Bureau of Primary Health Care (BPHC)
Advancing Oral and Primary Health Care Integration to Support Diabetes Prevention and Management

November 29, 2018
1:00pm-2:00pm ET

Coordinator: Please continue to stand by for today's conference. We will begin in approximately two minutes. Please continue to stand by. Thank you.

Welcome and thank you all for standing by. All participants will be in a listen only mode for the rest of the call today. The call is being recorded. If you have any objections, you can disconnect at this time. You may begin, ma'am**.**

Vy Nguyen: Thank you. My name is Vy Nguyen . I want to thank everyone for joining us today. I am hear from the Office of Quality Improvement . The webinar today is Advancing Oral and Primary Health Care Integration to Support Diabetes Prevention and Management Webinar . We have a great lineup of speakers today. Before we get started I wanted to run through a few logistical items. The PowerPoint for the presentation today is available on the lower left side by download. We also hope to have time dedicated at the end of the session to answer questions from the speakers, so feel free to type your questions into the chat box at any time throughout the session and we will try to get to them at the end. This session will also be recorded and we will let you know when it is available.

Let's start with the learning objectives, to understand the Bureau's mission, strategic goals and priorities to advance oral health and primary care integration to support diabetes prevention management. To understand the connection between oral health and diabetes. To explore different integrated models and activities and health

centers and community oral health programs targeting diabetes and oral health. And to learn one example of a collaborative oral health and diabetes integration project.

I like to start off with the health center program mission . It serves as the foundation for all of our activities, to improve the health of the nation's underserved communities and vulnerable populations by assuring access to comprehensive culture he competent quality primary health care services. We have three strategic goals through that mission to help advance our work towards the integration and advancement of oral health and overall health. They are, to increase access to care, advance quality and impact, and optimize operations. In 2017, HRSA initiated the diabetes quality improvement initiative. It includes three goals to improve diabetes treatment and management, increase diabetes prevention efforts, and reduce health disparities. The root of these efforts them from what we know about the impact of diabetes on our health center patients with complications including heart attacks, stroke, kidney disease, blindness, nerve damage and Terry O'Donnell disease which is considered the sixth complication of diabetes. This highlights the importance of coordinated and comprehensive care for our health center patients. In 2017, 2.4 million health center patients were diagnosed with either type I or type II diabetes, this is higher than the national average of those who have diabetes, which is 9%. On top of that one third of these patients have poor control of their diabetes. This shows an opportunity for a collaborative effort between oral health and primary care teams to address diabetes within our health center population. I am glad to see so many of you that have joined us today. With that, I want to transition over to our speakers.

Our first speaker is Dr. Pam Allweiss, an endocrinologist with the CDC division of diabetes translation. She is work there since 1999. She's working on dentistry initiatives, the CDC national health work site program and the CDC emergency preparedness program. She completed her program at the Cedars-Sinai Center. She received a Masters in science and public health while completing a residency in preventive medicine and occupational health at the University of Kentucky. She has been in private practice and served on the faculty of the University of Kentucky medical school.

Pam Allweiss: Thank you. I am very glad to be here. I will try to give you a perspective from decision point of use. Also my husband is a dentist. It's very important to teach people between the direction of diabetes and oral health problems. As you mentioned, the mouth and body connection is what we consider the sixth complication of diabetes. You talked about cardiovascular disease, etc., but it is underdiagnosed, especially from physicians. We notice that periodontal problems can complicate the management of diabetes, and uncontrolled diabetes may aggravate periodontal disease . My message is that working together, the medical and dental care providers can make a difference in a patient's overall health and well-being. I'm going to go over very briefly some of the periodontal diseases , very briefly about them and I will show you some examples of resources and research that shows the attitudes that primary care providers may have that perhaps you can educate the more about this bidirectional relationship. We always have to talk about the evidence. I wanted to give you two examples of resources. You can download the slides. These can show you the evidence about diabetes and oral health issues, because we have to start with evidence. Those are resources for you. We know that periodontal diseases are very common , we talk about tooth loss, dental caries, etc.. Many primary care physicians think it is a cavity but for a person with diabetes it may not be just another cavity. I was at a talk where a dentist set that if we put that problem on the foot, a physician would notice it immediately, so we have a big educational issue here. We know that gum disease is more problem -- is more common in people with diabetes. Young adults with diabetes have about twice the risk of those without. We've also seen uncontrolled diabetes. People are three times more likely to have severe oral problems. We look at smokers and about one third of them with severe periodontal disease have a loss of attachment to the gums as well. We come to the conclusion, which came first, the chicken or the egg? It is bidirectional. Periodontal is associated with diabetes and vice versa. I will show you some disease studies. There is an altered host response. We see alterations in connective tissue. There can be some genetic predisposition as well. I wanted to go over some of the evidence. We look at the prevalence of periodontal disease with

people in type I diabetes we see between the age group of 19-32, 39% have periodontal disease. We know that the evidence is there. This is a study done with the Pima Indians. and they also correlated periodontal disease with ischemic heart disease and diabetic no prophecy. They rarely make the connection to periodontal and a person with diabetes may be a risk factor for these devastating complications. So as I say, we have to educate folks on that. This is another slide showing the periodontal infection with those with diabetes can be problematic for overt nephropathy. Now, what are some of the barriers to oral health and diabetes management? People with diabetes don't even know it can affect their oral health. People with diabetes are less likely to visit in a den -- to visit with a dentist in the last 12 months. The main reason, they didn't think they needed to. About 50%-80% of people with diabetes believe that there dentist already knew that they had diabetes. Many healthcare providers feel it isn't their responsibility, it is someone else's. 81% never ask patients if they have been diagnosed with periodontal disease . Most of them said they never received training about periodontal disease in medical school. And many felt it was somebody else's responsibility to even talk about it. Over 20% said they never refer patients to dentists. So as I said, a big educational opportunity. There was another study looking at diabetes education in South Carolina and many had not learned about oral health in their training. Some did advise patients on some aspects of oral health. Another study looked at nurse practitioners and 23% screened patients for oral health problems but again, the training may not have been there. People are trying to correct this. The American Association of diabetes educators are trying to develop programs on oral health and diabetes as well. These are some of the dental management things that oral health folks need to consider. The nephropathy, hypertension, heart disease . Do these patients also smoke? Are they pregnant? Do they have gestational diabetes? You need to look at medications. You certainly need to realize healing can be slower with people with controlled diabetes. These are some of the general considerations. You want to look at what kind of infection the person has. You want to really really encourage team care. Interprofessional relationships are very, very report -- very very important. Referrals are also very important. You could have the patient bring the meter to your office. Check the blood glucose before the procedure. Some

offices may have glucose meters in the office, but it is something to consider. Most patients know how to do glucose monitoring. From the dental management perspective it is an opportunity for diagnosis and education. It isn't just a cavity when you see oral health changes, it's an opportunity to diagnose diabetes or prediabetes in people with risk factors. If you know you have a patient with prediabetes or risk factors, you know it could be a risk factor for other family members as well. Another study looked at the number of missing teeth and the percentage of deep pocket periodontal pockets . These measures are very effective in identifying the majority of undiagnosed hyperglycemia. Some offices have A1c testing devices in their offices as well. We have tried to address this. In the past there was a national diet -- diabetes diagnosis program. There was a project called PPOD. often a PPOD provider is the first person to see someone with diabetes. PPOD providers can embrace a team approach to diabetes care. They can reinforce the importance of annual screening and healthy habits. They can educate people about diabetes and prediabetes and encourage self-management. Later on we will hear more specific examples about that in the webinar. A PPOD provider may be the first person to see a person having a new problem. It is an opportunity to say, have you been diagnosed? Some people may say they had borderline diabetes before, no such thing, but this is a chance for education. We came up with a toolkit for providers and consumers as well. The toolkit has a chapter for each of the specialties. Each chapter was written by a specialist for others. Dental professionals wrote the dental chapter not for dentist but for primary care folks, pharmacist, up, stress, etc. we are trying to do general education questions and we are trying to encourage collaboration and a team approach. We have resources for patients, we have a patient care checklist. It lists things including oral health, etc. We also have PPOD patient fact sheets. One is called healthy things matter. Here is the link where you can find all of this information. Our goal is to review and identify the best strategies to help you people with diabetes. These are some of the messages we try to get to medical care providers, ask patients if they have a dentist and when was the last time they visited him or her. This can send a message that it is as important as checking your feet or other complications. Medical care providers need to facilitate communication about this particular complication. We would like medical

care providers to discuss the importance of oral health. All people with diabetes should be advised to see a dentist on a regular basis. Medical care providers need to refer patients to a dentist if there is a problem. These are key questions to ask your patient. Do you visit your dental provider at least once a year for a full mouth exam? Do you know how diabetes can affect your mouth and gums? We developed those questions. The bottom line is multiple teams, patients and providers can improve outcomes for people with diabetes. There are resources, the CDC division of diabetes translation, the CDC division of oral health, and other teams. We are encouraging folks to make new friends. How can the state diabetes teams work with the state oral health teams to educate people about diabetes and prediabetes. In summary, periodontal disease can complicate the management of diabetes and uncontrolled diabetes may aggravate periodontal disease . Working together can make a difference in the patient's overall health and well-being. Remember oral conditions may be a complication of diabetes. Thank you so much. I will turn it back over to Vy.

Vy Nguyen: Thank you so much Dr. Allweiss for the relationship between oral health and diabetes.

Now I want to introduce our next speaker. Dr. Susan McKernan, an assistant professor in community dentistry at the University of Iowa College of dentistry and public policy center. She conducts oral health services research. She received her DMD from the University of Florida College of dentistry. She is also a diplomat of the American Board of American public health and an instructor at the University of Iowa graduate program. Dr. Susan McKernan research is on dental care, dental workforce adequacy and implementation of evidence-based services. I would like to handed over to Dr. Susan McKernan now.

Susan McKernan:

Thank you, Vy . I will be talking to you a little bit about some findings from our recent scan looking at oral health and public settings. This project was supported by the CDC. The objective was to identify best practices for medical and dental

integration in public health activities and to identify opportunities to identify oral health and oral health care reform. I would like to identify my colleagues that worked on this project with me, they are listed right here. Let's go back to the two healthy people 2020 objective. It is to increase the proportion of adults who receive preventive interventions in dental offices. They look for tobacco screenings and see station counseling, screenings for oral cancel -- oral cancer and dental visits. Objective D-8 calls for increasing the proportion of people diagnosed with diabetes to have at least and annual dental exam. 5.7% of adults were tested for glycemic control and the 2020 target is to raise that up to 7.5%. A quick look at the methods we use for this environmental scan included primary and secondary data collection. We conducted three separate surveys of state oral health programs, chronic disease programs, along with local health programs. We collected information about current activities that integrated oral health and primary care. We also conducted a series of key informant interviews and obtained additional information about programs. We specifically selected programs that appeared promising but had few published details. As part of our literature review we looked at existing state oral health plans to find out which areas of integration were being addressed by the state oral health programs. Currently, five states directly addressed the topic of diabetes and integration in their state oral health plans. Among these five, there are some excerpts here where Idaho calls for incorporating oral health education along with diabetes self-management education programs. Minnesota is promoting risk assessments among medical and dental providers. And Oregon is calling for reimbursement of dental professionals for chronic disease prevention activities, including diabetes screenings. Among the of -- among the programs we identified we found most activities could be broadly had a gourd -- broadly categorized as one of these. First, blood glucose screenings of adult dental patients. The second category is referring medical patients with diabetes for dental care. Number 3, co-locations of medical and dental services to address the needs of patients with the need of dental services. And integrating medical and dental insurance benefits is the fourth. Often there is overlap. Each category here recognizes that the coordinated management of diabetes and periodontal disease can improve outcomes for both diseases. We will focus on the first three categories for the presentation today. First,

blood glucose screenings of adult dental patients. The purpose is to identify and manage cases of prediabetes or diabetes. This is one area where there are a lot of existing studies. Before dental patients receive blood glucose screenings they are typically prescreened to identify at risk adults to see who would benefit from the screenings. This is a risk assessment test that we saw being used . It is available online for use. The risk scores range from 0-11. a score of 5 or higher indicates a higher risk for diabetes. If they have that score they received the blood who close screenings. I want to point out at least two studies did not find an association between a high risk score and an abnormal blood glucose level. The pilot study in dental settings is done by measuring glucose levels or hemoglobin levels. Those studies were pilot studies in dental settings. These are reports that the majority of dentists are willing to perform finger-stick testing, especially if dentists receive training in how to perform this. The second study, a pilot test found that after training, 100% of dental personal thought finger-stick testing was easy to perform. The approximate cost for screening was $9 and it took 14 minutes and that included time for patient education. It's important to remember that results in these tests are not sufficient for diagnosis and dentists and dental hygienists are not permitted to diagnose diabetes. So they need to refer to primary care physicians to manage the disease and diagnose the disease. There are several studies that look at successful dental screenings and encouraging patients to follow up with their primary care provider. The first study found that they identified 34% of patients with either diabetes or prediabetes and half of them did contact their primary care provider afterwards to notify them of those findings. We see arrange here from about 22% to over 80% of patients following up with a primary care provider. That usually depends on what steps providers are taking to prompt patients into action. We identified several limitations to dental chair side screenings that should be identified for clinics looking to implement screening in the dental setting. There are no clear guidelines or procedures first of all. Secondly there was some hesitancy found about professional organization positions about chair side screenings. Third, if Dennis are reimbursed for chair side screenings there is concern of duplication of provider reimbursement that is required to be completed by a PCP. Time management is always a concern. There were also concerns about scope of practice issues. One

study found high rates of false positives and so the type of device that is used in these programs should be considered carefully. So far talked about the issues related to feasibility and implementation of chair side screenings in dental settings. Most combine those with referrals for primary dental care. This is a bidirectional referral that looks something like this. The dentist or hygienist screen patients and make referrals to primary medical care as necessary. And primary medical care refers patients for dental care. These are a few representative examples that utilize those types of bidirectional referrals for medical and dental management. Several programs were identified and these are described in our published report, but this is just a selection of what we see. One thing we also noted is programs that target diabetes also frequently target other common risk factors including cardiovascular disease, risk assessments, blood pressure assessments, or tobacco cessation services and education. In our interviews, we found several factors were found to facilitate programs utilizing bidirectional referrals, including shared electronic health records would can bring up a prompt to refer a patient to a dental clinic. Physical co-location of medical and dental services allows for warm handoffs where patients can receive help scheduling a follow-up appointment. And finally, expanded oral health training -- or expanded oral health teams can increase oral health center capacities. We listed some that utilize rental health therapists along with community health workers to expand the services for patients with diabetes. This is the final category about activities that we identified and I will only be touching on this briefly. There are a few -- a few programs that provide cost savings by providing dental benefits to members with chronic medical conditions. These are a few of the more prominent examples and I encourage you to look at these and we have more information about this in our report. I will finish up with a few broad recommendations from our project. First, state oral health programs and chronic disease programs can integrate care within their state plans. Professional guidelines and toolkits can improve provider confidence and improve standardization across programs. Programs that want to provide chair side screenings should use a fingerstick test that is certified by the NGSP. and patients should be provided with screening letters that describe the test results. Finally follow-up calls from the dental office can remind patients to seek care and answer questions. I have referenced our environmental scan if you

would like additional information, it is available here. There should be a link that you can click on. Finally, we are very grateful for the input and assistance provided by our colleagues at the following organizations listed on the slide. I would like to close by giving you all my e-mail address if you would like to contact me with any follow-up questions. With that, I will turn the presentation back over to Dr. Vy .

Vy Nguyen: Thank you so much Dr. Susan McKernan for sharing all the work you have done in this area.

Now I will introduce my next speakers, Holly Kingsbury from the Colorado community health network. She provides training and technical assistance on oral health integration to Colorado community health centers. She supports oral health initiatives and partnerships with community health centers and other state oral health partners. Holly has a Masters degree in public health. And Dr. Carol Niforatos began a community health clinic and an inner-city health center in Denver, Colorado. She provides 13 years of service and leadership in underserved areas of Colorado. She currently holds the position of dental director at the Colorado coalition of the homeless in Denver where she has advocated for the dental needs of the homeless. She received her DDS at Northwestern University dental school in Chicago, Illinois. She graduated from the University of Colorado school of dental medicine with the BS in dental hygiene. Since that time she has worked in private practice, teaching. In the last for your she is taught for public health at the coalition for the homeless. With that, I will turn it over to you all.

Holly Kingsbury: Great, thank you Dr. Vy for that introduction. This is Holly for the Colorado community health network. I will give you a background about the project. I will turn it over to Dr. Niforatos so they can tell you about the Colorado coalition for the homeless.

You just heard our introductions. The Colorado Department of Public health and environment were another key role in this. We will talk about that later. This is a quick snapshot of a couple of people on the team. Again, before we get started, we

want to acknowledge our gratitude for the support from the CDC for this project as well as that as the Department of Public Health. To set the framing for this project I want to highlight some of the unique policies and scope of practices information that we have in Colorado that helps facilitate this project . It includes a pretty broad scope for registered dental hygienist, bill providers, Medicaid benefits, point-of-care testing as well as same-day billing for medical, dental and behavioral health. This is a highlight of some of the things that we help -- things that help facilitate our work. As a primary care Association, we gather information about how Colorado community health centers are addressing diabetes or prediabetes by integrating oral health. A lot of what we found in Colorado describes a lot about what was previously described, environmental scans. Many health centers have identified patients with diabetes and pre-diabetes as a target and then referral to a dental clinic. Several are considering the A1c in the dental team daily huddle. Others have integrated dental hygienists into medical clinics to provide the full scope of care for patients with prediabetes and diabetes. What you will hear more today is about doing HbA1c point-of-care testing. As we started to design what we call a diabetes oral health integration package, we look back at some of the work that we at the primary care Association had done around integration. A few years ago, we looked at the existing literature on oral health integration to try and understand why integration was important for them and what concepts were the key framing concepts to moving that forward. We created this oral health integration manual. We will have link for that for you. It identifies these training concepts that help drive our work on this project including engaged leadership, team-based care, patient centered care, data-driven quality improvement, transformative access, and community relationships and partnerships. These all probably sound familiar. We looked at all of the changes that better integrate oral health in primary care for patients with diabetes and prediabetes. This is the DOHI project overview . A couple of quick notes about what Carol and Carol will talk about with the DOHI project. The goal is to develop and test a change package to enhance comprehensive, patient cared centers for prediabetes and diabetes and they will talk more about that.

I wanted to note this practice coaching which supports the work of the coalition. We work with an amazing team of medical and dental status -- dental staff at the coalition here to support the project utilizing the model for improvement. We have a very diverse group of staff involved. With that little bit of background I will turn it over to Carol and Carol to talk about the work at the coalition.

Carol Niforatos: Thank you for the introduction. The Colorado coal addition -- the Colorado coalition for the homeless started back in the 80s. It is now 2018 and we are still going forward. We give assistance to over 15,000 individuals and families each year. We are located in Denver, Colorado. Why this project? 40% of our patients seen at Colorado Coalition for the Homeless dental have an access primary care for any needs and they may not have a medical home. We are unique in that our patients are not required to have a medical provider in the same facility. CCH has a unique approach to homelessness by providing integrated healthcare and affordable housing and strong case management support. This is an image of the largest health center, the lower floors are healthcare and the three upper floors are residential with 10 units of affordable housing. We have several big things -- we have several buildings throughout the Denver Metro area. Implementation at the coalition. Dr. Allweiss and Dr. Susan McKernan talked about this, making friends. And Dr. McKernan looked at the risk assessment that we use and the screening tool. We do HbA1c testing in the clinic and they are uniform throughout medical and dental. Changes to support this implementation. Health information technology was very key to have our systems talking to one another. We were you using diabetes education by training a wide variety of staff on the American Association diabetes of education training website. We wanted to make sure that we had an approved curriculum and that people were getting the message in the same curriculum throughout medical, dental, and management. We also created flows to support this. This will give you a headache if you look at it too closely . It is the debacle -- it is the dental to medical workflow. Dental hygienist or an assistant will administer the risk assessment that Dr. McKernan referenced before and enter it into a digital template. This is for people without a prediabetes diagnosis that came to the dental clinic. If they were given a diagnosis of 5 or higher they received point-of-care

testing. If that was 5 or higher we would make referral to medical via a template and Next General and talking to each other to make sure it doesn't fall through the cracks. This is the questionnaire that we use. This is the digital diabetes questionnaire offered to all patients without that diagnosis. We had great response and great acceptance to that. This is the medical to dental workflow chart. Medical, again, didn't have much of an understanding of dental but did go through the smiles for life curriculum and understood the necessity and bidirectional referral importance. The workflow for the patient was already in flow with the dental hygienist, but this was kind of reinforced and encouraged so that not only do people who had been there a while but anybody new or on boarding could go through the curriculum and understand the workflow.

Carol Niforatos: Our team at the coalition has been working on integration and team-based care for four years. We just received a patient medical center home certification. We were at the top skills of collaborating and coming up with workflows and tracking electronic workflows. That is part of the deliverable for this grant project, to track those referrals . It sounds easy but it was actually a lot of work. We created a core team of stakeholders from all different departments including primary care and dental and a variety of different services. We were able to come up with a complex workflow and supported with electronic features. We actually did not release date, it took almost 1 work -- one year with the templates before we had our first kickoff date which was February 5, 2018. We worked very hard on it but there was minimal impact to time in the actual workflow. We have not reduced our access to care because of this system because we worked so hard and trained the staff with multiple trainings, as needed. We do receive data every month. We continue to meet monthly together. We just brought together these few factors that you see in front of you. We also have a lot more that we look at, but for the purposes of this webinar, we will just be looking at these few items. This is through September, 2018. We provided 544 of the questionnaires that you have seen. As result of the patient response, we administered the point-of-care A1c and provided 114 point-of-care tests at the dental care site. Of those, 21 indicated a need for referral. These 21 were referred through the electronic template, just the way the medical team is

accustomed to doing and the dental team reflected that and sent a trackable referral that went to the patient navigator and to the three suites of primary care and dental staff. A patient that was over 5.7 with the results on the A1c received a primary care appointment the same day. In the event it was a possible because of the patient's schedule, we then followed up with an appointment the next day or whenever the patient navigator was able to coordinate that. We are really excited about the results. We're doing excited about being able to track this . It was a tremendous amount of work. I won't go into too much detail about this slide but there was some administrative work that needed to be done. We had to look at the state scope of practice. We had to add some procedures and policies so the reimbursement would be under state standards. Project successes include the use of the oral health patient navigator, again a unique position across the United States. There are not many. We had staff salary paid through a grant. It made a tremendous difference in our ability to follow up with referrals and bring down the social deterrents of health. The staff training has been at game changer. We had the smiles for life primary care. We had between 20 and 50 hours of education given to 18 staff members, medical, dental, and administrative. We also have a diabetes program manager. The project challenges were multiple. We have and at risk homeless population with very few resources, very little control over their food. We address that by supporting our patient population with evidence-based educational model and working with our peer navigation and mentor staff to assist the patient with healthy choices and understanding more about how they can get control of their A1c . That is part of our goal and part of their goal as well. We were maintaining buy-in from clinical staff. We had a complete change in leadership. Continuing to educate new staff and this was very important. We did have some errors initially and we had to work on training and expertise with that. Our next steps will include expansion to chronic diseases, other chronic diseases. And further education. We had a diabetes LoDo and we show that earlier. These are some resources that you can work with in your clinic or with the people you have influence over. It has been rewarding and satisfying to do this. It changes the conversation at the patient chair for the Dr., dental assisting, and the patient . It is extremely valuable. With that I will turn it back over to Dr. Vy.

Vy Nguyen: Thank you so much. Dr. Niforatos for sharing all of that great work.

Now we have time for questions. If you have a question, please go ahead and type it into the chat box.

Thank you for such an incredibly informative webinar. You could not see me but there was a lot of people nodding their heads in the room as you are each presenting the work that you are doing and the various findings. A question I have is with regard to the referral to your navigators for scheduling of appointments for patients found to have an abnormal hemoglobin A1c in the chair . I was curious as to the timing of their referral to the navigator. Is that happening while the patient is still in the chair, getting the appointment, or is that something that is happening when the patient is done with their visit?

The oral health patient navigator who is pretty key to this is here every day and is directly connected. We try to do a warm hand off immediately if we can. If we cannot, it is generally made within 24 hours of the referral. We try to follow up quickly. Our challenge is that the client or patient may not have a way to be communicated with and so we try to make it as quickly as possible, not only because of communication potential labs but also the sense of urgency. We need to make sure that the patient knows that the providers talk to one another and wants to collaborate care. So a warm hand off is usually how it is done. If not a referral is made within 24 hours.

Do you have a mechanism for tracking whether the patient actually made it to the clinic for that appointment?

We do and we run that. We also print a letter out for the patient if they have outside medical care so that we have a scanned letter in the system and a trackable way to see if they followed up. We try to stay on top of that. For the unreachable patients, sometimes it is difficult but we do make a minimum of three attempts to see if they

have followed up or try to get the care or classes or educational resources to help them get the care that they need.

Thank you.

Another question from the chat box for the Colorado team. Can you share a bit more about what the oral health navigator's role is and what they do day today?

Our oral health patient navigator is responsible for taking care of social determinants of health. In other words, if the patient needs oral surgery from an exterior provider, we do provide a lot of oral surgery here but not quite everything or if the patient needs to go to the University or needs to follow up with Padla while -- with pathology, the navigator is informed. We use a spreadsheet which is accessed by the dental providers. The patient information is put on the spreadsheet and the contact information as well and the navigator will call the patient and assist the patient in getting their needs met in a timely matter. Sometimes we can do a warm hand off. Sometimes we can do it that very day but most of the time we add it to the spreadsheet so the patient navigator can follow up. We also have a patient navigator supporting our pediatric outreach and other outreaches as well. Thank you so much.

Vy Nguyen: Unfortunately, we are close on time and I see other questions in the chat box. What we will do is take those questions and share them with our speakers and get in touch with you all again through the information in the registration for this webinar. Before we go,, I would like to thank all of our presenters, Dr. Allweiss, Dr. McKernan , Holly and Carol and Dr. Niforatos . Thank you for sharing your work around this topic. And I thank you for your support. I'm going to leave you with some additional resources. The website underneath the oral health section is where the webinar recording will be posted under the BPHC . I will also leave you with my contact information for any additional questions. This is also commander branch's information as she is the point of contact for the diabetes workgroup. Also,

before you log off, there is a brief questionnaire. Please fill that out. With that, we will conclude our webinar for today. Have a great rest of your day.

Coordinator:

Thank you. That does conclude today's conference. You may disconnect your lines at this time. And speakers standby for post conference. [Event Concluded]

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