Connecting to the Community: A Provider's Work Beyond the Dental Chair

CareQuest Institute Continuing Education Webinar

September 27, 2023

Housekeeping

- We will keep all lines muted to avoid background noise.
- We will send a copy of the slides and a link to the recording via email after the live program.
- We'll also make the slides and recording available on carequest.org.

To receive CE Credits:

- Look for the evaluation form, which we'll send via email within 24 hours.
- Complete the evaluation by **Friday, October 6.**
- Eligible participants will receive a certificate soon after via email.

We appreciate your feedback to help us improve future programs!

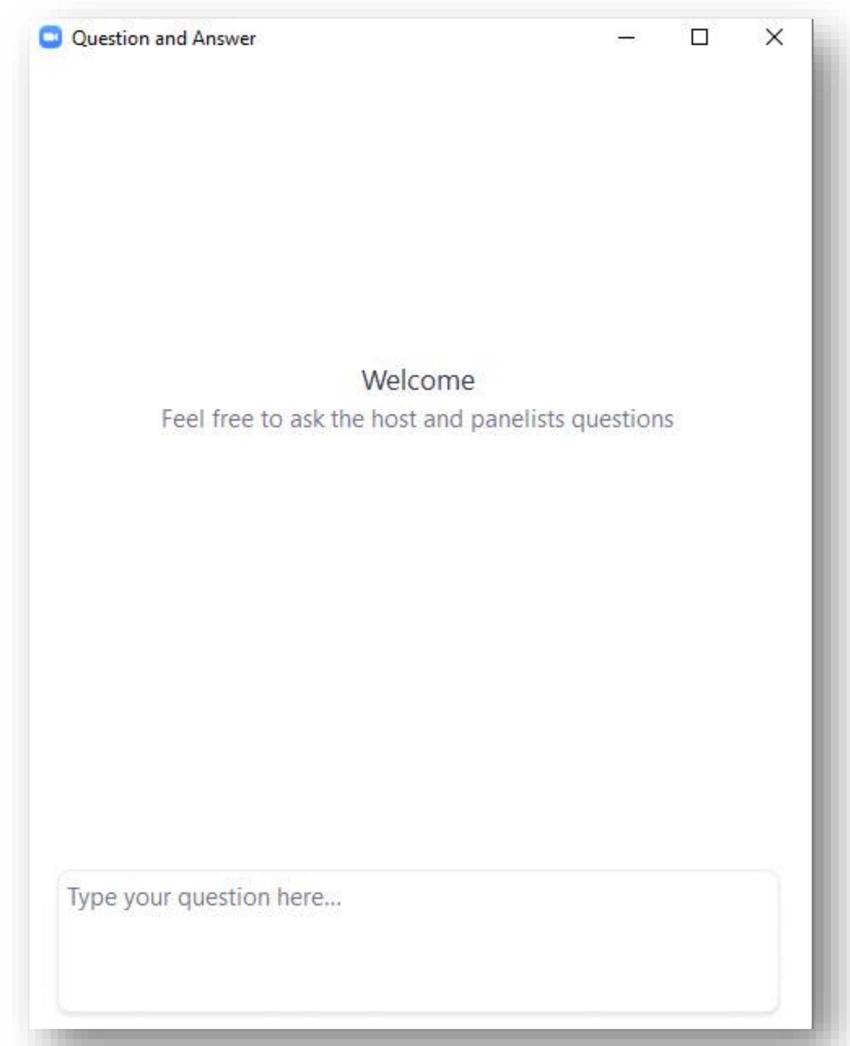
ADA C·E·R·P® | Continuing Education Recognition Program

The CareQuest Institute for Oral Health is an ADA CERP Recognized Provider. This presentation has been planned and implemented in accordance with the standards of the ADA CERP.

*Full disclosures available upon request

Question & Answer Logistics

- Feel free to enter your questions into the **Question & Answer box** throughout the presentations.
- We will turn to your questions and comments toward the end of the hour.



Thank You!

Learning Objectives

At the end of this webinar, you'll be able to:

- Define the concept of social care coordination and its relevance in modern dental practices.
- Differentiate between traditional dental practice workflows and those integrating social care coordination.
- Propose strategies for adapting social care coordination methodologies from FQHCs to private practices.
- Evaluate the importance of a dental provider's role in the broader community.

Connecting to the Community: A Provider's Work Beyond the Dental Chair

WEBINAR | Wednesday, September 27, 2023 | 2–3 p.m. ET | ADA CERP Credits: 1

MODERATOR & PRESENTER

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Dental Director, La Clinica

Significance of Social Care Coordination in Dental Practice

What is social care coordination?

Why does it matter to and how does it impact health outcomes?

Disparities

***Preventable** differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.*

CDC

Health Equity

The attainment of the highest level of health ***for all people****, where everyone has a* ***fair and just opportunity*** *to attain their optimal health* ***regardless of*** *race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, and other factors that affect access to care and health outcomes.*

Source: CMS

EQUALITY

EQUITY

EQUALITY:

EQUITY:

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Social Drivers of Health

Social and economic factors

- Education
- Employment
- Income
- Family and social support
- Community safety

Physical environment

- Air and water quality
- Housing and transit

Health behaviors

- Tobacco, alcohol, and drug use
- Access to healthy food
- Opportunities for physical activity
- Sexual activity

Clinical care

- Quality of care
- Access to health care

Modified from: Kaiser Permanente / University of Wisconsin

The whole picture of health

While just one piece of the puzzle, social and economic factors greatly impact overall health.* Addressing a person's unmet social needs can have a positive effect on their physical and mental health and quality of life.

Systemic forces impact all health factors

- Policies and programs
- Biases
- Discrimination
- Racism
- Trauma

40% Social and economic factors

- Education
- Employment
- Income
- Family and social support
- Community safety

10% Physical environment

- Air and water quality
- Housing and transit

30% Health behaviors

- Tobacco, alcohol, and drug use
- Access to healthy food
- Opportunities for physical activity
- Sexual activity

20% Clinical care

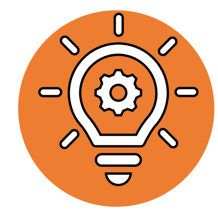
- Quality of care
- Access to health care

Modified from: Kaiser Permanente / University of Wisconsin

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context
Employment Income Expenses Debt Medical bills Support	Housing Transportation Safety Parks Playgrounds Walkability Zip code / geography	Literacy Language Early childhood education Vocational training Higher education	Hunger Access to healthy options	Social integration Support systems Community engagement Discrimination Stress
2x Greater mortality risk for Medicaid beneficiaries vs. private insurance[5]	**26-36** Years of reduced life expectancy for those experiencing homelessness[3]	**9 years** Gap in life expectancy for those without a high school diploma vs. college graduates[7]	**74%** Of food insecure households had to choose between paying for food and medicine[4]	**26%** Increased risk of mortality resulting from loneliness[6]

Modified from: KFF
CDC

What Is Social Care Coordination?



Recognizing & identifying non-clinical needs of our patients

Our space to lead as oral health provider

Intentional & proactive engagement to reduce obstacles faced by our communities

Housing or food insecurity, behavioral health, substance use disorder management

Our patients’ health and our community’s wellbeing are impacted by these drivers.

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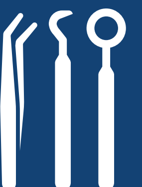
The Clinician’s Role Beyond the Practice

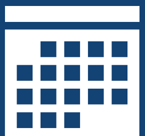
Connecting to the Community: A Provider’s Work Beyond the Dental Chair

September 27, 2023

Dental Providers: Thinking Beyond Clinical Care and Engaging with the Community

- Your utility and resourcefulness as a dental professional goes far beyond what you do in the dental chair!
- Community outreach and leadership opportunities are eagerly awaiting the involvement of dental professionals.
- Your commitment need not entirely alter your practice style or professional life – you set the boundaries!
- These experiences undoubtedly benefit your existing patient base.





Medical Reserve Corps (Local)

- **300,000 volunteers** in roughly **800 community-based units** located throughout the US
- Respond to emergencies and to support ongoing preparedness initiatives
- Improve the health and safety of their communities
- Types of services provided:
  - Community education and outreach
  - Vaccination clinics
  - Emergency preparedness and response trainings
  - Disaster medical and behavioral health support
  - Mass dispensing efforts (e.g., medication, water)
  - Disease testing and surveillance
  - First aid and medical support during large public gatherings

Possible types of "front-line" medical and public health volunteers include:

- Physicians (including surgeons, medical specialists, osteopaths)
- Physician Assistants
- Nurses (nurse practitioners, registered nurses, licensed practical nurses, nursing assistants)
- Pharmacists
- Dentists
- Dental Assistants

- Find your MRC unit at https://experience.arcgis.com/experience/b6e7f63818804808beaad6de1afbd512
- Inspiration: Dr. Kim Turner

Board/Commission of Health (Local)

- **NACCHO Directory of Local Health Departments:** https://www.naccho.org/membership/lhd-directory
- **Inspiration: Dr. Caswell Evans**

Medical Care Advisory Committee (State)

- “Each State Medicaid program is required by Federal Regulations to have a Medical Care Advisory Committee (MCAC) which includes provider, consumer, and government representatives and which participates in policy development and program administration.”
- Inspiration: Dr. Jessica Meeske

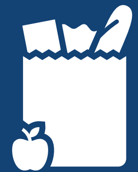
Health Centers & Community Organizations (Local)

- Outreach and education opportunities
- Community member board positions
- Referral relationships and service extension from the center to your practice
- Think about opportunities even at health centers with*out* dental services!
- Get familiar with those in your community at https://findahealthcenter.hrsa.gov/

Find a Health Center

- **Example:**

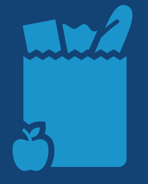
Other Outreach Opportunities



Social Influencers of Health – Community Connect

Screener: In the past 3 months, have you or your family experienced any concerns related to housing, food, transportation, utilities or safety?

1. In the last 12 months, was there a time when you were not able to pay the mortgage or rent on time?
2. How hard is it for you to pay for the very basics like food, housing, medical care, and heating?
3. In the past 12 months, has lack of transportation kept you from meetings, work, or from getting things needed for daily living?
4. Within the past 12 months, you worried that your food would run out before you got the money to buy more.
5. Has there been a time that you and/or your child have not felt safe in your home and in your neighborhood?
6. If you answered yes to any of the questions - Would you like help with any of these needs?



Connecting Patients to Community Resources

Example resources from my neck of the woods on:

- Affordability & Coverage
- Food Security & Nutrition
- Transportation
- Housing

Health IT Infrastructure Is Ready!

USING Z CODES:

The **Social Determinants of Health (SDOH)** Data Journey to Better Outcomes

What are

SDOH-related Z codes ranging from Z55-Z65 are the ICD-10-CM encounter reason codes used to document SDOH data (e.g., housing, food insecurity, transportation, etc.).

SDOH are the conditions in the environments where people are born, live, learn, work, play, worship and age.

Step 1 Collect SDOH Data

Any member of a person's care team can collect SDOH data during any encounter.

- Includes providers, social workers, community health workers, case managers, patient navigators, and nurses.
- Can be collected at intake through health risk assessments, screening tools, person-provider interaction, and individual self-reporting.

Step 2 Document SDOH Data

Data are recorded in a person's paper or electronic health record (EHR).

- SDOH data may be documented in the problem or diagnosis list, patient or client history, or provider notes.
- Care teams may collect more detailed SDOH data than current Z codes allow. These data should be retained.
- Efforts are ongoing to close Z code gaps and standardize SDOH data.

Step 3 Map SDOH Data to Z Codes

Assistance is available from the ICD-10-CM Official Guidelines for Coding and Reporting.[1]

- Coding, billing, and EHR systems help coders assign standardized codes (e.g., Z codes).
- Coders can assign SDOH Z codes based on self-reported data and/or information documented by any member of the care team if their documentation is included in the official medical record.[2]

Step 4 Use SDOH Z Code Data

Data analysis can help improve quality, care coordination, and experience of care.

- **Identify individuals'** social risk factors and unmet needs.
- **Inform health care** and services, follow-up, and discharge planning.
- **Trigger referrals** to social services that meet individuals' needs.
- **Track referrals** between providers and social service organizations.

Step 5 Report SDOH Z Code Data Findings

SDOH data can be added to key reports for executive leadership and Boards of Directors to inform value-based care opportunities.

- Findings can be shared with social service organizations, providers, health plans, and consumer/patient advisory boards to identify unmet needs.
- A Disparities Impact Statement can be used to identify opportunities for advancing health equity.

Health IT Infrastructure is Ready!

Z code Categories

- **Z55** – Problems related to education and literacy
- **Z56** – Problems related to employment and unemployment
- **Z57** – Occupational exposure to risk factors
- **Z58** – Problems related to physical environment
- **Z59** – Problems related to housing and economic circumstances
- **Z60** – Problems related to social environment
- **Z62** – Problems related to upbringing
- **Z63** – Other problems related to primary support group, including family circumstances
- **Z64** – Problems related to certain psychosocial circumstances
- **Z65** – Problems related to other psychosocial circumstances

This list is subject to revisions and additions to improve alignment with SDOH data elements.

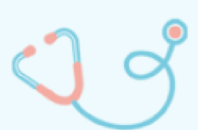
Health Care Team

Use a SDOH screening tool.

- Follow best practices for collecting SDOH data in a sensitive and HIPAA-compliant manner.
- Consistently document standardized SDOH data in the EHR.
- Refer individuals to social service organizations and appropriate support services through local, state, and national resources.

Affordability

MEDICAID & CHIP
HOW-TO Information



- APPLY NOW through the Health Insurance Marketplace or directly with your state Medicaid agency
- HOW TO see if you are eligible for Medicaid or CHIP
- HOW TO get a new Medicaid/CHIP card
- HOW TO contact your state

https://www.medicaid.gov/about-us/beneficiary-resources/index.html

Transportation

Non-emergency medical transportation (NEMT) is an important benefit for people who need assistance getting to and from medical appointments. Our resources for providers explain important guidelines such as the difference between emergency and non-emergency medical transportation, accepted types of transportation, the types of transportation service delivery systems, and driver and vehicle acceptance criteria. We also discuss common fraud schemes and provide fraud and abuse prevention tips. The fact sheet for beneficiaries gives an overview of the NEMT benefit.

https://www.cms.gov/medicare/medicaid-coordination/states/non-emergency-medical-transportation

Food & Nutrition

Find Your Local Food Bank

The Feeding America nationwide network of food banks and food programs helps millions of people find food and grocery help in their communities every year. Connect with your local food bank to learn about upcoming free food distributions and to apply for national food programs like SNAP and WIC.

Search by Zip Code *or* State

Zip Code or State

Enter your zip code for your nearest food bank

Enter your state to see all food banks serving your state.

GO

Housing

What issue are your facing?	Where to get help
At risk of or experiencing homelessness	• In Chicago: Call 311 and ask for "short-term assistance" • Outside Chicago: Call 211 or contact your local homeless service provider
Help with paying rent	• Rental Help: Illinois to find emergency rental assistance programs • Local Community Action Agency • Illinois Department of Human Services at (833) 234-6343
Need affordable rental housing	• The HUD Resource Locator to find HUD-assisted and affordable housing • Use Illinois Housing Search • Go to Rental Help: Illinois

https://www.hud.gov/states/illinois/offices

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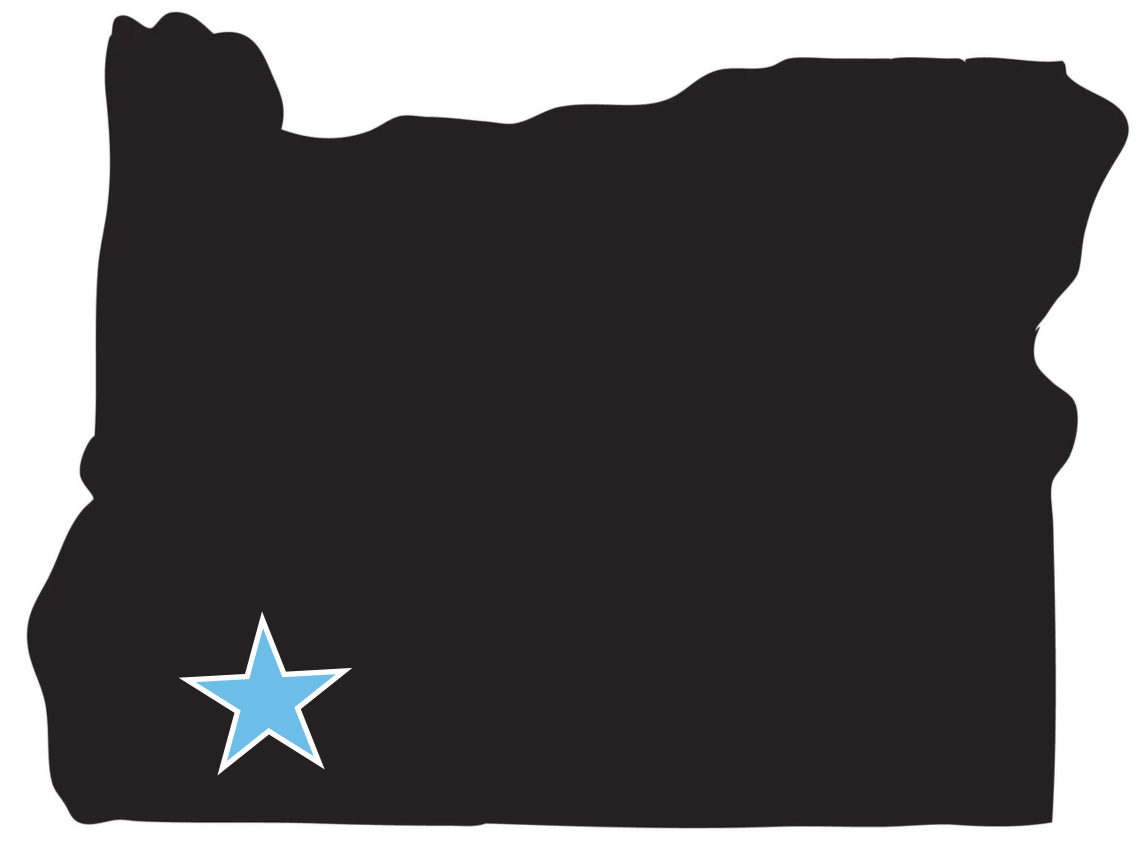
Social Care Coordination in Action at La Clinica

Alayna Schoblaske, DMD
Dental Director, La Clinica
(she/her)

Where I Practice

- **Oregon** – Medicaid expansion in 2014 to include comprehensive adult dental benefit

- **Jackson County** – semi-rural population of **218,000**
  - **~85,000** people eligible for Medicaid **(39%)**
  - **~20** dentists to serve them



About My Clinic

- FQHC w/ 2 dental sites
- About 80 dental staff
  - 10 dentists
  - 7 hygienists
- 7 other clinics
  - Medical
  - Behavioral health
  - The Learning Well
  - 19 school-based sites
- 1 mobile clinic
- And…

Community Resource Team

Who are they?

- 10 Community Resource Specialists helped connect 2,300 patients to services last year.
- We have one CRS dedicated to the Dental department.

What do they do?

- Cell phones
- Cab vouchers
- Medical transportation
- Food assistance (SNAP)
- Temporary housing and shelters
- Hotel vouchers
- Clothing voucher (Goodwill, Kohls, etc.)
- Insurance enrollment

Meet Stephanie & Bob*

“I can never schedule appointments with you guys.”

“I’m couch surfing right now and I lost my cell phone a couple of weeks ago. I can’t afford to get a new one, so I don’t have a phone number to give you or call you from.”

Stephanie connected patient with a free basic cell phone through Lifeline.

Referrals Happen The Other Way, Too

PCP Appointment

- “My teeth are really bothering me, and I want to see a dentist.”

Warm Hand-Off

- Scheduled urgent care dental appointment
- Arranged transportation to appointment
- Discussion revealed that patient was homeless and very anxious about dental care

What Happened

- Rapid rehousing program (through local partner Access)
- Behavioral health appointments
- Multiple dental visits

A Note On Referrals

- If Stephanie is not available, Ryan is our go-to.

- Behavioral Health Support Specialist

Internal resources we offer our patients:

- Weighted blanket
- Essential oils + cotton rolls
- Stress ball
- Fidgets
- Breathing exercises

What You Can Do

1. Listen to your patients.
2. Get to know what services are available in your city/county.
3. Make a handout or have flyers available.

An Example

- **Courtesy of Dr. Britta Martinez**
  Wallace Medical Concern
  Portland, Oregon

- Survey given to patients once per year with sliding scale paperwork.

Patient Support Survey

There are many things that may affect your health. The more we know about you, the better care we can provide.
While we cannot help with every need, we can connect you with someone that may be able to help.

How can we contact you?

- ☐ I would like to talk to someone about this today
  - ☐ Phone: ________________ (☐ Call or ☐ Text)
  - ☐ MyChart
- ☐ Do not contact me about this form
- ☐ I prefer not to do this survey today
- ☐ I have no concerns today

What concerns do you have?

PATIENT CARE COORDINATOR	☐ Utilities	☐ Employment
	☐ Food	☐ Education
	☐ Housing Needs	☐ Hygiene Products
	☐ Transportation	☐ Clothing
BEHAVIORAL HEALTH	☐ Relationship Safety	☐ Physical Activity
	☐ Mental Health	☐ Social Support
PRIMARY CARE PROVIDER	☐ Kids and Babies	☐ Vision/Eye Care
	☐ Dental (Tooth) Care	☐ Hearing
	☐ Medicine	☐ Other: ________________

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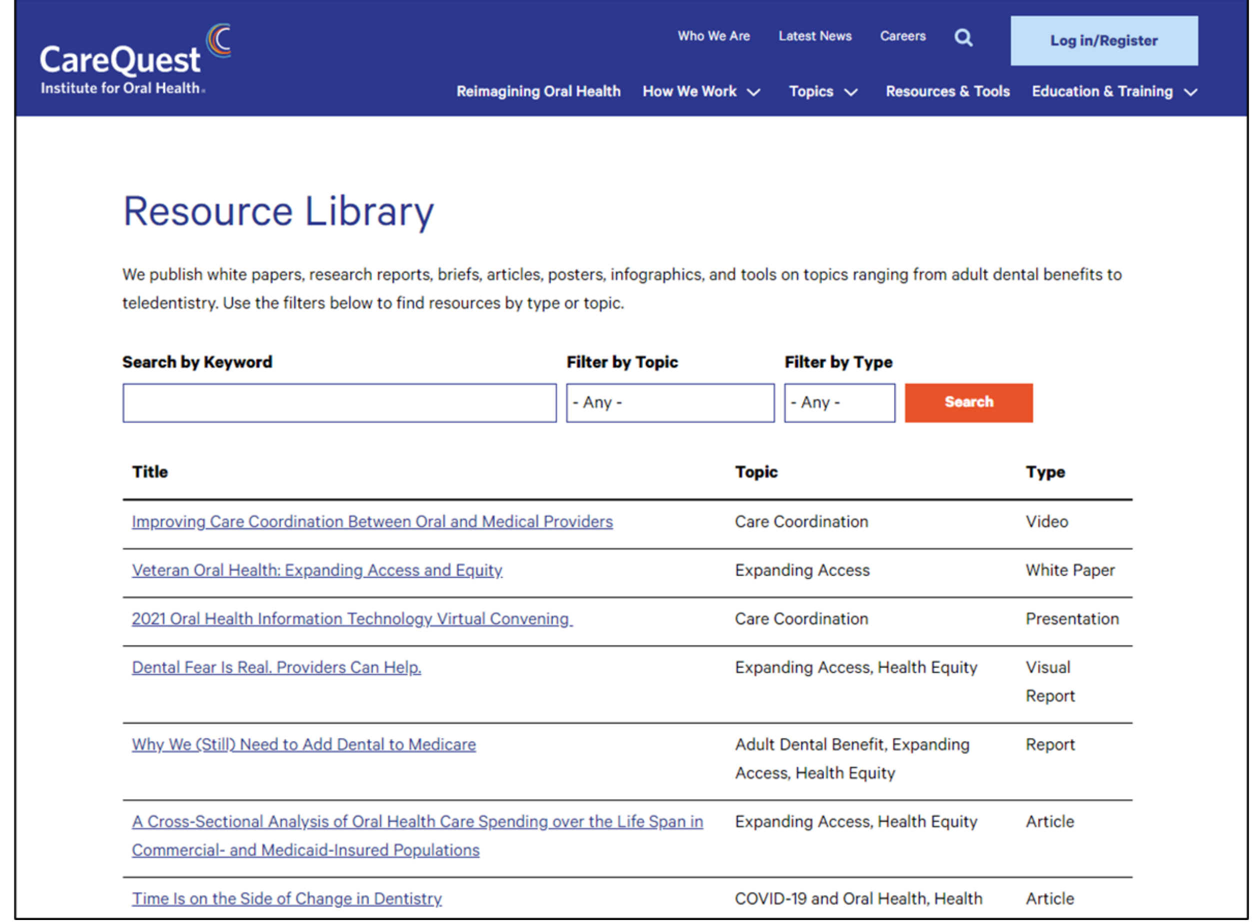
Question & Answer

To Explore More Industry-Leading Research



www.carequest.org/resource-library

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Missed Connections

Providers and Consumers Want More Medical-Dental Integration

Oral health and overall health are inextricably linked. There is mounting evidence to suggest that poor oral health is related to a variety of chronic health conditions, such as high blood pressure, dementia, diabetes, and obesity. Despite this known connection, dental care is still largely siloed from medical care. The Centers for Disease Control and Prevention (CDC) estimates that integrating basic health screenings into a dental setting could save the health care system up to $100 million every year.[1]

CareQuest Institute for Oral Health conducted a nationally representative survey in January and February 2021 to assess consumers' perspectives on oral and overall health (n=5,320). CareQuest Institute also conducted a nationwide survey of oral health providers to assess perspectives and current behaviors related to interprofessional practice (n=377). Consumers and oral health providers described a lack of integration between medical and oral health care, and a desire for increased interprofessional collaboration.

Key Findings:

Medical-dental collaboration is currently uncommon.

63% of consumers report that their **primary medical doctor "rarely" or "never" asks about their oral health.**

33% of consumers report that their **oral health provider "rarely" or "never" asks about their overall health.**

45% of responding oral health providers report **"rarely" integrating their care with clinicians outside of dentistry,** with only **14%** reporting it is **part of their "daily" practice.**

- **Less than a third** of consumers report **receiving general health screenings from their oral health provider.**
- **A majority (89%)** of adults report **never receiving a referral from their oral health provider to a non-oral health professional.**
- **Almost a fourth (24%)** of participating oral health providers report **currently implementing interprofessional practice.**

Webinar Evaluation

Complete the **evaluation by Friday, October 6** to receive CE credit. You will receive a link to the survey within 24 hours.

Next Webinars:

Recognizing and Responding to Intimate Partner Violence in the Dental Setting on **October 19 at 7 p.m. ET**

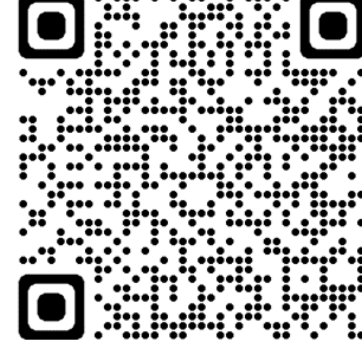
And sign up to receive our newsletter to get more information on future webinars!

Sign up for News and Updates

Email*

CareQuest Institute for Oral Health uses the information you provide to share updates on work and offerings to improve the oral health of all. You may unsubscribe at any time (See Privacy Policy).

Submit



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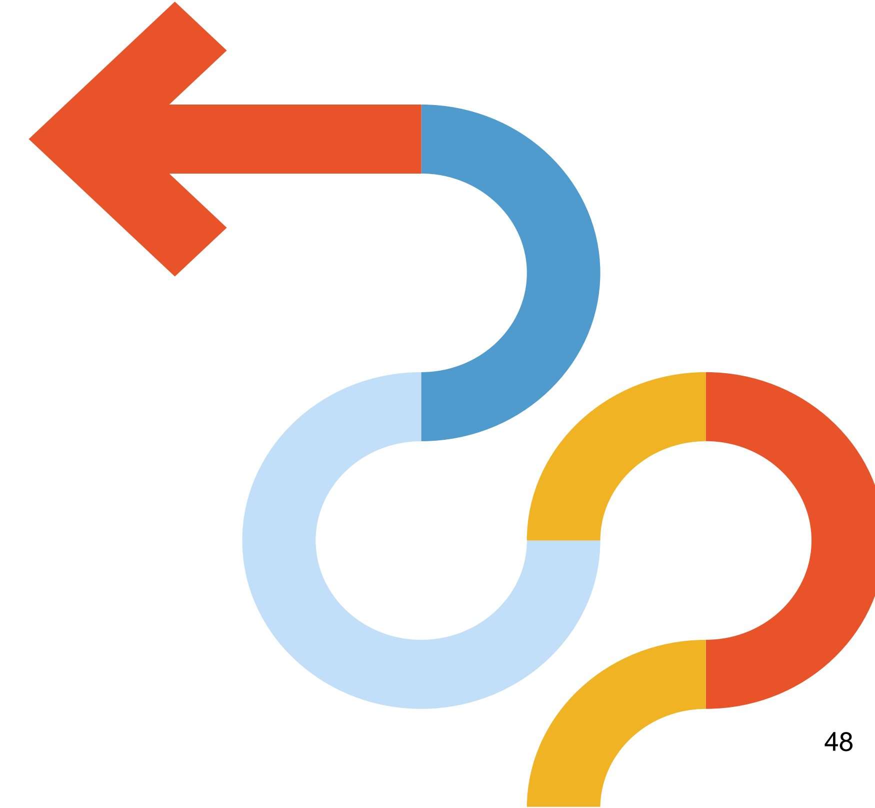

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