“I-Smile”
The Systematic “Dental Home”

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Advancing Health Through the Generations

The Dental Home – A Systematic Concept

- Dental decay is a multi-factorial, infectious, and chronic disease process that arises from the concerted action of many genes, environmental factors, and risk-conferring behavior
- Dental decay belongs in the same category as many complex chronic diseases such as cancer, diabetes and certain psychiatric illnesses

The “Dental Home”

American Academy of Pediatric Dentistry

- Provides oral health education and anticipatory guidance
- Provides access to primary prevention oral health care services
- Provides access to secondary prevention and interceptive oral health care services
- Provides referral access to secondary and advanced interceptive emergency dental services

Current Problem

- Disjointed/fragmentary oral health delivery system
  - Private/public
  - Dental care/primary care
  - Preventers/treaters
  - Clinicians/communities
- Blind, untargeted one-size fits all dated approaches to service delivery

Current Problem

- There are an insufficient number of practicing dentists in Iowa, particularly in lower-income and rural parts of the state—79 counties are estimated to be designated dental shortage areas.
- Many dental practices are very busy and do not accept *any* new patients, especially if patients cannot pay at current market rates.

Current Problem

- The majority of Iowa general practice dentists are uncomfortable or unwilling to see children under age three.
- Dentists are reluctant to accept Medicaid-enrolled patients due to low reimbursement and poor dental appointment compliance issues.
- Enrollment of children into the Iowa Medicaid program is increasing at an average rate of 1 percent per month.

“Realistic” AAPD Dental Home

- **The objective is to focus on the “child” and not the providers of care**

Iowa

- Decreasing and aging oral health workforce
- Increasing health profession shortages
- Mal-distribution of available dental providers
- Too costly limiting access to late interceptive disease treatment
- Extremely limited available secondary, special needs and emergency care dental providers and facilities

Relatively high levels of oral disease and decay rates among large numbers of children with significant disparities of access among rural poor and racial/ethnic minorities

Iowa

- **Less than 45 percent of all children enrolled in Medicaid have a dental visit during a year.**
- **In SFY 2005, there were 164,965 children six months through 12 years of age enrolled in Iowa Medicaid**
- **Of these, just 55,825 (34 percent) received a dental examination from a dentist**
- **In SFY 2005, 1,464 Medicaid-enrolled children were hospitalized or received general anesthesia for advanced dental treatment. Over 528 of these children were between the ages of one and three**

Iowa

- **In SFY 2005, the total Medicaid expenditures for all dental services provided to children age 12 and under were $13,799,863**
- **Of that amount, only $1,147,176 (8 percent) was for preventive screenings, fluoride varnish and/or sealants provided through local maternal and child health agencies and/or physicians**

The I-Smile Solution

- **Continuous, coordinated, risk-based use of effective measures that promote oral health, control oral disease, restore damaged oral structures and reduce future risk of disease**
- **Strategic, data-driven approaches that recognize and respect diversity among people and communities and engage a broad group of stake holders to address local needs**

Emphasis on realistic, achievable, and cost-effective approaches to oral health care

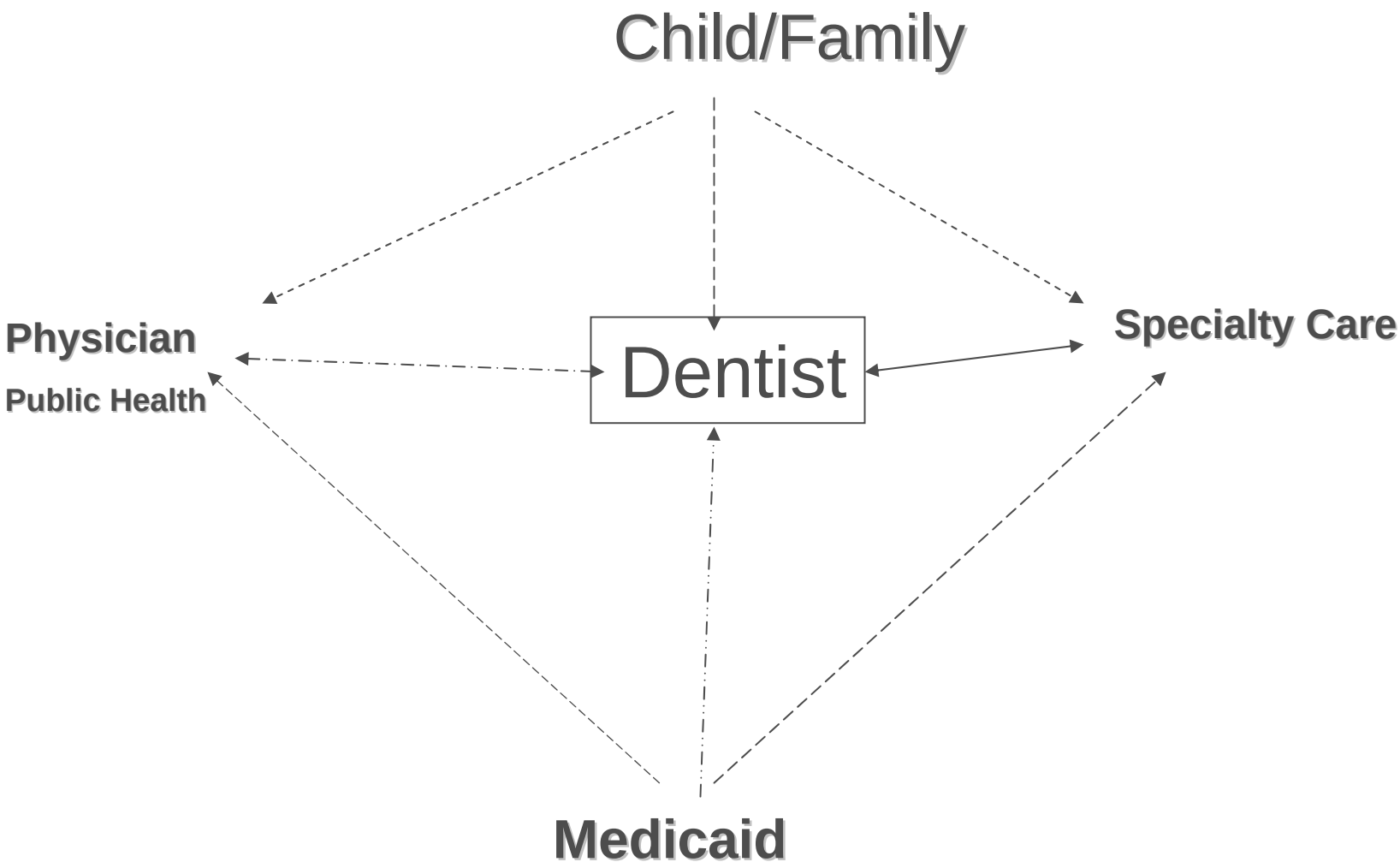
How?

- Systems Integration approach to oral health care management
- Care Coordination and case management for anticipatory guidance and identification of resources on the local level
- Enhanced educational efforts and social relevant promotions of oral health self- help models
- Increase training of primary care workforce, both dental and medical to address the oral health needs of pediatric populations

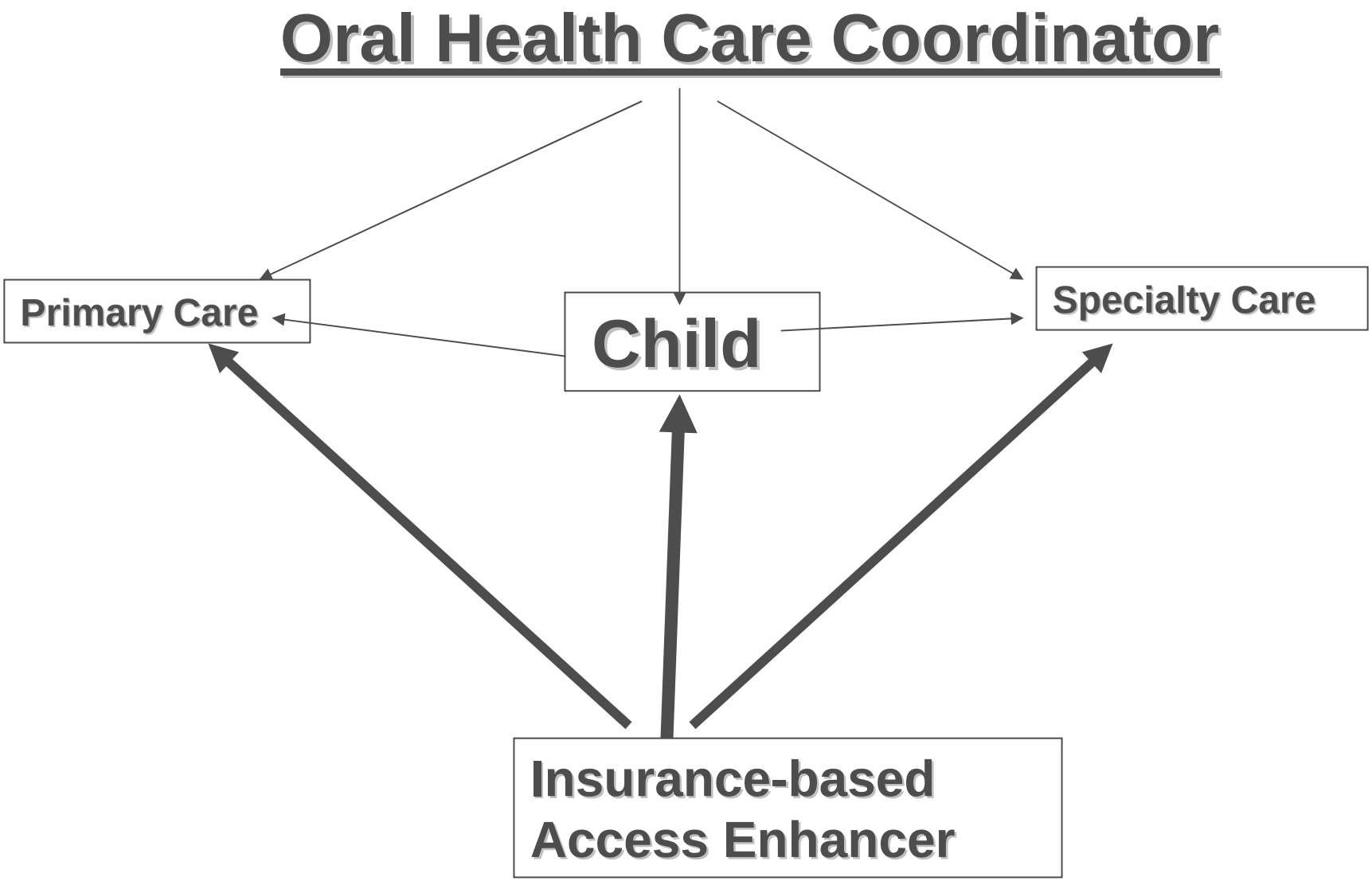
Increase Medicaid dental rates and more efficient use of mid-level and allied health care providers

Increase access to evidence-based prevention techniques as the preferred method of addressing oral health on a large scale

Current Medicaid Model



The Systematic Dental Home

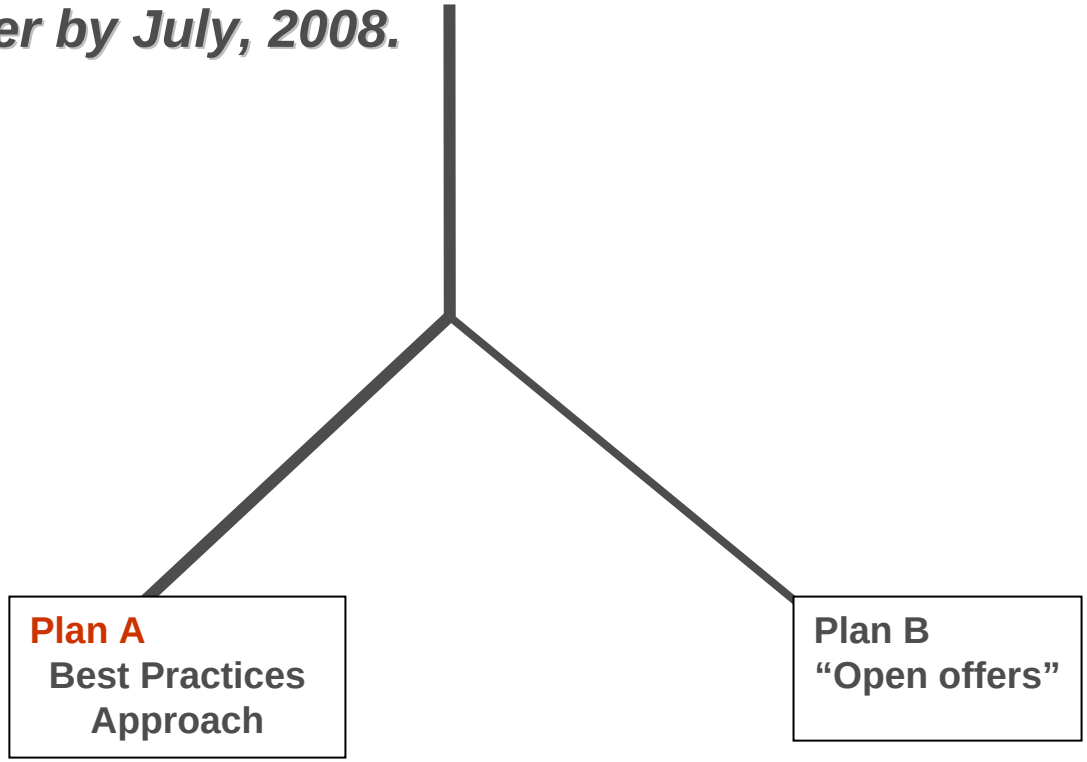


The Systematic Dental Home

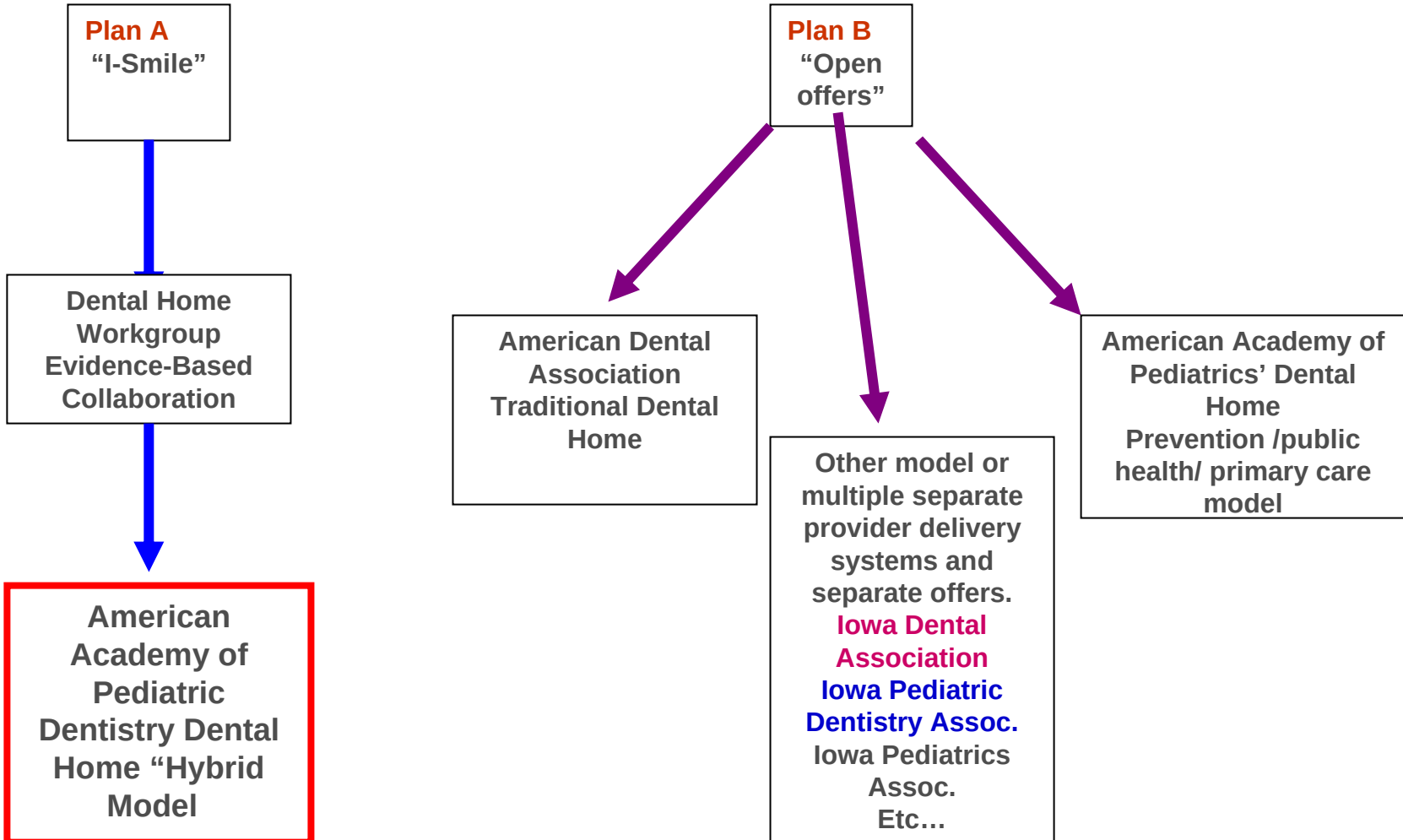
- Registry
- Care Coordination
- Guidelines
- Family Enabling
- Prevention focused
- Screening and surveillance
- Continuous quality assessment
- Continuous source of care

Road Map of the Iowa Dental Home Project

- **“IowaCares” HF-841 (May, 2005)**
- ***-establish a dental home for Medicaid enrolled children twelve and under by July, 2008.***



Road Map of the Iowa Dental Home Project



Integrated Dental Home System

- Policy Implications:
  - Standardization across systems
  - Accountability, outcome measurement
  - Incentives vs. mandates
  - No scope of practice changes
  - Turning pilots into working networks
  - Use current level of technology
  - Utilizes available resources

Integrated Dental Home System

- Negative Policy Implications:

"*RESISTANCE* to Change"

Incentive-Based "Volunteer" Provider Plan

- Advantages include:
  - Free market value system
  - Less politically charged
  - Minimal scope of practice issues
  - Prevention focused to reduce demand on private dental practices
  - Uses current public health and existing health care system

Policy Recommendation

- Increase public health prevention network and clinical capacity.
- Provide incentives to primary care providers to perform dental screenings, fluoride varnish applications, parental education and referrals.

Policy Recommendation

- Establish a dental hygienist as lead oral health care coordinator at all state Title V Child Health Agencies and form linkages with WIC clinics, Head Start programs, preschools and schools were possible

Role of Dental Hygienist

- **Prioritizing dental treatment needs and facilitating distribution of children among all local dental offices,**
- **Providing oral health education and guidance to parents and caregivers,**
- **Providing prevention services to children below age four that are sometimes considered too young to be seen by the dental office,**

Role of Dental Hygienist

- **Decreasing cancelled and/or “no show” scheduled appointments,**
- **Providing a single contact point for dental providers to report patient compliance issues, and**
- **Arranging transportation and translation services if needed.**

Policy Recommendation

- Train and give incentives to primary health care providers to perform oral health risk screenings and apply preventive fluoride varnishes.

Policy Recommendation

- Create a Insurance-based reimbursement system like Iowa's *hawk-i/S-Chip* program to increase dental provider willingness to treat Medicaid children.

Medicaid/*hawk-i* Comparison

- Dental utilization was 9% higher for children enrolled for 11-12 months in ***hawk-i*** than in the Iowa Medicaid program in 2001
- 46% in Medicaid compared to 57% for ***hawk-i***).

Hughes RJ, Damiano PC, Kanellis MJ, Kuthy R, Slayton R. Dentists' participation and children's use of services in the Indiana dental Medicaid program and SCHIP: assessing the impact of increased fees and administrative changes. J Am Dent Assoc. 2005 Apr;136(4):517-23.

Policy Recommendations

- Establish a state dental student loan repayment and/or Iowa dental student sponsorship program using Delta Dental of Iowa's student loan program as a model.
- Strengthen state support for dental programs in community health centers and rural acute care hospitals

Policy Recommendations

- Increase statewide media-based public health campaign targeting oral health care promotions
- Develop a mandated early childhood oral health care continuing education curriculum for general dentists and physicians

Outcome Measures and Next Steps

- Assign annual outcomes measures using Medicaid provider participation rates, oral health access coding and periodicity data.
- Sustain sufficient funding throughout program 5-year cycle.