RoMoNOH
ROCKY MOUNTAIN
NETWORK OF ORAL HEALTH

Oral Health Services Environmental Scan
Arizona, Colorado, Montana, and Wyoming

2020

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This environmental scan was conducted and summarized by the American Academy of Pediatrics (AAP) staff. This publication was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of Cooperative Agreement Number HRSA-UK7MC33230. This information or content and conclusions are those of the AAP and RoMoNOH project staff and should not be construed as the official policy of HRSA, HHS, the U.S. government, AAP, or Denver Health nor should any endorsements be inferred.

RoMoNOH Oral Health Environmental Scan Results

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Acronyms

AAP – AMERICAN ACADEMY OF PEDIATRICS
EPSDT –EARLY AND PERIODIC SCREENING, DIAGNOSITIC AND TREATMENT
FQHC – FEDERALLY QUALIFIED HEALTH CENTER
NOHI-NETWORKS FOR ORAL HEALTH INTEGRATION
PCA – PRIMARY CARE ASSOCIATION
RoMoNOH – ROCKY MOUNTAIN NETWORK OF ORAL HEALTH

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Project Overview

Oral Health is essential to overall health. To improve access to and utilization of comprehensive, high-quality oral health care for pregnant women, infants, and children at high risk for oral disease, the Health Resources and Services Administration's Maternal and Child Health Bureau funded the **Networks for Oral Health Integration** (NOHI) within the Maternal and Child Health Safety Net. Three projects were awarded funding to three regions: the Midwest, Rocky Mountain area, and East coast.

- **The Midwest Network for Oral Health Integration (MNOHI)** is focusing on children ages 6–11 years who are receiving health care in 50 Federally Qualified Health Centers (FQHCs) throughout Illinois, Iowa, Michigan, and Ohio.
- **The Rocky Mountain Network of Oral Health (RoMoNOH)** is focusing on primary prevention of dental caries in pregnant women and infants and children from birth to age 40 months who are receiving health care in 30 FQHCs throughout Arizona, Colorado, Montana, and Wyoming.
- **Transforming Oral Health for Families (TOHF)** is focusing on increasing access to preventive oral health care and primary prevention of dental caries in pregnant women and infants and children from birth to age 40 months who are receiving health care in 30 FQHCs throughout the District of Columbia, Maryland, New York, and Virginia.

This environmental scan focuses on the four Rocky Mountain Network of Oral Health states: Arizona, Colorado, Montana, & Wyoming. The purpose of this environmental scan was to discover policy factors that impact medical-dental integration efforts.

Key Findings

- **Medical teams providing preventive oral health services**
    - Payment and scope of practice for non-dental clinical providers varies widely across the RoMoNOH states which makes consistent approaches to service delivery challenging.
    - Delegation of preventive oral health services to members of the medical team is variable across RoMoNOH states and is a barrier to efficiency delivery of services to patients.
    - Care coordination of oral health including dental referral tracking and management are not paid in either the medical or dental system.
- **Dental services**
    - Limited scope of practice for dental hygienists, dental therapists, nurses, and medical assistants may hinder oral health preventive services in rural and medically underserved areas, particularly in Wyoming.
    - Dental hygienists in Arizona, Colorado, Montana, and Wyoming have additional services they can perform in public health settings. Each state has different requirements for hygienists to practice in a public health setting. Wyoming does not allow dental hygienists to bill Medicaid directly.

- **Preventive oral health services by community support staff**
    - Support staff such as community health workers, Head Start teachers, or WIC employees are not paid for preventive oral health services in any Rocky Mountain State.
- **Tele-dentistry**
    - The practice and payment for tele-dentistry expanded due to the COVID-19 pandemic; however, these changes may not endure past the public health emergency.

Future Strategies

- **Medical teams providing preventive oral health services**
    - Support policies at the state and healthcare system levels that ensure all provider types can practice at the top of their licensure within their state.
    - Expand delegation of preventive oral health services to different members of the healthcare team to optimize efficacy of care delivery and minimize costs.
- **Dental services**
    - Use successes in states where alternative provider types (Dental therapists or dental hygienists) are integrated into primary care to advocate for expanded scopes-of-practice and Medicaid recognized reimbursable providers within other states.
- **Preventive oral health services by community support staff**
    - Consider the value of payment of oral health preventative services by community service provider such as community health workers, head start teachers, or WIC employees.
- **Tele-dentistry**
    - Support integration of electronic medical and dental health records to improve patient care and reduce unnecessary redundancies of care and related costs.
    - Sustain tele-health visit support and payment to optimize delivery of safe preventive oral health services.

Introduction

Oral Health is essential to overall health. However, optimal oral health remains out of reach for many in the United States. According to the National Health and Nutrition Examination Survey, nearly one in every four children aged 2-5 had dental caries in their primary teeth.[1] That number raises to three in five by age 12-19 in their permanent teeth.[1]

For this project, Federally Qualified Health Centers (FQHCs) and Primary Care Associations (PCAs) worked together to improve the oral health of the patient population. FQHCs are medical safety nets and serve as the largest source of primary care for underserved populations. Medical-dental integration is a challenge largely because the medical and dental systems in the United States operate in parallel with different training, service delivery approaches, payment of coding, and insurance coverage. Even FQHCs that have co-located dental services, the number of patients who see both medical and dental remains stubbornly low. It is estimated that each year 108 million Americans

see a physician but not a dentist and conversely 27 million Americans have a dental visit but no medical visit.[2]

Methods

The three Network for Oral Health Integration (NOHI) projects worked together to develop the environmental scan tool and included questions that focused on scope of practice of medical and dental providers, Medicaid payment, and other oral health topics. The American Academy of Pediatrics staff conducted oral health environmental scans for the Rocky Mountain region states of Arizona, Colorado, Montana, and Wyoming. AAP staff conducted extensive searches online related to policy, scope of practice, and legislation. When information was not available online, AAP staff worked with PCA staff, Medicaid officials, and state dental offices to obtain relevant information.

RoMoNOH State Results

The participating four states in the Rocky Mountain Network of Oral Health differ greatly by population and racial demographics (Table 1 and Table 2). Wyoming is the least populated state in the nation and Montana ranks near the least populous state at #44. In contrast, Arizona and Colorado are much more populous at 14th and 21st most populous states, respectively. Wyoming and Montana are more racially homogeneous at 84% and 86% white, respectively. Arizona and Colorado are more racially diverse. It is important to note that race is a social construct and not a biological difference between peoples. Race is mentioned here to look at the societal oppression peoples may face. To overcome health disparities in oral health outcomes in different racial groups, some states have created specially tailored programs such as dental therapists to work in medically underserved areas in Arizona.[3] Arizona, Colorado, Montana, and Wyoming have similar levels of poverty and rates of insurance coverage (Table 3 and Table 4).

Table 1: Rocky Mountain Oral Health Network Demographics, Census.gov 2019[8]

	Arizona[4]	**Colorado[5]**	**Montana[6]**	**Wyoming[7]**	**United States**
Total Population	7,278,717	5,748,736	1,068,778	578,759	328,239,523
States Ranked According to Population	14	21	44	52 (includes DC and Puerto Rico)	n/a
Female	50.3%	49.6%	49.7%	49.1%	50.8%
Children under 5 years of age	5.9%	5.8%	5.7%	6%	6%
Children under 18 years of age	22.5%	21.9%	21.4%	23.1%	22.3%
Adults over age 65	18%	14.6%	19.3%	17.1%	16.5%

Table 2: Rocky Mountain Oral Health Network Racial Demographics, Kaiser 2018[9]

	Arizona	**Colorado**	**Montana**	**Wyoming**	**United States**
White / Caucasian	54%	68%	86%	84%	60%
Black / African American	4%	4%	<1%	0%	12%

Hispanic	32%	22%	4%	10%	18%
American Indian/Alaskan Native	4%	<1%	6%	2%	1%
Asian	3%	3%	1%	1%	6%
Native Hawaiian/Other Pacific Islander	<1%	<1%	n/a	n/a	<1%
Two or more races	2%	3%	3%	2%	3%

Table 3: Rocky Mountain Oral Health Network Total Population by Federal Poverty Level, Kaiser 2018[9]					
	Arizona	**Colorado**	**Montana**	**Wyoming**	**United States**
Under 100%	14%	10%	12%	11%	13%
100-199%	20%	15%	20%	16%	17%
200-399%	31%	30%	33%	33%	30%
400%+	35%	46%	35%	40%	40%

Table 4: Rocky Mountain Oral Health Network Insurance Coverage, Kaiser 2018[10]					
	Arizona	**Colorado**	**Montana**	**Wyoming**	**United States**
Employer	44%	52%	44%	55%	49%
Non-group*	5%	7%	7%	7%	6%
Medicaid	22%	18%	21%	10%	20%
Medicare	16%	12%	17%	15%	14%
Military	1%	2%	2%	2%	1%
Uninsured	11%	8%	8%	11%	9%

*those covered by a policy purchased directly from an insurance company, either as policy holder or dependent

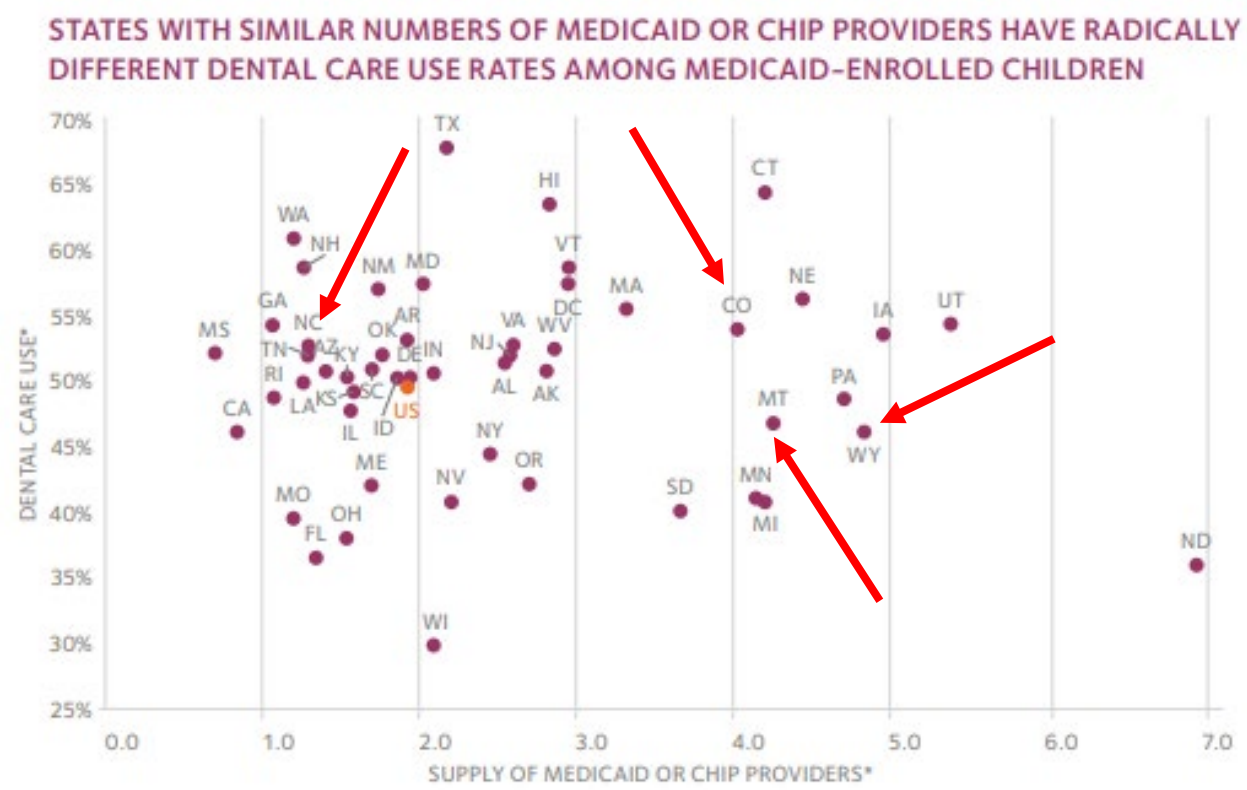
Two of the four states, Arizona, and Wyoming have dentists per 100,000 at a lower rate than the national average (Table 5). Montana is at the national average, and Colorado exceeds it. Colorado, Montana, and Wyoming have higher than the national average of dentists accepting Medicaid or CHIP. Additionally, there is a great difference between dental health professional shortage areas (HPSA) between Wyoming (33) and Arizona (210) (Table 6). Health professional shortage areas are calculated by looking at the populations to provider ratio. Areas can differ in size from a single census tract to several counties. Wyoming would only need 5 strategically placed practitioners to remove all HPSA, whereas Arizona would need nearly 400 (Table 6).

Table 5: Rocky Mountain Oral Health Network Dentist Information, Health Ratings, 2019[15] & ADA, 2015[16]					
	Arizona[11]	**Colorado[12]**	**Montana[13]**	**Wyoming[14]**	**United States**
Dentists per 100,000 Health Ratings, 2019[15]	54.4	70.1	61.0	53.1	61.0
Dentist participation in Medicaid, 2015 ADA[16]	27.2%	58.1%	73.1%	75.9%	38%

Table 6: RoMoNOH Dental Care Health Professional Shortage Areas (HPSA), Kaiser 2019[17]					
	Arizona	**Colorado**	**Montana**	**Wyoming**	**United States**
Total Dental Care HPSA Designations	210	110	127	33	6,782
Population of Designated HPSA	2,338,245	848,143	351,150	49,650	56,006,702

Percent of need met	34.50%	37.99%	31.98%	51.72%	29.79%
Practitioners needed to remove HPSA designation	380	137	61	5	9,951

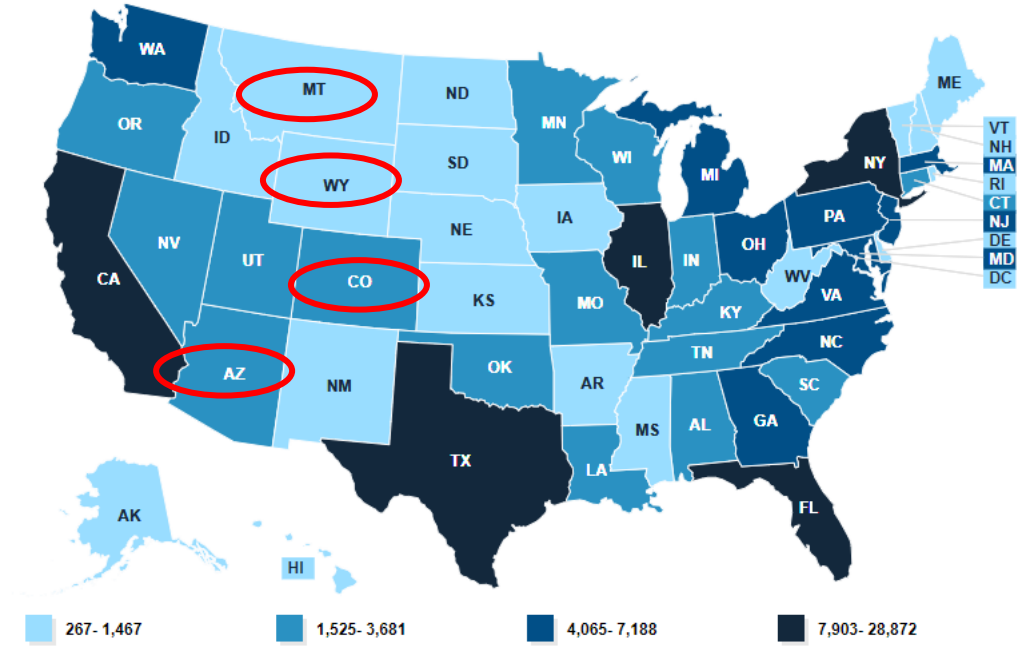
According to the American Dental Association,[18] states with similar number of dentists who accept Medicaid or CHIP in 2015 saw very different rates of children receiving dental care. To have the best outcomes, a state would fall into the top right quadrant of the following chart. Within the RoMoNOH states, Arizona had the lowest supply of dentists accepting Medicaid or CHIP. Wyoming has the most providers, at nearly 5 per 1,000 children but the lowest dental visits at around 45%. Colorado and Montana lie in the middle of the chart with a provider for 4 in 1,000 children with 50-55% receiving dental care. States also varied in the amount of practicing dentists and Medicaid payment as a percentage of private payment (Table 7).



*"Dental Care Use is the percent of children enrolled in Medicaid for 90 continuous days with a dental visits in 2015. In some states, the dental care use rate might account for CHIP-enrolled children as well. Supply of Medicaid or CHIP providers is the ratio of the number of dentists participating in Medicaid or CHIP in 2015 per 1,000 Medicaid or CHIP children enrolled for 90 continuous days in 2015." Source: Health Policy Institute of the American Dental Association[18]

Table 7: Rocky Mountain Oral Health Network Dental Access, ADA, 2016[19] & Kaiser 2020[21]				
	Arizona	**Colorado**	**Montana**	**Wyoming**
% children under age 5 who received an oral health service from a non-dental clinical provider[19]	4.7% (2019, < age 3, FV only)	8.55% (2017)	Missing (2019)	0.3% (2018)
% children under age 5 who received any dental service[19]	Missing	Missing	46% (2019)	46% (2018)
Medicaid fee-for-service payment as a percentage of private dental insurance payment, Child Dental Services, 2016 [20]	73.8%	55.7%	63.1%	64.4%
Professionally active dentists, Kaiser 2020[21]	3,681	3,570	551	267

Distribution of Professionally Active Dentists, 2020



Source: Kaiser Family Foundation (2020). State Health Facts: Professionally Active Dentists[21]

The environmental scan investigated the scope of practice of several medical and dental provider types as well as information pertaining to the payment for fluoride varnish application, oral health screening (risk assessment), education, referral, and case management. Oral health education (anticipatory guidance) is stressed during a well child visit (early and periodic screening, diagnostic and treatment visit (EPSDT); however, since there is no medical procedure code for it, it is difficult to track the number of non-dental clinical providers offering oral health education, for example. Although there are dental codes for oral health education and case management, they are usually not reimbursable when the services were provided by a medical professional. There is not a payment code for referral from a medical to a dental professional. The table below lists the providers who are paid for fluoride varnish application. For non-dental clinical providers within the FQHC setting, fluoride varnish is usually paid as part of the well child visit encounter rate. Arizona and Wyoming non-dental clinical providers bill the Current Procedural Terminology (CPT) code 99188. In Montana and Colorado, non-dental clinical providers can bill either the Current Procedural Terminology (CPT) code 99188 or D1206. While some providers, like midwives, have prescriptive authority and can get paid for applying fluoride varnish, it does not mean that they are actively providing this service or coding for it in these states since midwives rarely see infants with dentition.

A relatively new certification from the American Dental Association was also researched: Community Dental Health Coordinators (CDHC).[22] Since this certification is only available to those with a clinical background such as dental assistants and dental hygienists who would already be able to offer dental health services, this certification is not included on any of the following tables.

Table 8: Rocky Mountain Oral Health Network Fluoride Varnish Application Scope of practice				
	Arizona[19, 23]	**Colorado**[19]	**Montana**[19,27]	**Wyoming**[19,29]
Physicians (MD/DO)	Yes	Yes	Yes	Yes
Nurse Practitioners	Yes	Yes	Yes	Yes
Physician Assistants	Yes	Yes	Yes	Yes
Registered Nurses	Only through delegation	Only through delegation	Only through delegation	Only through delegation
Medical Assistants	No	Only through delegation	Only through delegation	Only through delegation
Dentists	Yes	Yes	Yes	Yes
Dental Hygienists	Yes	Yes	Yes	Yes
Dental Assistants	Yes, under direct supervision (Expanded function under general supervision)	Yes, under indirect supervision	Yes, under direct supervision	Yes, under indirect supervision
Dental Therapists	Yes	n/a*	Yes	n/a*
Pharmacist	Yes	No	No	No
Midwives	No	Yes	Yes	No
Community Health Workers	No	No	No	No

*n/a means dental therapists are not a provider type within that state.

Table 9: Rocky Mountain Oral Health Network Fluoride Varnish Application Parameters				
	Arizona[23, 24]	**Colorado**[25, 26]	**Montana**[27, 28]	**Wyoming**[29]
How often can fluoride varnish be applied by non-dental clinical providers?	Every 6 months for children ages 6 months to 2 years of age.	Children 0-4 can receive 2 applications per year regardless of risk. If assessed to be high risk, 4 total applications can be applied per year. Children and adolescents aged 5-20 can receive up to 3 regardless of risk level.	6 times a year if assessed to be high risk for children ages 0-20	3 times per year for children ages 6 months to 3 years of age in conjunction with well child visit.
Does fluoride varnish need to be combined with another visit for payment?	Yes	Yes	Yes	Yes
Can fluoride varnish be delegated to nurses?	Yes	Yes	Yes	Yes

The following clinical providers can receive payment for oral health risk assessments. Similar to fluoride varnish for non-dental clinical providers within the FQHC setting, payment is part of the well child visit encounter rate (no separate payment for risk assessment or fluoride varnish). In Colorado, non-dental clinical providers can bill D0145, oral evaluation for those less than three years of age, or D0190 comprehensive oral evaluation over age three years. In Colorado FQHCs, fluoride varnish should be itemized on the claim even though payment is at the encounter rate. In all four RoMoNOH states, registered nurses cannot bill Medicaid directly nor receive payment the oral health risk assessment. However, in Montana and Wyoming registered nurses can perform risk assessments if a provider delegates the task to them.

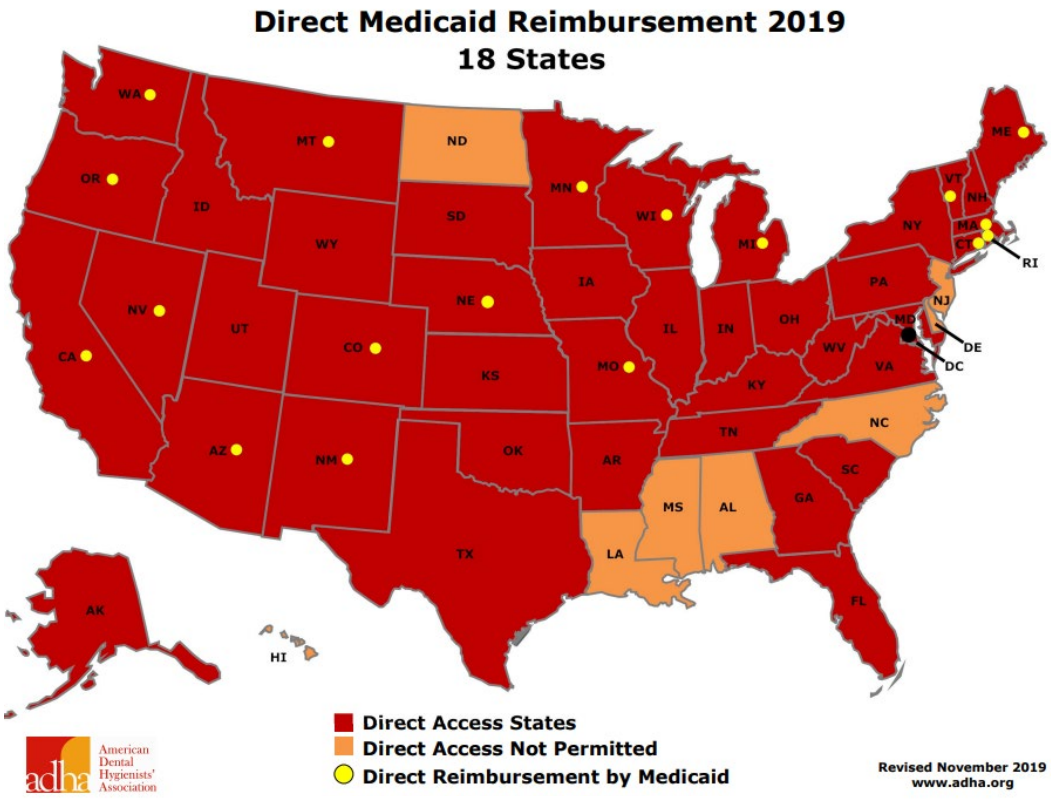
Table 10: Rocky Mountain Oral Health Network Conduct Risk Assessment* Scope of practice				
	Arizona[19]	**Colorado[19]**	**Montana[19]**	**Wyoming[19]**
Physicians (MD/DO)	Yes	Yes	Yes	Yes
Nurse Practitioners	Yes	Yes	Yes	Yes
Physician Assistants	Yes	Yes	Yes	Yes
Registered Nurses	No	No, cannot be delegated	Only through delegation	Only through delegation
Medical Assistants	No	No, cannot be delegated	Only through delegation	No
Dentists	Yes	Yes	Yes	Yes
Dental Hygienists	Yes	Yes	Yes	Yes
Dental Assistants	No	No	No	No
Dental Therapists	Yes	n/a**	Yes	n/a**
Pharmacist	No	No	No	No
Midwives	No	Yes	Yes	No
Community Health Workers	No	No	No	No

*Risk assessment for non-dental clinical providers is also part of the encounter rate and not billed separately.
**n/a means dental therapists are not a provider type within that state.

Table 11: Rocky Mountain Oral Health Network Training, Tools, & Medicaid				
	Arizona[23, 24]	**Colorado[25, 26]**	**Montana[27, 28]**	**Wyoming[29]**
Are non-dental clinical providers required to take a training?	Yes & must submit proof to Medicaid office	Yes & must keep on file in case of audit	No but encouraged to complete	No
Is there a risk assessment tool required?	No	Yes, Cavity Free at Three	No	No
Can patients receive a medical and dental visit on the same day?	Yes	Yes	Yes	Yes
Is there an oral health benefit for pregnant women on Medicaid?	No, just presumptive eligibility and income threshold increase. Adults on Medicaid limited to $1,000 spending on dental care	No, Pregnant women allowed presumptive eligibility and given extended income threshold to qualify for $1,500* annual Adult Medicaid dental benefit.	No, just presumptive eligibility and income threshold increase	No, just presumptive eligibility and income threshold increase
Can Medicaid recipients opt out of dental benefits?	No	No	No	No
Are medical and dental Medicaid benefits paid from the same budget?	Yes	No	Yes	Yes
Medicaid	Managed by the AZ Health Cost Containment Center	State Administered	State Administered	State Administered

*reduction to $1,000 likely due to COVID budget constraints.

Dental Hygienists can be embedded into a medical setting to see patients during their medical visits. Because some of the FQHCs in this project are using a dental hygienist embedded into a medical setting model, scope of practice for dental hygienists was included in the environmental scan. Arizona, Montana, and Colorado allow direct access hygienists to directly bill Medicaid for payment.[30] Wyoming does not recognize dental hygienists as an eligible provider for billing (see 2019 map). All four participating states (AZ, CO, MT,& WY) have a certification often called "Direct Access" that enables hygienists to have more autonomy (see Tables 13 and 14 comparing hygienist scope of practice with and without direct access certification), often allowing them to practice and bill Medicaid directly. This certification usually entails a certain number of years or hours practicing and is restricted to certain settings (schools, FQHCs, nursing homes, public health clinics, etc). In Colorado, all dental hygienists are automatically direct access which enables all dental hygienists to practice at the top of their license.



Source: American Dental Hygienists' Association [28]

Table 12: Rocky Mountain Oral Health Network Direct Access Certification Dental Hygienists, ADHA 2019[31]

	Arizona	Colorado	Montana	Wyoming
Is there a direct access dental hygienist certification?	Yes, Affiliated Practice	Yes, Unsupervised Practice	Yes, Limited Access Permit (LAP)	Yes, Public Health Dental Hygienist
Are direct access dental hygienists restricted to certain areas?	Yes	No	Yes	Yes
Are there requirements for direct access dental hygienist licensure?	Yes	No	Yes	Yes
Can direct access dental hygienists own their own practice?	No	Yes	No	No
Can direct access dental hygienists supervise dental assistants?	Yes	No	No	No

Table 13: Rocky Mountain Oral Health Network States Dental Hygienists Scope of Practice (no direct access/public health/affiliated practice certificate) practicing in a public health setting*, ADHA 2019[31]				
	Arizona	**Colorado**	**Montana**	**Wyoming**
Silver diamine fluoride application	General supervision	General, Direct, or Telehealth	General and Limited Access Permit	General Supervision
Prophylaxis	Direct Access	Direct Access	General Supervision	General Supervision
X-rays	Direct Access	Direct Access	General Supervision	General supervision
Local Anesthesia	General supervision	General supervision	General supervision	Direct Supervision
Topical Anesthesia	Direct Access	Direct Access	General Supervision	General supervision
Fluoride	Direct Access	Direct Access	General Supervision	General Supervision
Pit/Fissure Sealants	Direct Access	Direct Access	General Supervision	Direct Supervision
Root Planning	General supervision	Direct Access	General Supervision	General supervision
Soft Tissue Curettage	General supervision	Direct Access	General Supervision	No
Administer N2O	Direct Supervision	Direct Supervision	No	Direct Supervision
Study Cast Impressions	General supervision	Direct Access	General supervision	General supervision
Place and remove Periodontal Dressings	Direct Supervision	General supervision	General supervision	Direct Supervision
Place Sutures	Direct Supervision	No	No	No
Remove Sutures	General supervision	General supervision	General supervision	General supervision
Hygienist Diagnosis	No	Direct Access	No	No
Hygienists Treatment Planning	No	Direct Access	No	No
Hygienist Assessment	No	Direct Access	No	No
Prescriptive Authority	No	Direct Access	General Supervision	No

*The definition of public health settings may differ by state

Image from the AAP photo library

Table 14: Rocky Mountain Oral Health Network States Direct Access Certified Dental Hygienists Scope of Practice, ADHA 2019[31]				
	Arizona	**Colorado**	**Montana**	**Wyoming**
Silver diamine fluoride application	General supervision	General, Direct, or Telehealth	General and Limited Access Permit	General Supervision
Prophylaxis	Direct Access	Direct Access	Direct Access	Direct Access
X-rays	Direct Access	Direct Access	Direct Access	General supervision
Local Anesthesia	Direct Access	Direct Access	General supervision	Direct Supervision
Topical Anesthesia	Direct Access	Direct Access	Direct Access	General supervision
Fluoride	Direct Access	Direct Access	Direct Access	Direct Access
Pit/Fissure Sealants	Direct Access	Direct Access	Direct Access	Direct Supervision
Root Planning	General supervision	Direct Access	Direct Access	General supervision
Soft Tissue Curettage	Direct Access	Direct Access	Direct Access	No
Administer N2O	General supervision	General supervision	No	Direct Supervision
Study Cast Impressions	Direct Access	Direct Access	General supervision	General supervision
Place and remove Periodontal Dressings	Direct Access	General supervision	General supervision	Direct Supervision
Place Sutures	Direct Access	No	No	No
Remove Sutures	Direct Access	General supervision	General supervision	General supervision
Hygienist Diagnosis	No	Direct Access	No	No
Hygienists Treatment Planning	No	Direct Access	No	No
Hygienist Assessment	No	Direct Access	No	No
Prescriptive Authority	No	Direct Access	Direct Access	No

Image from the AAP photo library

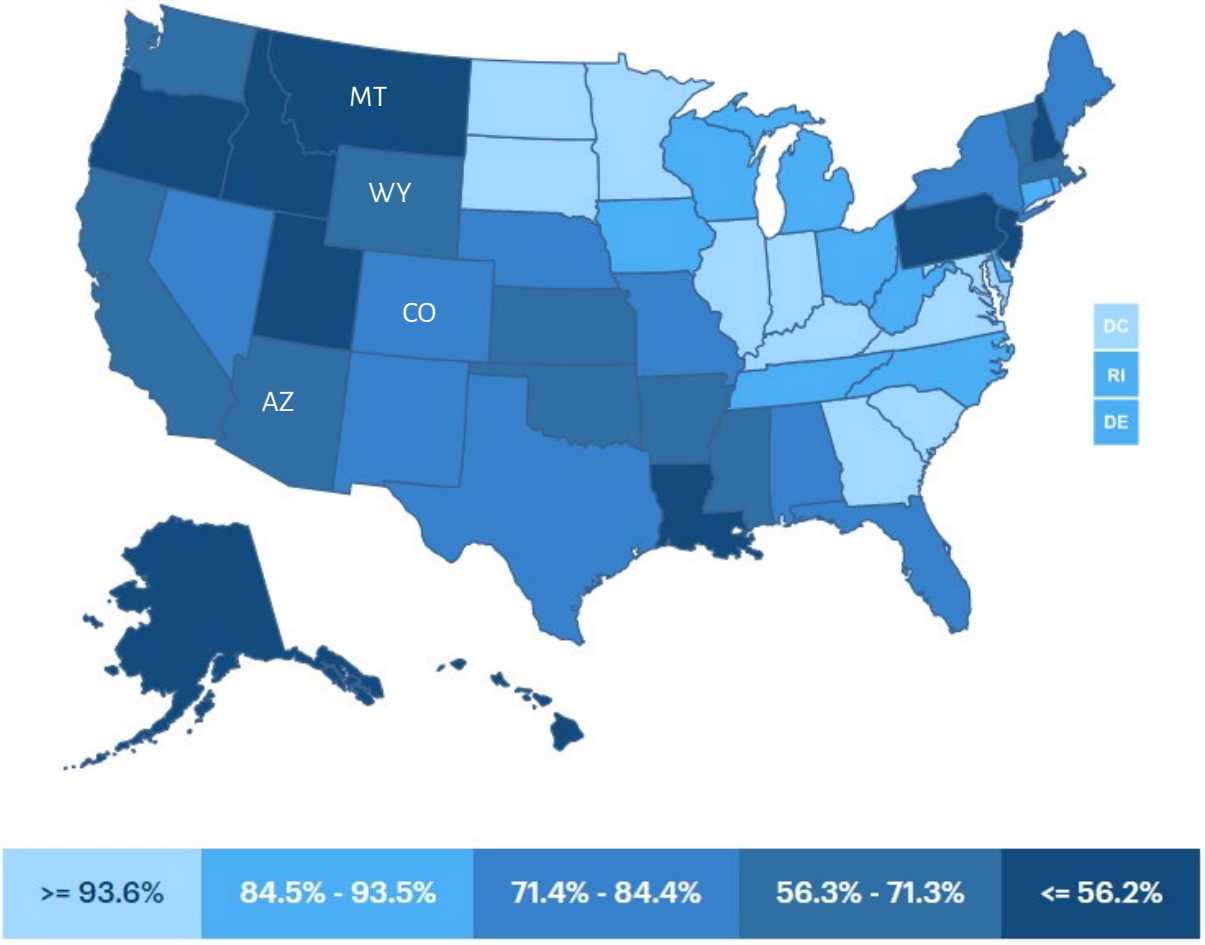
Telehealth and teledentistry have become more commonly used during the COVID-19 pandemic. The table below compares the pre- and post-COVID-19 pandemic impacts on the four participating states.

Table 15: Rocky Mountain Oral Health Network Teledentistry				
	Arizona	**Colorado**	**Montana**	**Wyoming**
Teledentistry (Synchronous D9995 Asynchronous D9996)	Before COVID-19, dental providers were utilizing asynchronous teledentistry (store and forward information to the supervising dentist to create a treatment plan model).	Before COVID-19, dental hygienists were utilizing teledentistry. (store and forward information to the supervising dentist to create a treatment plan model)	2017 teledentistry legislation (SB129) requires insurers to cover teledentistry services if that same service would be covered during an in-person visit. Medicaid has been covering synchronous ONLY.	Teledentistry codes are not paid by Medicaid. Telehealth visits can bill dental codes, but private insurers may not pay the same rate as in person.
COVID-19 Pandemic Impacts	Expanded dental codes that can billed. Codes must be paid at the same rate as in-person visit. Also, opened ability for dentists to bill synchronous tele-dental visits.	Health First Colorado will allow payment for an emergency only dental consultation only by a dentist to a member that is conducted via interactive audiovisual connection.	Increased the adoption and people willing to try the virtual model. Medicaid has been covering asynchronous telehealth during the public health emergency.	Synchronous telehealth was allowed during COVID-19 ONLY.

All four participating states have fluoridated water levels at or below the national average. Colorado is on par with the national average. Montana has the lowest of the four states at only 33.7% of communities providing fluoride in the public water system.[32]

Table 16: Rocky Mountain Oral Health Network Fluoride Access[32]					
	Arizona	**Colorado**	**Montana**	**Wyoming**	**United States**
% of population served by community water systems that receive fluoridated water in 2018, CDC[32]	58.0%	74,9%	30.7%	57.1%	73.0%

Percentage of population served by community water systems that receive fluoride, 2019[33]



Source: America's Health Rankings: United Health Foundation[33]

Project Challenges

Each state faces unique challenges to medical-dental integration including scope of practice laws, payment rates, and practice challenges. Across all states the challenge of tracking medical-dental integration persists. Non-dental clinical providers working in FQHCs are paid for providing preventive oral health services as part of their encounter rate. When fluoride varnish is applied, non-dental clinical providers are encouraged to code this procedure; however, without a payment incentive it is unclear if the reported number of non-dental clinical providers applying fluoride varnish across RoMoNOH states are low 8% (Colorado) to <1% (Wyoming) or if more non-dental clinical providers are providing oral health services but not coding for such services. Additionally, there are no standard medical billing codes for non-dental clinical providers for oral health education, risk assessment, referral, or case management.

Conclusion

Medical-dental integration is a challenged by two healthcare systems (medical and dental) operating in parallel and independence. It is estimated that each year 108 million Americans see a physician but not a dentist and conversely 27 million Americans have a dental visit but no medical visit[2]. There is growing evidence that two different healthcare systems to treat the same patient results in additional cost and lack of quality outcomes[3,4]. Movement to integrate preventive oral health services has made progress over the past 15 years; however, uptake is slow and practice change remains challenging. There remains much work to be done. This report serves as a baseline report for the states participating in the Rocky Mountain Network of Oral Health. Where possible, states are encouraged to utilize this report and other research/reports to advocate for policies that do not thwart medical-dental integration efforts and can help to improve the oral health of the children. Potential opportunities include:

- **Increase age eligibility and periodicity of fluoride varnish application:** Broaden the insurance member benefit to include children of all ages and include at least 4 fluoride varnishes within one year.
- **Expand access to preventative oral health services by utilizing different clinicians and support staff:** Consider if you have enough members of the oral health prevention team in your state. If not, consider how other providers may be able to help ensure that all children in your state receive some preventive dental care. This may include training community health workers to provide oral health education, embedding dental hygienists in medical practice, or considering how dental therapists might be able to address underserved populations.
- **Training to apply fluoride varnish:** Encourage oral health training as part of certificate and degree programs and provide efficient remedial training for graduates.
- **Payment for care coordination:** Payment for oral health services in primary care could increase utilization (such as dental referral, oral health education, or fluoride varnish outside of well child visits). If these services are currently not being paid, consider advocacy for payment.
- **Pay-for-Performance Indicators**: Reimbursing providers based on oral health outcomes (such as patients completing a dental visit, or no emergency room visits for oral health) could impact care. Performance indicators may be something to consider in a comprehensive plan to incentive providers and improve oral health.
- **Supportive Technology**: Supportive technology such as integrated medical and dental electronic health records and referral systems could make medical-dental integration more efficient and improve the patient experience. Advocate for programs that help to fund these efforts and track their impact on children's oral health.

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