as a COHA has been enhanced by:

1. Taking the two educational modules on the Oral Health Website - the one hour training and the PACT 9+ hour training.
2. Linking with academic pediatric dentists as well as private ones on a regular basis to discuss recent advances and concerns.
3. Linking with another practice in developing procedures, ideas for implementation, places to store information, etc.
4. Group educational/information sharing session with local dentists seeing children.
5. Setting up grand rounds in local hospitals in conjunction with pediatric dentist to teach oral health and varnish application.
6. Developing methods that increase office efficiency in performance of oral health care.
7. Work with state Head Start programs as they develop their oral health program.
8. Work with dental schools - their residents can come and teach practices and they can provide quality educational opportunities for pediatricians - free of charge (eg. Temple Pediatric Dental Program)

Don't be discouraged if it takes you a year or so to "find your wings" and please contact me if I can help.