



Multi-Directional Integration of Oral Health, Primary Care, and Mental Health

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Learning Objectives

- List three examples of medical-dental integration;
- Describe how integrated care can improve patient outcomes; and
- Describe opportunities and barriers related to medical-dental integration.

Multi-Directional Integration

- Rationale
- Opportunities and Barriers
- Examples
- IHS Lessons Learned
- Future

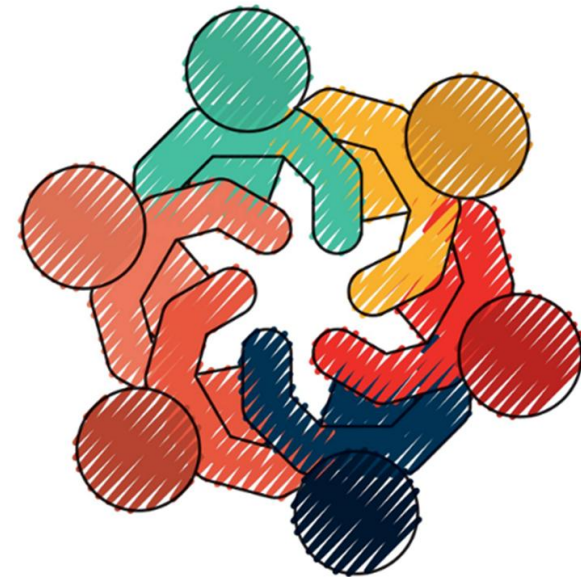


Table 1. Six Levels of Collaboration/Integration (Core Descriptions)

COORDINATED KEY ELEMENT: COMMUNICATION		CO LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Behavioral health, primary care and other healthcare providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
» Have separate systems » Communicate about cases only rarely and under compelling circumstances » Communicate, driven by provider need » May never meet in person » Have limited understanding of each other's roles	» Have separate systems » Communicate periodically about shared patients » Communicate, driven by specific patient issues » May meet as part of larger community » Appreciate each other's roles as resources	» Have separate systems » Communicate regularly about shared patients, by phone or e-mail » Collaborate, driven by need for each other's services and more reliable referral » Meet occasionally to discuss cases due to close proximity » Feel part of a larger yet non-formal team	» Share some systems, like scheduling or medical records » Communicate in person as needed » Collaborate, driven by need for consultation and coordinated plans for difficult patients » Have regular face-to-face interactions about some patients » Have a basic understanding of roles and culture	» Actively seek system solutions together or develop work-a-rounds » Communicate frequently in person » Collaborate, driven by desire to be a member of the care team » Have regular team meetings to discuss overall patient care and specific patient issues » Have an in-depth understanding of roles and culture	» Have resolved most or all system issues, functioning as one integrated system » Communicate consistently at the system, team and individual levels » Collaborate, driven by shared concept of team care » Have formal and informal meetings to support integrated model of care » Have roles and cultures that blur or blend

Rationale: Why Integrate Care?

- **Shared patients and shared risk factors.** Smoking, poor diet, diabetes, and inflammation cut across both domains. The same patient population moves through both.
- **Screening opportunity.** Dental visits reach patients who may not see a physician regularly, creating openings to screen for undiagnosed diabetes, hypertension, and high cholesterol, and to refer.
 - **99% of I/T/U dental programs are co-located** with another health program (e.g. medical program)
 - **Promotes “Health Home”** Health team (medical, dental, mental health, etc.)
- **Outcomes.** Improving oral health can contribute to better diabetes outcomes; clinic data has shown that as more patients receive dental services, uncontrolled diabetes rates decline.
- **Cost.*** Claims analyses consistently show savings. Periodontal treatment was associated with roughly 12% lower overall healthcare costs for commercially insured patients with diabetes and about 14% lower for Medicaid patients. One estimate projected average savings of roughly \$5,900 per person for individuals with diabetes and periodontitis who received treatment.

*"Periodontal Treatment Associated With Decreased Diabetes Mellitus–Related Treatment Costs: An Analysis of Dental and Medical Claims Data." Journal of the American Dental Association, April 2023.



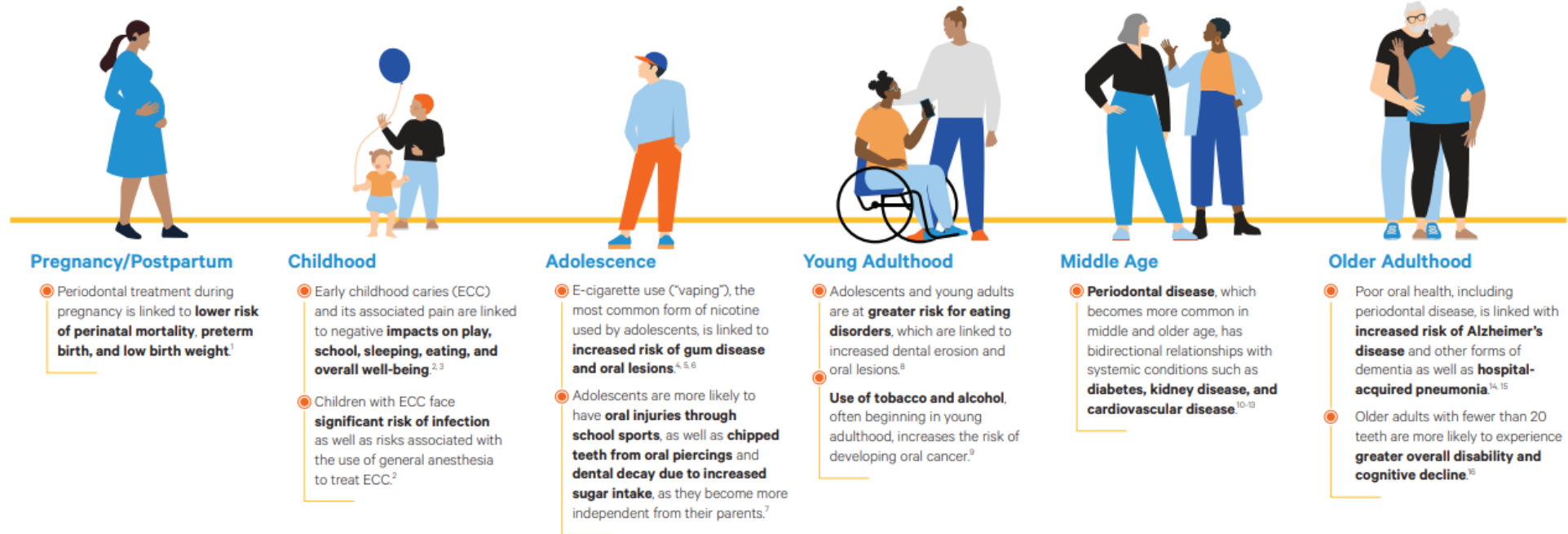
Cultural Shift

- Medical-dental integration implementation represents a **cultural shift** for the whole organization, from the front desk to the clinician.
- Initial steps in establishing integrated care models
 - aligning expectations
 - obtaining leadership buy-in
 - building infrastructure (including interoperable electronic health records)
 - closing referral loops

Overall Health Linked to Oral Health



The Oral-Systemic Connection Across the Lifespan



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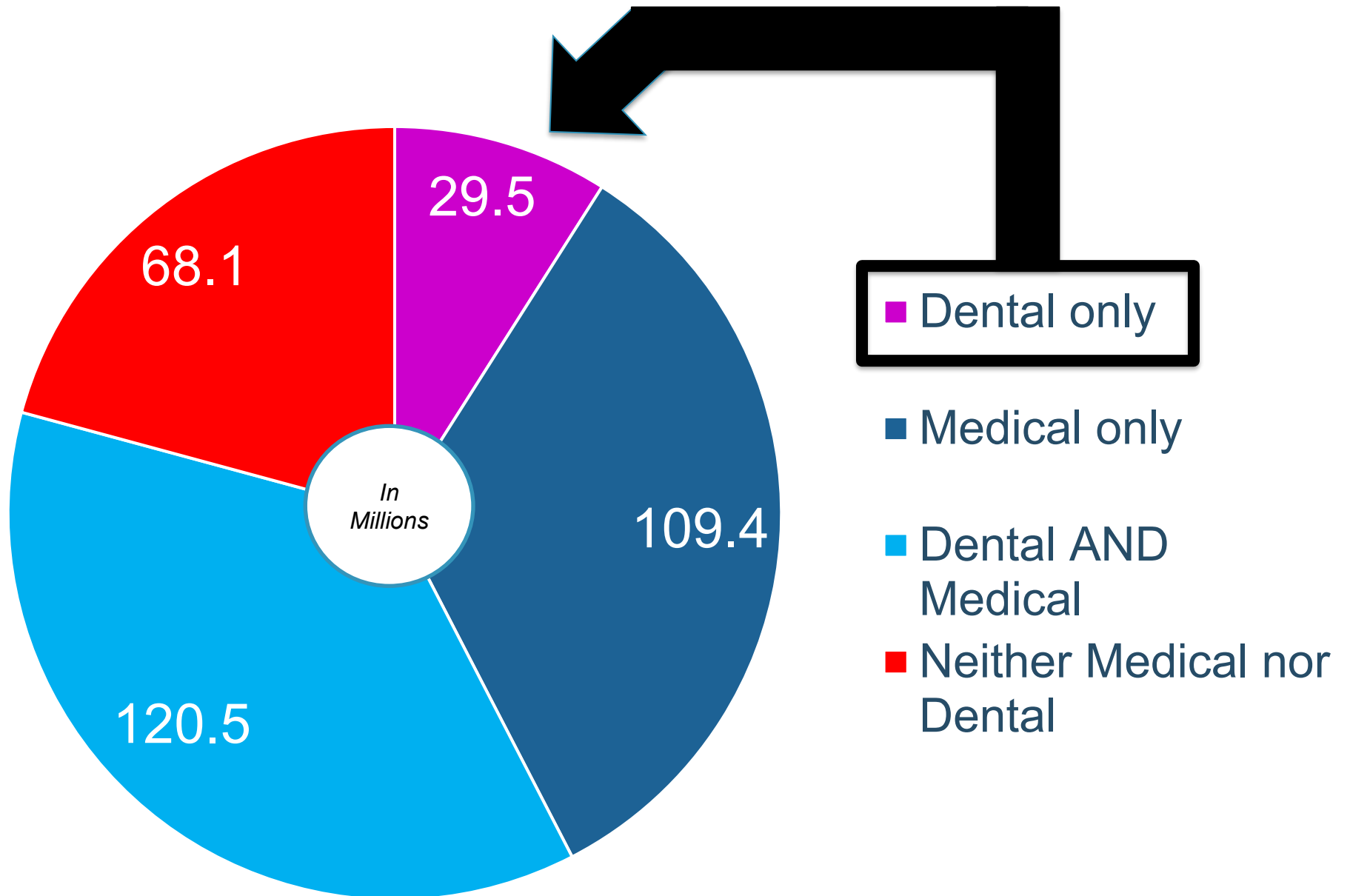
How Oral Health Affects the Body

- Chronic periodontal (gum) disease is a persistent inflammatory condition driven by bacterial biofilm.
 - Two mechanisms impact overall health:
 - **Direct** entry of oral bacteria (such as *P. gingivalis*) into the bloodstream
 - **Indirect** effects through elevated systemic inflammation—circulating inflammatory mediators such as IL-6, TNF- α , and C-reactive protein that promote endothelial dysfunction and atherogenesis.
 - **Gum disease** is *associated* with the following conditions:
 - cardiovascular disease, diabetes, adverse pregnancy outcomes, respiratory disease (including COPD), rheumatoid arthritis, and possible links to Alzheimer's disease

Opportunities

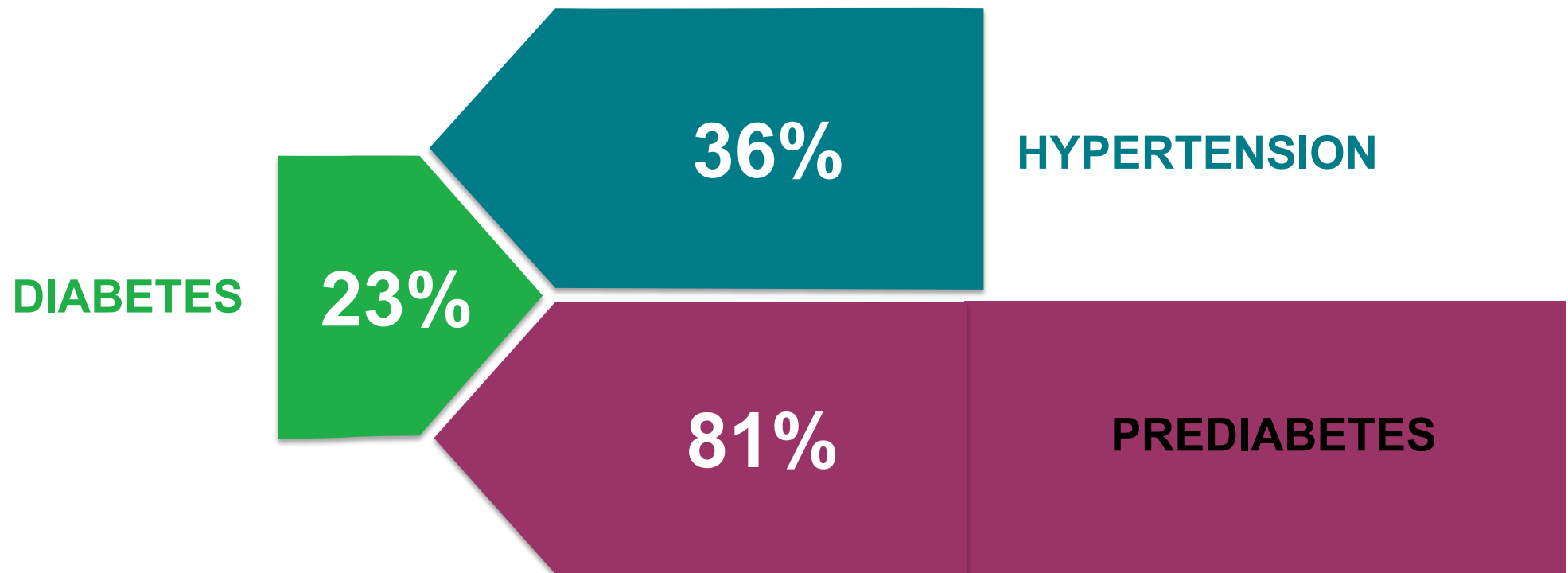


Opportunity: Bridge the Gap Between Oral Health & Overall Health



Opportunity: Rates of Undiagnosed*

*Among adults 18 or over with the condition



Virani SS, Alonso A, Benjamin EJ, Bittencourt MS, Callaway CW, Carson AP, et al. <https://doi.org/10.1161/cir.0000000000000757>. *Circulation* 2020;141:e139-596.

Opportunity: Reducing Costs

SCREENING FOR CHRONIC
DISEASES IN DENTAL OFFICES
COULD REDUCE U.S. HEALTH
CARE COSTS BY ...

up to
\$102.6
MILLION per year



OR

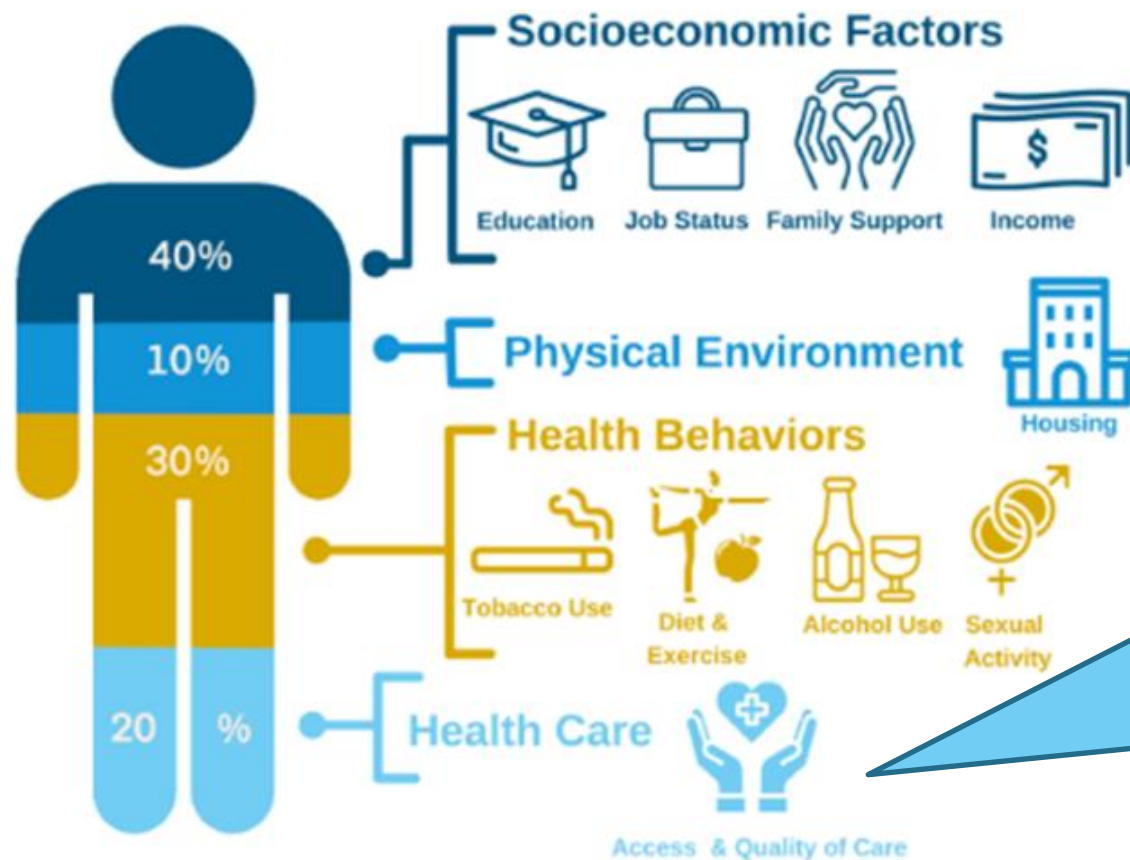
up to
\$32.72
per person screened



24

Nasseh K, Greenberg B, Vujcic M, Glick M. The effect of chairside chronic disease screenings by oral health professionals on health care costs. Am J Public Health. 2014 Apr;104(4):744-50. doi: 10.2105/AJPH.2013.301644. Epub 2014 Feb 13. PMID: 24524531; PMCID: PMC4025684.

Opportunity: Work as a Team



With the 20% influence of health care on our patients' overall health, we need to work as a health care team (through integration)—medical, dental, and behavioral health – to improve health outcomes.

Opportunities: Improve Health Outcomes

	AI/AN Rate 2009-2011	U.S. All Races Rate - 2010	Ratio: AI/AN to U.S. All Races
ALL CAUSES	999.1	747.0	1.3
Diseases of the heart (Heart Disease)	194.7	179.1	1.1
Malignant neoplasm (cancer)	178.4	172.8	1.0
Accidents (unintentional injuries)*	93.7	38.0	2.5
Diabetes mellitus (diabetes)	66.0	20.8	3.2
Alcohol-induced	50.0	7.6	6.6
Chronic lower respiratory diseases	46.6	42.2	1.1
Cerebrovascular diseases (stroke)	43.6	39.1	1.1
Chronic liver disease and cirrhosis	42.9	9.4	4.6
Influenza and pneumonia	26.6	15.1	1.8
Drug-induced	23.4	15.3	1.5
Nephritis, nephrotic syndrome (kidney disease)	22.4	15.3	1.5
Intentional self-harm (suicide)	20.4	12.1	1.7
Alzheimer's disease	18.3	25.1	0.7
Septicemia	17.3	10.6	1.6
Assault (homicide)	11.4	5.4	2.1
Essential hypertension diseases	9.0	8.0	1.1

- Per capita healthcare expenditures are \$4,078 compared to \$9,726 for the U.S.
- Average life expectancy of AI/ANs today is 5.5 years less than the U.S. general population (73.0 to 78.5 years, respectively)
- Compared to the general U.S. population, AI/ANs have higher morbidity and mortality in many disease and conditions.

Opportunity: Improve Screening Rates

- Increase Integration = Increase Prevention Efforts

Table 2. Logistic regression analysis of medical care gap closure,* by total MDI[†] population and MDI model type.

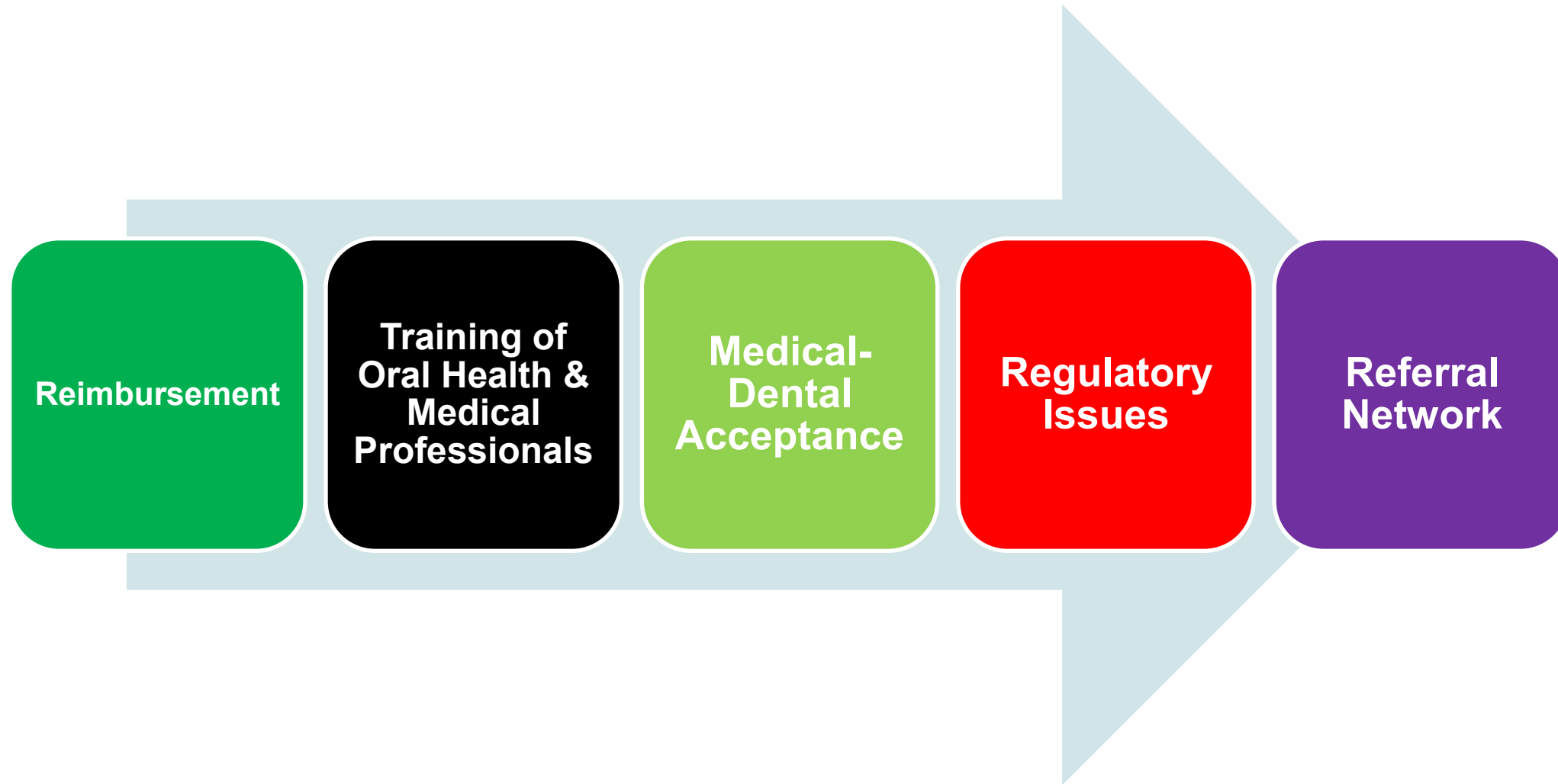
MDI POPULATION CHARACTERISTICS	ODDS RATIO	95% CONFIDENCE INTERVAL	P VALUE
Total MDI Population			
MDI population	1.46	1.29-1.65	< .0001
Non-MDI population	1.00	NA [‡]	NA
MDI Model Type, Dental Clinic			
Least integration: Colocated medical and dental office, nonembedded medical staff. Salmon Creek	1.18	1.02-1.37	< .0007
Moderate integration: Stand-alone dental office, embedded medical staff. Glisan	1.70	1.36-2.12	< .0346
Most integration: Colocated medical and dental office, embedded medical staff. Beaverton, Cedar Hills	2.08	1.73-2.50	< .0001
Non-MDI population	1.00	NA	NA

* Population includes patients enrolled in Medicare who were patients 65 years or older with 1 or more care gaps at baseline. All care gap closure assessed at 30 days after index visit, except for fecal immunochemical testing, mammography, annual diabetes mellitus examination, retinopathy examination, and smoking cessation, which was assessed at 60 days after index visit. P value from logistic regression analysis. † MDI: Medical-dental integration. ‡ NA: Not applicable.

Barriers

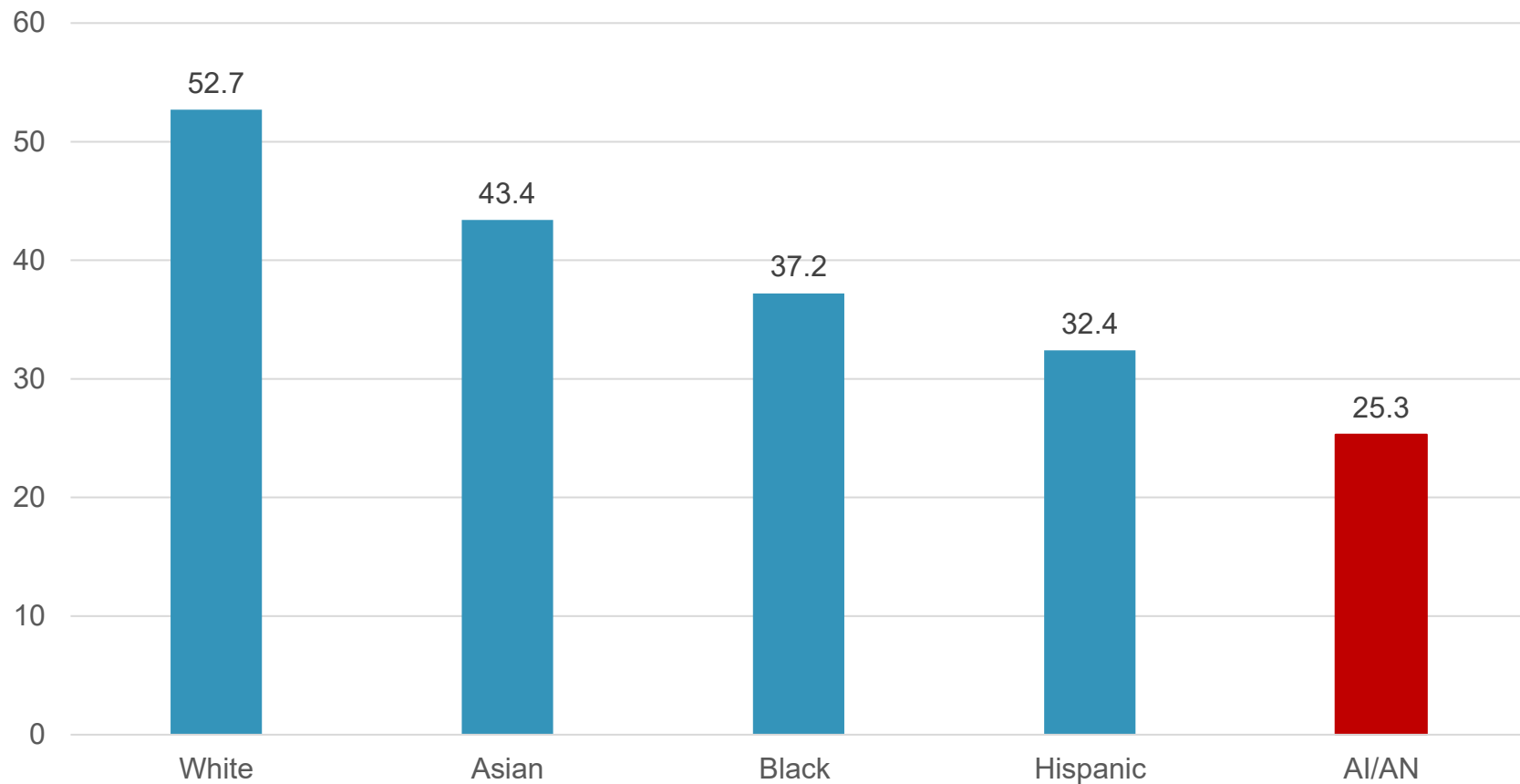


Barriers to Integration



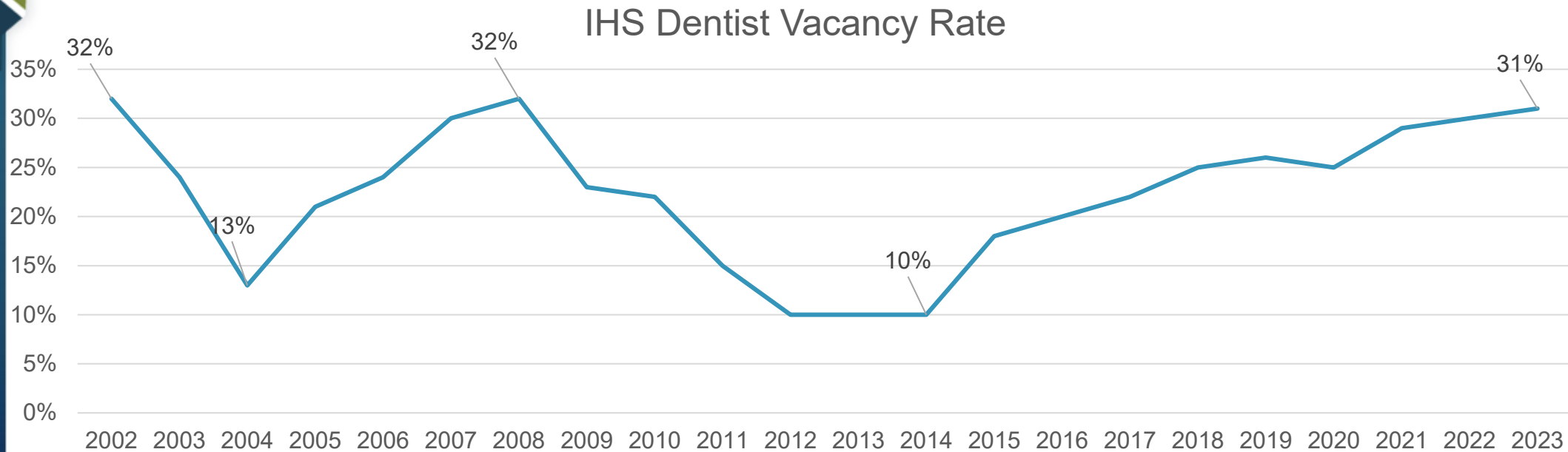
Barrier Example: Accessing Dental Care

Percent with Dental Visit in the Last Year, by Race/Ethnicity
2023



Vujcic et al. American Dental Association Health Policy Institute, Dental Visits in Last Year, 2022.
IHS Office of Public Health Support. GPRA Final Report, 2022.

Barrier Example: Dentist Vacancy Rate

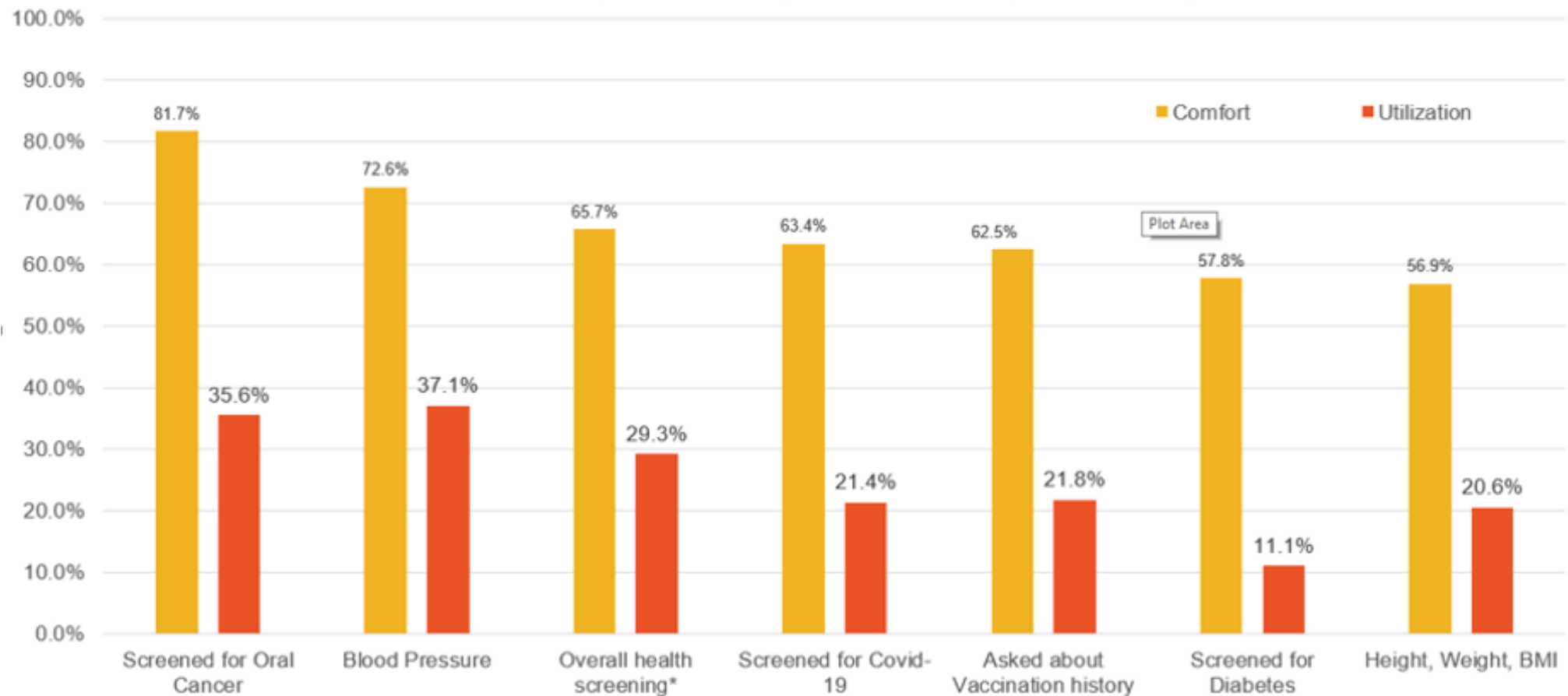


2023:

- Dentist vacancy rate: 31%
- Dental hygienist vacancy rate: 31%
- Dental assistant vacancy rate (fed): 36%
- Overall dental asst. vacancy rate: 41%

Patient Acceptance is NOT a Barrier

Comfort: Are you comfortable with your oral health provider measuring or screening for the following?
Utilization: Has your oral health provider checked any of the following?



Sonnek et al. CareQuest Institute for Oral Health. Consumers Experiences with and Attitudes toward Receiving Health Screenings at Dental Visits, November 8, 2022 Presentation at APHA.

Examples of Integration





Where Is Medical-Dental Integration Happening?

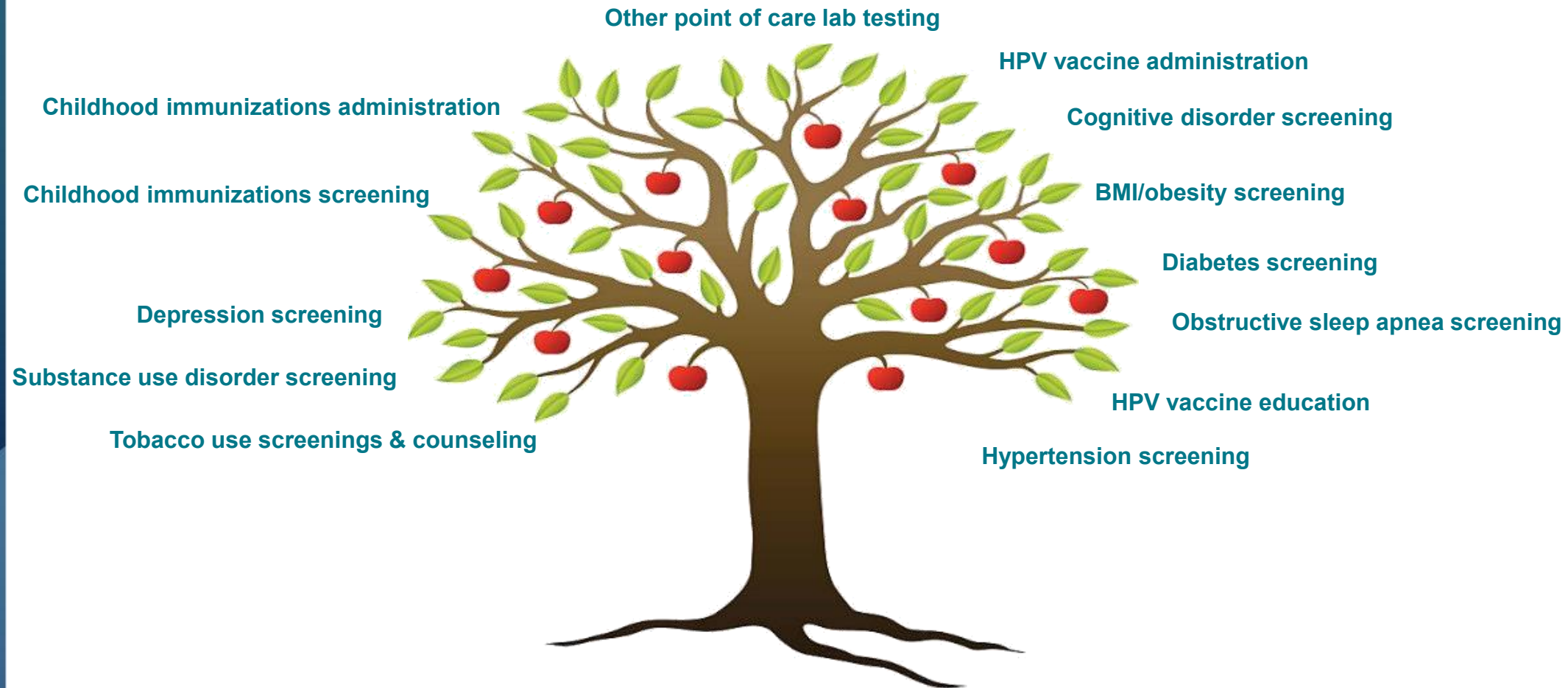
- Academic, clinical, and public health settings
 - **IHS**
 - Universities
 - Residency programs
 - Communities
 - Community clinics and federally qualified health centers
 - Safety-net and public health programs (e.g., Head Start, WIC clinic)
 - School-based clinics
 - Hospitals
 - Medical and dental offices/clinics
 - Senior assisted living/long-term care/community centers
 - Co-located medical and dental clinics



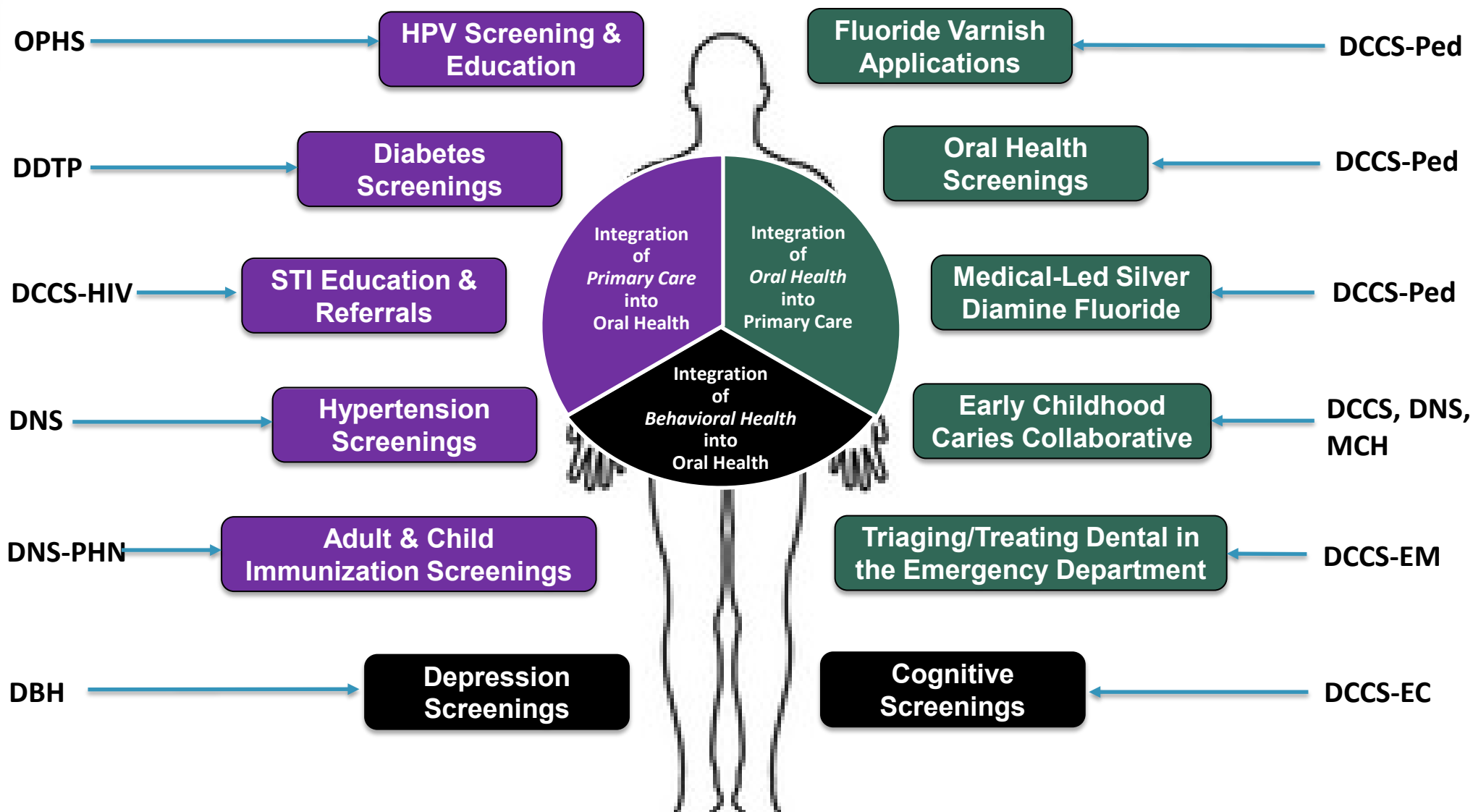
Who Is Doing Medical-Dental Integration?

- Entire health care team, not just dentists and physicians
 - Dental hygienists
 - Dental therapists
 - Community Health Workers
 - Care navigators/coordinators
 - Nurses and nurse assistants
 - Nurse practitioners
 - Physician assistants
 - Midwives
 - Nutritionists
 - Pharmacists
- Health care professional faculty and students

Opportunities for Integration in Dental Setting



Opportunities: IHS Multi-Directional Integration Initiatives



Collaborators: OPHS – Office of Public Health Support; DDTP – Division of Diabetes Treatment and Prevention; DNS – Division of Nursing Services, DNS-PHN – Public Health Nursing; DBH – Division of Behavioral Health; DCCS – Division of Clinical and Community Services; Ped – Pediatric Chief Consultant; EM – Emergency Medicine Chief Consultant; EC – Elder Care Program; HIV – HIV/STI Program; MCH – Maternal & Child Health; DDTP, DNS, DCCS, MCH, and DOH are all components of OCPS, the Office of Clinical and Preventive Services.



Examples of IHS Medical-Dental Integration Initiatives

- IHS Early Childhood Caries Collaborative
- Depression Screening in Dental Settings
- Cognitive Screening in Dental Settings
- Triaging and Treating Dental Conditions in the Emergency Dept.
- Medical-Led Silver Diamine Fluoride Project

IHS Early Childhood Caries Collaborative (2009-2017)

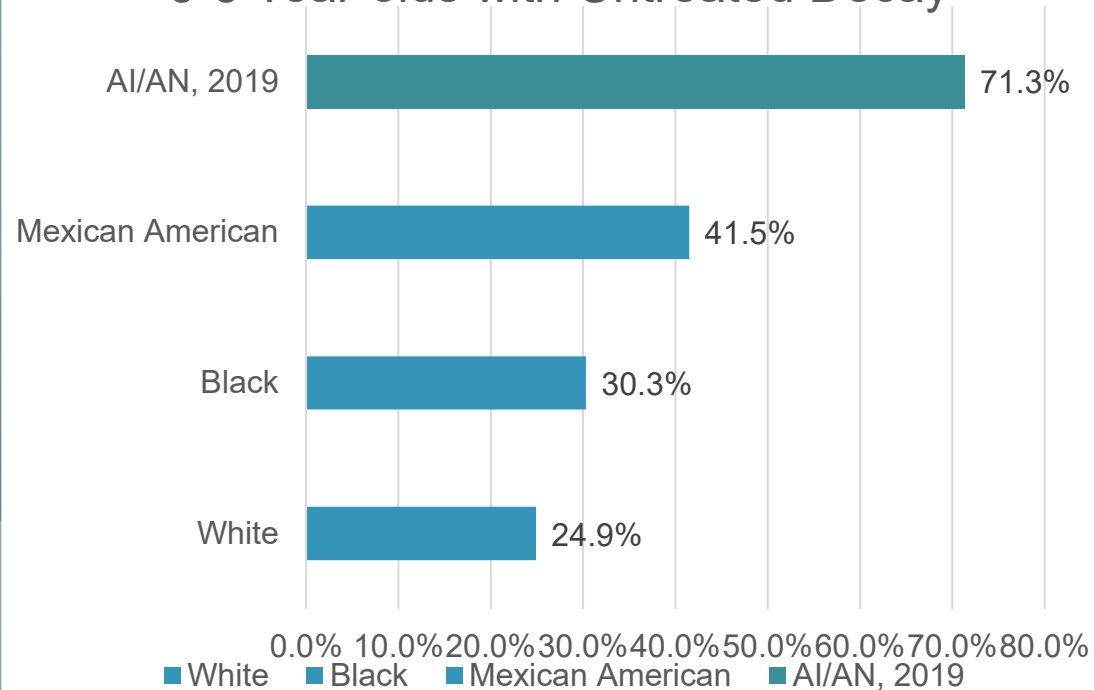
- Goals were to increase access to dental care by 25%, increase dental sealants by 25%, increase the number of patients receiving fluoride varnish by 25%, and increase therapeutic fillings by 50%
- Used a multi-disciplinary model of community and medical collaborators



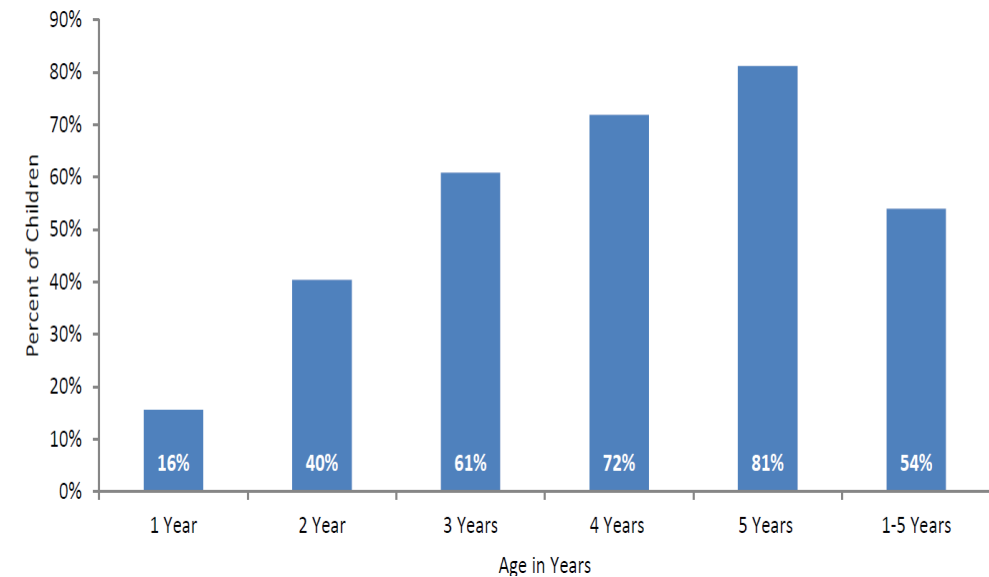
IHS Early Childhood Caries Collaborative (2009-2017)

Why?

3-5 Year-olds with Untreated Decay



ECC by Age, AI/AN

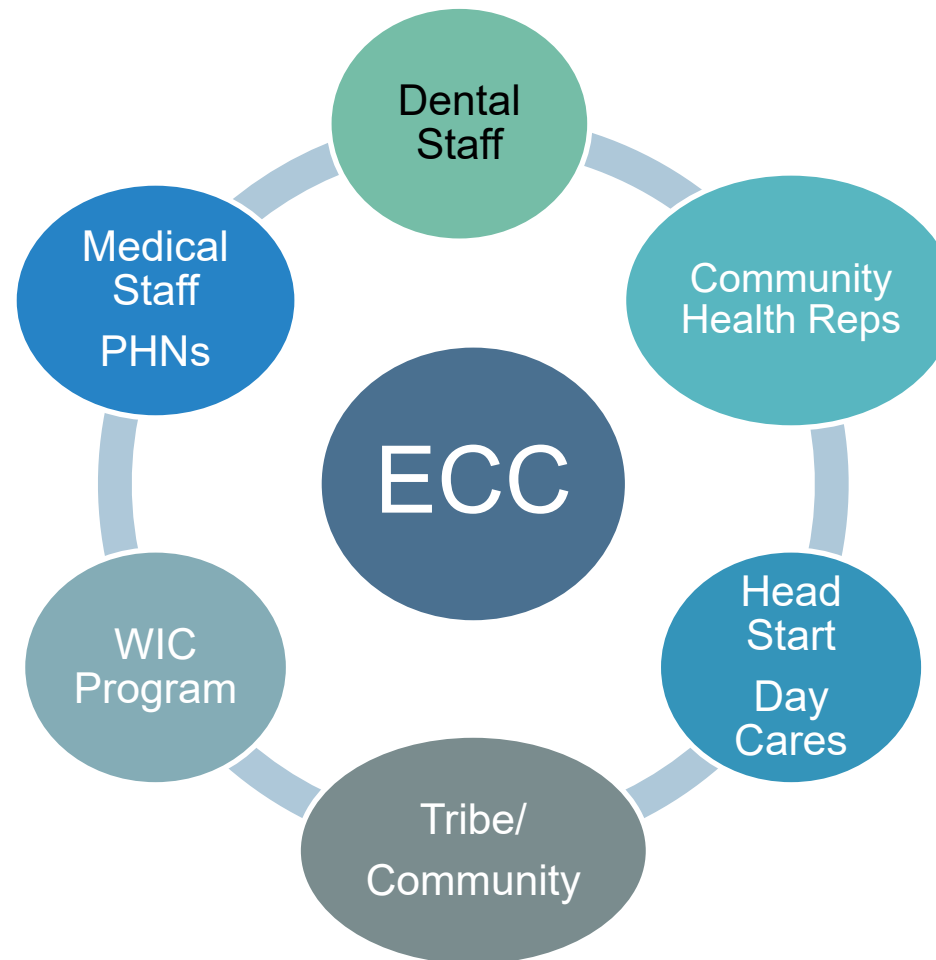


IHS Early Childhood Caries Collaborative (2009-2017) Why?

- Delayed speech development
- Poorer nutrition
- Missed school or Head Start days
- Low self-esteem
- Pain & Infection



Step 1: Define ECC as a HEALTH problem



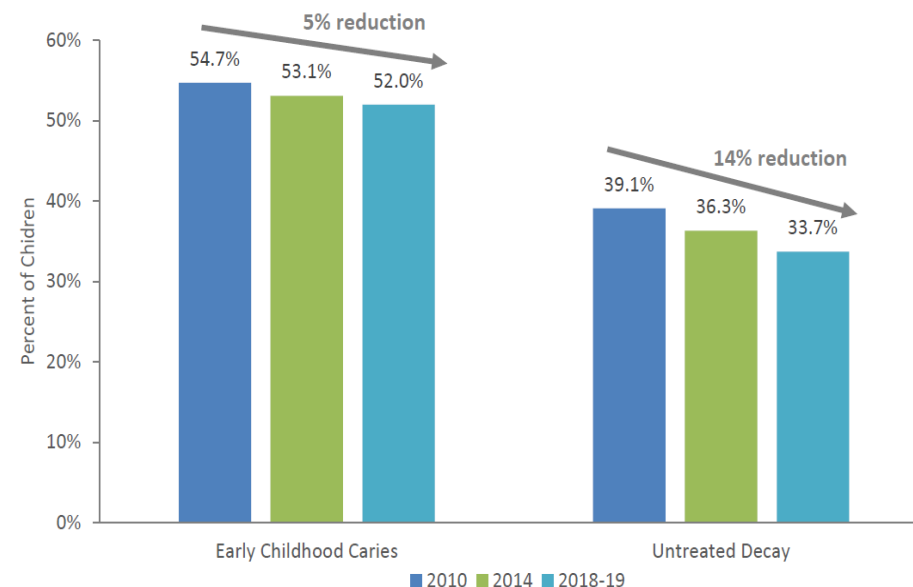
Step 2: Engage Non-Dental Partners



Step 3: Promote FV by Medical Providers & Promote Referrals to Dental

- Access to care, 1-5 year-olds
 - 22% increase
 - **14% were referrals from outside the health system**
- Dental sealants, 1-5 year-olds
 - 48% increase
- Fluoride varnish applications
 - 115% increase, including
 - **335% increase among non-dental**
 - **(227% increase among 1-2 year-olds)**
- Interim therapeutic restorations, 1-5 year-olds
 - 232% increase

Figure 1. Prevalence of early childhood caries and untreated decay in AI/AN children 1-5 years of age at the 53 service units that participated in the 2010, 2014 and 2018-19 IHS oral health surveys



Phipps KR, Ricks TL, Mork NP, and Lozon TL. The oral health of American Indian and Alaska Native children aged 1-5 years: results of the 2018-19 IHS oral health survey. Indian Health Service data brief. Rockville, MD: Indian Health Service. 2019. Available at www.ihs.gov/doh

Depression Screenings in a Dental Setting

Why?

- Data: An estimated 10 million people in the U.S. suffer from undiagnosed depression.
 - <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5769115/>
- U.S. Preventive Services Task Force Recommendation:

Population	Recommendation	Grade
General adult population, including pregnant and postpartum women	The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.	B There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.
Adolescents aged 12 to 18 years	The USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years.	B

- <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/depression-in-adults-screening>
- <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/screening-depression-suicide-risk-children-adolescents>

Depression Screenings in a Dental Setting

Why?

- Adults with depression report both brushing and flossing their teeth less often than those without depression.
- Adults with poor mental health (including depression) are more likely to have one or more unmet oral health need and are less likely to seek care for these needs than those with better mental health.
- Depression is linked to higher levels of dental caries (decay).
- Scores on measures of depression are higher in individuals with a temporomandibular disorder (TMD)—that is, chronic pain in the face and jaw—compared to those without a TMD.
 - <https://www.carequest.org/resource-library/how-depression-linked-oral-health#:~:text=Adults%20with%20depression%20report%20both,those%20with%20better%20mental%20health.>

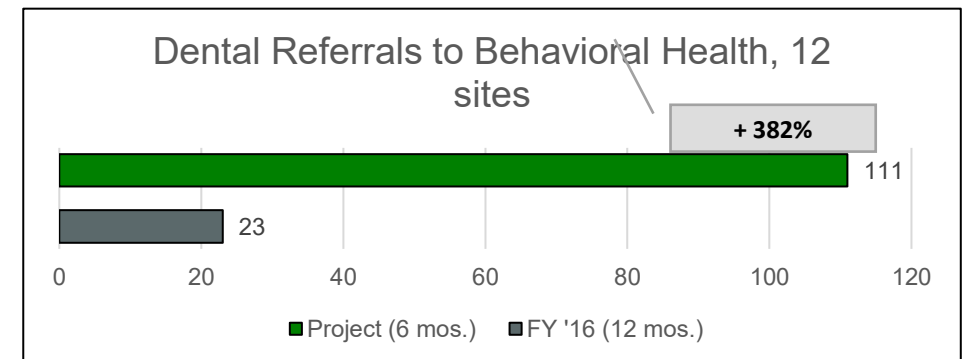
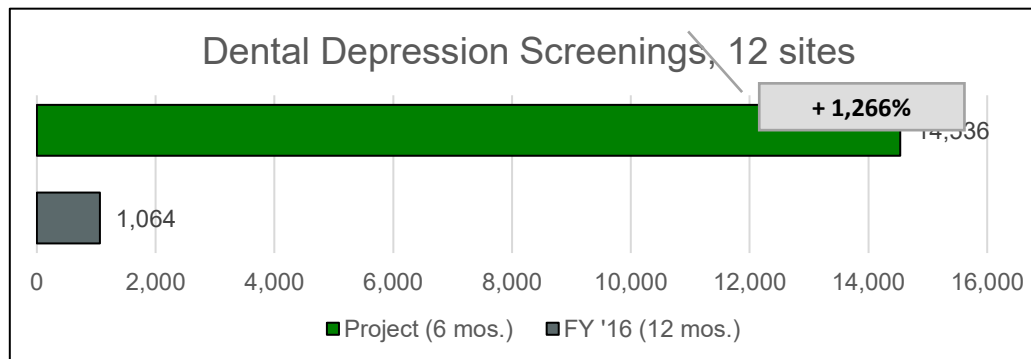
Depression Screenings in a Dental Setting

Outcomes

The IHS Division of Oral Health recommends that IHS, Tribal, and Urban dental programs screen all patients ≥ 12 years for depression at least once annually using the scored PHQ-2 form.

- Frequency: Annually
- Ages: 12 years and over
- Form: PHQ-2 Scored, Adult & Adolescent versions
- Referral: When the patient has a score of 3 or higher overall

In the past 2 weeks, have you?	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

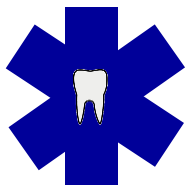


Triaging and Treating Dental Conditions in the Emergency Department (2023)

1. Improve the recognition of specific dental conditions of patients presenting to IHS and tribal emergency departments (EDs).
2. Increase timely referrals from EDs to IHS and tribal dental programs.
3. Through recognition and triage of patients with dental conditions, promote antibiotic stewardship and reduce opioid prescriptions in the ED for dental conditions.
4. Enhance skills of ED medical providers in administering local anesthesia for patients presenting with dental pain.

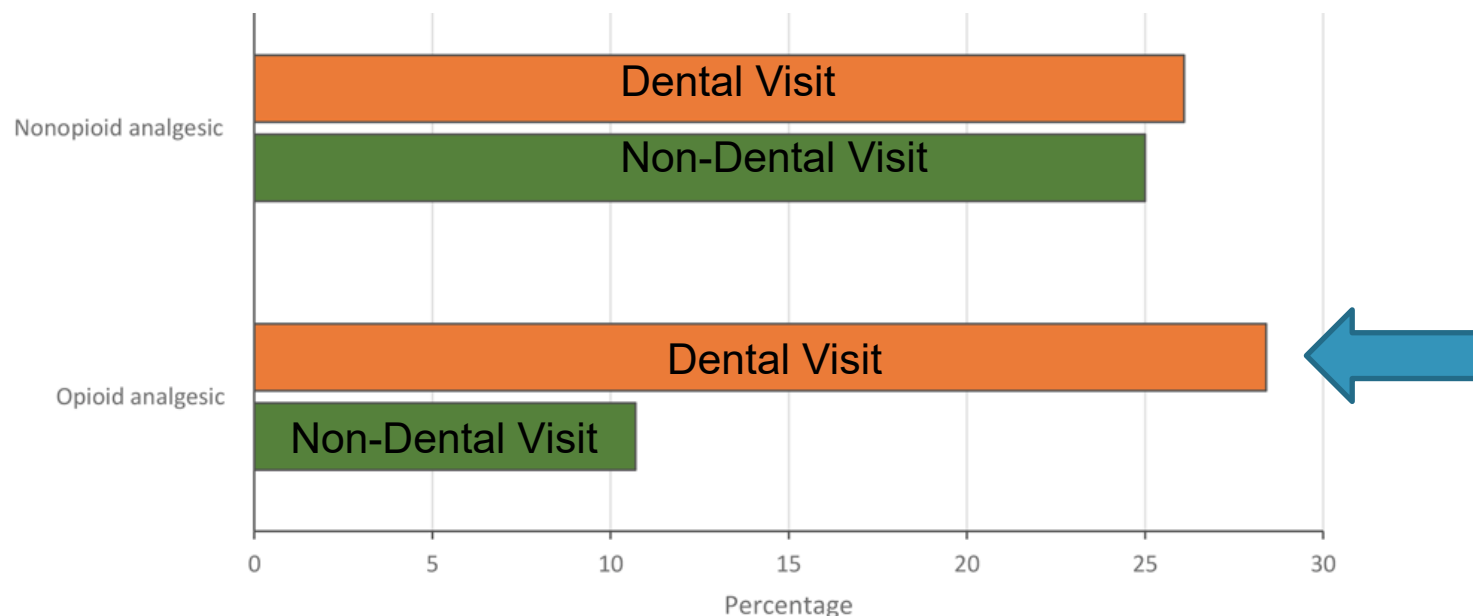


Collaboration with Wisconsin State Dental Director & IHS Emergency Medicine Chief Clinical Consultant



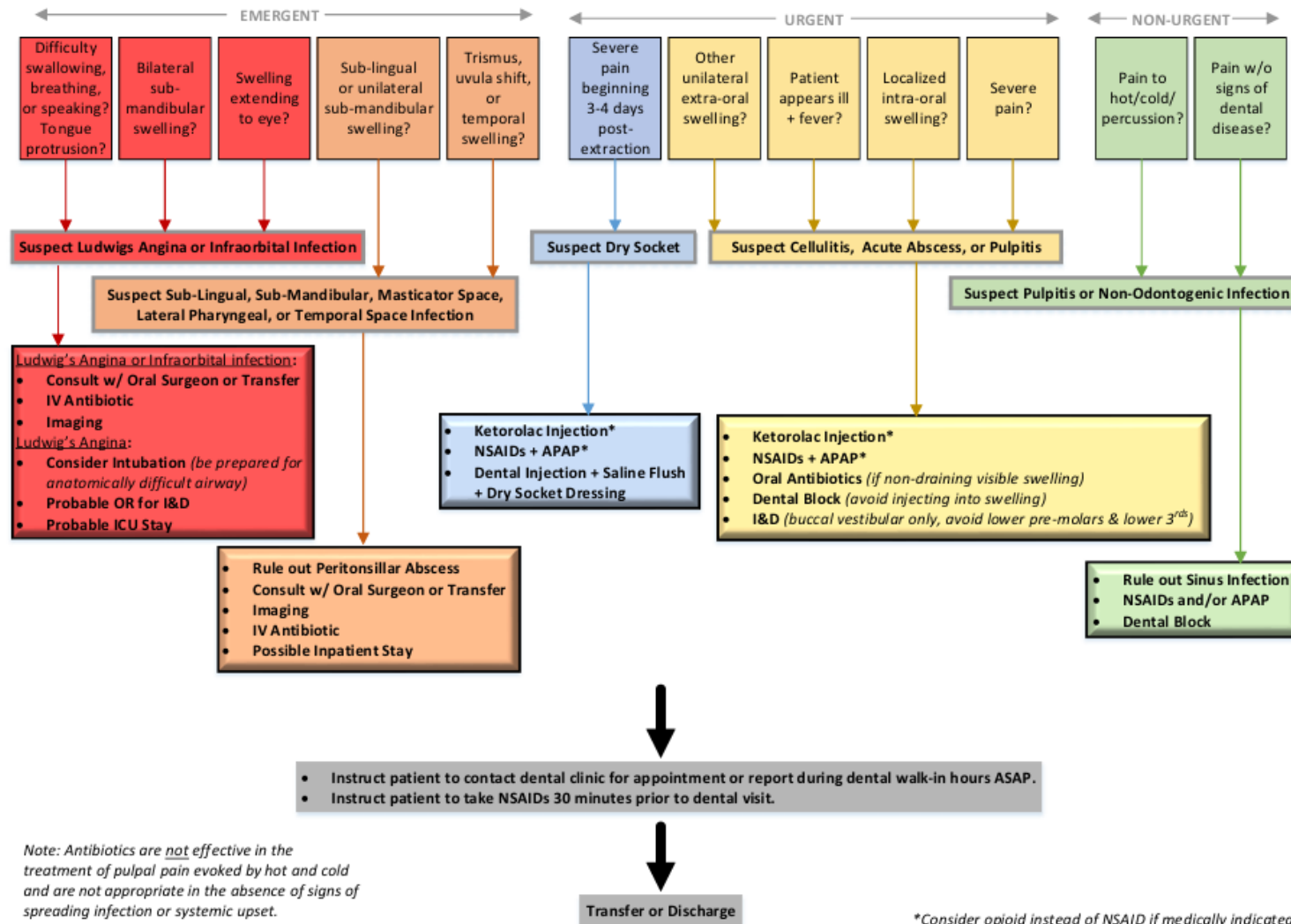
Triaging and Treating Dental Conditions in the Emergency Department – Why?

- Dental ED visits had a significantly higher likelihood than non-dental visits of receiving an opioid prescription than no analgesic after controlling for demographic and clinical characteristics, insurance status, pain scores, and other covariates.



Triaging and Treating Dental Conditions in the Emergency Department

Indian Health Service Acute Dental Pain ED Protocols (for non-trauma tooth-related pain)



Triaging and Treating Dental Conditions in the Emergency Department (2023-2024)

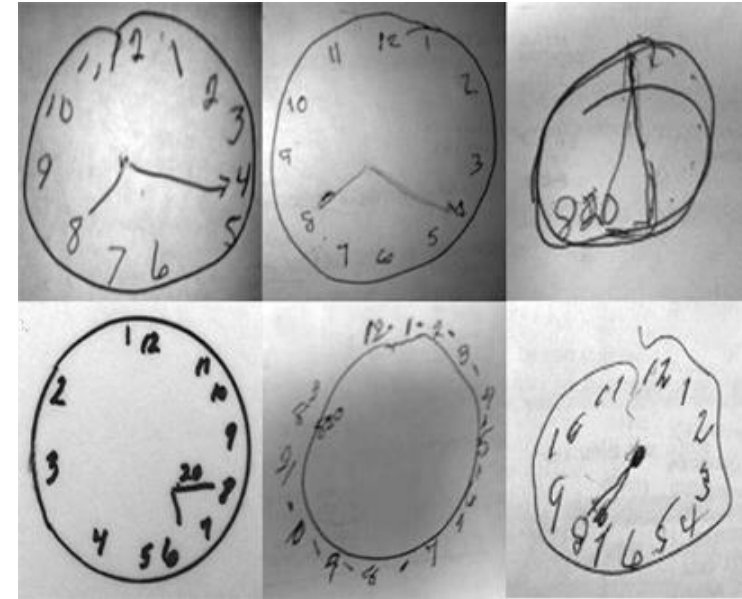
- 2024 Initiative Participants
 - 3 IHS EDs (1 ED previously participated in 2023 initiative)
- Overall (2023-2024) Results
 - 52 ED staff received training through the Power Point
 - 41 ED staff receiving hands-on training
- While the project period has ended, training at these seven sites will continue to be conducted as there continues to be staff turnover

[https://www.ihs.gov/doh/documents/FY%202024%20IHS%20Oral%20HPDP%20Funding%20Initiative%20\(Multi-Directional%20Integration\).pdf](https://www.ihs.gov/doh/documents/FY%202024%20IHS%20Oral%20HPDP%20Funding%20Initiative%20(Multi-Directional%20Integration).pdf)



Implementation of Cognitive Screenings in a Dental Setting (2023)

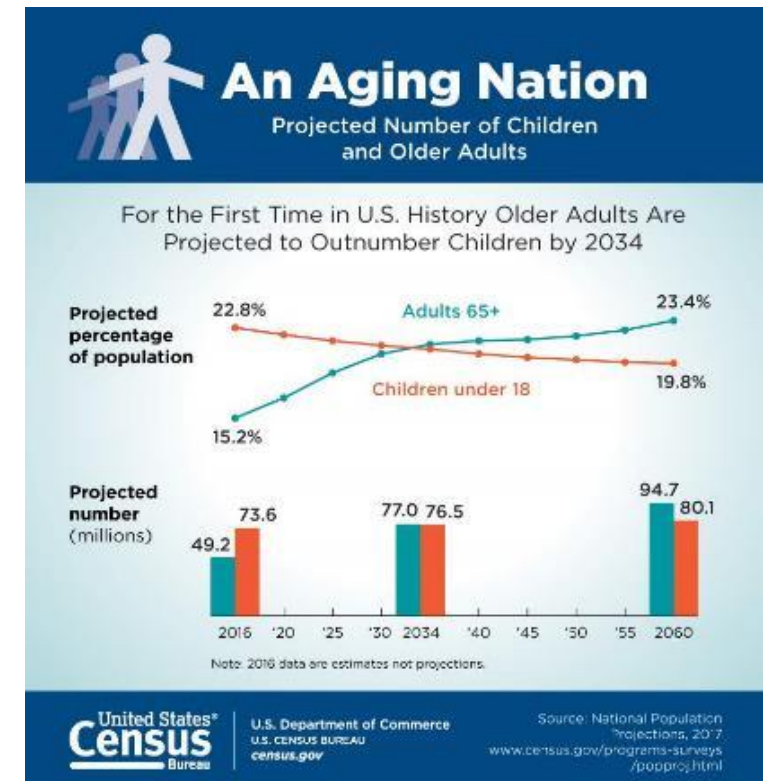
- Premise: After the successful depression screening project in 2016-17, and upon request of the Division of Clinical and Community Services (DCCS), we explored the possibility of doing cognitive screenings in dental settings with 5 programs.
- This project should help establish a dental-behavioral health referral network as well.
- Assessment takes about 5 minutes.



Implementation of Cognitive Screenings in a Dental Setting (2023) – Why?

- Estimates vary, but experts report more than 7 million people ages 65 or older had dementia in 2020. If current demographic and health trends continue, more than 9 million Americans could have dementia by 2030 and nearly 12 million by 2040.

- <https://www.prb.org/resources/fact-sheet-u-s-dementia-trends>



Implementation of Cognitive Screenings in a Dental Setting (2023) – Why?

- U.S. Preventive Services Task Force:

Population	Recommendation	<u>Grade</u>
Older adults	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for cognitive impairment in older adults.	I

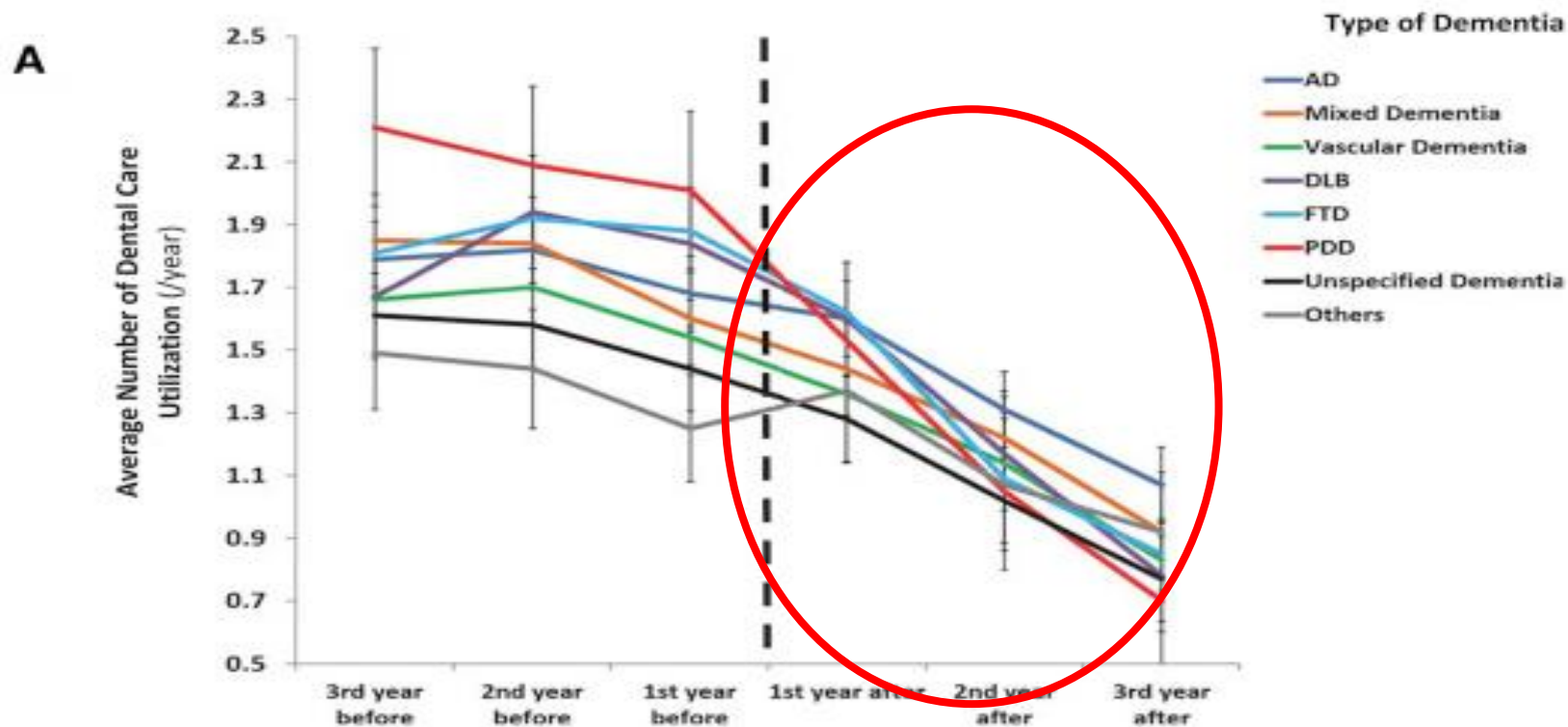
<https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cognitive-impairment-in-older-adults-screening>

- Alzheimer's Association: Individuals with memory concerns or other cognitive complaints should be evaluated for cognitive impairment. Non-memory triggers include personality change, depression, deterioration of chronic disease without explanation, and falls or balance issues.

<https://www.alz.org/professionals/health-systems-medical-professionals/cognitive-assessment>

Implementation of Cognitive Screenings in a Dental Setting (2023) – Why?

- Dental care utilization in patients with dementia



Fereshtehnejad, S. M., Garcia-Ptacek, S., Religa, D., Holmer, J., Buhlin, K., Eriksdotter, M., & Sandborgh-Englund, G. (2018). Dental care utilization in patients with different types of dementia: A longitudinal nationwide study of 58,037 individuals. *Alzheimer's & Dementia*, 14(1), 10-19.

Implementation of Cognitive Screenings in a Dental Setting

Mini-Cog™

Instructions for Administration & Scoring

ID: _____ Date: _____

Step 1: Three Word Registration

Look directly at person and say, "Please listen carefully. I am going to say three words that I want you to repeat back to me now and try to remember. The words are [select a list of words from the versions below]. Please say them for me now." If the person is unable to repeat the words after three attempts, move on to Step 2 (clock drawing).

The following and other word lists have been used in one or more clinical studies.^{1,9} For repeated administrations, use of an alternative word list is recommended.

Version 1	Version 2	Version 3	Version 4	Version 5	Version 6
Banana	Leader	Village	River	Captain	Daughter
Sunrise	Season	Kitchen	Nation	Garden	Heaven
Chair	Table	Baby	Finger	Picture	Mountain

Step 2: Clock Drawing

Say: "Next, I want you to draw a clock for me. First, put in all of the numbers where they go." When that is completed, say: "Now, set the hands to 10 past 11."

Use preprinted circle (see next page) for this exercise. Repeat instructions as needed as this is not a memory test. Move to Step 3 if the clock is not complete within three minutes.

Step 3: Three Word Recall

Ask the person to recall the three words you stated in Step 1. Say: "What were the three words I asked you to remember?" Record the word list version number and the person's answers below.

Word List Version: _____ Person's Answers: _____

Scoring

Word Recall: _____ (0-3 points)	1 point for each word spontaneously recalled without cueing.
Clock Draw: _____ (0 or 2 points)	Normal clock = 2 points. A normal clock has all numbers placed in the correct sequence and approximately correct position (e.g., 12, 3, 6 and 9 are in anchor positions) with no missing or duplicate numbers. Hands are pointing to the 11 and 2 (11:10). Hand length is not scored. Inability or refusal to draw a clock (abnormal) = 0 points.
Total Score: _____ (0-5 points)	Total score = Word Recall score + Clock Draw score. A cut point of <3 on the Mini-Cog™ has been validated for dementia screening, but many individuals with clinically meaningful cognitive impairment will score higher. When greater sensitivity is desired, a cut point of <4 is recommended as it may indicate a need for further evaluation of cognitive status.

Implementation of Cognitive Screenings in a Dental Setting

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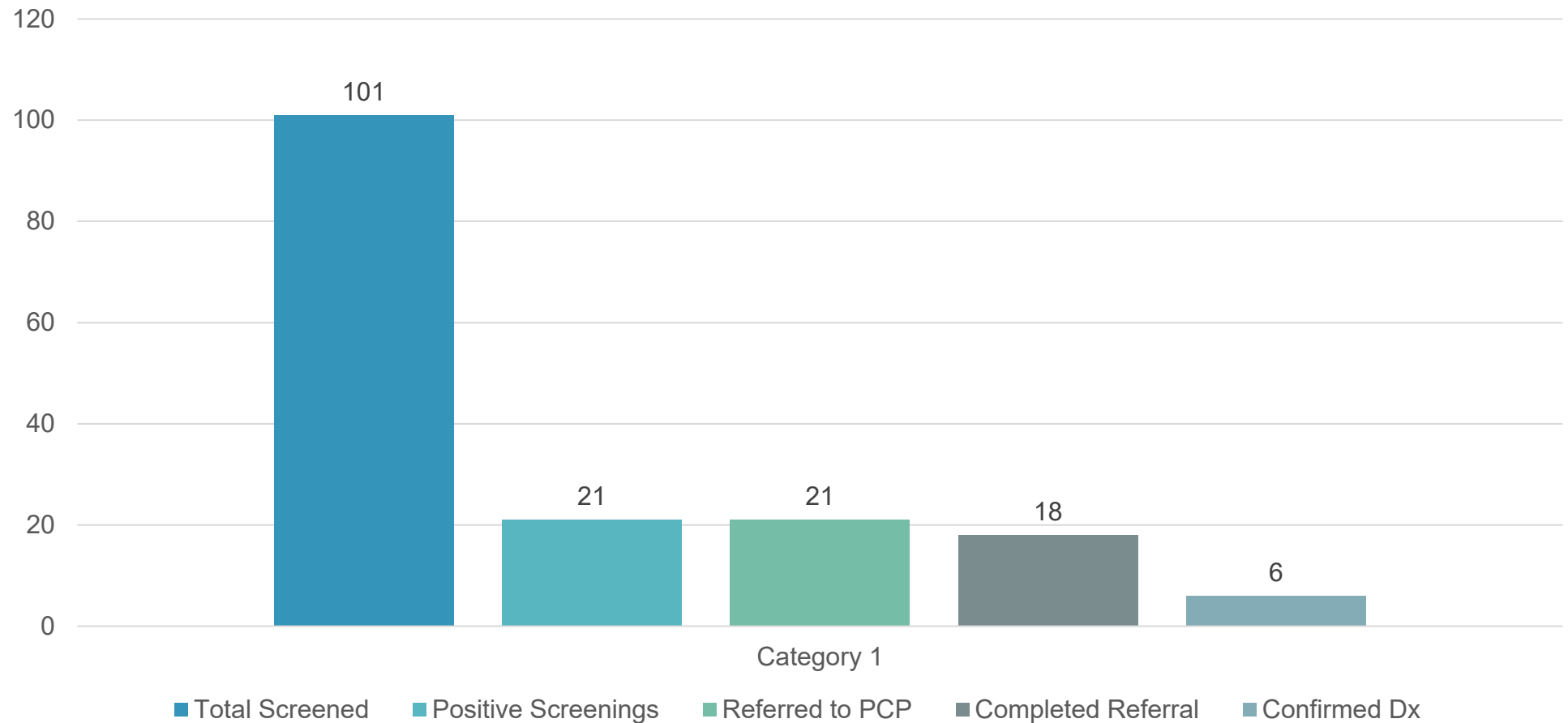
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Implementation of Cognitive Screenings in a Dental Setting (2023) – Outcomes

Cognitive Screening Pilot Project – 5 sites, January-June 2023

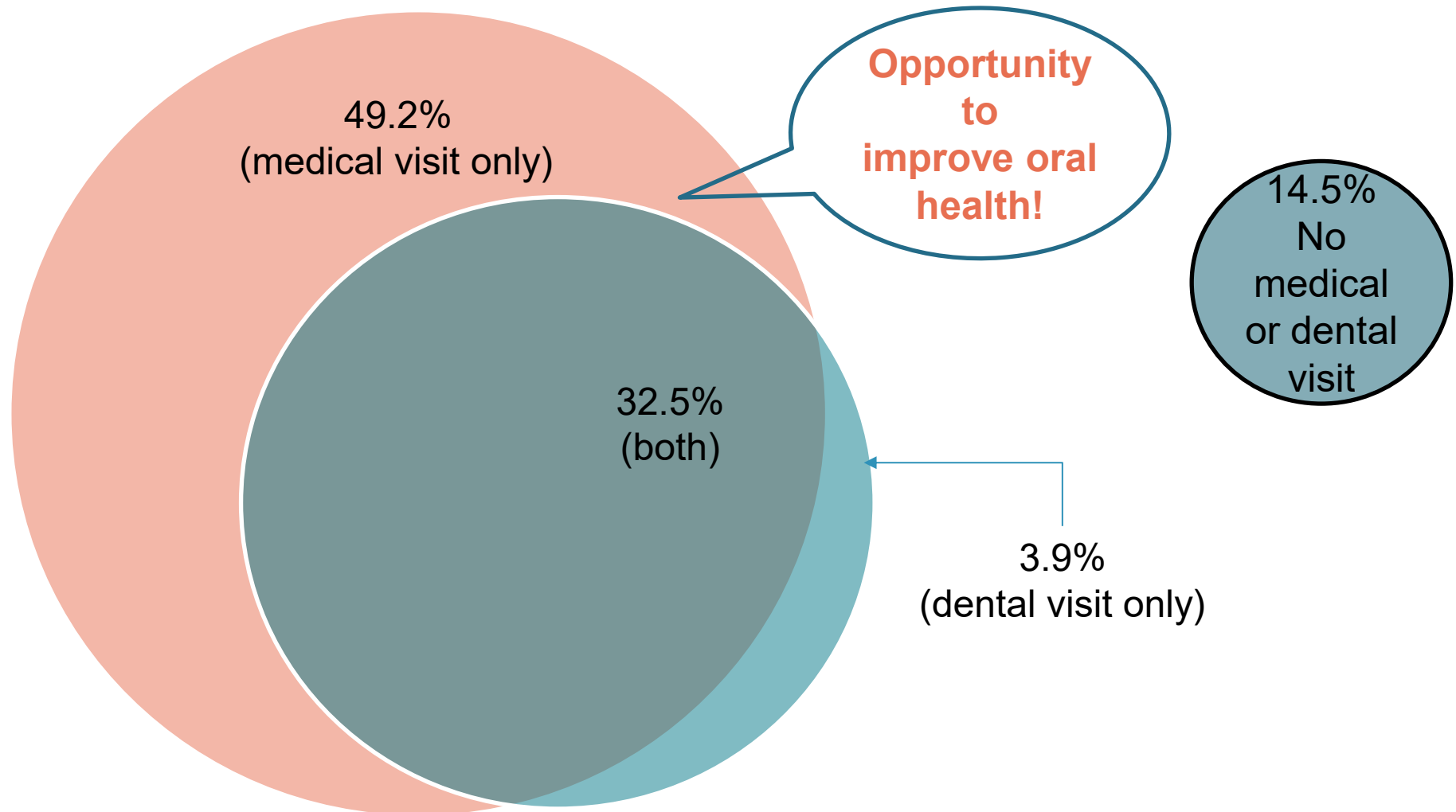


Medical-Led Application of Silver Diamine Fluoride (2021-2022)

- Goals:
 - Teach medical providers how to apply silver diamine fluoride in AI/AN children 1 to 5 years of age to arrest development of existing caries
 - Promote early referral of AI/AN children from medical to dental

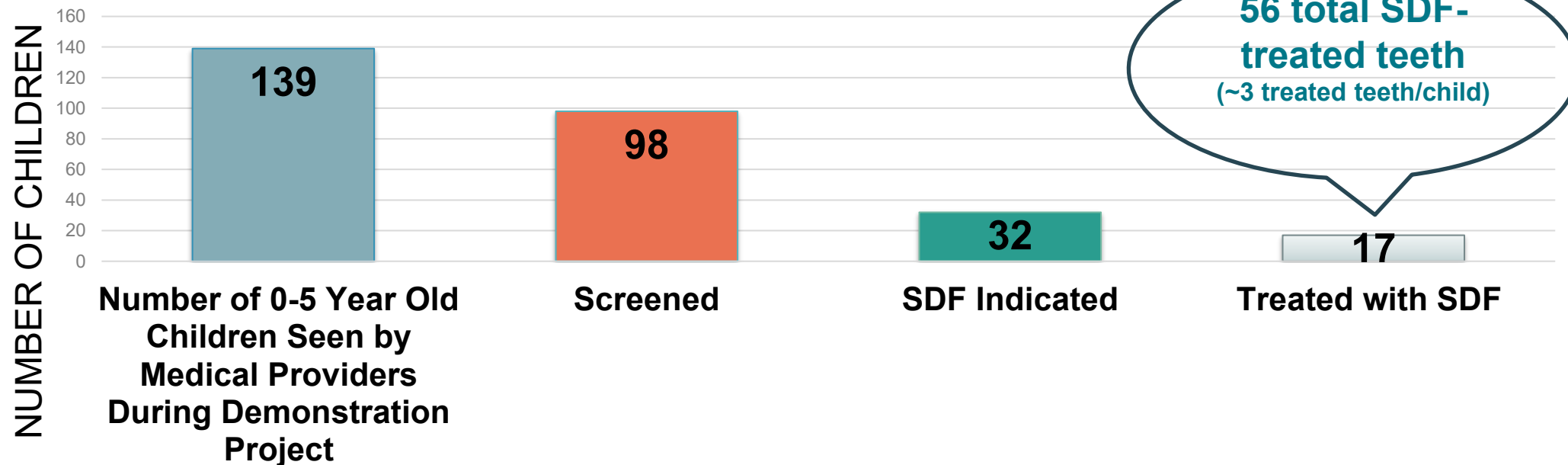


Medical-Led Application of Silver Diamine Fluoride –Why? (0-5 year old AI/AN children)



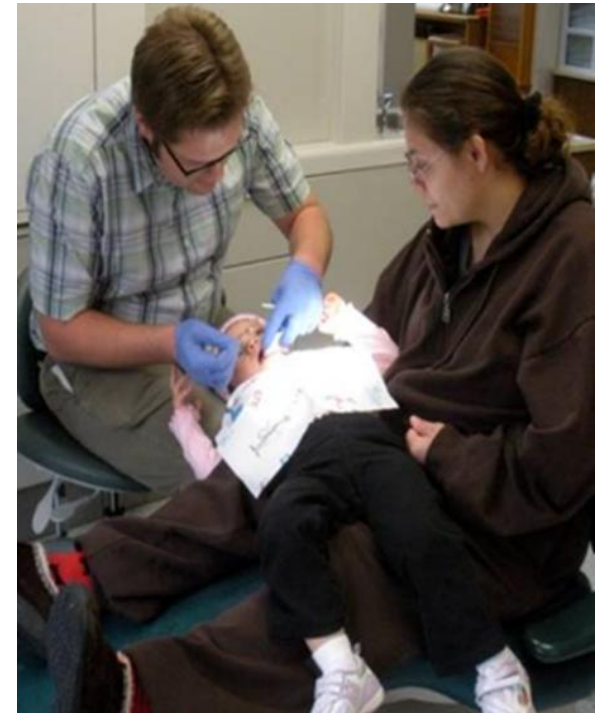
IHS Oral Health Screenings by Medical Providers

Children Screened By Medical Department (2 clinics)



Referral to Dental Clinic

- Dental visit after medical screening?
 - 76% - No dental encounter
 - 18% - Dental encounter
 - 6% - Scheduled for dental appointment





Medical Provider's Perspective

- I tried different ways of laying the kids down and holding their heads still but **no one way worked well with the furniture I have.**
- + My assistant **getting the stuff ready and handing it to me from that cart worked well.**
- **Most** of who I see in that age group are parents trying to get their kids into **head start or preschool so they are required to see the dentist** and have forms that need to be filled out by the dentist.
- I would recommend that a clinic that might start a new program try it out like we did first and see what the demand tends to be before advertising that they have it available permanently.

Dental Provider's Perspective

- A patient referral system between Medical and Dental was created in the Electronic Health Record (EHR) charting system.
- A **different subset of Native American children** ages 1-5 years were accessed by having a SDF program carried out by medical providers.
- **Medical providers need more awareness of oral disease** allowing them to make appropriate referrals to the dental department.
- The participating medical provider separated from the service unit, creating a **medical staffing shortage**.





IHS Lessons Learned from IHS Collaborations

- **Short and/or easy assessments are easily adopted**
 - Depression Screenings (on medical history or separate form)
 - Hypertension Screenings at the exam appointment
 - Cognitive Assessments (3-5 minutes, sparingly performed)
 - HPV Screenings in adolescents
- **Some screenings are too difficult**
 - Diabetes Screenings (fasting)
 - Immunization Screenings (too many vaccinations to try to remember)
 - SDF (7 minutes out of a 15-minute appointment)
- **Medical really has to take the lead on some of these:**
 - Immunization Screenings
 - SDF
 - Oral Health Screenings
 - Fluoride Varnish
 - Diabetes

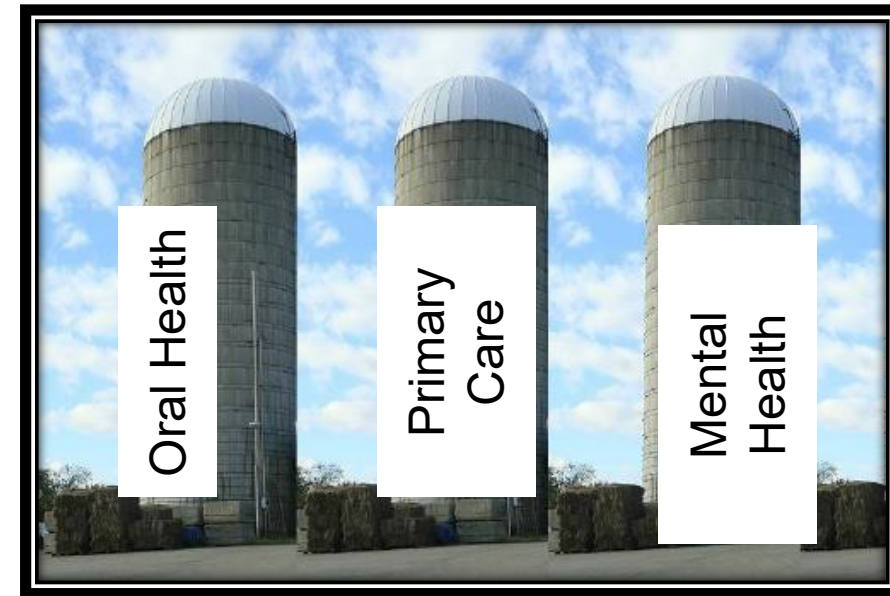
IHS Lessons Learned: Ingredients for Successful Integrated Care

- Co-location
- Local champions
- Teamwork/training
- Providers see benefit of integration
- EHR-EDR integration
- Communication, communication, communication
- Revenue generation
- Convenient for patients
- Efficient – finding “flow”



IHS Lessons Learned: ~~Barriers~~ Opportunities for an Integrated Model

- **Behaviors**
 - Dentist (and Hygienist) Perceptions & Acceptance of integrated care
 - Provider Time (e.g. 51st task!)
 - Medical/Behavioral Health Provider Acceptance
 - Patient Acceptance
- **Reimbursement Potential**
 - Coding (ADA CDT or CPT)
- **Scope of Practice**
 - Malpractice Concerns
 - State Practice Acts & Definition of “Dentistry”
- **Infrastructure**
 - Medical/Behavioral Health Referral Link & Communications
 - Dentist (and Hygienist) Training
 - Clinical Laboratory Improvement Amendments (CLIA)

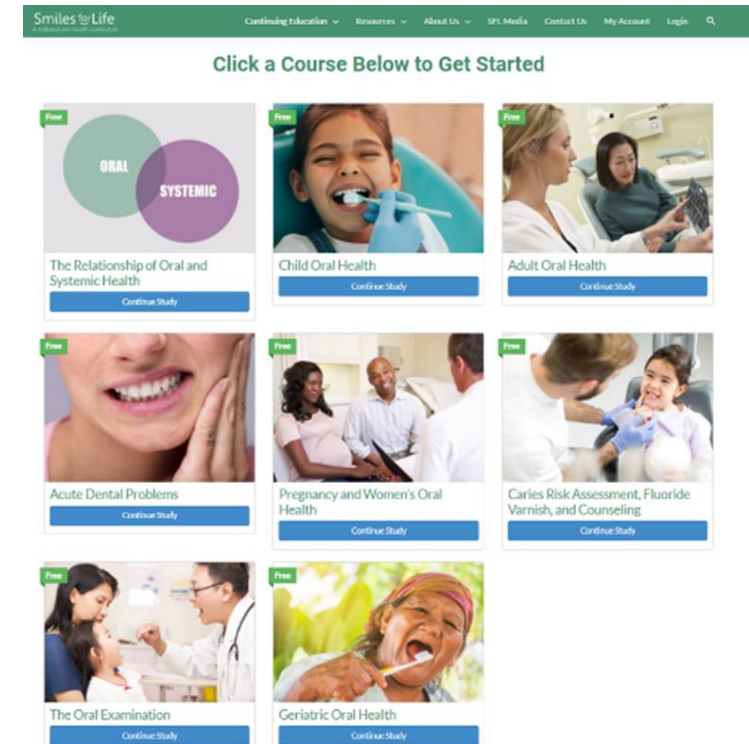


Future of Integrated Care



Example: Education Systems

- Education System
 - Participate in medical-dental integration during school
 - Graduates see value in integrated care
- Continuing Medical/Dental Education Opportunities



Example: Smiles for Life – free oral health training for medical staff.

<https://www.smilesforlifeoralhealth.org/all-courses/>

Example: Incentivized Fee Schedule

CMS highlights medical-dental integration in 2026 Medicare Physician Fee Schedule

Physicians incentivized to take oral health training, refer to dentists



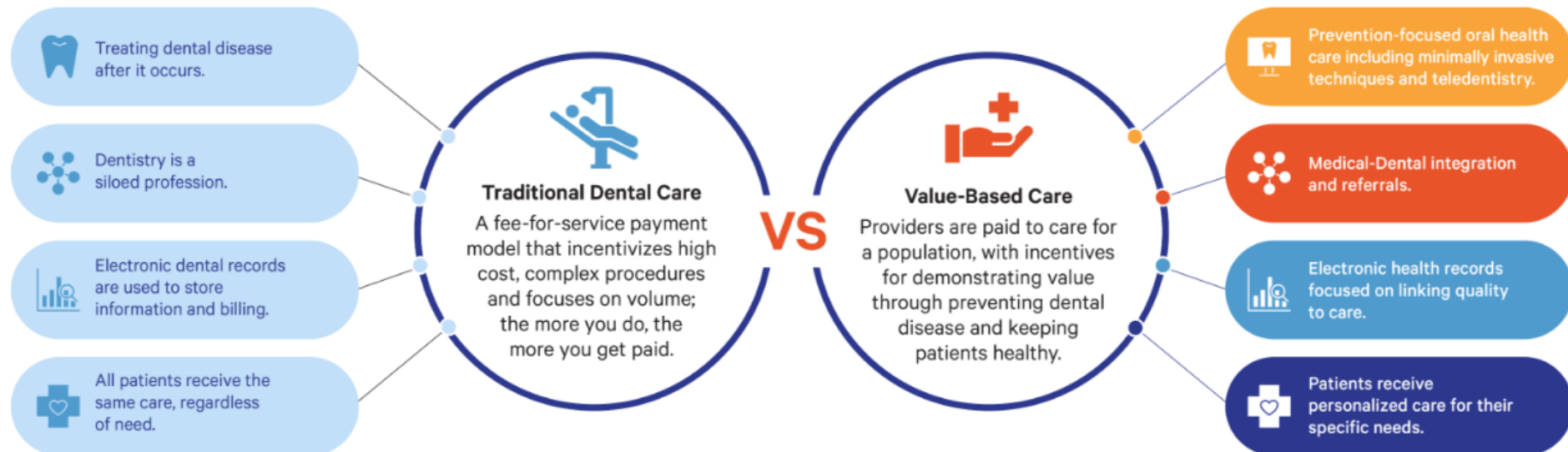
- To qualify, Medicare-participating physicians **must complete training through Smiles for Life**, a free online curriculum that includes “The Oral Examination” course and implement a referral process, contact local dental providers and assess their capacity.
- **Must take at least one step to integrate oral health into their practice**, such as creating a dental referral network, adding oral health questions to patient intake forms, performing intraoral screenings or referring patients without a dental home.

Value-Based Care

Improving the Patient Care Experience

For more than two centuries dentists have practiced in a fee-for-service (FFS) reimbursement environment. Workflow, care delivery, business plan, staffing, documentation, health information technology, scheduling billing, goals, productivity, policies and procedures, and communication have all been designed and implemented around a care and financing model that emphasizes volume over value.

The transition to value-based care (VBC) has the potential to change each of those areas in a significant way.



Division of Oral Health Key Contacts

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 - (240) 393-7282
- IHS Dental Portal (data briefs, initiatives)
 - <https://www.ihs.gov/doh>
- IHS Recruitment Page (job opportunities)
 - <https://www.ihs.gov/dentistry>





QUESTIONS