2015 National Medicaid and CHIP Oral Health Symposium

Session # 8

Pediatric Dentist Opinion and Inter-professional Practice in 2015

Maria Cordero-Ricardo, DDS, MS
Paul Casamassimo, DDS, MS

Washington Marriott Wardman Park
Monday, June 1st, 2015
Learning Objective(s)

Participants will gain knowledge in:

1. Understanding contemporary IP practice in pediatric dentistry

2. Those IP procedures currently active in pediatric dentistry practice

3. Obstacles and issues relate to IP as stated by a sample of pediatric dentists
Disclosure and Conflict of Interest Declaration

- I declare that neither I nor any member of my family have a financial arrangement or affiliation with any corporate organization offering financial support or grant monies for this continuing dental education program, nor do I have a financial interest in any commercial product(s) or service(s) I will discuss in the presentation.
Background

- Pediatric dentists treat children with special needs, provide sedation and GA services and have an interest and commitment to the health of young children
- Typically, pediatric dentists may perform BPs, height/weight, check on immunizations, and address other health issues in a variety of contexts
- These procedures are typically uncompensated, but have importance in the care of the child
Additional Background

HRSA recommends:

• Apply oral health core competencies within PCP to increase oral health care access for safety net populations in US

• Develop infrastructure…. that enhances adoption of oral health core competencies

• Modify payment policies to address costs of implementing oral health competencies

• *Execute programs to develop and evaluate implementation strategies*

USDHHS, HRSA. Integration of Oral Health and Primary Care Practice. February 2014
Additional Background

Institute of Medicine (IOM) concludes:

• Without a purposeful and more comprehensive system of engagement between education and health delivery system, evaluating impact of IPE and outcomes will be difficult,

• Having a comprehensive conceptual model would enhance description and purpose of IPE,

• More purposeful, well-designed and thoughtfully reported studies are needed
Additional Background from IOM

IOM recommends:

• *All parties should commit resources to a coordinated series of well-designed studies on association between IPE and collaborative behavior*

• Health professions educators and academic and health systems leaders should adopt a mixed methods research approach for evaluating the impact of IPE on health and systems outcomes

Pediatric Dental Workforce Attitudes Toward Interprofessional Collaborative Practice

• This is investigation attempted to determine attitudes, barriers, and feasibility of interprofessional practice in context of current pediatric dentistry in the US.

• The study attempted to quantify current practices, application of knowledge, interest and anticipated barriers to expansion of responsibilities and scope of practice of pediatric dentists.
Study Design and Implementation

• Sample of all pediatric dentist members of AAPD across the US
• University IRB approved
• Non-validated questionnaire, expert reviewed
• Survey Monkey distribution
• Resurvey once
Results

- 1025 Surveys were started
- 606 (64%) were completed
- Male 56.4%
- 4.5% in training

Small Private (1-2 practitioners) (315, 47.7%)
Large Private (3+ practitioners) (163, 24.7%)
Corporate Practice (28, 4.2%),
Federally Qualified Health Center (45, 6.8%)
Academia (109, 16.5%)
ICP Important to 92% of Pediatric Dentists (610 of 661)
PDs Likely to Screen, Refer, Discuss

Screen by Interview

Refer to Physician for Consultation

Discuss Results Chairside
PD are Less Likely to Screen with Biometric Data (BMI)

Very unlikely (94, 14.2%), Unlikely (209, 31.7%), Likely (255, 38.6%), Very Likely (102, 15.5%)
PDs Unlikely to Screen by Specimen Collection

- Very unlikely: 159 (24.1%)
- Unlikely: 243 (36.8%)
- Likely: 200 (30.3%)
- Very Likely: 58 (8.8%)
What Most PDs Do in ICP

<table>
<thead>
<tr>
<th>Activity</th>
<th>Participation Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verification of Immunizations</td>
<td>45%</td>
</tr>
<tr>
<td>Validate Medical Home</td>
<td>83%</td>
</tr>
<tr>
<td>Ask about Child Safety</td>
<td>46%</td>
</tr>
<tr>
<td>Take Blood Pressure Measurements</td>
<td>52%</td>
</tr>
<tr>
<td>Take Height and Weight Measurements</td>
<td>54%</td>
</tr>
<tr>
<td>Calculate BMI</td>
<td>19%</td>
</tr>
<tr>
<td>Screen for GERD</td>
<td>43%</td>
</tr>
<tr>
<td>Screen for Diabetes</td>
<td>26%</td>
</tr>
</tbody>
</table>
Of 52% Who Take BP Measurements, Only 13% Perform it on All Patients
81% of PDs do not Calculate BMI

Most common reasons:

- I do not consider it part of my professional responsibility (263, 49.3%)
- I do not want to track the most current medical guidelines (30, 5.6%)
- I do not want any liability for errors (55, 10.3%)
- I do not want to follow up with families (31, 5.8%)
- It does not alter my willingness or ability to treat the child (292, 54.7%)
- I do not want to train or retrain my staff in this service (45, 8.4%)
# Finances May Be More Important Than Attitudes

<table>
<thead>
<tr>
<th>Statement</th>
<th>Agreed</th>
</tr>
</thead>
<tbody>
<tr>
<td>I should be reimbursed for all these services comparable to other health professionals.</td>
<td>70%</td>
</tr>
<tr>
<td>I am willing to do these to enhance my practice without reimbursement.</td>
<td>59%</td>
</tr>
<tr>
<td>I need to be reimbursed only for those that deviate from my current practice routine.</td>
<td>51%</td>
</tr>
<tr>
<td>I need to be reimbursed only for those that require staff time and equipment.</td>
<td>65%</td>
</tr>
<tr>
<td>Third parties should reimburse pediatric dentists performing the interprofessional services described above.</td>
<td>81%</td>
</tr>
<tr>
<td>Third party reimbursement would make you perform some interprofessional services you do not currently provide.</td>
<td>61%</td>
</tr>
</tbody>
</table>
Conclusions

1. Pediatric dentists believe ICP is important
2. The greatest motivator is a PD’s sense of professionalism and duty toward patient care
3. Barriers are:
   a. The greatest barrier is the attitude that the findings will not alter treatment
   b. The practice or the PD’s responsibility
4. Financial considerations would impact individuals willingness to participate
Diverse Comments Revealing

• I have to pick my battles...
• We pediatric dentists have to do what we do best.... all other areas refer to pediatrician
• If we do these, they need to be reported to medical providers to prevent duplication
• I get a lot of denials for fluoride because the pediatricians are billing insurance....
• These are money losers for pediatric dentists in private practice and money could be better invested elsewhere...
• It can be difficult to get compliance for OHI, so why burden parents with BMI?
• I think ICP is important when there is no MD....
• I practice in an area with excellent pediatricians, so not necessary...
• If we are doing these, we better be darn sure we are doing them right.....
• Best done if access to EHR....
• If I have concerns, I refer to pediatricians
• Seems like a reasonable demand for a pediatric dentist without compensation....
• Who came up with this stuff? I have more kids to care for than to get into MD stuff!
Contact Information

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2015 National Medicaid and CHIP Oral Health Symposium

Session # 6

When Two Becomes One

Mark Doherty DMD MPH
Safety Net Solutions

Washington Marriott Wardman Park
Monday, June 1st, 2015
The comprehensive health care system supports Oral Health collaborations/integration that treats the patient at the point of care where the patient is most comfortable and applies a patient-centered approach to treatment.
Collaboration or Integration

**Collaboration** = primary care and oral health working *with* one another

**Integration** = oral health working *within* and as part of primary care or vice versa.....Provision of dental services *within* primary care
Primary Care Workforce

Can make a difference!

- Family Medicine: 105,000
- Pediatrics: 45,000
- General Internists: 70,000
- Nurse Practitioners: 150,000
- Physician Assistants: 36,000
Menu Components

- Caries Risk Assessment
- OH Screening/evaluation
- Behavior Change through Anticipatory Guidance
- The FL varnish piece
- Institutionalized Referral Process
- Designated Access Appointments
- EMR/EDR Interface
- Case/Care Management
- Warm-handoffs
- Curbside Consults
- Installed a dental suite in Pediatrics
Barriers

We are brought up in a *Bifurcated care system*

- Educated separately
- Licensed separately
- Regulated separately
- Practice independently
- PCPs see the mouth as the property of dentists
- Sharing of information rarely occurs
- Seen by the public/patients as separate
- Oral Health training for health professionals has been sparse to non-existent
- Non-integrated benefits/insurance programs
Outcomes

- Improved Health
- Early Interventions
- Prevention
- Portal to the family
- One stop shopping
- > OH Literacy
- < OH disparities
- >OH Promotion
- Innovative Finance and Service Delivery

- Improves Accountability
- Healthy People 2020
- Expanded Workforce
- Increased Access
- Improved Efficiency
- Reimbursement for children’s dental services
- Patient Centric
- Wellness Achieved
The ECOH Model

The Early Childhood Oral Health (ECOH) program was developed in Ohio with a goal of improving oral health outcomes for Ohio’s youngest and most vulnerable citizens by *integrating preventive oral health practices within the primary care setting*.

To achieve that goal, the ECOH business plan was developed.

The purpose of the ECOH business plan is to clearly define the goals and objectives of an early childhood oral health program and provide the strategy to achieve them.
Sustainability of the ECOH initiative will not come from the application of preventive oral health practices within the primary care setting as Medicaid will not reimburse for these services as a separate visit apart from the well-child visit.

Sustainability will be achieved by the increase in dental revenue that will result from referrals of children of all ages from pediatrics and family practice to the dental clinic.

To facilitate medical referrals to dental, ensure that
Case Managers

• Facilitating referrals
• Help parents enroll in publicly available insurance programs
• Assist in removing barriers to care
• Referral follow up
• Track and report the results of the initiative

An effective and accountable case manager will be able to cover his or her salary several times over through the additional dental revenue that will result from his or her efforts.
ECOH Vision

• Improvement in **payer mix** through referral of more children of all ages to dental (50% Medicaid to 62% Medicaid)

• **Increased revenue for dental** as a result of change in payer mix (+$137,020)

• Dental invests $65,000 in **case manager/coordinator** (salary plus fringe)—critical to program success

• **Dental reimburses medical** $18,842 to reimburse medical for supplies and staff time to do screenings, referrals, AG and FL varnish

• **“Baby Days”** in dental one day per week generates 736 additional visits to dental for children < age 3

• Investment generates nearly **$53,000** in additional revenue for dental **AFTER** all costs
# ECOH Program Assumptions

<table>
<thead>
<tr>
<th>Dental Program w/o ECOH Integration</th>
<th>Dental Program with ECOH and Integration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic operates 46 weeks/year</td>
<td>Clinic operates 46 weeks/year</td>
</tr>
<tr>
<td>4 operators</td>
<td>4 operators</td>
</tr>
<tr>
<td>Total visits: 5,313</td>
<td>Total visits: 6,049</td>
</tr>
<tr>
<td>Hours: M-F 8-5</td>
<td>Hours: M-F 8-5</td>
</tr>
<tr>
<td>Staffing: 1 FTE dentist/clinical director, 2 FTE dental assistant, 1 FTE hygienist, 2 FTE reception/registration clerks</td>
<td>Staffing: 1 FTE dentist/clinical director, 2 FTE dental assistant, 1 FTE hygienist, 2 FTE reception/registration clerks, plus 1 FTE case manager</td>
</tr>
<tr>
<td>ECOH program adds 736 additional visits to the dental program (ages 0-3)</td>
<td>ECOH program adds 736 additional visits to the dental program (ages 0-3)</td>
</tr>
</tbody>
</table>
Calculations

• Looked at UDS data for Ohio and divided total number of pediatricians by number of FQHCS to get an average of 1.5 FTE pediatricians per health center

• 33,808 unduplicated children in Ohio health centers under age 3 in 2010 ÷ 32 health centers = average of 1,057 unduplicated children under age 3 per health center

• Guesstimated on the 1,035 well child visits where FL varnish would be applied:
  – Pediatrician would see 18 patients per day. 9 of these would be well-child visits x 230 days for a total of 2,070 well child visits per year. Assumed that half of these would be children under 3 years of age (given the high number of well child visits in the first three years of life)

• Assumed each pediatrician would have a panel size of 1,000 unduplicated patients for a total of 1,500 unduplicated pediatric patients per health center
Calculations cont.

• Assumed a third of these unduplicated patients are over age 3 and are referred to dental at least once per year

• Assumed the following for the 500 unduplicated patients >age 3:
  • All 500 would get a new patient visit
  • 250 would come back in 6 months for a recall visit
  • 150 children would need at least one restorative visit
  • 150 children referred would be eligible for sealants
  • For a total of 1,050 visits

• For a Health Center dental program doing “Baby Days” one morning per week with block scheduling for children 3 years of age, 16 kids would be seen per morning x 46 weeks = 736 visits (70% of unduplicated children under age 3)
Calculations cont.

- Payer mix after integration is 62% Medicaid, 23% Uninsured/SFS, 10% Commercial and 5% $0 pay

- $130 average per visit fee from Medicaid, $40 per visit fee from uninsured

- Assumed average pediatrician or FP’s hourly rate would be $75. Assumed it would take 10 minutes of their time to do screening and anticipatory guidance (with mid-level doing the actual FL varnish application). 10 minutes x 1035 visits = 10,350 minutes ÷ 60 minutes = 172.5 hours per year x $75/hour = $12,938 (value of physician’s time)
<table>
<thead>
<tr>
<th></th>
<th>Dental Program Without ECOH &amp; Integration</th>
<th>Dental Program With ECOH &amp; Integration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>REVENUE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 1</strong></td>
<td>5,313 visits</td>
<td>6,049 visits*</td>
</tr>
<tr>
<td>Self-Pay (35%)</td>
<td>$74,400 $40/visit</td>
<td>Self-Pay (23%)</td>
</tr>
<tr>
<td>Medicaid (50%)</td>
<td>$345,410 $130/visit</td>
<td>Medicaid (62%)</td>
</tr>
<tr>
<td>Commercial Insurance (10%)</td>
<td>$98,235 $185/visit</td>
<td>Commercial Insurance (10%)</td>
</tr>
<tr>
<td>Free care patients (5%)</td>
<td>$0</td>
<td>Free care patients (5%)</td>
</tr>
<tr>
<td><strong>Total Patient Net Revenue</strong></td>
<td>$518,045</td>
<td>$655,065</td>
</tr>
<tr>
<td>Grant Revenue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>330 Allocation</td>
<td>$250,000</td>
<td>330 Allocation</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td>$768,045</td>
<td>$905,065</td>
</tr>
<tr>
<td><strong>Direct Expenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Personnel Related</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries</td>
<td>$322,400</td>
<td>Salaries</td>
</tr>
<tr>
<td>Fringe Benefits (25%)</td>
<td>$80,600</td>
<td>Fringe Benefits (25%)</td>
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<tr>
<td>Malpractice Insurance</td>
<td>$0</td>
<td>Malpractice Insurance</td>
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<td><strong>Subtotal Personnel Costs</strong></td>
<td>$403,000</td>
<td><strong>Subtotal Personnel Costs</strong></td>
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<tr>
<td></td>
<td></td>
<td>$468,000</td>
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<tr>
<td>Support costs</td>
<td>Support costs</td>
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<tr>
<td><strong>Dental Supplies</strong></td>
<td><strong>Dental Supplies</strong></td>
<td></td>
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<tr>
<td>$42,504</td>
<td>$8/visit</td>
<td></td>
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<tr>
<td>$42,504</td>
<td>$8/visit</td>
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<tr>
<td><strong>Dental Lab Services</strong></td>
<td><strong>Dental Lab Services</strong></td>
<td></td>
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<tr>
<td>$20,000</td>
<td>130 patients @ $150/patient</td>
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<tr>
<td>$11,250</td>
<td>75 patients @ $150/patient</td>
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<tr>
<td><strong>Equipment Repair/Maintenance</strong></td>
<td><strong>Equipment Repair/Maintenance</strong></td>
<td></td>
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<tr>
<td>$9,500</td>
<td>$9,500</td>
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<tr>
<td><strong>Housekeeping</strong></td>
<td><strong>Housekeeping</strong></td>
<td></td>
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<tr>
<td>$6,000</td>
<td>$6,000</td>
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<tr>
<td><strong>Conference/Travel</strong></td>
<td><strong>Conference/Travel</strong></td>
<td></td>
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<tr>
<td>$2,000</td>
<td>$2,000</td>
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<tr>
<td><strong>Office Supplies</strong></td>
<td><strong>Office Supplies</strong></td>
<td></td>
</tr>
<tr>
<td>$3,000</td>
<td>$3,000</td>
<td></td>
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<tr>
<td><strong>Computer Maintenance, License Fees</strong></td>
<td><strong>Computer Maintenance, License Fees</strong></td>
<td></td>
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<tr>
<td>$12,000</td>
<td>$12,000</td>
<td></td>
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<tr>
<td><strong>Books &amp; Subscriptions</strong></td>
<td><strong>Books &amp; Subscriptions</strong></td>
<td></td>
</tr>
<tr>
<td>$1,000</td>
<td>$1,000</td>
<td></td>
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<tr>
<td><strong>Fees &amp; Dues</strong></td>
<td><strong>Fees &amp; Dues</strong></td>
<td></td>
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<tr>
<td>$3,500</td>
<td>$3,500</td>
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<tr>
<td><strong>Recruitment Expenses</strong></td>
<td><strong>Recruitment Expenses</strong></td>
<td></td>
</tr>
<tr>
<td>$3,000</td>
<td>$3,000</td>
<td></td>
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<tr>
<td><strong>Insurance</strong></td>
<td><strong>Insurance</strong></td>
<td></td>
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<tr>
<td>$10,000</td>
<td>$10,000</td>
<td></td>
</tr>
<tr>
<td><strong>Printing</strong></td>
<td><strong>Printing</strong></td>
<td></td>
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<tr>
<td>$2,000</td>
<td>$2,000</td>
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<tr>
<td><strong>Postage</strong></td>
<td><strong>Postage</strong></td>
<td></td>
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<tr>
<td>$2,000</td>
<td>$2,000</td>
<td></td>
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<tr>
<td><strong>Depreciation</strong></td>
<td><strong>Depreciation</strong></td>
<td></td>
</tr>
<tr>
<td>$30,000</td>
<td>$30,000</td>
<td></td>
</tr>
<tr>
<td><strong>Bad Debt</strong></td>
<td><strong>Bad Debt</strong></td>
<td></td>
</tr>
<tr>
<td>$11,500</td>
<td>$11,500</td>
<td></td>
</tr>
<tr>
<td><strong>Total Support Costs</strong></td>
<td><strong>Total Support Costs</strong></td>
<td></td>
</tr>
<tr>
<td>$158,004</td>
<td>$149,254</td>
<td></td>
</tr>
</tbody>
</table>
## Building-Related Costs

<table>
<thead>
<tr>
<th>Maintenance</th>
<th>FL Varnish</th>
<th>Medical Materials Costs (Anticipatory Guidance)</th>
<th>Medical Staff allocation to reimburse for time spent in screening, FV application and AG</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rental/Mortgage</strong></td>
<td><strong>$6,000</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Utilities</strong></td>
<td><strong>$30,000</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Telephone/Internet</strong></td>
<td><strong>$10,000</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Total Building Costs

- **Total Building Costs**: $5,000

### ECOH Program Costs

<table>
<thead>
<tr>
<th>Maintenance</th>
<th>FL Varnish</th>
<th>Medical Materials Costs (Anticipatory Guidance)</th>
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<td></td>
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</tr>
<tr>
<td><strong>Utilities</strong></td>
<td><strong>$30,000</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Telephone/Internet</strong></td>
<td><strong>$10,000</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Total ECOH Program Costs

- **Total ECOH Program Costs**: $18,842

## Total Direct Expenses

- **Total Direct Expenses**: $6,000
- **Rent/Mortgage**: $30,000
- **Utilities**: $10,000
- **Telephone/Internet**: $5,000

### Indirect Expenses

- **Total Support & Admin Allocation (12% of direct expenses)**: $73,440
- **Telephone/Internet**: $5,000

### TOTAL EXPENSES

- **TOTAL EXPENSES**: $685,444
- **Total Building Costs**: $51,000

### TOTAL REVENUE

- **TOTAL REVENUE**: $768,045

### PROFIT

- **PROFIT**: $82,601

### Total Direct Expenses

- **Total Direct Expenses**: $687,096

### Indirect Expenses

- **Total Support & Admin Allocation (12% of direct expenses)**: $82,452

### TOTAL EXPENSES

- **TOTAL EXPENSES**: $769,548

### TOTAL REVENUE

- **TOTAL REVENUE**: $905,065

### PROFIT

- **PROFIT**: $135,517
Partnering to Strengthen and Preserve the Oral Health Safety Net

Mark J. Doherty, DMD, MPH

A PROGRAM OF THE

DentaQuest INSTITUTE
2015 National Medicaid and CHIP Oral Health Symposium

Session # 8
Operations Manager
School Based Oral Health Clinic Project Director

Jennifer Pilapil

Washington Marriott Wardman Park
Monday, June 1st, 2015
Disclosure and Conflict of Interest Declaration

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Learning Objective(s)

Participants will gain knowledge and understanding of:

• How school based healthcare may advance health outcomes for children
• How integrated oral and primary healthcare models in school based clinics have advanced to comprehensive healthcare service delivery
• Why Medicaid policies should support school-based healthcare
• How integrated models can help sustain school based healthcare services
Background

• “Mommy, It Hurts to Chew,” conducted in 2006 by the Dental Health Foundation assessed the oral health of California’s 3rd graders with the result that the oral health of California’s children is substantially worse than national objectives set forth by Healthy People 2010.

• Project developed in response to Health Resource Services Administration (HRSA) Funding Opportunity Announcement (FOA)
Integration Within School District

- Mental Health
- School Based Dental Office
- Primary Health Care
- School Nurses
- Vision
- Child Health and Disability Program
- Audiometry
Identifying Need and Location for Services

Spatial analysis conducted
• Location(s) identified
• Coordination with:
  • Head Start programs
  • Early Education Centers
  • WICs
  • Schools
  • Hospitals
  • Dental providers
  • Other community agencies
  • Community health navigators
The CHDP Program and Medicaid Enrollment

<table>
<thead>
<tr>
<th>CHDP FUNCTIONS</th>
<th>MEDI-CAL FUNCTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Early</strong></td>
<td>Diagnostic</td>
</tr>
<tr>
<td>• Assessing and identifying problems early</td>
<td>• Performing diagnostic tests to follow up when a risk is identified, and</td>
</tr>
<tr>
<td></td>
<td>Diagnostic</td>
</tr>
<tr>
<td><strong>Periodic</strong></td>
<td>Treatment</td>
</tr>
<tr>
<td>• Checking children’s health at periodic, age-appropriate intervals</td>
<td>• Control, correct or reduce health problems found</td>
</tr>
<tr>
<td></td>
<td>Treatment</td>
</tr>
<tr>
<td><strong>Screening</strong></td>
<td></td>
</tr>
<tr>
<td>• Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems</td>
<td></td>
</tr>
</tbody>
</table>
**CHDP ASSESSMENT**

Indicate outcome for each screening procedure.

<table>
<thead>
<tr>
<th>Code</th>
<th>Procedure</th>
<th>Referral</th>
<th>Date of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>History and Physical Exam</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>Dental Assessment/Referral</td>
<td>B</td>
<td></td>
</tr>
<tr>
<td>03</td>
<td>Nutritional Assessment</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>04</td>
<td>Health Education</td>
<td>D</td>
<td></td>
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<tr>
<td>05</td>
<td>Developmental Assessment</td>
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<tr>
<td>06</td>
<td>Sickle Cell or Equivalent</td>
<td></td>
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<tr>
<td>07</td>
<td>Audiometric</td>
<td></td>
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<tr>
<td>08</td>
<td>Hemoglobin or Hematocrit</td>
<td></td>
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<tr>
<td>09</td>
<td>Urine Dipstick</td>
<td></td>
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<tr>
<td>10</td>
<td>Complete Urinalysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>TB Mantoux</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**FOLLOW UP CODES**

- 1. NO EVEN INDICATED ON PREVIOUS VISIT, SCHEDULED FOR DRS. OR PERSONNEL TO PROVIDE FOLLOW UP
- 2. QUINTESSENTIAL RECHECK, 3.X, ON MAC AND RX STARTED
- 3. NO REFERRAL, RX STARTED

**COMMENTS/PROBLEMS**

If a problem is diagnosed, please enter your diagnosis in this area.

**IMMUNIZATIONS**

Please refer to the chart of immunization codes.

- **GIVEN TODAY**
  - Height: ________________
  - Weight: ________________
  - Body Mass Index: __________
  - Blood Pressure: __________

- **NOT GIVEN TODAY**
  - Height: ________________
  - Weight: ________________
  - Body Mass Index: __________
  - Blood Pressure: __________

**DIAGNOSIS CODES**

- **THE QUESTIONS BELOW MUST BE ANSWERED**
  1. Patient is Exposed to Passive (Second Hand) Tobacco Smoke, Yes [ ] No [ ]
  2. Tobacco Used by Patient, Yes [ ] No [ ]
  3. Counseled About/Referred For Tobacco Use Prevention/Cessation, Yes [ ] No [ ]

**RENDERING PROVIDER**

<table>
<thead>
<tr>
<th>Name of Provider</th>
<th>(Print Name)</th>
</tr>
</thead>
</table>

**HEALTHPLAN CODE / PROVIDER NUMBER**

<table>
<thead>
<tr>
<th>Healthplan Code</th>
<th>Provider Number</th>
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</thead>
</table>

**STATE OF CALIFORNIA-CHILD HEALTH AND DISABILITY PREVENTION PROGRAM**

**CONFIDENTIAL SCREENING/BILLING REPORT**

COPY 1 - MAIL TO MEDICAL CHDP
Table 21.1  CHDP PERIODICITY SCHEDULE FOR HEALTH ASSESSMENT REQUIREMENTS BY AGE GROUPS

<table>
<thead>
<tr>
<th>Screening Requirement</th>
<th>≤ 1 mo</th>
<th>2 mos</th>
<th>4 mos</th>
<th>6 mos</th>
<th>9 mos</th>
<th>12 mos</th>
<th>15 mos</th>
<th>18 mos</th>
<th>2 Yr</th>
<th>3 Yr</th>
<th>4-5 Yr</th>
<th>6-8 Yr</th>
<th>9-12 Yr</th>
<th>13-16 Yr</th>
<th>17-20 Yr</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interval Until Next CHDP Exam</td>
<td>1 mo</td>
<td>2 mos</td>
<td>2 mos</td>
<td>3 mos</td>
<td>3 mos</td>
<td>3 mos</td>
<td>6 mos</td>
<td>1 yr</td>
<td>1 yr</td>
<td>2 yr</td>
<td>3 yr</td>
<td>4 yr</td>
<td>4 yr</td>
<td>None</td>
<td></td>
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<tr>
<td>History and Physical Examination</td>
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<tr>
<td>Dental Assessment</td>
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<td>Nutritional Assessment</td>
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<td>Psychosocial/Behavioral Assessment</td>
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<td>Developmental Screening</td>
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<td>Developmental Surveillance</td>
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<td>Tobacco Assessment</td>
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<td>Head Circumference</td>
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<td>Sensory Screening</td>
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<tr>
<td>Vision - Visual Acuity Test</td>
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<td>Vision - Clinical Observation</td>
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<td>Hearing - Audiometric</td>
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<td>Hearing - Clinical Assessment</td>
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</tbody>
</table>
| Hematocrit or Hemoglobin | | | | | | | | | | | | | | *
| Blood Lead Risk Assessment/ Anticipatory Guidance | | | | | | | | | | | | | | |
| Blood Lead Test | | | | | | | | | | | | | | |
| TB Risk Assessment | | | | | | | | | | | | | | |
| Anticipatory Guidance | | | | | | | | | | | | | | |

Note: The number of health assessments may be increased using MNIHA, as appropriate.1

Note: Perform health assessment within 1 month of screening requirement age for children 2 years and under, and within 6 months for children 3 years and older.

Note: Children coming under care who have not received all the recommended procedures for an earlier age should be brought up-to-date as appropriate.

Other Laboratory Tests

<table>
<thead>
<tr>
<th>When health history and/or physical examination warrants:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urine Dipstick or Urinalysis 11</td>
</tr>
<tr>
<td>TST15 - see Tuberculosis HAG</td>
</tr>
<tr>
<td>Sickle Cell</td>
</tr>
<tr>
<td>Ova and Parasites</td>
</tr>
<tr>
<td>FBG and Total Cholesterol</td>
</tr>
<tr>
<td>Papanicolaou (Pap) Smear</td>
</tr>
<tr>
<td>VDRL or RPR13</td>
</tr>
</tbody>
</table>

Annually if sexually active; more often as clinically indicated:

<table>
<thead>
<tr>
<th>STI testing when risk identified by history/physical . See STI HAG.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gonorrhea Test13</td>
</tr>
<tr>
<td>Chlamydia Test13</td>
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</tbody>
</table>

Immunizations14

<table>
<thead>
<tr>
<th>Key:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required by CHDP one time within the interval given</td>
</tr>
<tr>
<td>o Recommended by AAP, Bright Futures and CHDP</td>
</tr>
<tr>
<td>* Perform when indicated by risk assessment.</td>
</tr>
<tr>
<td>x Perform if no documented lead level at 24 months</td>
</tr>
</tbody>
</table>

1. CHDP intervals are greater than recommended by Bright Futures. Providers may use MNIHA for necessary assessments that fall outside of periodicity such as school, sports or camp physical, foster care or out-of-home placement, or follow-up indicated by findings on a prior health assessment that need monitoring including additional anticipatory guidance, perinatal problems or significant developmental delay.

2. Age-appropriate physical examination, including oral examination, is essential with child unclothed, and draped for older child or adolescent.

3. See Dental HAG.

4. Schedule indicates recommended ages for developmental screening and psychosocial/behavioral assessment. For reimbursement information, see CHDP PIN 09-14.

5. Pelvic exam recommended within 3 years of first sexual intercourse. Subsequent pelvic exams may be performed as part of MNIHA when clinically indicated by symptoms such as pelvic pain, dysuria, dysmenorrhea. See STI HAG.

6. Blood pressure before 3 years for at risk patients, then at each subsequent health assessment. See Blood Pressure HAG.

7. See Vision Screening HAG.

8. See Hearing Assessment HAG.

9. Hb/Hct starting at 9-12 months of age. See Iron Deficiency Anemia (IDA) HAG.

10. Test between the ages of 2 and 6 years if no documented lead level at or after 24 months. Test at any age when indicated by risk assessment or if lead risk changes. See Lead HAG.

11. Urine Dipstick or Urinalysis only when clinically indicated . See Urinalysis HAG.

12. Tuberculosis risk factor screen at each visit. TST when indicated. See TB HAG.

13. STI testing when risk identified by history/physical . See STI HAG.

14. Provide immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP).
### American Academy Pediatrics Periodicity Schedule

#### INFANCY

<table>
<thead>
<tr>
<th>AGE</th>
<th>Prenatal</th>
<th>Newborn</th>
<th>3-5 d</th>
<th>By 1 mo</th>
<th>2 mo</th>
<th>4 mo</th>
<th>6 mo</th>
<th>9 mo</th>
</tr>
</thead>
<tbody>
<tr>
<td>HISTORY Initial/Interval</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
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<td>MEASUREMENTS Length/Height and Weight</td>
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<td>Weight for Length</td>
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<td>Body Mass Index</td>
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<tr>
<td>Blood Pressure</td>
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<td>★</td>
<td>★</td>
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<td>★</td>
<td>★</td>
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<tr>
<td>SENSORY SCREENING Vision</td>
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<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
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<tr>
<td>Hearing</td>
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</tr>
</tbody>
</table>
| DEVELOPMENTAL/BEHAVIORAL ASSESSMENT Developmental Screening | | | | | | | | |}
| Autism Screening | | | | | | | | |}
| Developmental Surveillance | | | | | | | | |}
| Psychosocial/Behavioral Assessment | | | | | | | | |}
| Alcohol and Drug Use Assessment | | | | | | | | |}
| Depression Screening | | | | | | | | |}
| PHYSICAL EXAMINATION | ● | ● | ● | ● | ● | ● | ● | ● |
| PROCEDURES Newborn Blood Screening | | | | | | | | |}
| Critical Congenital Heart Defect Screening | | | | | | | | |}
| Immunization | | | | | | | | |}
| Hematocrit or Hemoglobin | | | | | | | | |}
| Lead Screening | | | | | | | | |}
| Tuberculosis Testing | | | | | | | | |}
| Dyslipidemia Screening | | | | | | | | |}
| STI/HIV Screening | | | | | | | | |}
| Cervical Dysplasia Screening | | | | | | | | |}
| ORAL HEALTH | | | | | | | | |}
| ANTICIPATORY GUIDANCE | ● | ● | ● | ● | ● | ● | ● | ● |
Integration between SBC and SBOHC

CHDP
School Based Health Clinic
Provides Early Periodic Screening services

School Based Oral Health Clinic Provides Diagnostic and Treatment services

Cross – Referral System

Temporarily enrolled into benefits

Medicaid

Enrolled into benefits

Health Insurance Navigators
Sustainable School-based Oral Health Model

- Presence of a quality dashboard
- Presence of a solid business plan
- Supportive State Medicaid Policies
- Multidisciplinary Teams
- Portable Clinic Model
- Supportive School Oral Health Policies
- "Comprehensive" on-site care
- Multi-Site Model
- Community Collaborative Practice Model

Supportive School Oral Health Policies

Presence of a solid business plan

Multidisciplinary Teams

Portable Clinic Model

"Comprehensive" on-site care

Supportive State Medicaid Policies

Presence of a quality dashboard

Community Collaborative Practice Model

Multi-Site Model
Conclusion

• Expand preventive services to *comprehensive* primary care
• Evolve public health screening and prevention programs to becoming true healthcare access sites in schools where children are located
• Expand collaboration and coordination of school-based programs and providers
• Utilize Medicaid and other third party payment for sustainability of services
• Utilize Medicaid administrative activities for outreach, enrollment and education of families
• Monitor program services regularly for PI
Considerations for Policy Makers

• Mandate public policies that support integrated healthcare in school-based sites
  e.g. kindergarten oral health screenings, coordinate efforts with 6th graders Tdap (whooping cough) immunizations

• Develop a business plan & metrics utilizing Plan, Do, Study, Act
  • Measure procedures performed, staff time, reimbursements collected
  • Create a dashboard
References


2. California Department of Health Care Services, Systems of Care Division, Children's Medical Services, CHDP Periodicity Schedule for Health Assessment Requirements By Age Groups, January 2012.


Acknowledgements

This project is/was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number and title for grant amount (specify grant number, title, total award amount and percentage financed with nongovernmental sources). This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government. Additional funding provided by First 5 Los Angeles and the DentaQuest Foundation. Special thanks to Mary Foley, Dr. Timothy Martinez, Theresa Anselmo, Los Angeles Unified School District, LA Trust, and Western University College of Dental Medicine.
Jennifer Pilapil, is the Operations Manager at the Center for Oral Health. Jennifer started her career in public health 20 years ago working in health education and project coordination for a variety of MCH (Maternal, Child, and Health) and communicable disease programs. She was formerly a trainer and LAUSD School Outreach Coordinator for the Healthy Families program when outreach efforts were being conducted State-wide by RHA. During this time, she provided health insurance outreach and technical assistance for Healthy Families and Medi-Cal insurance enrollment in the southern region of California and was on the California School Health Connections School Outreach Advisory Board. She worked with community based agencies, school districts, and Los Angeles County Department of Public Social Services and Department of Public Health helping coordinate efforts in their “We’ve Got You Covered” campaign and collaboratively creating the Los Angeles Unified School District’s Children’s Health Access and Medi-Cal Program (CHAMP). By 2001, she moved to the Pasadena Public Health Department to administer Medi-Cal programs, and later became the Deputy Director for the Child Health and Disability Prevention (CHDP) program at the Pasadena Public Health Department. She administratively oversaw the child health clinic, tuberculosis, comprehensive perinatal services program, and Medi-Cal programs. She co-chaired the Health Access Task Force and served on the Los Angeles County Service Planning Area (SPA) 3 Access to Care Committee. Jennifer graduated from the University of California, Irvine, with a BA in Social Sciences and completed post baccalaureate studies in GIS.

Center for Oral Health, 309 E. 2nd Street, Pomona, CA 91716
Phone: (909) 469-8302       Email: jpilapil@tc4oh.org
2015 National Medicaid and CHIP Oral Health Symposium

Session # 8

Patient Centered Integrated Healthcare
Emerging Models of Service Delivery and Payment

John Snyder, DMD

Washington Marriott Wardman Park
Monday, June 1st, 2015
Learning Objective(s)

Participants will gain knowledge in:

– Kaiser Permanente Integrated Model
– Key Enablers for Integrated Care
– Current Challenges for Integration
Disclosure and Conflict of Interest Declaration

☐ I declare that neither I nor any member of my family have a financial arrangement or affiliation with any corporate organization offering financial support or grant monies for this continuing dental education program, nor do I have a financial interest in any commercial product(s) or service(s) I will discuss in the presentation.

☐ I declare that I have a financial interest/arrangement or affiliation with the corporate organization offering financial support or grant monies for this continuing dental education program, or I do have a financial interest in any commercial product(s) or service(s) I will discuss in the presentation.
PDA Relationship with Kaiser

- Dental Service Agreement (DSA)
- Memorandum of Understanding (MOU) - Annual Contract
- Global Payment
KP Membership / Permanente Physician Groups

• 7 autonomous KP regions (Colorado, Hawaii, Georgia, Mid-Atlantic, Northern California, Southern California, and Pacific NW (OR & WA))

• Nearly **10 Million** medical members across all 7 Regions

• 7 autonomous Permanente physician groups

• **1** autonomous Permanente Dental group (Pacific NW)

• **236,000** Dental members and **502,000** Medical members in the NW region

• **90%** Dental members also have KP Medical coverage
PDA Dentists

ASSOCIATES 37
SHAREHOLDERS 98
SPECIAL CONTRACT 6
AVERAGE TENURE 9 YEARS
*Ave Tenure > 1 Yr w PDA

*11 YEARS
Evidence-Based Dentistry Philosophy

• “An approach to oral health care that requires the judicious integration of systematic assessments of clinically relevant scientific evidence, relating to the patient's oral and medical condition and history, with the dentist's clinical expertise and the patient's treatment needs and preferences.” *ADA

ADA Policy--Definition of Oral Health

• Oral health is a functional, structural, aesthetic, physiologic and psychosocial state of well-being and is essential to an individual’s general health and quality of life. *2014 ADA House of Delegates
“Integrated” Technology & Human Resources

• Epic (HealthConnect) snapshot view of EMR

• Patient Support Tool: identified care gaps

• Shared Human Resources: Tobacco Cessation Counselors
## Diabetes Outreach Project- Comparison

### Population Health Outreach Calls Pilot

Comparison of Intervention Group and Usual Group Data ran on 10/27/14

<table>
<thead>
<tr>
<th></th>
<th>Cascade Park Intervention Group</th>
<th>Salmon Creek Usual Group</th>
<th>Difference between Intervention Group and Usual Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting number in group - As of 4/1/14</td>
<td>525</td>
<td>460</td>
<td></td>
</tr>
<tr>
<td>Number in group as of 9/15/14</td>
<td>495</td>
<td>438</td>
<td></td>
</tr>
<tr>
<td>Number that lost coverage</td>
<td>30</td>
<td>22</td>
<td>0.9%</td>
</tr>
<tr>
<td>Number that were seen, but programming unable to determine new OHS</td>
<td>4</td>
<td>0</td>
<td>0.8%</td>
</tr>
<tr>
<td>Number that had either had or scheduled an exam appointment as of 10/27/14</td>
<td>166</td>
<td>67</td>
<td>17.1%</td>
</tr>
<tr>
<td>-Number that had an exam appointment</td>
<td>151</td>
<td>57</td>
<td>16.4%</td>
</tr>
<tr>
<td>-Number that had scheduled an exam appointment</td>
<td>15</td>
<td>10</td>
<td>0.7%</td>
</tr>
<tr>
<td>Improved OHS</td>
<td>147</td>
<td>57</td>
<td>15.6%</td>
</tr>
<tr>
<td>-Improved to OHS-1</td>
<td>10</td>
<td>1</td>
<td>1.7%</td>
</tr>
<tr>
<td>-Improved to OHS-2</td>
<td>61</td>
<td>25</td>
<td>6.2%</td>
</tr>
<tr>
<td>-Improved to OHS-3</td>
<td>76</td>
<td>31</td>
<td>7.7%</td>
</tr>
</tbody>
</table>
Diabetic population receiving dental care have lower costs per member per month (PMPM) than those NOT receiving dental care; after adjusting for patient characteristics.

**Overall costs:**
- Diabetic population receiving dental care had **$129 PMPM** lower costs overall than those NOT receiving dental care

**Inpatient costs:**
- Diabetic population receiving dental care had **$101 PMPM** lower inpatient costs than those NOT receiving dental care

**ED-Urgent care costs**
- Diabetic population receiving dental care had **$13 PMPM** lower ED/urgent costs than those NOT receiving dental care
Practice of Choice for Dentists and Care Teams
PDA Reimbursement vs. Traditional Reimbursement

EVIDENCE BASED Reimbursement

- Insurance Company
  - Global Payment
    - Permanente Dental Associates, P.C.

  Claims Data
  Lists the procedures done by the dentist, including preventative measures that the evidence supports.

- Payment
  - Dentist

TRADITIONAL Reimbursement

- Insurance Company
  - Payment
    - Dentist

  Claims Data
  Lists the procedures done by the dentist from which payments will be made.
How the Measures for Reimbursement are Structured

Pay for dentists is structured according to performance incentives. The total pay is derived from three methods of reimbursement:

- 55%: Fixed salary
- 25%: Individual performance
- 20%: Dental office performance
Variable Base Compensation (VBC): General Dentists

TOTAL HEALTH SOLUTION

– % of Dentists using Patient Support Tool (PST)
– % of eligible patients receiving PST sheet
Summary: Critical Enablers

- Shared Total Health Philosophy
- Shared Population (Medical and Dental)
- Co-located Facilities
- Shared Informatic Platform
- Global Payment
• **John J. Snyder, DMD**
  - Completed his dental education at Oregon Health & Science University School of Dentistry
  - General Practice Residency at Hartford Hospital in Connecticut
  - Joined Permanente Dental Associates (PDA) in 1987
  - Elected Dental Director in 2008

Remains a strong advocate for evidence-based dental practice, oral health research, and medical-dental integration and has enjoyed numerous national and international speaking opportunities to share his passion for expanding total health and wellness.

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