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CENTER for INTEGRATED
HEALTH SOLUTIONS

Before You Say Ahhhh…Integrating Oral Health and Behavioral Health in Primary Care Settings

SAMHSA-HRSA CENTER for INTEGRATED HEALTH SOLUTIONS

Moderators:

Nick Szubiak, Integrated Health Consultant Roara Michael, Associate, CIH

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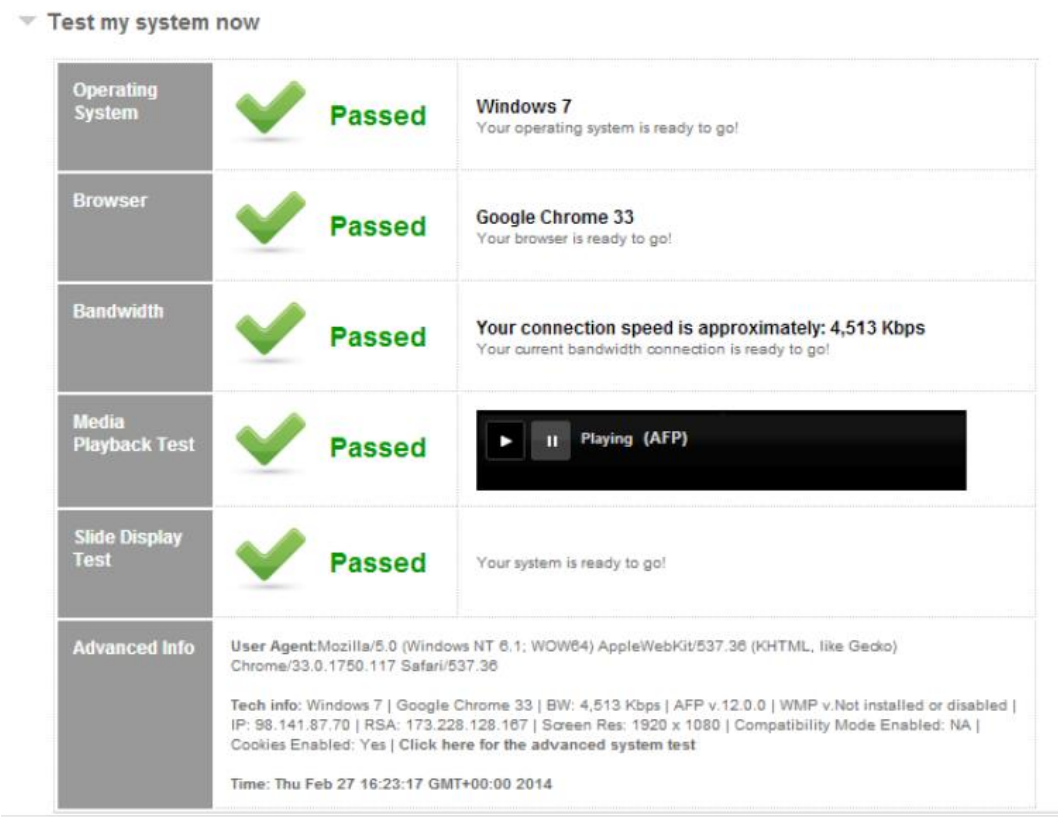

Before We Begin

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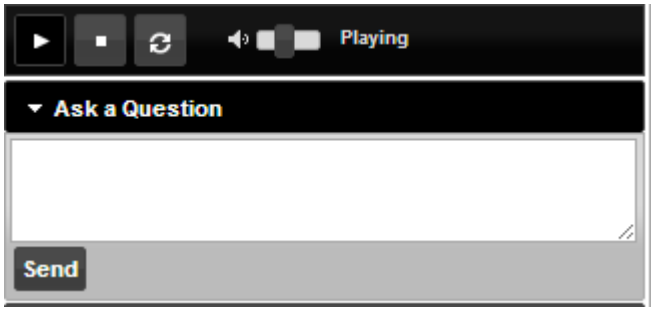


Learning Objectives

- Engage patients in effective conversations about their oral health
- Identify when a patient may have an oral health concern
- List resources and strategies for effectively addressing oral health issues

Today's Speakers

Anita Duhl Glicken, MSW
Director, PA Leadership Initiative in Oral Health

Renee W. Joskow, DDS, MPH, FAGD, FACD
Captain U.S. Public Health Service
Senior Dental Advisor, Health Resources and Services Administration

Before You Say Ahhhh… Integrating Oral Health and Behavioral Health in Primary Care

Anita Glicken, MSW

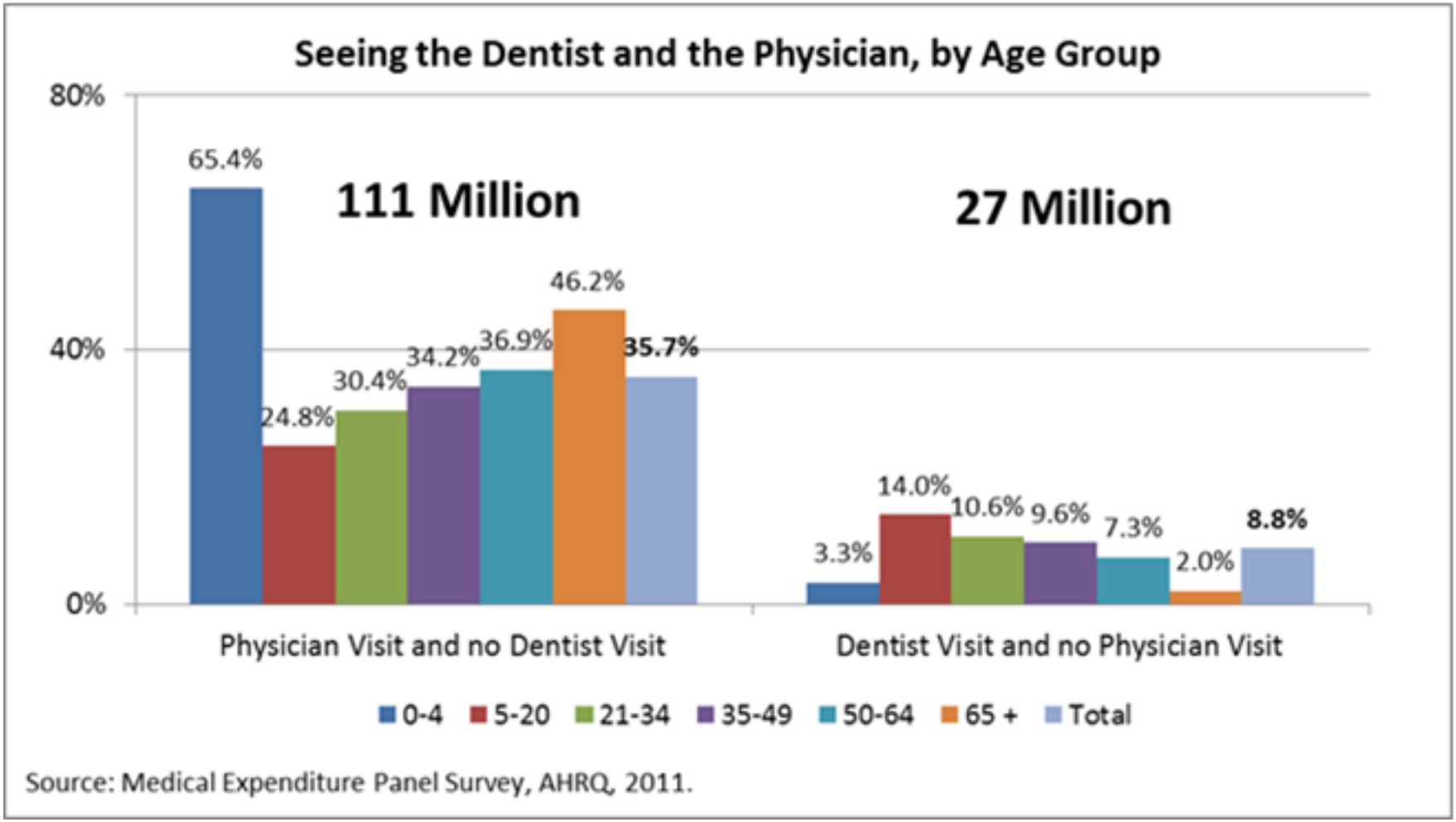
Renée W. Joskow, DDS, MPH, FAGD, FACD

Behavioral Health Providers (BHPs) and Oral Health

- Why are BHPs involved in oral health?
- How can BHPs recognize when a client has an oral health issue?
- How can BHPs engage/ empower patients in promoting oral health?
- How can BHPs get involved and learn more about oral health?

Deamonte's Story…
A Story of Need

Medicine and Dentistry - Separate Systems



Source: Medical Expenditure Panel Survey, AHRQ, 2011.

aximize Momentum

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CEN

2000

Oral Health in Ar
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Department of Health and Human Services
U.S. PUBLIC HEALTH SERVICE

2003

A National Call to
to Promote Oral

A Public-Private Partnersh
Under the Leadership o
The Office of the Surgeon Ge

U.S. Department of Health and Human Services

2009

THE U.S. ORAL HEALTH
IN THE COMING DECAD

WORKS

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

2010

"Promoting and Enhancing the Oral Health of the Publi

HHS ORAL HEALTH
INITIATIVE 2010

2011

American Association of Colleges of Nursing
AACP
ADEA

Core Competencies for
Interprofessional Collaborative P

Sponsored by the Interprofessional Education Collaborative*

Report of an Expert Panel
May 2011

2011

Advancing
Oral Health
in America

Improving Access to
Oral Health Care for
Vulnerable and
Underserved Populations

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NATIONAL RESEARCH COUNCIL

2014

Integration of Oral Health an
Primary Care Practice

U.S. Department of Health and Human Services
Health Resources and Services Administration
February 2014

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ASPPH

2015

Oral Health:
An Essential Component
of Primary Care

White Paper

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Before You Say Ahhhh…

Research

Original Investigation

The Effect of Nonsurgical Periodontal Therapy on Hemoglobin A_{1c} Levels in Persons With Type 2 Diabetes and Chronic Periodontitis

A Randomized Clinical Trial

Steven P. Engebretson, DMD, MS, MS; Leslie G. Hyman, PhD; Bryan S. Michalowicz, DDS, MS; Elinor R. Schoenfeld, PhD; Marie C. Gelato, MD, PhD; Wei Hou, PhD; Elizabeth R. Seaquist, MD; Michael S. Reddy, DMD, DMSc; Cora E. Lewis, MD, MSPH; Thomas W. Oates, DMD, PhD; Deepti Tripathy, MD; James A. Katancik, DDS, PhD; Philip R. Orlander, MD; David W. Paquette, DMD, MPH, DMSc; Naomi Q. Hanson, MS; Michael Y. Tsai, PhD

Supplemental content at jama.com

IMPORTANCE Chronic periodontitis, a destructive inflammatory disorder of the supporting structures of the teeth, is prevalent in patients with diabetes. Limited evidence suggests that periodontal therapy may improve glycemic control.

OBJECTIVE To determine if nonsurgical periodontal treatment reduces levels of glycated hemoglobin (HbA_{1c}) in persons with type 2 diabetes and moderate to advanced chronic periodontitis.

DESIGN, SETTING, AND PARTICIPANTS The Diabetes and Periodontal Therapy Trial (DPTT), a 6-month, single-masked, multicenter, randomized clinical trial. Participants had type 2 diabetes, were taking stable doses of medications, had HbA_{1c} levels between 7% and less than 9%, and untreated chronic periodontitis. Five hundred fourteen participants were enrolled between November 2009 and March 2012 from diabetes and dental clinics and communities affiliated with 5 academic medical centers.

INTERVENTIONS The treatment group (n = 257) received scaling and root planing plus chlorhexidine oral rinse at baseline and supportive periodontal therapy at 3 and 6 months. The control group (n = 257) received no treatment for 6 months.

ARTICLE IN PRESS

Impact of Periodontal Therapy on General Health

Evidence from Insurance Data for Five Systemic Conditions

Marjorie K. Jeffcoat, DMD, Robert L. Jeffcoat, PhD, Patricia A. Gladowski, RN, MSN, James B. Bramson, DDS, Jerome J. Blum, DDS

Background: Treatment of periodontal (gum) disease may lessen the adverse consequences of some chronic systemic conditions.

Purpose: To estimate the effects of periodontal therapy on medical costs and hospitalizations among individuals with diagnosed type 2 diabetes (T2D); coronary artery disease (CAD); cerebral vascular disease (CVD); rheumatoid arthritis (RA); and pregnancy in a retrospective observational cohort study.

Methods: Insurance claims data from 338,891 individuals with both medical and dental insurance coverage were analyzed in 2011–2013. Inclusion criteria were (1) a diagnosis of at least one of the five specified systemic conditions and (2) evidence of periodontal disease. Subjects were categorized according to whether they had completed treatment for periodontal disease in the baseline year, 2005. Outcomes were (1) total allowed medical costs and (2) number of hospitalizations, per subscriber per year, in 2005–2009. Except in the case of pregnancy, outcomes were aggregated without regard to reported cause. Individuals who were treated and untreated for periodontal disease were compared independently for the two outcomes and five systemic conditions using ANCOVA; age, gender, and T2D status were covariates.

Results: Statistically significant reductions in both outcomes ($p < 0.05$) were found for T2D, CVD, CAD, and pregnancy, for which costs were lower by 40.2%, 40.9%, 10.7%, and 73.7%, respectively; results for hospital admissions were comparable. No treatment effect was observed in the RA cohorts.

Conclusions: These cost-based results provide new, independent, and potentially valuable evidence that simple, nonimvasive periodontal therapy may improve health outcomes in pregnancy and other systemic conditions.

(Am J Prev Med [redacted]) © 2014 American Journal of Preventive Medicine

Introduction

There is a growing body of evidence that periodontal (gum) disease is associated with negative systemic health consequences for individuals with certain diseases and conditions. To the extent that this is true, it is reasonable to expect that successful treatment of periodontal disease might prevent or mitigate at least some adverse effects associated with medical conditions such as type 2 diabetes (T2D); rheumatoid arthritis (RA); cerebral vascular disease (CVD); and adverse pregnancy outcomes.

Direct confirmation of such links generally poses formidable difficulties arising from the long time course of chronic disease, the complex and multifactorial nature of the medical outcomes, and the ethical issues surrounding controlled clinical trials. Nevertheless, the potential preventive value of such a simple and low-risk inter-

J Clin Periodontol 2016; 43: 104–113 doi: 10.1111/jcpe.12502

Journal of Clinical Periodontology

Association between periodontitis and mortality in stages 3–5 chronic kidney disease: NHANES III and linked mortality study

Praveen Sharma[1,*], Thomas Dietrich[1,*], Charles J. Ferro[2], Paul Cockwell[2] and Iain L. O. Chapple[1]

[1]Periodontal Research Group, School of Dentistry, University of Birmingham, Birmingham, UK; [2]Department of Nephrology, University Hospital Birmingham, Birmingham, UK

Sharma P, Dietrich T, Ferro CJ, Cockwell P, Chapple ILC. Association between periodontitis and mortality in stages 3–5 chronic kidney disease: NHANES III and linked mortality study. J Clin Periodontol 2016; 43: 104–113. doi: 10.1111/jcpe.12502.

Abstract

Introduction: Periodontitis may add to the systemic inflammatory burden in individuals with chronic kidney disease (CKD), thereby contributing to an increased mortality rate. This study aimed to determine the association between periodontitis and mortality rate (all-cause and cardiovascular disease-related) in individuals with stage 3–5 CKD, hitherto referred to as "CKD".

Methods: Survival analysis was carried out using the Third National Health and Nutrition Examination Survey (NHANES III) and linked mortality data. Cox proportional hazards regression was employed to assess the association between periodontitis and mortality, in individuals with CKD. This association was compared with the association between mortality and traditional risk factors in CKD mortality (diabetes, hypertension and smoking).

Results: Of the 13,784 participants eligible for analysis in NHANES III, 861 (6%) had CKD. The median follow-up for this cohort was 14.3 years. Adjusting for confounders, the 16-year all-cause mortality rate for individuals with CKD increased from 32% (95% CI: 29–35%) to 41% (36–47%) with the addition of periodontitis. For diabetes, the 10-year all-cause mortality rate increased to 43% (38–49%).

Conclusion: There is a strong association between periodontitis and increased mortality in individuals with CKD. Sources of chronic systemic inflammation (including periodontitis) may be important contributors to mortality in patients with CKD.

*Contributed equally to this publication.

Key words: chronic kidney disease; NHANES; periodontitis; survival

Accepted for publication 24 December 2015

Chronic kidney disease (CKD) affects between 8 and 13% of the global population (Jha et al. 2013) and is associated with increased mortality and morbidity. Cardiovascular disease (CVD)-related events are the main cause of mortality in patients with CKD (Go et al. 2004) and systemic inflammation is recog-

Conflict of interest and source of funding statement

The authors declare that they have no competing interests. Praveen Sharma is funded by a National Institute for Health Research (NIHR) Doctoral Research Fellowship and Charles J. Ferro is funded by an NIHR Post-Doctoral Fellowship. The views expressed in this article are those of the authors and not necessarily those of the NHS, the NIHR or the Department of Health.

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Fetal medicine

Periodontal infection and preterm birth: successful periodontal therapy reduces the risk of preterm birth

M Jeffcoat,[a] S Parry,[b] M Sammel,[a] B Clothier,[a] A Catlin,[a] G Macones[c]

[a] School of Dental Medicine, University of Pennsylvania, Philadelphia, PA, USA [b] Department of Maternal and Fetal Medicine, University of Pennsylvania, Philadelphia, PA, USA [c] Washington University in St Louis, St Louis, MO, USA

Correspondence: Prof M Jeffcoat, University of Pennsylvania, 240 S. 40th Street, Philadelphia, PA 19104, USA. Email jeffcoat@dental.upenn.edu

Accepted 28 July 2010. Published Online 15 September 2010.

Objective This study tested the hypothesis that successful periodontal treatment was associated with a reduction in the incidence of spontaneous preterm birth (PTB).

Design This was a randomised, controlled, blinded clinical trial.

Setting Hospital outpatient clinic.

Population Pregnant women of 6–20 weeks of gestation were eligible.

Methods Of 322 pregnant women with periodontal disease, 160 were randomly assigned to receive scaling and root planing (SRP, cleaning above and below the gum line), plus oral hygiene instruction, whereas the remaining 162 received only oral hygiene instruction and served as an untreated control group. Subjects received periodontal examinations before and 20 weeks after SRP, and were classified blindly according to the results of treatment into two groups: successful ('non-exposure') and unsuccessful ('exposure') treatment. Groups were compared using standard inferential statistics; dichotomous variables were compared using the chi-square test or logistic regression. Results are presented in terms of odds ratios.

Main outcome measure The main outcome measure was spontaneous preterm birth before 35 weeks of gestation.

Results No significant difference was found between the incidence of PTB in the control group (52.4%; n = 162) and the periodontal treatment group (45.8%; n = 160) ($P < 0.13$, Fisher's exact test). The incidence of PTB was compared within the periodontal treatment group, considering the success of therapy. A logistic regression analysis showed a strong and significant relationship between successful periodontal treatment and full-term birth (adjusted odds ratio 6.02; 95% CI 2.57–14.03). Subjects refractory to periodontal treatment were significantly more likely to have PTB.

Conclusions A beneficial effect on PTB may be dependent on the success of periodontal treatment.

Keywords Clinical trial, intervention, periodontal disease, pregnancy, preterm birth.

Please cite this paper as: Jeffcoat M, Parry S, Sammel M, Clothier B, Catlin A, Macones G. Periodontal infection and preterm birth: successful periodontal therapy reduces the risk of preterm birth. BJOG 2011;118:259–256.

Introduction

Known risk factors for spontaneous preterm birth (PTB) include a previous PTB, low body mass index, alcohol consumption during pregnancy, ethnicity, and smoking.[1] Other factors implicated in PTB include fetal fibronectin, inflammatory mediators such as interleukin-6 (IL-6) and prostaglandin E2 (PGE_2), infections of the genital tract (e.g. bacterial vaginosis, BV), and intrauterine infections. PTB occurs in 12.8% of births in the USA.[2]

There has recently been a focus on oral infection (specifically periodontal infection) as a risk factor or risk indicator for preterm birth.[3,4] The preponderance of the evidence indicates that maternal periodontal disease is associated with an increased incidence of preterm births.[5] Periodontopathic bacteria have also been associated with PTB[7–12] Despite the number of such studies, it is not clear which specific organism(s) may be associated with PTB, perhaps because the bacteria investigated and the techniques used varied widely.

An association between clinical measures of periodontal disease and the incidence of PTB does not imply that treating the periodontal disease will decrease the incidence of PTB. To address this important question, several intervention studies have been performed. Of the 16 such studies reviewed by the authors (including the present one), 12 showed a reduction in preterm births with periodontal treatment;[13–27] again, because of varying study designs and

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Case Examples

Identifying Oral Health Issues

FIGURE 8.2
Medical history form for use in dental practice

Medical History Form Date _____

Name _____ Home Phone (____) _____
Last First Middle

Address _____ Business Phone (____) _____
Number, Street

City _____ State _____ Zip Code _____

Occupation _____ Social Security No. _____

Date of Birth _____/_____/_____ Sex M F Height _____ Weight _____ Single _____ Married _____

Name of Spouse mo. day yr. _____ Closest Relative _____ Phone (____) _____

If you are completing this form for another person, what is your relationship to that person? _____

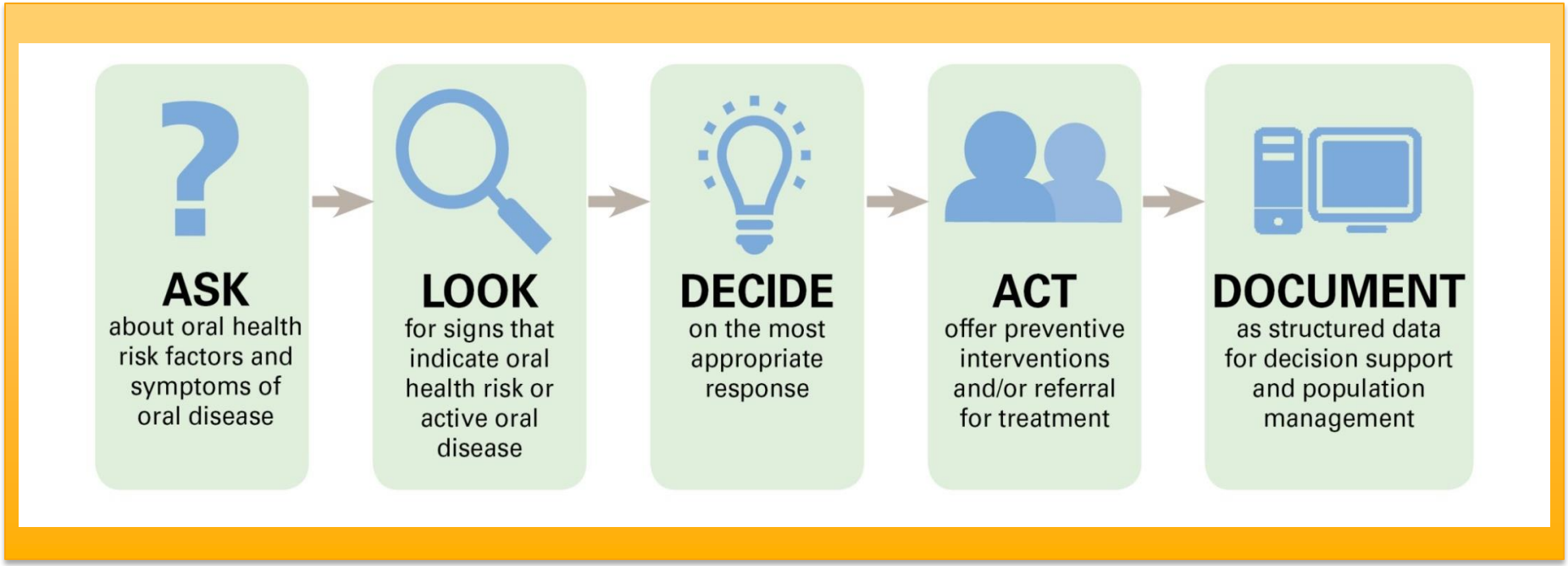
Referred by _____

For the following questions, *circle yes or no,* whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

1. Are you in good health? ..... Yes No
2. Has there been any change in your general health within the past year? ..... Yes No
3. My last physical examination was on _____
4. Are you now under the care of a physician? ..... Yes No
   If so, what is the condition being treated? _____
5. The name and address of my physician(s) is _____
6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? ..... Yes No
   If so, what was the illness or problem? _____
7. Are you taking any medicine(s) including non-prescription medicine? ..... Yes No
   If so, what medicine(s) are you taking? _____
8. Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease ..... Yes No
   b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) ..... Yes No
      1. Do you have chest pain upon exertion? ..... Yes No
      2. Are you ever short of breath after mild exercise or when lying down? ..... Yes No
      3. Do your ankles swell? ..... Yes No
      4. Do you have inborn heart defects? ..... Yes No
      5. Do you have a cardiac pacemaker? ..... Yes No
   c. Allergy ..... Yes No
   d. Sinus trouble ..... Yes No
   e. Asthma or hay fever ..... Yes No
   f. Fainting spells or seizures ..... Yes No
   g. Persistent diarrhea or recent weight loss ..... Yes No
   h. Diabetes ..... Yes No
   i. Hepatitis, jaundice, or liver disease ..... Yes No
   j. AIDS or HIV infection ..... Yes No
   k. Thyroid problems ..... Yes No
   l. Respiratory problems, emphysema, bronchitis, etc. ..... Yes No
   m. Arthritis or painful swollen joints ..... Yes No
   n. Stomach ulcer or hyperacidity ..... Yes No
   o. Kidney trouble ..... Yes No
   p. Tuberculosis ..... Yes No
   q. Persistent cough or cough that produces blood ..... Yes No
   r. Persistent swollen glands in neck ..... Yes No
   s. Low blood pressure ..... Yes No
   t. Sexually transmitted disease ..... Yes No
   u. Epilepsy or other neurological disease ..... Yes No
   v. Problems with mental health ..... Yes No
   w. Cancer ..... Yes No
   x. Problems of the immune system ..... Yes No
9. Have you had abnormal bleeding? ..... Yes No
   a. Have you ever required a blood transfusion? ..... Yes No

Oral Health Delivery Framework

5 actions primary care teams can take to protect and promote their patients' oral health. Within the scope of practice for primary care; possible to implement in diverse practice settings.



Hummel J, Phillips KE, Holt B, Hayes C. *Oral Health: An Essential Component of Primary Care*. Seattle, WA: Qualis Health; June 2015

Conversations About Oral Health

Addressing a Growing Problem

RESEARCH

The characteristics of hospital emergency department visits made by people with mental health conditions who had dental problems

Romesh P. Nalliah, BDS; John D. Da Silva, DMD, MPH, ScM; Veerasathpurush Allareddy, BDS, MBA, MHA, MMSc, PhD

The authors of a 2010 study stated that "routine dental attendance is associated with better oral health."[1] In the United States, people with special health care needs (SHCN) are less likely to have visited a dentist in the preceding 12 months than are people without SHCN.[2] If people do not visit the dentist regularly, they may go to hospital emergency departments (EDs) and receive a diagnosis of a dental problem.

The results of evaluations of ED visits made by the general population attributed to dental caries, pulpal and periapical lesions, gingival and periodontal lesions and mouth cellulitis/abscess using a nationwide sample were published in 2010 and 2011.[3-6] However, there is no similar study about ED visits attributed to the same conditions made by people with mental health conditions conducted by using a nationwide database. The results of a systematic review and meta-analysis

ABSTRACT

ARTICLE 3

Background. There is a paucity of knowledge regarding nationally representative estimates of hospital-based emergency department (ED) visits for dental problems made by people with mental health conditions. The authors conducted a study to provide nationwide estimates of hospital-based ED visits attributed to dental caries, pulpal and periapical lesions, gingival and periodontal lesions and mouth cellulitis/abscess made by people with mental health conditions.

Methods. The authors used the Nationwide Emergency Department Sample, which is a component of the Healthcare Cost and Utilization Project sponsored by the Agency for Healthcare Research and Quality. ED visits attributable to dental caries, pulpal and periapical lesions, gingival and periodontal lesions and mouth cellulitis/abscess were identified by the emergency care provider by using diagnostic codes in International Classification of Diseases, Ninth Revision, Clinical Modification. The authors examined outcomes, including hospital charges. They used simple descriptive statistics to summarize the data.

Results. In 2008, people with mental health conditions made 15,635,253 visits to hospital-based ED in the United States. A diagnosis of dental caries, pulpal and periapical lesions, gingival and periodontal lesions and mouth cellulitis/abscess represented 63,164 of these ED visits. The breakdown of the ED visits was 34,574 with dental caries, 25,352 with pulpal and periapical lesions, 9,657 with gingival and periodontal lesions, and 2,776 with mouth cellulitis/abscess. The total charge for ED visits in the United States was $55.46 million in 2008.

Conclusions. In 2008, people with mental health conditions made 63,164 visits to hospital-based EDs and received a diagnosis of dental caries, pulpal and periapical lesions, gingival and periodontal lesions or mouth cellulitis/abscess. These ED visits incurred substantial hospital charges. Programs designed to reduce the number of ED visits made by this population for common dental problems could have a substantial impact in reducing the use of hospital resources.

Practical Implications. Clinicians should implement preventive practices for patients with mental health conditions. The authors identified combinations of mental health conditions and dental problems that led to patients with mental health conditions making visits to hospital-based EDs for dental problems more frequently than did patients in the general population.

Key Words. Access to care; caries; delivery of health care; dental care for disabled; dental care for people with disabilities; dental care utilization; gingivitis; periodontitis; epidemiology; special-care dentistry.

JADA 2013;144(6):617-624.

Dr. Nalliah is a senior tutor and an instructor, Department of Restorative Dentistry and Biomaterials Sciences, Harvard School of Dental Medicine, 188 Longwood Ave., Boston, Mass. 02115, e-mail romesh.aus@gmail.com. Address reprint requests to Dr. Nalliah.
Dr. Da Silva is the chair, Department of Restorative Dentistry and Biomaterials Sciences, Harvard School of Dental Medicine, Boston.
Dr. Allareddy is a fellow, Cleft Craniofacial Orthodontics, Boston Children's Hospital, Boston.

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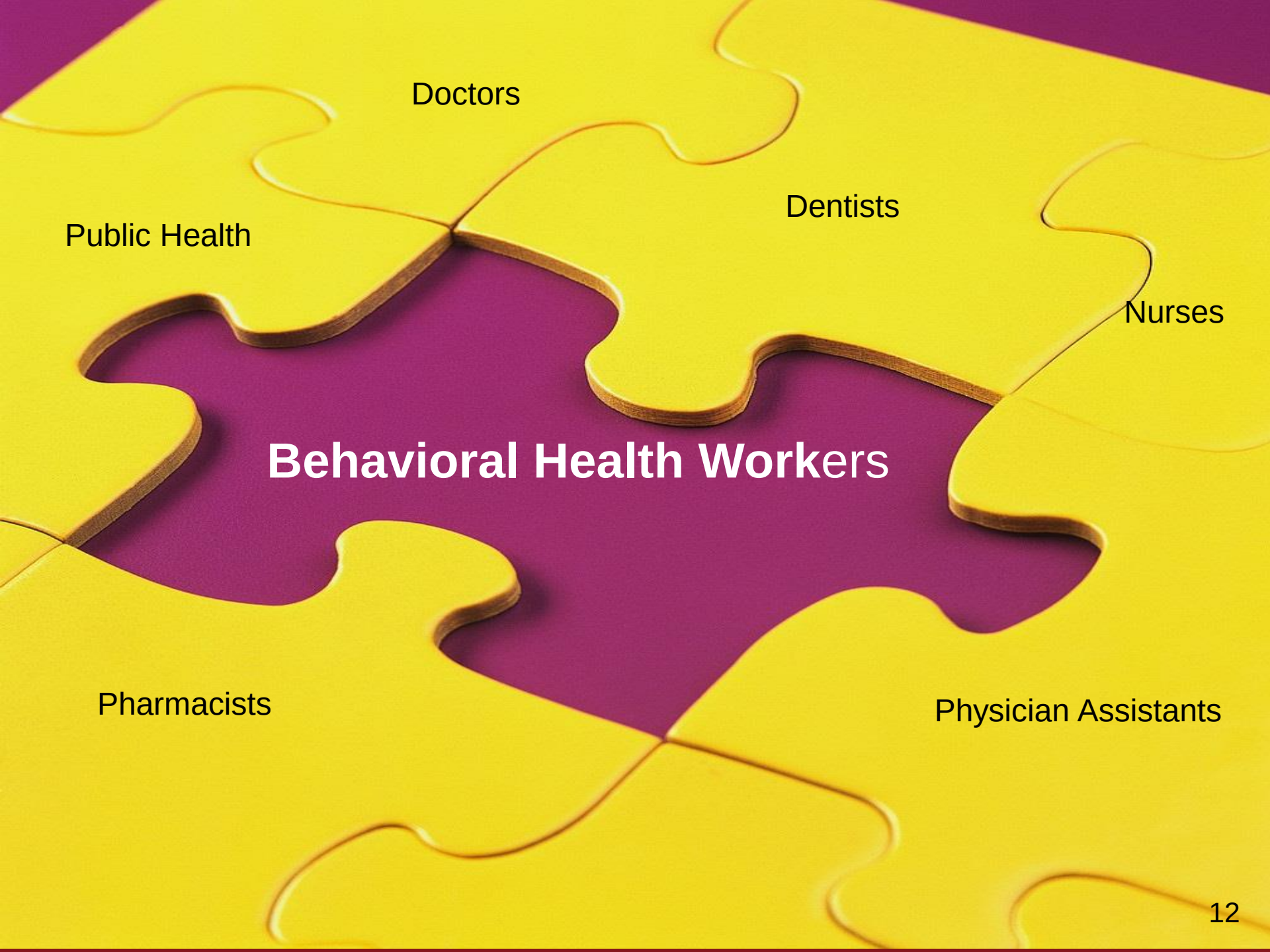
Best Practice Approaches

Emergency Department Referral Programs for Non-traumatic Dental Conditions

View Full Best Practice Approach Report

Current Examples

Practice Name Click to open PDF document	
Mountain Health Alliance	
State:	MD
Practice #:	23012
State Activity:	HTML
Last Reviewed:	September 2015
Last Updated:	September 2015
Children's Dental Services	
State:	MN


Doctors
Dentists
Public Health
Nurses
Behavioral Health Workers
Pharmacists
Physician Assistants

Resources and Tools

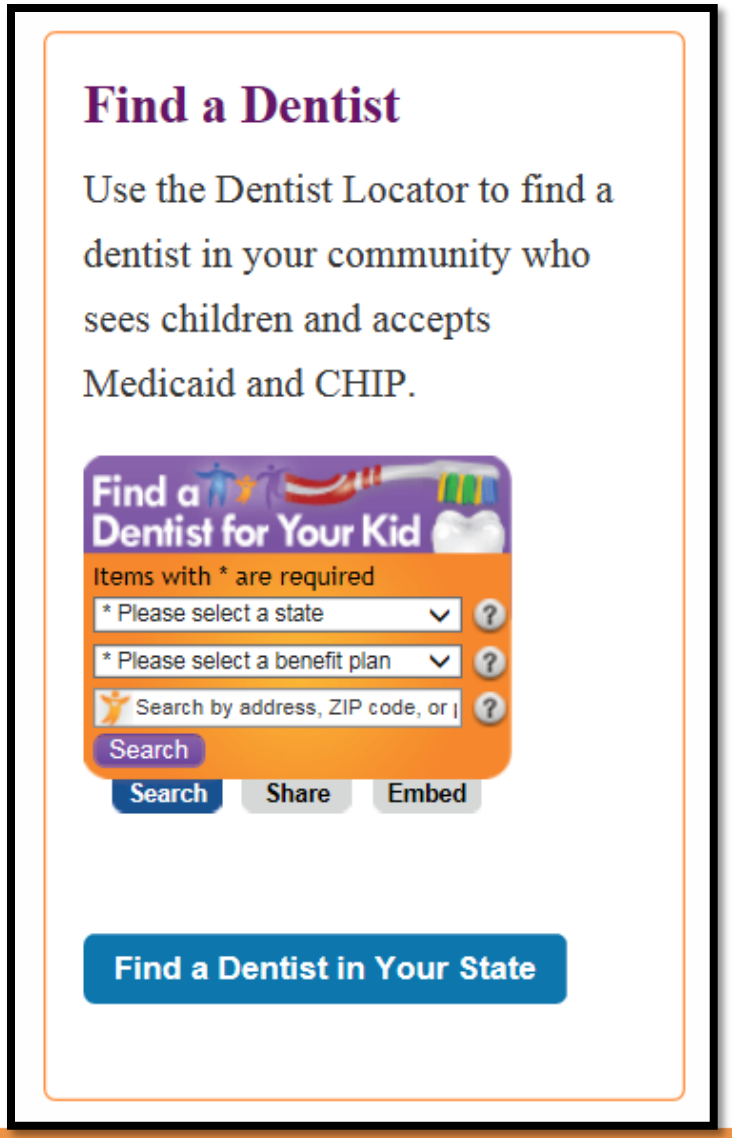
Dental Care and Services

Find a Health Center

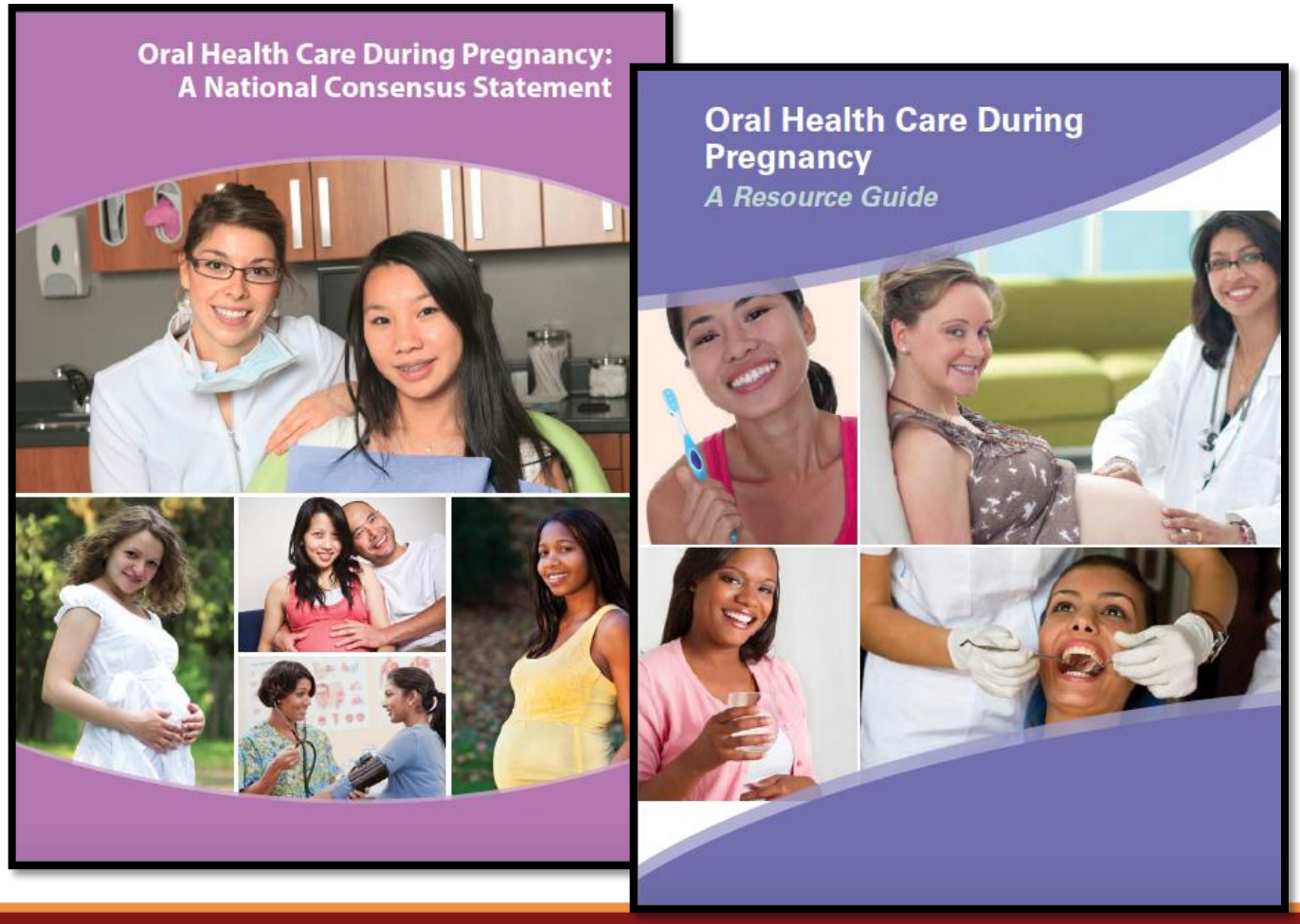
http://findahealthcenter.hrsa.gov/

Find Dental Plan

https://datawarehouse.hrsa.gov/ikn/Search_IKN.aspx



Oral Health Care During Pregnancy: A National Consensus Statement



Tools for Health Professionals

http://www.mchoralhealth.org/PDFs/OralHealthPregnancyConsensus.pdf

Guidance for Health Professionals to Share with Pregnant Women

Guidance provided to pregnant women should be modified based on risk assessment. Creating opportunities for thou
women and heal
effective ways to
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Share the inform
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Sources

American Academy of Pediatric Dentistry. 2011. Guideline on perinatal oral health care. *Reference Manual* 33(6):118–123. http://www.aapd.org/media/Policies_Guidelines/G_PerinatalOralHealthCare.pdf.

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Pharmacological Considerations for Pregnant Women

The pharmacological agents listed below are to be used only for indicated medical conditions and with appropriate supervision.

Pharmaceutical Agent	Indications, Contraindications, and Special Considerations
Analgesics	
Acetaminophen	May be used during p
Acetaminophen with Codeine, Hydrocodone, or Oxycodone	
Codeine	
Meperidine	
Morphine	
Aspirin	May be used in short 1st and 3rd trimester
Ibuprofen	
Naproxen	
Antibiotics	
Amoxicillin	May be used during p
Cephalosporins	
Clindamycin	
Metronidazole	
Penicillin	
Ciprofloxacin	Avoid during pregnar
Clarithromycin	
Levofloxacin	
Moxifloxacin	
Tetracycline	Never use during pre
Anesthetics	Consult with a prenat sedation or general an
Local anesthetics with epinephrine (e.g., Bupivacaine, Lidocaine, Mepivacaine)	May be used during p
Nitrous oxide (30%)	May be used during p inadequate. Pregnant sedation; consult with
Over-the-Counter Antimicrobials	Use alcohol-free prod

Guidance for Prenatal Care Health Professionals

Prenatal care health professionals may be the "first line" in assessing pregnant women's oral health and can provide referrals to oral health professionals and reinforce preventive messages.

Assess Pregnant Women's Oral Health Status

During the initial prenatal evaluation

- Take an oral health history. Following are examples of questions that prenatal care health professionals may ask pregnant women. This information may be gathered through a conversation or a questionnaire.
  - Do you have swollen or bleeding gums, a toothache (pain), problems eating or chewing food, or other problems in your mouth?
  - Since becoming pregnant, have you been vomiting? If so, how often?
  - Do you have any questions or concerns about getting oral health care while you are pregnant?
  - When was your last dental visit? Do you need help finding a dentist?
- Check the mouth for problems such as swollen or bleeding gums, untreated dental decay (tooth with a cavity), mucosal lesions, signs of infection (e.g., a draining fistula), or trauma.
- Document your findings in the woman's medical record.

- Encourage women to seek oral health care, practice good oral hygiene, eat healthy foods, and attend prenatal classes during pregnancy. (See

November 2015

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Key Facts:

- Over **47 million people** live in designated dental health professional shortage areas[i] – an increase of 43 percent since 2011[ii]
- Nearly **300 HRSA health center grantees** expanded oral health services in FY 2014[iii]
- HRSA's Community-Based Dental Partnership Program provided direct **dental services to more than 6,000 people** living with HIV /AIDS in 2013[iv]
- More than **1,300 National Health Service Corps dentists and registered dental hygienists** work in health professional shortage areas[v]
- HRSA Oral Health Training (OHT) programs trained **more than 2,500 oral health students** and nearly **500 primary care dental residents** in academic year 2013-2014[vi]
- **Sixty-two percent** of OHT program-supported students, residents, and fellows received clinical training in medically underserved communities in academic year 2013-2014[vii]
- **More than $1.2 million in scholarships for disadvantaged students** was dispersed to dental and dental hygiene students in FY 2013[viii]

HRSA Oral Health

Across the Agency

For the underserved and uninsured, the Health Resources and Services Administration (HRSA) is a safety net, delivering high quality health care for millions who lack access to primary care. HRSA oral health programs are dispersed across the agency and span the spectrum from clinical care to workforce development. HRSA programs provide funding to health centers, States, academic institutions and other entities to train, recruit and retain health professionals including dentists and dental hygienists in efforts to increase access to quality oral health care.

As HRSA's programs have evolved over the decades, so too has the understanding that good oral health is essential to good overall health. The 2000 ***Oral Health in America: Report of the Surgeon General*** (SG) is a landmark report intended "to alert Americans to the full meaning of oral health and its importance to general health and well-being."

In 2010, HRSA commissioned the National Academy of Sciences to produce two Institute of Medicine (IOM) reports that build upon the SG report and serve as new benchmarks on the nation's oral health status and oral health care. The two reports, ***Advancing Oral Health*** and ***Improving Access to Oral Health for Vulnerable and Underserved Populations,*** were published in 2011 with recommendations for HRSA and the U.S. Department of Health and Human Services to "improve access to oral health care, reduce oral health disparities, and improve oral health."

In response to the IOM reports, HRSA has tailored programs and activities that address many of the recommendations:

- Working across the agency, HRSA developed an essential set of oral health core clinical competencies for non-dental providers in efforts to improve access for early detection and preventive interventions leading to improved health.
- HRSA created the *Perinatal and Infant Oral Health Quality Improvement* initiative to target pregnant women and infants at high risk for dental diseases through community-based approaches for integrating oral health care into statewide health care systems.
- HRSA provides support to the National Maternal and Child Oral Health Resource Center to assist professionals in developing effective strategies to promote oral health services for the maternal and child health population.
- HRSA provides scholarships and loans for disadvantaged students to promote diversity among health professions students and practitioners to assure that qualified students are not denied a health professions career due to lack of financial resources.

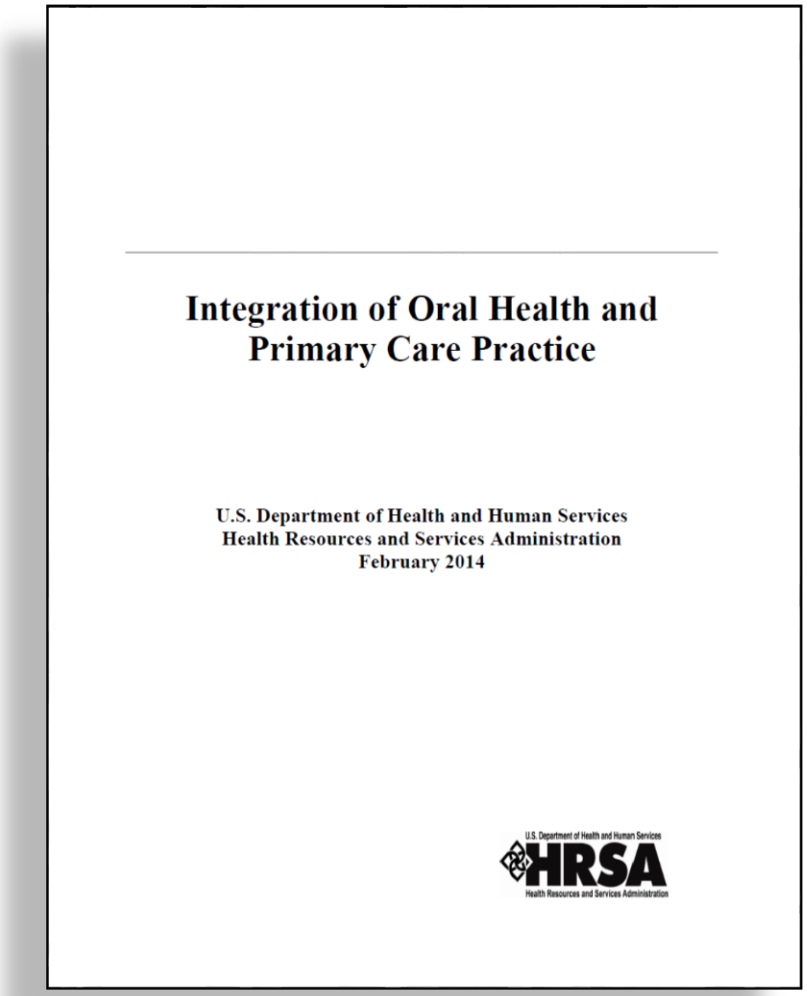
Additional key HRSA programs are ensuring that quality dental care is available for those who need it most. This is especially true for people living with HIV/AIDS (PLWHA); mothers, children and youth, including those with special health care needs; and those who receive care through the Health Center program. Examples include:

- The Ryan White HIV/AIDS Program provides related care and services to more than 500,000 people every year,

http://www.hrsa.gov/publichealth/clinical/oralhealth/oralhealthfactsheet.pdf

HRSA Report

http://www.hrsa.gov/publichealth/clinical/oralhealth/ primarycare/ integrationoforalhealth.pdf



Integration of Oral Health and Primary Care Practice

U.S. Department of Health and Human Services
Health Resources and Services Administration
February 2014

HRSA Supported Publications

- **Considerations for Oral Health Integration in Primary Care Practice for Children**

  http://www.hrsa.gov/publichealth/clinical/oralhealth/primarycare/oralhealthprimarycare.pdf
- **Oral Health Care During Pregnancy: A National Consensus Statement**

  http://www.mchoralhealth.org/PDFs/OralHealthPregnancyConsensus.pdf
- **Bright Futures in Practice: Oral Health—Pocket Guide (2nd ed.)**

  http://www.mchoralhealth.org/pocket.html
- **National Center for Health Workforce Analysis Dentists and Dental Hygienist Workforce Report**

  http://bhw.hrsa.gov/healthworkforce/supplydemand/dentistry/nationalstatelevelprojectionsdentists.pdf
- **The Role of Dental Hygienists in Providing Access to Oral Health Care**

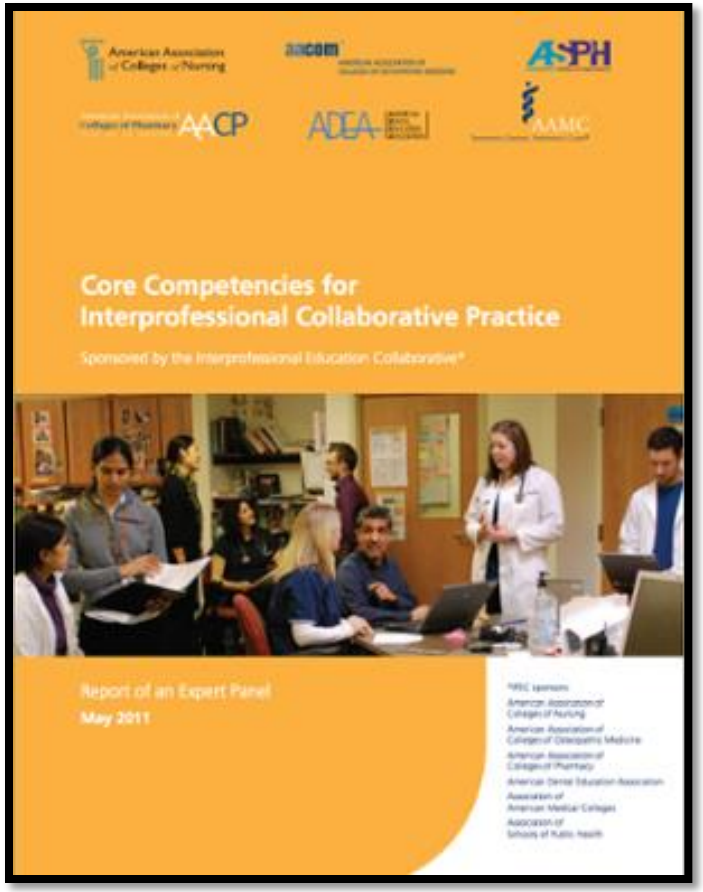
  http://www.nga.org/files/live/sites/NGA/files/pdf/2014/1401DentalHealthCare. pdf
- **Rural Oral Health Toolkit**

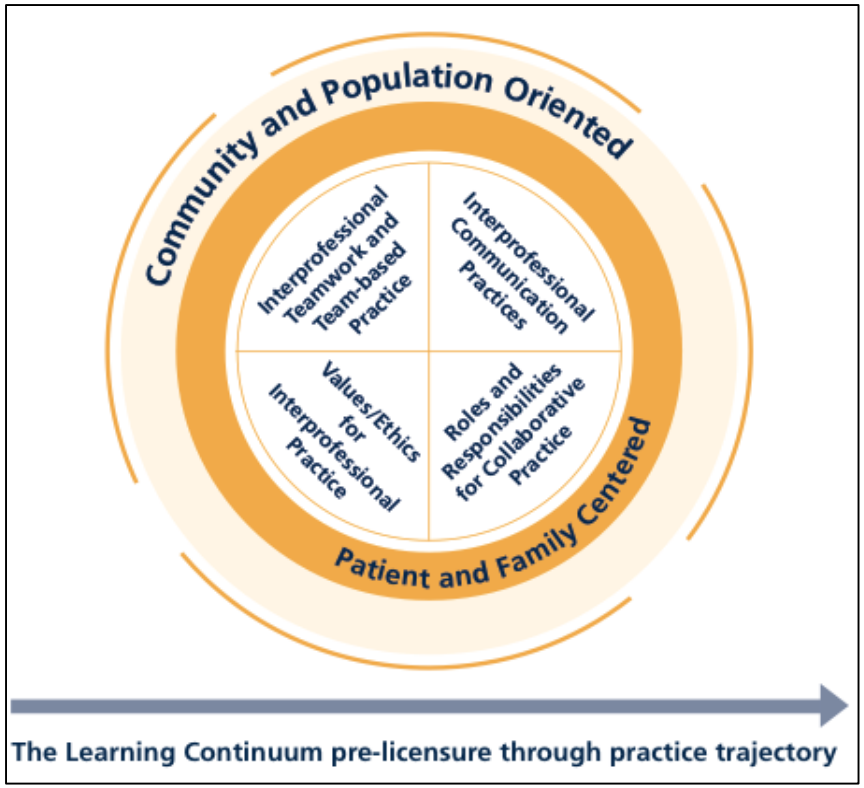
  https://www.ruralhealthinfo.org/community-health/oral-health
- **National Conference of State Legislatures Oral Health Primer**

  http://www.ncsl.org/documents/health/OralHTK13.pdf
- **National Academy for State Health Policy Oral Health Primer**

  http://www.nashp.org/advancing-oral-health-access-through-safety-net-

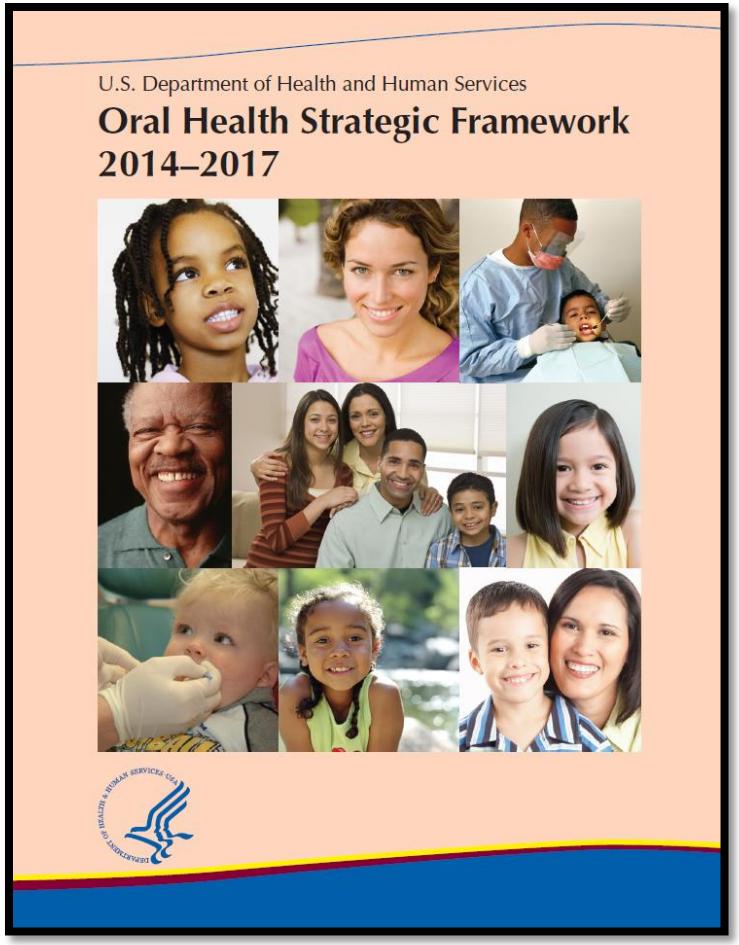
Interprofessional Education Collaborative

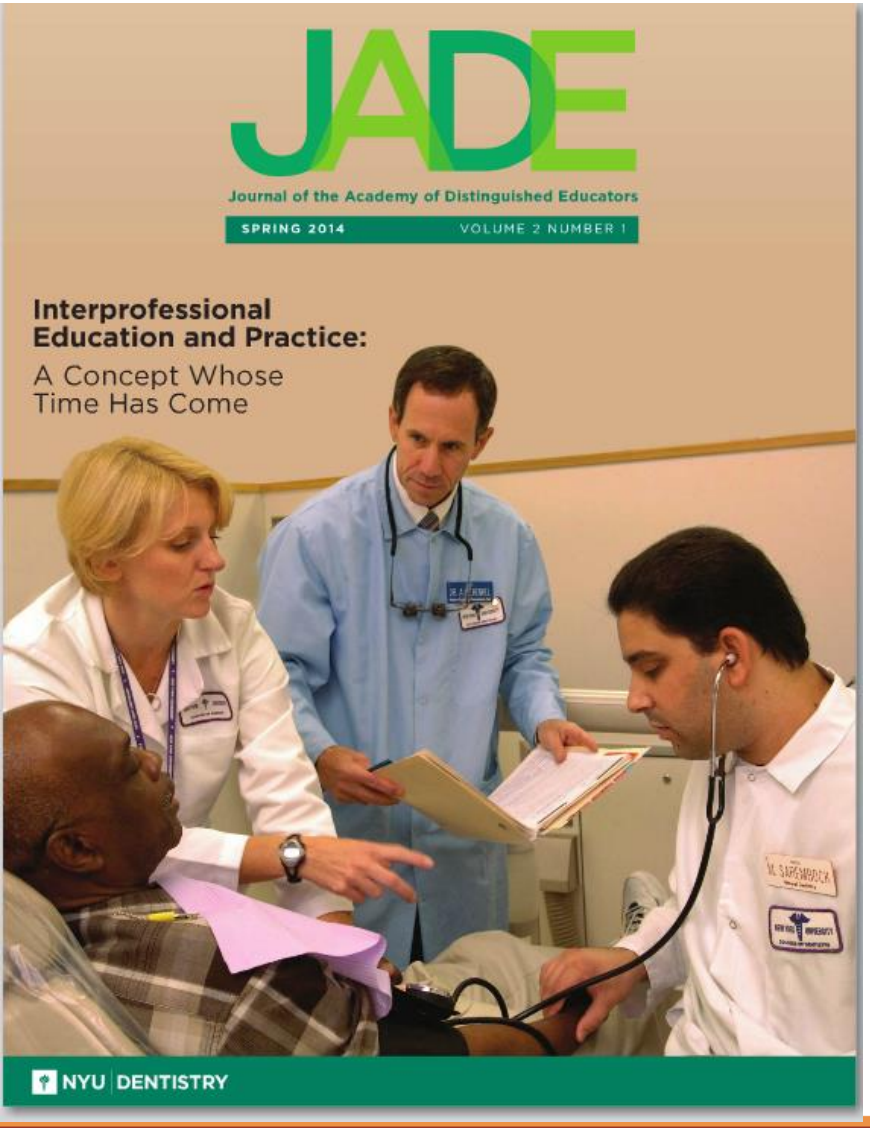




IPEC Competencies 2011

HHS Oral Health Strategic Framework

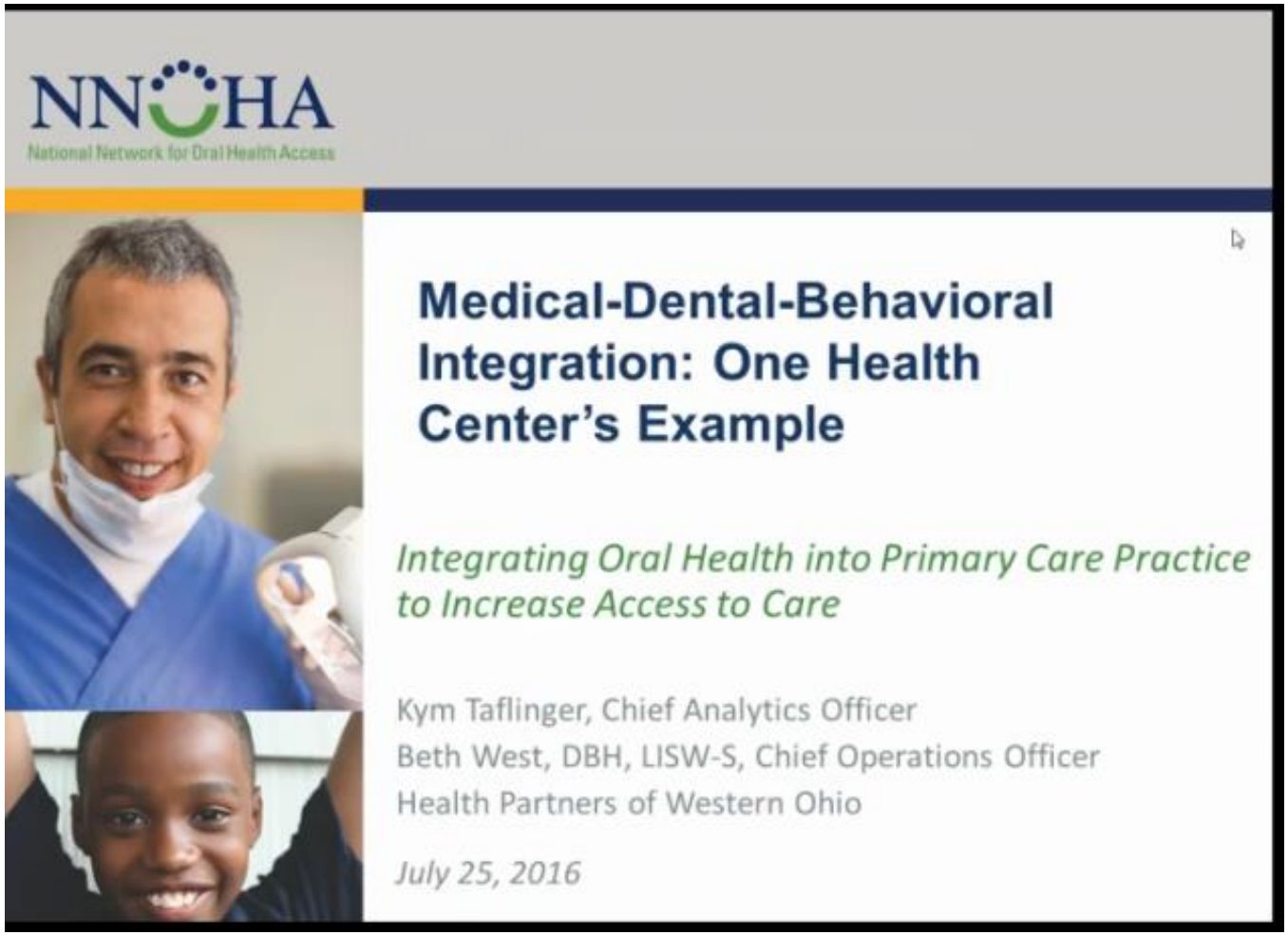




Interprofessional Education and Practice: An Opportunity to Reunite the Mouth with the Body and Make the Patient Whole

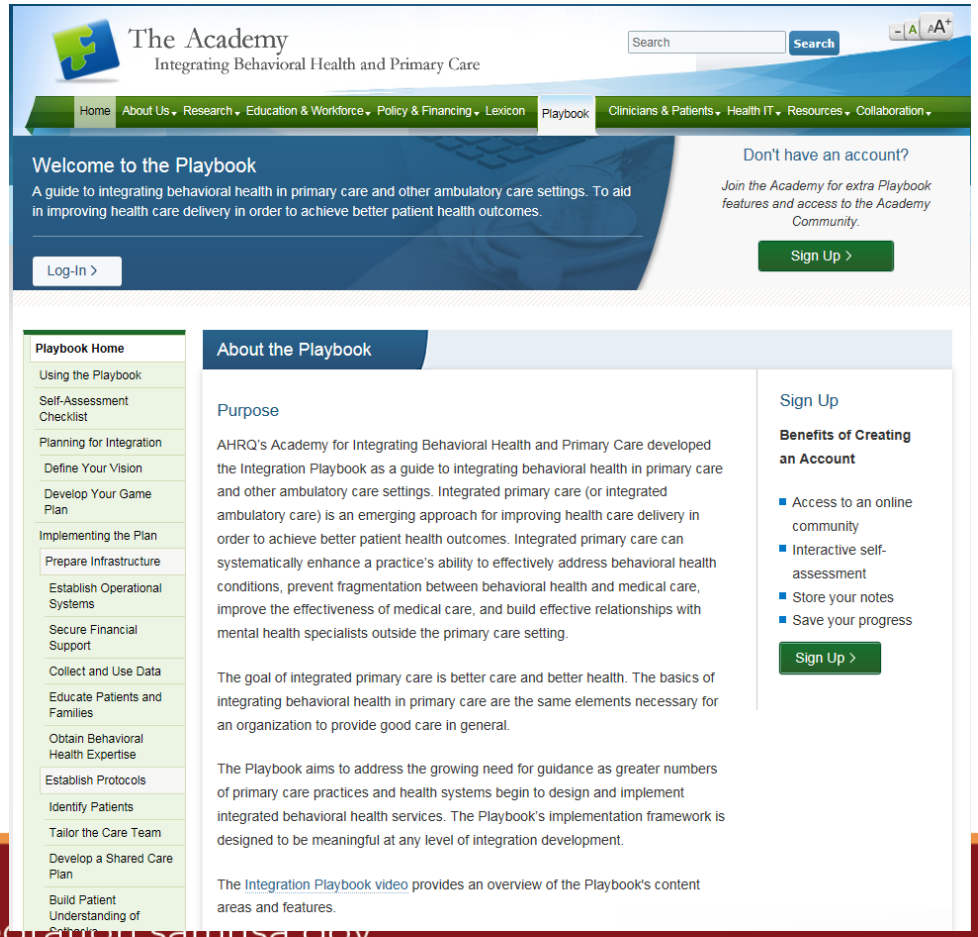
http://www.dental.nyu.edu/content/dam/nyudental/documents/jade/vol2/jade_v2_klink_joskow.pdf

http://www.nnoha.org/resources/5607-2/



A Guide to Integrating Behavioral Health in Primary Care and Other Ambulatory Care Settings

https://integrationacademy.ahrq.gov/playbook/about-playbook?_cldee=cmpvc2tvd0BocnNhLmdvdg%3d%3d&utm_source=ClickDimensions&utm_medium=email&utm_campaign=HRSA



Cultural Competency Program/Oral Health Environment

THINK CULTURAL HEALTH

About Us | National CLAS Standards | Education | Resources | Contact

Education > Oral Health Providers

https://www.thinkculturalhealth.hhs.gov/education/oral-health-providers

PROGRAM DETAILS

About This Program

As oral health disparities among cultural minority groups persist in our country, culturally and linguistically appropriate services (CLAS) are increasingly recognized as an important strategy for improving quality of care to diverse populations. This e-learning program will equip you with the knowledge, skills, and awareness to best deliver oral health services to all patients, regardless of cultural or linguistic background.

hhs.gov/about

NATIONAL CLAS STANDARDS

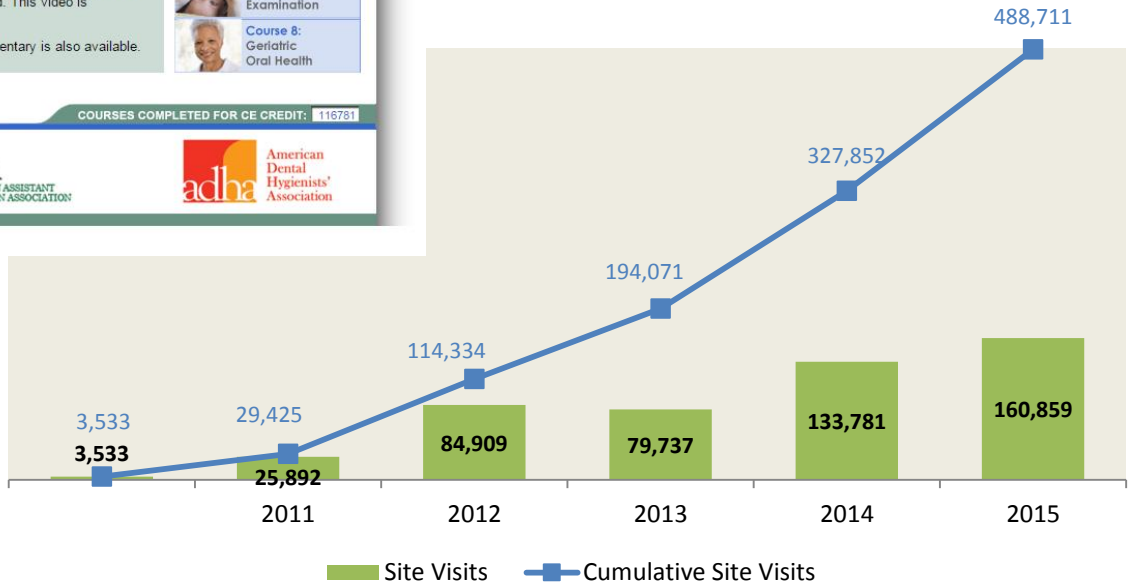
National CLAS Standards
(PDF – 48 KB)

This e-learning program is grounded in the HHS Office of Minority Health's National Standards for Culturally and Linguistically Appropriate Services

Smiles for Life National Oral Health Curriculum

Discrete Site Visits 2010-2015 (n=488,711)
Now 500,000+ visits

Endorsed by 7 Health Professions and 17 Professional Organizations



Oral Care is Rooted in Whole Health

SAMHSA/HRSA Center for Integrated Health Solutions

http://www.integration.samhsa.gov/about-us/esolutions-newsletter/e-solutions-jan-2015

Quick Tips: 5 Ways to Incorporate Oral Care in Integrated Settings

- Ask basic oral care questions during appointments to engage individuals and encourage preventive care. Questions can include if they experience any dental pain, if they have bleeding gums, or when they last visited a dentist.
- Provide educational materials on the importance of regular oral care in your center's common areas and exam rooms. The **National Institute of Dental and Craniofacial Research** and the Health Resources and Services Administration's **Maternal and Child Oral Health Resource Center** have brochures and fact sheets on a number of oral health topics.
- Know about your community's **free and no cost clinics** so, that you can make referrals, as appropriate, and visit **Donated Dental Services** to find programs in your state.

Quick Tips: 5 Ways to Incorporate Oral Care in Integrated Settings

- Consider the various ways you can bring dental care to your organization such as setting up a mobile van, inviting dental professionals to your center on a regular basis, partnering with local community health centers that offer dental services, or connecting with local dental providers as part of your coordinated care efforts. Check out these resources to get this process started:
  - HRSA's **Integration of Oral Health and Primary Care Practice** report
  - **User's Guide for Implementation of Interprofessional Oral Health Core Clinical Competencies**
  - **Increasing Access to Dental Care through Public Private Partnerships: Contracting Between Private Dentists and Federally Qualified Health Centers**
  - Know your state insurance coverage laws, including whether Medicaid offers any dental benefits.
- Visit our **Oral Care webpage** for more resources.

Featured Resource

- **Advancing Behavioral Health Integration within NCQA Recognized Patient-Centered Medical Homes** reviews the National Committee for Quality Assurance's (NCQA) patient-centered medical home (PCMH) standards and how they relate to the integration of behavioral health into primary care. HRSA-supported safety-net providers that have integrated behavioral health services can use this resource as a guide when preparing to apply to be recognized as a PCMH with NCQA.

Before You Say Ahhhh… Integrating Oral Health and Behavioral Health in Primary Care

Thank you

CIHS Tools and Resources

Visit www.integration.samhsa.gov or
e-mail integration@thenationalcouncil.org

Questions ?

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HEALTH SOLUTIONS

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