

ORAL HEALTH, MENTAL HEALTH AND SUBSTANCE USE TREATMENT

A Framework for Increased Coordination and Integration



NATIONAL
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EXECUTIVE SUMMARY

The National Council for Mental Wellbeing and Bowling Business Strategies developed this toolkit in partnership with a group of national experts convened to help advance the field of oral health, mental health and substance use treatment coordination and integration.

Why is better coordination and integration of oral, mental health and substance use treatment services important?

- Challenges with oral health,¹ mental health and substance use are exceedingly common in the United States and contribute heavily to the burden of disease in the nation. There are a multitude of bi-directional connections between oral health and behavioral health (mental health and substance use challenges). In other words, having a mental health or substance use challenge such as depression, anxiety or substance use disorder (SUD) can negatively impact one's oral health, and vice versa. Poor oral health can create or exacerbate problems with mental health, self-esteem, cognitive health, substance use and impede social functioning in areas such as employability and school engagement.

Definition of Behavioral Health

“Promotion of mental health, resilience and wellbeing; the treatment of mental and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities.”

Source: Substance Use and Mental Health Services Administration. **Behavioral Health Integration.**

Definition of Oral Health

“A state of being free from mouth and facial pain, oral and throat cancer, oral infection and sores, periodontal (gum) disease, tooth decay, tooth loss, and other diseases and disorders that limit an individual's capacity in biting, chewing, smiling, speaking, and psychosocial wellbeing.”

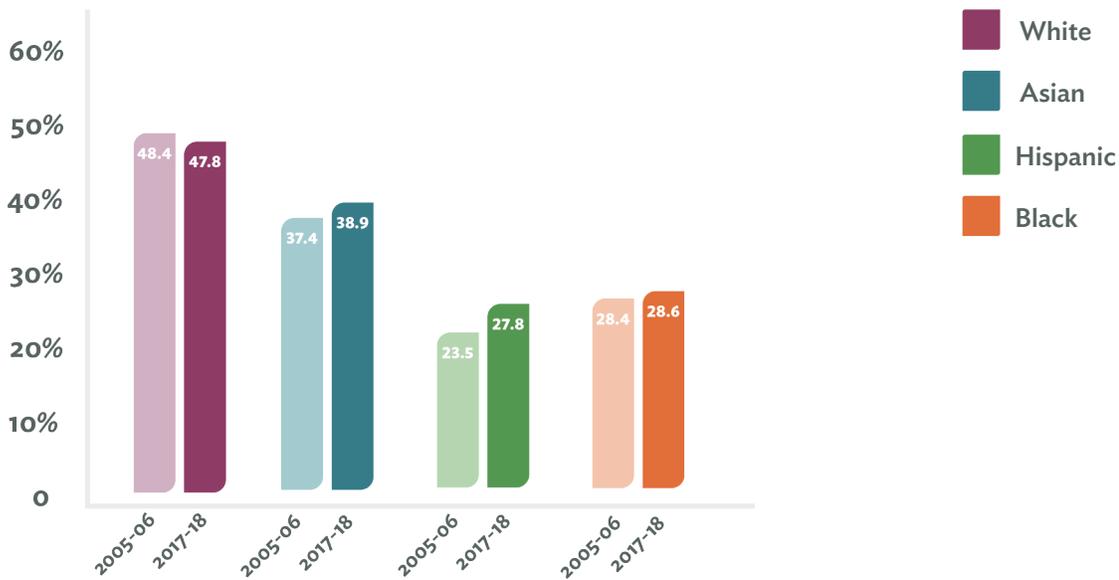
Source: Springer. **A Life Course Health Development Perspective on Oral Health.**

- Untreated oral, mental health and substance use challenges are costly and contribute to health disparities. Oral health, mental health and substance use challenges have historically been undertreated in the United States, often with stark disparities in access to care. According to the most recent data provided by the Substance Abuse and Mental Health Services Administration (SAMHSA), nearly 90% of the 20.4 million Americans with a SUD received no treatment, and more than 55% of the 51.1 million Americans with any mental illness received no treatment. Racial disparities in oral health (dental) care utilization, while declining for children, largely remain for the adult and senior population. In a recent study, toothaches were one of the top causes of avoidable visits to the emergency room, suggesting lack of access to regular oral health care. Emergency rooms are not only an expensive care setting, but are often not fully equipped to treat oral health conditions.



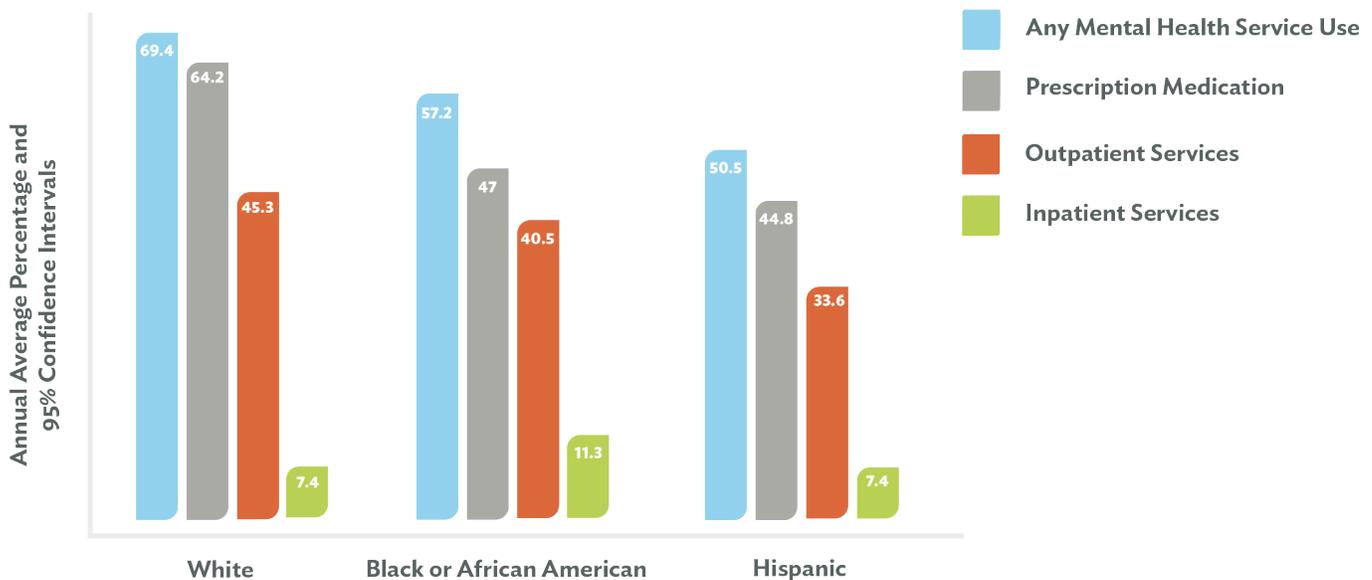
Exhibit A: Selected Examples of Disparities in Access to Care Across Oral, Mental Health and Substance Use Treatment

Figure 1: Percentage with a Dental Visit in the Past Year - Adults



Source: American Dental Association Health Policy Institute. **Dental Care Utilization Among the U.S. Population, by Race and Ethnicity.**

Figure 2: Mental Health Service Use in the Past Year among Adults with Serious Mental Illness, by Race/Ethnicity and Service Type, 2008-2012²⁹



Source: SAMHSA. **Racial/Ethnic Differences in Mental Health Service Use among Adults.**

- More integrated oral and behavioral health services hold promise to improve outcomes. Emerging evidence suggests that more coordinated or integrated oral, mental health and substance use treatment services can increase access to needed care, improve patient outcomes and potentially reduce health care costs. As one example, Project Facilitating a Lifetime of Oral Health Sustainability for Substance Use Disorder Patients and Families (Project FLOSS) found that providing comprehensive oral health care dramatically improved outcomes for patients with SUDs, including longer length-of-stay in treatment, higher rates of employment, higher rates of recovery and lower rates of homelessness. Interprofessional approaches to patient care can also improve clinicians' experience and work-life satisfaction.

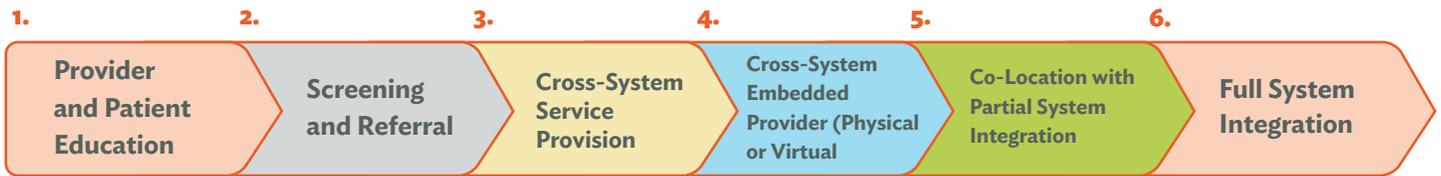
Why is this toolkit needed?

No comprehensive set of resources currently exists to help health organizations that may be interested in more coordination or integration across oral, mental health and substance use treatment services, specifically. This toolkit seeks to help oral health and behavioral health providers and organizations increase coordination and integration by offering practical suggestions, resources, strategies and on-the-ground examples for implementation of new care models across a continuum, ranging from cross-sector provider and patient education to full system integration. It provides innovative examples from leading-edge programs across the country about how to re-engineer traditional care pathways, especially given broader adoption of telehealth.



Lori's Story: "I was a person challenged with substance abuse issues from the time I was 13 years old, until I entered recovery at 39 years old. On July 27, 2009, I again entered the criminal justice system. At that time, I had seven remaining teeth in my mouth and it was not a good place for me mentally in any way. When I did stop using illicit substances, there was a whole world I needed to re-engage in, including attending 12-step meetings, being reunited with my child and getting a job. I had goals and dreams but no teeth in my mouth. When I was able to have my dental health addressed in a full way, many things began to change. I was able to obtain full dentures, that was a gamechanger. Now that I had a full set of teeth, it instilled a greater sense of confidence; my self-esteem shot up. I just graduated with my bachelor's degree from Temple University. I am currently in my second semester of a Master of Social Work program. I am fully involved in my family's life. I am currently employed with The Joy of Living Recovery Program. And I just celebrated 11 years of sobriety."





How should this toolkit be used?

This introductory toolkit contains detailed information for each of the 10 unique models in the coordination and integration framework, including four models tailored to dental providers, four models tailored to mental health and substance use treatment providers and two integrated care models geared toward larger health systems or organizations, such as Federally Qualified Health Centers (FQHCs), Certified Community Behavioral Health Clinics (CCBHCs) or Accountable Care Organizations (ACOs). In the toolkit, each model contains a dedicated section to help guide providers and organizations interested in pilot testing or implementing one of the models, along with the following subsections:

- A general model description.
- Examples of the model in practice.
- Key planning questions.
- Potential funding approaches.
- Potential data monitoring measures.
- A list of tools and resources.
- A “real-world” example or case study from the field.

While this document outlines many new and innovative care model ideas that may feel overwhelming, the continuum structure is designed to enable providers and organizations to start wherever they feel comfortable. In general, the foundational building blocks toward more coordinated and integrated oral, mental health and substance use treatment services include: 1) mental health and substance use treatment professionals incorporate oral health-related questions and screenings into their workflows and ensure there is a referral mechanism in place to connect people to dental care, as needed and 2) oral health professionals incorporate mental health and substance use screenings into their practice and ensure there is a referral mechanism in place to connect people to mental health and substance use treatment, as needed. Integration of oral health care into physical health services such as primary care, pediatrics or maternity, while of vital importance, is considered outside of the scope of this introductory toolkit.



INTRODUCTION

Challenges with oral health, mental health and recovery from substance use are exceedingly common in the United States and contribute heavily to the burden of disease in the nation. In 2019, it was estimated that at least 45.5 million people aged 12 and older suffered from a mental health condition, 10.4 million from a substance use disorder and 9.9 million from both.² These staggering statistics are only expected to worsen due to the COVID-19 pandemic due to, for example, increased rates of unemployment, depression, grief, anxiety, domestic violence and/or substance use. In fact, the Centers for Disease Control and Prevention (CDC) recently reported a surge in overdose deaths coinciding with the pandemic, with the largest number of drug overdoses in a 12-month period ever recorded in the United States.³ Although tooth decay – also known as dental caries or cavities – is largely preventable, it remains the most common chronic disease of children aged 6 to 19 years old.⁴ By age 20, nearly nine out of 10 people have some degree of tooth decay, and nearly half of adults aged 30 or older show signs of gum disease.⁵ Left untreated, poor oral health can affect nearly all aspects of a person’s life, including the ability to work, speak, smile, smell, taste, touch, chew, swallow, sleep and make facial expressions to show feelings and emotions.⁶ In extreme cases, untreated problems with the teeth and mouth can lead to severe infections and even death.

There are a striking number of relationships between oral health and general health. As a recent example, a new study found that periodontitis (gum disease) was associated with worse outcomes from COVID-19 infections, including death, admission to the intensive care unit and need for assisted ventilation.⁷ One possible explanation is ventilator-associated pneumonia, which can arise when bacteria from the mouth get pushed down into the lungs after insertion of a ventilator.⁸ Studies have also found clear associations between oral health and a multitude of other health conditions, including mental health, substance use recovery, birth outcomes, diabetes, stroke and heart disease. The World Health Organization (WHO) acknowledges the depth and breadth of the impact of oral health on overall health and wellbeing in its definition of oral health which is “a state of being free from mouth and facial pain, oral and throat cancer, oral infection and sores, periodontal (gum) disease, tooth decay, tooth loss and other diseases and disorders that limit an individual’s capacity in biting, chewing, smiling, speaking and psychosocial wellbeing.”⁹ A paper published in October 2020 by The National Council for Mental Wellbeing – “Environmental Scan of Oral Health and Behavioral Health Integration Models” – explored the specific associations between oral health, mental health and substance use challenges and highlighted the bi-directional nature of the relationship between these conditions.¹⁰ In other words, having a mental health condition such as depression or anxiety or a SUD can negatively impact one’s oral health, and vice versa; poor oral health can create or exacerbate problems with mental health, cognitive health and/or substance use. Exhibit B outlines select relationships across oral and behavioral health.



Exhibit B: Relationship Between Oral Health, Mental Health and Substance Use Challenges – Selected Examples ^a

Mental Health Impact on Oral Health	Substance Use Disorder Impact on Oral Health
<ul style="list-style-type: none"> ■ Anxiety. Teeth grinding (or bruxism) is associated with anxiety.^{11,12} ■ Bipolar and obsessive-compulsive disorder. Patients with bipolar disorder or obsessive-compulsive disorder can be overzealous with brushing, flossing and mouth washing.¹³ ■ Depression. Patients with depression have higher levels of dental caries, partly due to poor oral hygiene resulting from self-neglect and partly from dry mouth related to antidepressants.¹⁴ ■ Eating disorders. Patients with eating disorders, in particular patients with self-induced vomiting, suffer from tooth erosion.¹⁵ ■ Trauma. Individuals with significant trauma histories may reject oral health services and/or present with habitual teeth grinding and clenching and associated periodontal, abfraction (tooth tissue loss) and occlusal wear (tooth attrition) problems.¹⁶ ■ Medications for mental health. Xerostomia, or dry mouth, is a common side-effect of medications used to treat mental health disorders, such as antidepressants, anti-anxiety and antipsychotics.^{17,18,19} 	<ul style="list-style-type: none"> ■ Cannabis. Use of cannabis (hashish and marijuana) can lead to increased risk of oral cancer, dry mouth and periodontitis.²⁰ ■ Cocaine. Cocaine snorting is associated with nasal septum perforation, while crack cocaine smoking produces burns and sores on the lips, face and inside of the mouth.^{21,22} ■ Methamphetamine. Use of methamphetamine is associated with bruxism, excessive tooth wear, xerostomia and rampant caries. ■ Opioids. Use of opioids is associated with tooth loss, tooth extractions and generalized decay.²³ ■ Medications for substance use disorders. Medications used to help treat SUDs (e.g., buprenorphine, methadone) can result in tooth decay/dry mouth.²⁴
Oral Health Impact on Mental and Cognitive Health	Oral Health Impact on Substance Use Disorders
<ul style="list-style-type: none"> ■ Cognitive functioning. Physical inflammation from periodontitis may be a risk factor in exacerbating cognitive issues, including cognitive decline.^{25,26} ■ Dental phobia. A significant number of individuals experience anxiety about dental visits; some cases lead to phobia.²⁷ Dental treatment has also been identified as a trigger for memories of traumatic events.²⁸ ■ Quality of life. Poor oral health can negatively impact an individual’s employment, school and relationships. ■ Self-esteem. Oral health issues like tooth loss and tooth decay produce significant negative effect on an individual’s self-esteem and quality of life.²⁹ ■ Vital functioning. Poor oral health can impair functional abilities such as eating, breathing, swallowing and chewing, which can in turn impact social functioning and mental health.^{30,31} 	<ul style="list-style-type: none"> ■ Oral pain. Oral pain can exacerbate factors that lead to substance use (in part to help alleviate pain) or impede substance use recovery.³² ■ Opioid prescribing patterns. Oral health providers have been among the top prescribers of opioids in recent years.³³ ■ Use of emergency rooms. Individuals seeking care for oral health problems in emergency rooms are often prescribed pain medications rather than receiving complete oral care.³⁴

^aTable Note: This table provides selected examples of the relationship between oral health, mental health and substance use challenges. It emphasizes direct relationships, often physiological, between selected mental health and substance use challenges and oral health. There are many indirect effects and social risk factors associated with mental health and substance use challenges that can negatively impact oral health that are not listed in the table. These can include, among other things, neglected oral hygiene, malnutrition, high-sugar diets, homelessness and sporadic dental appointment patterns.³⁵

WHY INCREASE COORDINATION OR INTEGRATION OF ORAL HEALTH AND BEHAVIORAL HEALTH?

The first reason to consider more coordination or integration across oral health with behavioral health services is simply that there are so many connections between these conditions.

Second, oral health, mental health and substance use challenges have historically been underdiagnosed and undertreated in specific populations, often with stark disparities in access to care. According to the most recent data provided by SAMHSA, nearly 90% of the 20.4 million Americans with substance use challenges received no treatment,³⁶ and more than 55% of the 51.1 million Americans with any mental health challenges received no treatment. Racial disparities in dental care utilization, while declining for children, largely remain for the adult and senior population.³⁷ Toothaches were one of the top causes of avoidable visits to the emergency room, suggesting lack of access to regular dental care.³⁸ Emergency room settings are not only expensive, but are often not fully equipped to treat dental conditions. Availability of oral health, mental health and substance use treatment services has been further imperiled by the COVID-19 pandemic, as offices have limited in-person service provision and in some cases, shut their doors completely because of lost revenue. Integrated care models can be an option to help increase access to essential oral health, mental health and substance use treatment services.³⁹ The movement toward broader adoption of teledentistry because of COVID-19 also presents opportunities to re-engineer traditional care pathways toward more integrated care models, including those focused on both treatment of existing disease, as well as oral health promotion and disease prevention.⁴⁰

Third, many states and payers are adopting value-based payment approaches, shifting from traditional volume-based, fee-for-service payments to those tied more directly to cost and quality of care provided. Systems of care that are more coordinated and integrated hold promise to not only increase access to needed care, but also to improve outcomes and potentially reduce costs.

Fourth, interprofessional approaches to patient care can improve clinicians' experience and work-life satisfaction. Project FLOSS found that providing oral health care dramatically improved substance use treatment outcomes and dental providers felt enhanced satisfaction knowing their work could dramatically alter patients' lives. In short, better coordination and integration across oral health, mental health and substance use treatment services could help drive progress toward the quadruple aim for the U.S. health care system: lower costs, better outcomes, improved clinician experience and improved patient experience.



Kelli Beaumont's Story: An Expanded Practice Dental Hygienist Embedded in a Behavioral

Health Clinic. "With access to an expanded practice dental hygienist on site [at the behavioral health clinic] this gives the patients a chance to get dental care they might have not received elsewhere. The dental pain they endure and state of the mouths that I see in this population is shocking. The physical pain of the deterioration of the teeth with multiple cavities and with the appearance of their smiles has a total effect on how they see and feel about themselves.

Being able to connect with a dental hygienist on site at the behavioral health clinic gives hope to this population of a future with a healthy smile without decay. The most gratifying part of working in a behavioral health setting with dental services is that my patients are so appreciative of the dental care they have received. I believe that dignity and respect is needed for this population regardless of the overall state of their oral health. Access to dental care is key to building better overall mental and physical health for the communities that we live in."

Kelli Beaumont (top left) with a patient from Options for Southern Oregon.

While available evidence regarding the impact of increased coordination and integration specifically for oral health, mental health and substance use treatment services is limited, emerging evidence suggests this is a very effective yet underdeveloped approach to care. A few examples are listed here:

- Project FLOSS demonstrated that comprehensive dental care dramatically improved outcomes for patients with SUDs related to length-of-stay in treatment, higher rates of employment, higher rates of recovery and lower rates of homelessness.⁴¹ Dental students who helped treat patients with substance use disorders through this initiative also appreciated seeing how their work dramatically altered patients' lives.⁴²
- From September 2016 to April 2017, 12 Indian Health Service and Tribal dental programs participated in a demonstration project to assess the viability of conducting depression screenings in a dental setting. Over this six-month project, Indian Health Services increased dental depression screenings by 1,266% (from 1,046 to 14,563 over six months) and increased dental referrals to mental health and substance use treatment services by 382% (23 to 111) at the 12 pilot sites.
- In Massachusetts, five community health centers are participating in the Oral Health Substance Use Disorder Learning Network, an initiative implemented by the Massachusetts League of Community Health Centers. Each of the participating health centers aim to increase SUD screening among dental patients and refer to mental health and substance use treatment services when appropriate. From September 2020 through February 2021, these five health centers screened a total of 5,957 patients for SUDs. Two health centers tracked the number of patients who screened positive for a total of 158 patients and three health centers tracked the number of brief interventions or motivational interviews conducted for a total of 65 patients. The five participating health centers also referred a total of 27 patients for SUD treatment.



“The Researchers believe that providing complete oral care as part of treating the whole patient is critical to resurrecting self-esteem and restoring important body functions as an essential first step on the path to recovery from drug use.”

– **Glen Hanson, DDS, PhD, Dentistry Today**, “*Oral Healthcare Improves Substance Abuse Treatment.*”

HOW TO USE THIS INTRODUCTORY TOOLKIT

Despite the multitude of connections between oral health, mental health and substance use challenges, there are currently no universally agreed upon models or frameworks to better coordination or integration across these health systems. This introductory toolkit is designed to serve as a guide for providers, organizations, health systems, states and payers interested in better coordination or integration specifically across these two systems of care. Along this continuum of practice change, the strategy should align with available resources, existing staff and physical infrastructure – such as office building(s), provider equipment, electronic health records – and the ultimate goals for more coordinated or integrated oral health, mental health and substance use treatment systems.

This introductory toolkit is targeted toward health care providers and organizations, specifically oral health, mental health and substance use treatment services. It contains a coordination and integration framework with 10 unique models outlined across a continuum ranging from more basic strategies (e.g., provider education) to more sophisticated models (e.g., full integration). It outlines separate approaches for behavioral health and oral health providers and organizations, where applicable, and is designed to illustrate care models that could be implemented across a range of provider organizations, including independent mental health and substance use treatment clinics, independent dental practitioners and larger organizations such as FQHCs, CCBHCs and ACOs. **Each model contains a more detailed description that includes a general model description, examples of the model in practice, key planning questions, potential funding approaches, potential data monitoring measures, a list of tools and resources and a “real-world” example or case study from the field.**

The care models outlined in the framework include some services that may not currently be billable to insurance; however, these strategies could potentially be feasible in certain value-based payment arrangements or potentially covered by funds from external organizations, such as foundation or government grants. In other cases, potential billing codes are listed for reference, but providers should check with state and local regulations and health insurance partners to confirm which services are billable in their locations. While this document outlines many new and innovative care model ideas that may feel overwhelming, the continuum structure is designed to enable providers and organizations to start wherever they feel comfortable. In general, when working toward more coordinated and integrated care models, the same guidance applies

regardless of how large or sophisticated your practice is, or what health conditions you are managing: make referrals when you see a health problem outside of your scope of practice.

Given the magnitude of disparities in access to and utilization of oral health, mental health and substance use treatment services across different racial and ethnic groups, providers are also encouraged to assess the potential impact of any new policies, programs or procedures on different populations prior to implementation. The Racial Equity Impact Assessment tool developed by Race Forward could be used to help providers examine how different racial and ethnic groups may be affected by a proposed action or program.

Integration of oral health care into physical health services such as primary care, pediatrics or maternity, while of vital importance, is considered outside of the scope of this toolkit. This topic has been covered in many other resources and toolkits, which can be referenced as needed as part of a more comprehensive integration strategy that includes oral health, mental wellbeing and physical health.



INTEGRATION STRATEGIES FOR ORAL HEALTH AND BEHAVIORAL HEALTH PROVIDERS

The full coordination and integration framework for oral and mental health and substance use treatment providers and organizations is depicted in Figure 3. It includes 10 unique models – four models unique to oral health providers and four unique to mental health and substance use treatment providers and organizations (provider education, screening and referral, cross-system service provision and cross-system embedded provider) and two models are geared toward larger provider organizations, such as FQHCs, CCBHCs or ACOs. We view Models 1 through 4 in this framework as strategies for better “coordination” across oral and behavioral health, which may rearrange certain roles and tasks but largely maintains the same underlying separation of mental health and substance use treatment services and dental systems and provider functions. In contrast, we view Models 5 and 6 as strategies for increased “integration,” whereby separate oral and mental health and substance use treatment components are fused into a more holistic system of care, including joint venues for provider collaboration, documentation, negotiation, and feedback on an individual patient’s care.⁴³

Figure 3: Coordination and Integration Framework for Oral and Behavioral Health Providers

	Examples for Oral Health Providers	Examples for Mental Health and Substance Use Treatment Providers
1. Provider and Patient Education	Oral health providers receive training on common mental health and substance use challenges and learn new skills or techniques that could help better treat such patients in a dental office.	Mental health and substance use treatment providers receive training on common oral health issues associated with mental health or substance use challenges, including oral health impacts of medications for treatment, offering patient education as needed and appropriate.
2. Screening and Referral	Oral health providers screen patients for mental health and/or substance use challenges and make referrals to external providers as needed, to address identified needs.	Mental health and substance use treatment providers screen for basic oral health hygiene habits, problems with teeth or mouth and/or dental visit history and make referrals to oral health providers, as needed.
3. Cross-System Service Provision	Oral health providers offer service interventions for certain mental health and substance use challenges, as appropriate, and within scope of practice (e.g., tobacco cessation services).	Mental health and substance use treatment providers offer service interventions for certain oral health needs, as appropriate and within scope of practice (e.g., addressing behaviors that lead to poor oral health outcomes in goal planning).
4. Cross-System Embedded Provider (Physical or Virtual)	A mental health or substance use treatment provider (e.g., a social worker) is embedded within a dental practice or dental teaching clinic to address barriers to care and increase access to needed dental and behavioral health care.	An oral health provider (e.g., a dental hygienist) is embedded within a behavioral health practice to help expand access to needed oral health care. This staff person can provide oral health services onsite within the behavioral health practice, and/or via mobile or teledentistry.
5. Co-Location with Partial System Integration	Oral and mental health and substance use treatment providers located at the same site have some system integration (e.g., shared systems and records, some face-to-face communication).	
6. Full System Integration	Oral health and mental health and substance use treatment providers share a physical office space, use a common electronic health record (or have bi-directional access to patient information contained the EHR/EDR) and co-manage patients as needed using a single patient treatment plan and regular case conferences.	

FOR MENTAL HEALTH AND SUBSTANCE USE TREATMENT PROVIDERS INTERESTED IN INCREASED COORDINATION WITH ORAL HEALTH

Provider and Patient Education Model

General description: Although tooth decay is largely preventable, it affects more than nine in 10 adults and is the most common chronic childhood disease. Individuals with mental health and substance use challenges also tend to have poorer oral health than the general population, including greater and more severe dental caries (tooth decay) and periodontal disease (gum disease), but are less likely to receive dental care. Under this model, mental health and substance use treatment providers receive training on common oral health issues associated with trauma history, mental health or substance use challenges, such as the oral health-related side effects of medications used for addiction treatment (e.g., methadone or buprenorphine) and for mental health (e.g., antidepressants or antipsychotics) and subsequently offer education to patients as needed and appropriate.

Examples in practice: Nontraditional health care workers such as certified peer specialists, peer recovery supports or community health workers learn the basics of good oral health hygiene habits. Clinical psychologists or licensed clinical social workers receive training on dental pain management and strategies to support good oral health hygiene and learn how individuals with trauma histories may be more likely to engage in negative behaviors that adversely affect oral health and often feel more vulnerable receiving oral exams. Substance use treatment providers receive training on the unique impact of different illicit substances on oral health, as well as the oral health-related side effects of medications used to treat addiction (e.g., methadone or buprenorphine). Pediatric behavioral health providers understand how sleep disordered breathing can present as behavioral symptoms (see “Education Snapshot”) and leverage National Children’s Dental Health Month in February to ask everyone about oral health and distribute oral health hygiene kits, if resources allow.

Key Planning Questions:

- What type of training is most appropriate given your practice’s patient population (e.g., do you serve children or adults, what are the most common mental health or substance use conditions treated in your office)?
- Which staff members within the behavioral health clinic can and should be trained on these topics?
- Which trainings offer continuing education credits for licensed behavioral health staff?
- What educational materials could be distributed in the behavioral health office to help promote awareness of the importance of oral health?

Education Snapshot: Relationship Between Attention-Deficit/Hyperactivity Disorder, Sleep Disorders and Oral Health

ADHD or Sleep Disorder? A noteworthy link between oral and behavioral health is the association between attention-deficit/hyperactivity disorder (ADHD), sleep-disordered breathing and oral health/orofacial growth and development. ADHD is one of the most commonly diagnosed mental health disorders in children, with 9.4% of children aged 2-17 years old (approximately 6.1 million) having received an ADHD diagnosis.⁴⁴ Educators, policymakers and scientists have referred to the exploding diagnosis of ADHD as a national crisis.⁴⁵

However, ADHD and sleep disorders have very similar symptoms – trouble paying attention, forgetfulness and poor impulse control. In fact, sleep-disordered breathing can be underdiagnosed in children and teenagers because the primary complaints reported by parents are more often behavioral symptoms.^{46, 47} This is one topic where increased provider education and coordination across oral and behavioral health might be beneficial, given that dental providers are in a unique position to assess for factors such as adenotonsillar hypertrophy (enlarged adenoids) or features such as a long and narrow face, narrow palate and severe crowding in the upper and lower jaw⁴⁸ that may predispose the child to disordered sleep patterns that ultimately contribute to other behavior issues.

The Pediatric Sleep Questionnaire (PSQ) can be used to investigate the presence of childhood sleep related breathing disorders and prominent symptom complexes, including snoring, daytime sleepiness and related behavioral disturbances. This questionnaire helps identify sleep related breathing disorders without the expense of a formal sleep study.⁴⁹

Potential funding approaches: Many high-quality, online training resources are available at no cost and can help licensed mental health and substance use treatment providers meet continuing education requirements. Providers can also seek funding through grants, provider associations and private foundations to help fund statewide provider education opportunities.

Model Tip: Leverage Educational Resources with Photographs of Teeth and Mouth

Clinical examples of the effects of methamphetamine use on teeth



Source: Smiles for Life. [Adult Oral Health and Disease – Substance Use Disorders](#).

Data monitoring:

- Assess the number and percent of staff who have been trained on the relationships between oral health, mental health and substance use challenges.
- Assess changes in the knowledge and skills of mental health and substance use providers.
- Conduct organizational self-assessment related to racial equity.
- Ensure all mental health and substance use treatment staff understand the basics of good oral hygiene.
- Assess whether educational materials and posters about oral health have been displayed in the behavioral health clinic.

Tools and resources: A general overview of the bi-directional relationships between oral and behavioral health can be found at [National Council for Mental Wellbeing Webinar: Oral Health and Behavioral Health: Rationale for Increased Coordination and Integration](#). For a general list of medications that cause dry mouth, including antidepressants, antipsychotics and anti-anxiety medications, see WebMD's article "[What Medications Can Cause Dry Mouth?](#)" For a more detailed list of 348 generic and name brand medications that cause dry mouth, see American Dental Association, [Medications that Cause Dry Mouth](#). [Smiles for Life](#) is a national oral health curriculum that consists of eight 60-minute modules covering core areas of oral health relevant to health professionals and includes classes on Child Oral Health, Adult Oral Health, and the Relationship of Oral and Systemic Health. [Oregon Oral Health Coalition](#) has oral health resources that may be useful for distribution in behavioral health offices, such as [Oral Health Care Tips for Children with Developmental or Behavior Concerns](#) and [Soda All Day = Tooth Decay](#). For a sample organizational self-assessment related to racial equity, see the Western States Center [Racial Justice Assessment Tool](#).

Example from the Field: Oral Health for Community Workers. A set of two brief educational modules ([An Introduction to Oral Health](#) and [An Oral Health Toolbox](#)) that provides oral health education tailored to community workers such as peer support specialists, peer recovery coaches and community health workers. For more information on accessing Oral Health for Community Workers, please contact the Michigan Community Health Worker Alliance (MiCHWA).

Screening and Referral Model

General description: Individuals with mental health and substance use challenges tend to have poorer oral health than the general population, including greater and more severe dental caries (tooth decay) and periodontal disease (gum disease), but are less likely to receive dental care. Under this model, mental health and substance use treatment providers screen for basic oral health hygiene habits, problems with the teeth or mouth and prior utilization of dental care and make referrals to oral health providers as needed. While following up on referrals to see if patients received care is considered a best practice, screening and referral strategies should still be implemented even if resources to conduct follow-up are limited.

Examples in practice: Mental health and substance use treatment providers add basic screening questions related to oral health hygiene, prior utilization of oral health care (e.g., last visit to the dentist) and any problems or pain with the teeth or mouth to patient intake forms, psychosocial assessments and/or verbal histories. Mental health and substance use treatment providers develop referral partnerships with local oral health providers that accept Medicaid or otherwise offer free or low-cost dental care, which could include FQHCs or dental schools. Mental health and substance use treatment providers with supported employment programs adopt screening and referral models, given that a deteriorated mouth makes it difficult to get a job. As a general consideration, mental health and substance use treatment providers may want to consider pilot testing models within specific programs—such as targeted case management or assertive community treatment (ACT)—to pilot and learn under Plan, Do, Study, Act (PDSA) cycles.

Potential funding approaches: In Oregon, physicians, nurse practitioners and physician’s assistants with a Smiles for Life or First Tooth certification can bill for D0191 (assessment of a patient that covers a limited clinical inspection performed to identify possible signs of oral or systemic disease, malformation or injury and the potential need for referral for diagnosis and treatment). In absence of that option, behavioral health organizations can explore use of codes for screening and assessment (e.g., 96160), care coordination (e.g., 99401) and/or e-consults (99451, 99452) to help reimburse for time spent on screening and referral activities. Another option is to work with payers to develop a value-based payment arrangement or propose a pilot project to a local foundation or other funder to cover unbillable services and help demonstrate positive outcomes and return on investment to help advocate for more sustainable funding moving forward.

Data monitoring:

- Monitor number and percent of patients with mental health or substance use challenges screened for oral health conditions, oral health hygiene and recent utilization of dental care (including most recent visit to dentist’s office) as well as those with positive screens.
- Assess number and percent of patients with oral health needs referred to a dental provider and, if possible, those who obtained follow-up care as recommended.
- Assess impact of oral health treatment on mental health and substance use treatment-related outcomes, such as length of time in treatment for mental health and/or substance use challenges, symptom reduction and other related quality of life outcomes such as employment and homelessness.
- Stratify (separate) data by social risk factors, race/ethnicity and gender to identify and address disparities in care. **A Framework for Stratifying Race, Ethnicity and Language Data may be a helpful resource.**

Key Planning Questions:

- What oral health-related issues will you screen for (e.g., prior utilization of dental care, hygiene habits, past or current problems with teeth or mouth)?
- What oral screening tool(s) will you use? Will they differ for pediatric versus adult populations?
- How often will screening be conducted? Can it be added into existing screening, assessment, and/or goal planning processes?
- Who will conduct the screening (e.g., receptionist, social worker, clinical psychologist, psychiatrist.)?
- How will the screening be done (e.g., written, electronic, verbal)?
- How will the screening be scored and used in practice?
- Who will serve as an ongoing referral partner? Will the referral relationship be bi-directional (e.g., mental health and substance use providers refer out to dental practice as needed and vice versa)?
- How will your practice document referrals: in the electronic medical record, on paper or another mechanism?
- How will your practice “close the loop” to ensure the patient received services with referred provider?
- What related services are billable in your state and by your insurance carriers?
- Does Medicaid cover dental care for adults in your state?

Model Tip: Distinguish Between Urgent and Non-urgent Referrals

Reasons for urgent referrals could include:

- Severe dental pain affecting sleep, eating and drinking.
- Oral infection (facial swellings, pus adjacent to teeth).
- Trauma to teeth (possibly after a fall).
- Teeth that are so mobile they may be an aspiration risk.
- Broken/lost dentures.
- Ulcers caused by trauma from broken teeth/dentures.

Source: NHS, Health Education England.
Mouth Care Matters.

Tools and resources: The American Academy of Pediatrics has developed the **Oral Health Risk Assessment Tool**, which has been reviewed and endorsed by the National Interprofessional Initiative on Oral Health, for documenting risk caries of children up to age 6. The American Dental Association also has a **Caries Risk Assessment Form for Ages 0 to 6**, and **Ages 6 and older**. For adult oral health screenings, Mouth Care Matters, an initiative based out of NHS' Health Education in England, has developed user-friendly tools such as an **Oral Health Needs Assessment** that could easily be adapted for use by health care providers in the United States. The **Medicaid Adult Dental Benefits Coverage by State** outlines whether states provide no benefit, emergency-only, limited, or extensive dental benefits for adults on Medicaid. DentaQuest's **"Find A Dentist"** feature enables users to search for dentists by specialty, health plan and state. For an example of a basic referral form that could be easily adapted for referrals from mental health and substance use treatment providers to dental providers, see Oregon Oral Health Coalition's **Oral Health Toolkit** (p.19).

Example from the Field: The Oral Health Recovery Initiative. Faculty at the University of Michigan developed and are currently implementing and evaluating a peer specialist-led model that is designed to help improve oral health and access to dental care among Medicaid-insured individuals with psychiatric disabilities. In Michigan, CPSSs are individuals who draw on their lived experiences of recovery from mental illness, substance use challenges or both to promote recovery among others sharing similar experiences. CPSSs provide outreach and support in public mental health settings such as Veterans Administration and community mental health clinics and, in many states, their services are Medicaid-billable. The three components of the Oral Health Recovery Initiative are:

- **Outreach:** Peer specialists identify and engage Medicaid-insured individuals with psychiatric challenges who may have high oral health needs. This may include flyers and resource lists provided in waiting rooms, in recreational spaces and with their current clients.
- **Support:** Peer specialists deliver brief educational interventions focused on oral health home-care topics that can be assumed within the peer workers' scope of practice that are designed to improve oral health knowledge, self-care behaviors and health care utilization. Peer specialists are not expected to become "oral health specialists," but to have a basic understanding of the importance of oral home care, information from written materials on how to care for teeth at home and knowledge of local oral health care resources.
- **Linkages:** Peer workers provide warm handoffs to local dental clinics and follow up to ensure appointments are completed.

Service Interventions for Oral Health Needs

General description: Mental health and substance use treatment providers and organizations are well-situated to offer interventions for certain oral health problems due to the regularity of patient visits as well as deep, trusting relationships and understanding of personal, family and social structures that may impact personal health practices, health behaviors and need for care.⁵⁰ For some patients, mental health and substance use treatment providers may be the only regular source of care, such as those receiving care in an inpatient setting, in a residential treatment facility or any other high-intensity level of mental health or substance use treatment, such as ACT, intensive outpatient or partial hospitalization. Under this model, mental health and substance use treatment providers offer service interventions and care coordination for certain oral health needs, as appropriate and within scope of practice. Services may be billable depending upon state regulations, insurance carrier guidelines and/or local scope of practice requirements.

Examples in practice: Mental health and substance use treatment providers and organizations offer patient education on oral health side-effects of prescription medications that treat mental health or substance use challenges. Inpatient or residential behavioral health providers help coordinate oral health care as needed (e.g., by scheduling appointments for and transporting patients to and from dental visits or arranging for mobile or teledentistry visits). Mental health and substance use treatment providers and organizations that include physical health care team members such as physicians or nurses (e.g., ACT teams) leverage physical health staff to apply fluoride varnish or silver diamine fluoride as appropriate. Case managers, peers, community health workers or other nontraditional health care workers incorporate education regarding good oral health hygiene habits into their regular services. Counselors, therapists and other licensed clinicians address behavioral change related to oral health hygiene and/or dental fear/trauma as part of patient goal planning. Mental health and substance use treatment providers leverage telemedicine by taking photos of teeth or mouth of patients who are experiencing dental pain or other oral health problems and share with dental providers for diagnostic and treatment expertise, as well as feedback on appropriate next steps.

Model Tip: Oral Health Team Member Sets the Goal, but Behavioral Health Does the Follow Up

Leverage regular mental health and substance use treatment visits to educate patients on oral health and motivate patients to change behaviors, coordinating with oral health teams via telehealth as needed for follow-up care. Under this strategy, mental health and substance use treatment providers would coordinate with an oral health team member to help set patient goals around oral health and good oral hygiene, but the ongoing services would be provided by behavioral health. This would include use of regular encounters with behavioral health providers to educate on oral health and motivate patients to change behaviors as needed and appropriate, and using telehealth to coordinate and follow-up with dental as needed.

Potential funding approaches: Services such as scheduling and transporting patients to oral health appointments may be covered under certain programs, such as ACT. If mental health and substance use treatment providers are addressing oral health needs as part of patient goal planning, these services could be incorporated into standard behavioral health encounters (e.g., psychotherapy codes 90832-90838). Fear of dental care or dental phobia is a billable diagnosis code (F420.232). Other services may also be billable depending on state and local guidelines, such as counseling for risk factor reduction and behavior change interventions (99401-99412), transportation (e.g., T2001), medication management (e.g., 90863, 99201-99215), interprofessional consultations or e-consults (99446-99449) and/or education and training for patient self-management by qualified, nonphysician health care professionals (98060, 98961, 98962). Oregon Medicaid reimburses certain medical providers for oral health assessments (D0191) and application of fluoride varnish (D1026 or 99188).⁵¹

Data monitoring:

- Assess the number and percent of mental health and substance use patients with oral-health related needs who have oral health hygiene or other oral health related goals as part of patient goal planning.
- Assess integration of patient education on oral health side effects of prescription medications that treat mental health or substance use challenges as part of medication management visits.
- Stratify (separate) data by social risk factors, race/ethnicity and gender to identify and address disparities in care.

Key Planning Questions

- What related services are billable in your state and by your insurance carriers?
- What nontraditional health care workers are certified in your state that could be leveraged for oral health education and promotion activities?
- What oral health-related trainings or certifications may be needed for mental health and substance use treatment providers to begin offering and/or billing for interventions for oral health-related needs?

Tools and resources: For mental health and substance use treatment providers caring for children or adolescents who may be interested in exploring application of fluoride varnish, Smiles for Life has a number of resources, including [Fluoride Varnish Ordering and State Specific Information](#). For a guide to billing for telehealth encounters, including use of interprofessional or e-consult codes, see Center for Connected Health Policy’s [“Billing for Telehealth Encounters: An Introductory Guide on Fee-for-Service.”](#)

Example from the Field: Minnesota Health Care Programs -- Community Health Worker Patient Education Program. Community health workers participating in Minnesota Health Care Programs are eligible to enroll as fee-for-service providers under the supervision of a dentist to provide diagnosis-related patient education and self-management to promote oral health. In Minnesota, a community health worker is defined as a health worker who is trusted member or has an unusually close understanding of the community served that enables them to provide information about health issues that affect the community and link individuals with the health and social services they need to achieve wellness. These community health workers may bill self-management education and training codes (98060, 98961, 98962) in 30-minute units, with a limit of four units per 24 hours and 24 units (12 hours) per calendar month per member. A physician, nurse practitioner, dentist, certified public health nurse or mental health professional must order that the community health worker provides the service(s).

Source: Minnesota Department of Human Services. [Community Health Worker](#). Provides details on eligible providers, eligible members, billing and covered and non-covered services.

Oral Health Provider Embedded in Behavioral Health Clinic

General Description: Individuals with mental health and substance use challenges tend to have poorer oral health than the general population, including greater and more severe dental caries (tooth decay) and periodontal disease (gum disease). Mental health and substance use challenges are also associated with risk factors such as neglected oral hygiene, malnutrition, high-sugar diets, homelessness and sporadic dental appointment patterns, that can indirectly lead to worse oral health outcomes. Under this model, an oral health provider is embedded within a behavioral health clinic to help expand access to needed oral health care. This staff person can provide oral health services directly within the four walls of the clinic and/or via mobile or teledentistry.

Examples in practice: A behavioral health clinic embeds a dental hygienist within the office one or two days a week to help expand access to diagnostic, preventive and restorative oral health care. An inpatient psychiatric facility provides urgent dental care onsite. Mental health and substance use treatment providers leverage increased teledentistry capabilities to develop “on call” or consulting relationships with oral health providers.⁵² This kind of virtual co-location could enable patients to receive oral health education, evaluation, triage and/or referral from a dental provider using teleprevention while the patient is receiving services at a behavioral health clinic.

Potential funding approaches: Oral health services provided by licensed dental providers should be billable under appropriate Current Dental Terminology (CDT) codes, such as oral health assessments (D0190 and D0191), patient education to improve oral health literacy (D9994), application of sealants or fluoride varnish (D1206, D1208), preventive oral health services (D1310, D1330), oral evaluation (D0140) and/or selected oral procedures (D7140). Some states have expanded dental codes for triage and screening services performed via telehealth during the COVID-19 pandemic. Mental health and substance use treatment providers could also explore use of interprofessional consultations or e-consult codes (99446-99449) as part of a virtual co-location model.

Key Planning Questions

- Will the oral health provider have a physical presence within the behavioral health clinic and/or provide virtual or mobile services?
- If the dental provider is physically embedded in the behavioral health clinic, what resources are readily available (e.g., a sink, a reclining chair for the patient) and what might the dental provider need to bring (e.g., portable x-ray machine, water suction, laptop)?
- What is the level of need within your dental practice? Should the dental provider be available every day or on a select day or days?
- What is the appropriate level of the service provider (e.g., dental assistant, dental hygienist, dental therapist, dentist)?
- Would the position be funded completely via billable services?

Model Tip: Use Teledentistry to Expand Access to Care, Especially During COVID-19

A dental professional does not necessarily need to be physically embedded within a behavioral health clinic to expand access to oral health care; rather, mental health and substance use treatment providers can leverage the expanding use of teledentistry to create virtual co-location of providers. Petaluma Health Center in Petaluma, Calif., began teledentistry visits at the end of March 2020 in response to the COVID-19 pandemic.⁵³ Examples of evidence-based dental services that could be provided via teledentistry include:

- Screening
- Caries risk assessment
- Tobacco / nicotine cessation counseling
- Motivational interviewing
- Oral hygiene instructions
- Nutritional counseling
- Treatment planning
- Self-administered care: fluoride varnish, toothbrush prophylaxis, diet modifications
- Case management
- Pre-operative and post-operative care for in-office visits

Source: National Network for Oral Health Access. [Using Teledentistry to Ensure Continuity of Care during COVID-19: Petaluma Health Center](#)

Data monitoring:

- Assess number and percent of mental health and substance use clients receiving dental care, as well as types of dental services provided.
- Determine whether receiving oral health care impacts other health or life outcomes (e.g., length in treatment, abstinence from drugs, employment, homelessness).
- Stratify (separate) data by social risk factors, race/ethnicity and gender to identify and address disparities in care.

Tools and resources: The National Network for Oral Health Access developed an [Oral Health Infrastructure Toolkit](#) which contains many useful resources for mental health and substance use treatment organizations exploring colocation of dental staff, including: [Partnering with Academic Institutions and Residency Programs to Develop Dental Service Learning Programs](#), [Creative Staffing with Professional Volunteers](#) and resources for utilizing new dental team members, including [dental therapists](#) and community dental health coordinators. The [Dental Clinic Comparison Chart](#) provides the pros, cons, capacity and costs between fixed dental clinics, mobile clinics and clinics using portable equipment that could help a mental health or substance use treatment organization decide which mechanism of delivery might work best. The [National Maternal and Child Health Resource Center](#) lists resources that provide a detailed “how-to” for creating mobile or portable systems of dental care for vulnerable populations and provides cost estimates and staffing considerations for setting up functional portable dental units. For a general overview of teledentistry and how it could be used to create virtual colocation, see [Delivering Care to Underserved Communities Through Telehealth Connected Teams](#).

Example from the Field: Options Oregon. AllCare Health is a coordinated care organization based in southern Oregon that manages care for about 50,000 Medicaid members. It is paid a global budget by the state to manage physical, oral, mental and substance use treatment services. In 2019, AllCare Health worked with Capitol Dental Care, a subcontracted dental health plan, to embed an expanded practice dental hygienist within Options for Southern Oregon – a clinic that serves people with mental health and substance use treatment needs – one day per week. The hygienist’s salary is largely covered by the dental subcontractors, as well as quality payments made by AllCare Health to the dental subcontractors. The expanded practice dental hygienist offers a range of services onsite, including but not limited to:

- Oral health assessments
- Periodontal maintenance
- Prophylaxis (thorough teeth cleaning) for children and adults
- Sealants
- Fluoride varnish and/or silver diamine fluoride application
- Tobacco cessation counseling
- Intraoral photos or x-rays
- Periodontal scaling (removal of plaque and tartar above and below gumline) and root planing (smoothing teeth roots to help gums reattach to teeth)
- Oral hygiene instructions



FOR ORAL HEALTH PROVIDERS INTERESTED IN INCREASED COORDINATION WITH MENTAL HEALTH AND SUBSTANCE USE TREATMENT ORGANIZATIONS

PROVIDER AND PATIENT EDUCATION MODE

General description: more than 60 million Americans suffer from mental health and substance use challenges, and this number is expected to increase due to the COVID-19 pandemic. For example, the Centers for Disease Control and Prevention (CDC) reported a surge in overdose deaths coinciding with the pandemic.⁵⁴ Some literature has indicated that one of the biggest factors in return to substance use is prescriptions of narcotics for dental pain.⁵⁵ Further, provision of dental care has been called a “smorgasbord” of trauma triggers, due to the way care is often provided – loud sounds from drills, the need to lie down and have objects inserted into the mouth – can be re-traumatizing for many individuals, including those who have suffered from sexual abuse or domestic violence. Under this model, oral health providers receive general training on the many “bi-directional” relationships between oral and behavioral health, and/or training on specific concepts related to the intersection of oral health, mental health and substance use challenges.

Examples in practice: Oral health providers receive training related to pain management and opioid prescribing, including the impact of opioid prescriptions for individuals with SUDs, use of over-the counter medications and use of state prescription drug monitoring databases. Oral health providers receive trauma-informed oral health care training and/or Mental Health First Aid (MHFA) training. Oral health providers learn Screening, Brief Intervention and Referral to Treatment (SBIRT) to manage patients with substance use challenges and/or motivational interviewing skills to help promote positive change related to, for example, good oral hygiene or use of tobacco or nicotine. Oral health providers acquire health education materials such as brochures and mouth models that are designed for people with chronic oral health problems, including mental health and substance use challenges, as opposed to solely educational materials tailored for children. The materials cater to people with low literacy and health literacy, and do not inadvertently reinforce hopelessness by over-emphasizing prevention instead of promoting recovery.

Key Planning Questions:

- What type of training is most appropriate given your practice’s patient population (e.g., pediatric practices may choose to focus on oral health effects of mental health and substance use challenges that are common in children, while adult dental practices may want to focus on relationships between oral health and substance use challenges or serious mental illness)?
- Which staff members within the dental practice can and should be trained on these topics?
- Which trainings offer continuing dental education credits?
- What new knowledge or capabilities might your practice be interested in promoting to patients and/or insurers?

Model Tip: Drill Down on Trauma-informed Care and Sample Communication Strategies for Oral Health Providers

SAMHSA lists four key elements to facilitate the transformation from a traditional practice to into a trauma-informed practice or organization, including 1) **realize** the impact of trauma; 2) **recognize** signs and symptoms of trauma in patients, families and staff within the organization; 3) **respond** by integrating knowledgeable about trauma into policies procedures and practices; and 4) **resist** retraumatizing patients and staff.

Sample trauma-informed communication techniques for oral health providers include:

- “What can I do to make you more comfortable during the procedure or examination today?”
- “Before we proceed, is there anything else you think I should know?”
- “Just to let you know, this is generally how this type of appointment runs. First, I will get a history, then we will take a look in your mouth and then we will take x-rays. I’ll come back to talk and answer questions.”

- “So you know what to expect, what we would normally do for this type of appointment is first discuss your history. Next, I will look in your mouth and, if necessary, we’ll take x-rays. Please feel free to ask me any questions along the way or get my attention by raising your hand if you need a break.”
- “I am going to do a percussion test on your tooth. To do this, I will gently tap your teeth. Let me show you on my hand or we can use yours. It will feel like this [tap on hand]. Let’s try it on your tooth.”

Source: The Illinois ACEs Response Collaborative. [Trauma-informed Care and Oral Health: Recommendations for Practitioners](#)

Potential funding approaches: Many high-quality, online training resources are available at no cost and can help licensed providers meet ongoing requirements for continuing dental education. Providers can also seek funding through grants, provider associations, state oral health coalitions and private foundations to help fund statewide provider education opportunities.

Data monitoring:

- Assess the number and percent of staff who have been trained on the relationships between oral and behavioral health.
- Assess changes in the knowledge and skills of dental providers.
- Assess your practice on the [Trauma-informed Care pyramid](#).
- Conduct an organizational self-assessment related to racial equity.
- Monitor whether dentists have registered with and use prescription drug monitoring programs.
- Assess opioid prescribing among dentists in your practice.

Tools and resources: A general overview of the bi-directional relationships between oral and behavioral health can be found at [National Council for Mental Wellbeing Webinar: Oral Health and Behavioral Health: Rationale for Increased Coordination and Integration](#). Project Extension for Community Healthcare Outcomes (ECHO) has developed an Opioid Training Series for dental professionals called [Pain Management and Substance Use Disorders Dental ECHO](#), which offers a six-part webinar series that includes didactic presentation on topics ranging from opioid alternatives to identifying patients with substance use challenges and managing dental pain for people on medication-assisted treatment for substance use. Similarly, HealthKnowledge offers free online learning and low-cost continuing education credits, including [Dental School Screening, Brief Intervention and Referral to Treatment \(SBIRT\) Curriculum](#), an evidence-based model for managing patients with substance use disorders. The Illinois ACEs Response Collaborative has published [Trauma-informed Care and Oral Health: Recommendations for Practitioners](#). The American Dental Association has put out a statement on the [use of opioids in the treatment of dental pain](#), and has noted that nonsteroidal anti-inflammatory drugs (NSAIDs) have been shown to be more effective at reducing pain than opioid analgesics and are, therefore, recommended as the first-line therapy for acute pain management.

Example from the Field: Wisconsin Primary Care Association. The Wisconsin Primary Health Care Association is working to more closely integrate oral health and behavioral health within selected health center locations. It plans to start by conducting Mental Health First Aid training for oral health providers working within the Wisconsin health centers and facilitate peer-to-peer learning for all health centers interested in beginning oral health and behavioral health integration efforts. The Wisconsin Primary Health Care Association already has oral health and behavioral health peer learning networks, which provide a mechanism for facilitating trainings and integration work. Source: Minnesota Department of Human Services. [Community Health Worker](#). Provides details on eligible providers, eligible members, billing and covered and non-covered services.

SCREENING AND REFERRAL MODEL

General description: Mental health and substance use challenges are already exceedingly common and undertreated in the U.S. and they have worsened since the start of COVID-19. Misuse of tobacco, alcohol and illicit drugs leads to more death and disability than any other preventable health condition, yet a remarkably small percentage of users are connected to treatment within health care settings.⁵⁶ The U.S. Preventive Services Task Force has issued level “B” recommendations (moderate certainty that the net benefit is moderate to substantial) for conducting patient screenings for depression, illicit drug use, alcohol, tobacco and intimate partner violence, particularly when supports or referral relationships are in place. Dental providers should feel motivated to help address mental health and substance use challenges out of care about patients’ overall health and well-being and because substance use and mental health challenges can negatively impact oral health treatment and outcomes. Under this model, oral health providers screen patients for mental health and/or substance use challenges and make referrals to external providers as needed to help address these needs. While following up on referrals is considered a best practice, screening and referral strategies should still be implemented even if resources to conduct follow-up are limited.

Examples in practice: Oral health providers add screening questions related to mental health and substance use challenges to patient intake forms or verbal health histories. Oral health providers assess the patient’s mouth for risk factors associated with substance use or mental health challenges, including symptoms associated with eating disorders. Oral health providers develop referral partnerships with local mental health and/or substance use treatment providers or organizations and make referrals as needed to help address any identified behavioral health needs. Oral health providers check prescription drug monitoring databases for history of prescription drug use and make referrals to treatment as needed.

Model Tip: Launch a “We Ask Everyone” Campaign in the Dental Office

Dental providers may feel uncomfortable asking questions about or discussing mental health or substance use. Rhode Island launched a “We Ask Everyone” campaign, providing posters and lapel pins for providers to have onsite to increase comfort with asking these questions and tell patients that providers ask everyone these questions to help put them at ease.

Source: RI SBIRT. *Leveraging Innovation to Transform Health Systems and Improve Population Health.*

Key Planning Questions:

- Which behavioral health-related conditions will you screen for (e.g., tobacco, depression, substance use, trauma history)?
- What screening tool(s) will you use? How often will it be administered?
- Who will conduct the screening (receptionist, dentist, hygienist, dental assistant)?
- How will the screening be done (included in the dental health history questionnaire or verbal)?
- How will the screening be scored and used in practice?
- What related services are billable in your state and by your insurance carriers?
- Who will serve as an ongoing referral partner?
- Will the referral relationship be bi-directional (e.g., oral health refers out to behavioral health as needed, and vice versa)?
- How will your practice document referrals: in the EDR/EHR, on a resource and referral platform or on paper?
- How will your practice “close the loop” to ensure the patient received services with referred provider?



Potential funding approaches: Oral health providers should contact their state behavioral health authority to see if there are funds available, such as through the **State Opioid Response Grants**, which are designed to help expand access to treatment of opioid use disorder and reduce unmet need. Oral health providers can also consider billing related Current Dental Terminology (CDT) codes as appropriate and when payable according to state regulations and insurer guidelines. Potentially relevant CDT codes include consultation with a medical health care professional (D9311), addressing appointment compliance barriers (D9991) and/or care coordination (D9992).

Data monitoring:

- Monitor number and percent of patients screened for mental health and substance use challenges, as well as those with positive screens.
- Assess number and percent of patients who obtained follow-up care as recommended by a mental health or substance use treatment provider or organization.
- Monitor extent to which oral health professionals access prescription drug monitoring databases prior to making prescriptions, particularly for opioids.
- FQHCs may want to track any changes in two relevant Uniform Data System measures prior to and after implementation of screening and referral activities: 1) tobacco use: screening and cessation intervention and 2) screening for depression and follow-up plan.
- Stratify (separate) data by social risk factors, race/ethnicity and gender to identify and address disparities in care.

Tools and resources: Screening tools recommended by the U.S. Preventive Services Task Force include but are not limited to the **Patient Health Questionnaire** (depression), **Humiliation, Afraid, Rape, Kick** (intimate partner violence), **National Institute on Drug Abuse Quick Screen** (drug use), and **Alcohol Use Disorders identification Test-Consumption** (unhealthy alcohol use). For early detection of oral manifestations of disordered eating behaviors, consider using the **Evaluate, Assess, Treat Framework**.⁵⁷ To identify potential mental health and substance use treatment referral partners, **FindTreatment.gov** offers a database for state-licensed providers who specialize in treating substance use disorder and mental illness. Additionally, the **SAMHSA Opioid Treatment Program Directory** offers state-based listings of facilities certified to provide methadone and the **SAMHSA Buprenorphine Practitioner Locator** offers a list of waived buprenorphine prescribers. The American Academy of Pediatric Dentistry has recommended that pediatric dentists screen patients for snoring and sleep-related breathing disorders that can contribute to learning and/or behavioral problems and refer them to appropriate medical professional, as needed (see “Education Snapshot” on p. 12).⁵⁸ The Pediatric sleep questionnaire (PSQ) can be used to investigate the presence of childhood sleep-related breathing disorders (SRBD) and prominent symptom complexes, including snoring, daytime sleepiness and related behavioral disturbances. This questionnaire helps to identify SRBDs without the expense of polysomnography.⁵⁹ **Implementing Care for Alcohol and Other Drug Use in Medicaid Settings: An Extension of SBIRT: SBIRT Change Guide 1.0** contains practical tips for making clinical and organizational changes needed to successfully adopt SBIRT in different health care settings.

Example from the Field: Indian Health Service Depression Screening in Dental Programs. Beginning in 2016, the Indian Health Service Division of Oral Health spearheaded a campaign to promote depression screenings in a dental setting. Twelve dental programs were encouraged to work with their behavioral health and primary care teams to develop or improve their referral system following completion of depression screenings in adults and adolescents utilizing the Patient Health Questionnaire-2 (PHQ-2) screening tool. The demonstration project had dramatic results, with a 1,266% increase in depression screenings and a 382% increase in dental referrals. The Indian Health Service Division of Oral Health recommendation is that Indian Health Service, Tribal and Urban dental programs should screen all patients ≥ 12 years of age for depression at least once annually using the scored PHQ-2 form.

- **Frequency:** Annually
- **Ages:** 12 years and older
- **Form:** Patient Health Questionnaire-2 (PHQ-2)
- **Referral:** When the patient has an overall score of 3 or higher

Source: Indian Health Service, Oral Health Program Guide. Section W: **Depression Screening in Dental Programs**

SERVICE INTERVENTIONS FOR MENTAL HEALTH AND SUBSTANCE USE CHALLENGES

General description: Oral health providers are well-situated to offer interventions for certain mental health or substance use challenges due to the regularity of patient visits, the fact that oral health visits tend to be preventive in nature as opposed to problem-oriented and the ability to capitalize on negative cosmetic impacts of certain unhealthy behaviors, such as smoking and/or illicit drug use, including discoloring of teeth, halitosis or tooth decay.⁶⁰ For example, research shows that tobacco cessation interventions delivered by oral health professionals significantly increased the odds of quitting tobacco.⁶¹ Under this model, oral health providers offer service interventions for certain mental health or substance use challenges, such as tobacco or nicotine cessation counseling or brief interventions for identified problems with substance use, as appropriate and within scope of practice. Services may be billable depending upon state regulations, insurance carrier guidelines and/or local scope of practice requirements.

Examples in practice: Oral health providers offer tobacco or nicotine cessation services. Dental practices incorporate motivational interviewing to help motivate patients to improve oral hygiene behaviors and deliver smoking cessation and alcohol advice.⁶² Oral health professionals use the evidence-based SBIRT⁶³ model to help connect patients with substance use challenges to treatment.

Potential funding approaches: Oral health services provided by licensed oral health providers may be billable in certain states under appropriate Current Dental Terminology (CDT) codes, such as tobacco counseling for control and prevention of oral disease (D1320); counseling for control and prevention of adverse oral, behavioral and systemic health effectives associated with high-risk substance use (D1321); motivational interviewing (D9993); and/or addressing appointment compliance barriers (D9991).

Data monitoring:

- Assess use of nicotine/tobacco cessation counseling among oral health providers.
- Assess use of SBIRT for individuals with substance use challenges receiving care in dental practices.
- Stratify (separate) data by social risk factors, race/ethnicity and gender to identify and address disparities in care.

Tools and resources: The Centers for Disease Control and Prevention contains [resources for dental professionals](#) to help patients quit tobacco products, including the Tips® Campaign. Pennsylvania's Prescription Drug Monitoring Program and its training module, [Approaches to Addressing Substance Use Disorder with Patients Identified by the PDMP](#), which covers SBIRT.

Key Planning Questions:

- What related services are billable in your state and by your insurance carriers?
- What related trainings or certifications may be needed for oral health providers to begin offering and/or billing for interventions for mental health or substance use challenges?
- What types of dental staff might be qualified and best positioned to provide services interventions related to mental health and substance use challenges (e.g., dentist, dental hygienist, community dental health)?

Example from the Field: Oral Health Substance Use Disorder Learning Network. The Oral Health Substance Use Disorder Learning Network – an initiative led by the Massachusetts League of Community Health Centers – has been implemented with five community health centers in Massachusetts. Each of the participating health centers aims to increase substance use disorder screening among dental patients and refer to a substance use treatment provider or organization, when appropriate. HealthFirst Family Care Center in Fall River, Mass., utilized a screening tool that incorporated four substance use disorder screening questions about alcohol use and controlled substance use. This tool is administered to new and recall patients age 18+ as a written questionnaire given by the front desk and reviewed by the provider. If a patient answers socially or daily for alcohol consumption, motivational interviewing and brief intervention are conducted by the oral health provider using strategies promoted by the evidence-based SBIRT model. Referral for mental health and substance use treatment services is offered and if patient accepts, they are referred to the behavioral health department.

MENTAL HEALTH OR SUBSTANCE USE TREATMENT PROVIDER EMBEDDED IN DENTAL PRACTICE

General Description: Many people face barriers when pursuing oral health care, especially individuals with mental health or substance use challenges or histories of trauma; examples of such barriers include dental fear or phobia, limited transportation, limited access to and availability of dental services and/or financial constraints.⁶⁴ Under this model, a mental health or substance use treatment provider (e.g., a social worker) works with a dental practice or dental teaching clinic to help address identified barriers and increase access to needed dental, mental health and substance use treatment services. This staff person can provide services in-person and/or offer virtual support.

Examples in practice: A social worker is embedded within a dental school or dental practice to help patients and families overcome barriers to dental care such as transportation challenges, dental phobia and/or past trauma. A behavioral health consultant is onsite at a dental practice one or two days a week to offer consults around depression or anxiety, substance use challenges or help promote healthy lifestyles.

Potential funding approaches: Services provided by a licensed behavioral health provider, such as a social worker, may be billable; for example, fear of dental care or dental phobia is a billable diagnosis code (F420.232). Mental health and substance use treatment staff salaries may be covered in part by increased revenue for the dental practice if services help to increase number of patient visits and reduce no show rates.

Data monitoring:

- Assess the impact of the mental health or substance use treatment services on dental care patterns, including rates of preventive service visits and appointment no-shows (e.g., assess whether patients who receive social worker services have increased adherence to dental appointments).
- Stratify (separate) data by social risk factors, race/ethnicity, and gender to identify and address disparities in care.

Tools and resources: Salud Family Health Centers embedded a mental health and/or substance use treatment provider in the dental clinic twice a week to perform screenings, consults and interventions; see [Uncharted Territory: Creating Pathways for Behavioral Health and Dental Integration](#).

Key Planning Questions

- How will the dental clinic determine which patients may require service interventions from the mental health or substance use provider, and will services be provided prior to, during, and/or after dental care?
- Will the mental health or substance use provider have a physical presence within the dental practice or school and/or provide virtual support such as via phone, email, text, and/or video conference?
- If the provider is physically embedded in a dental office or school, is a private space available for the mental health or substance use provider to have sensitive conversations if needed?
- What is the level of need within your dental practice? What is the appropriate staff level (e.g., social worker, behavioral health coordinator) and should the mental health or substance use provider work full or part-time?
- How will the position be funded? If hiring a licensed provider, will services be billable?

Example from the Field: Patient Support Services: Bringing Smiles to Patient Care. In 2017, a collaboration between Columbia University's College of Dental Medicine and Columbia School of Social Work resulted in a new program designed to identify and help address psychological barriers that prevent patients from getting adequate and consistent oral health care. Under this program, two first-year social work graduate students and a program director use screenings and assessments with patients, then offer counseling services or interventions as needed. Some interventions, such as reduction of drill noises or providing stress balls, may appear simple but can effectively ease a patient's anxiety during dental procedures. University of Buffalo's dental school has developed a similar initiative designed to improve patient retention and access to oral health care called the CARES Programs (Counseling, Advocacy, Referral, Education and Service) which is a nationally recognized collaboration between University of Buffalo Schools of Dental Medicine and Social Work.^{65, 66}

FOR PROVIDERS INTERESTED IN PARTIAL OR FULL SYSTEM INTEGRATION ACROSS ORAL HEALTH, MENTAL HEALTH AND SUBSTANCE USE TREATMENT SERVICES

General description: Individuals with mental health or substance use challenges have considerably greater oral health needs than the general population.⁶⁷ For example, individuals with serious mental illness were nearly three times as likely to have lost all their teeth, compared to the general population, while individuals with substance use disorders had significantly more decayed teeth but fewer restorations, indicating reduced access to dental care.⁶⁸ Likewise, dental practitioners report frequently encountering patients with dental anxiety and/or other mental health and substance use challenges, yet typically lack a systematic approach for identifying needs or connecting individuals to treatment. Under a partial or full system integration approach, oral and mental health or substance use providers share a practice location (or work for the same umbrella organization if practicing at different sites) and have some or all the following capabilities:

System integration:

- Shared access for viewing and scheduling appointments across oral, mental and substance use treatment services.
- Bilateral access to electronic health records (oral and behavioral health providers have access to a shared electronic health record or behavioral health providers can access the electronic dental record, and dental provider can access the electronic medical records).

Clinical integration:

- Mental health and substance use treatment departments perform oral health screenings/education and refer to dental department.
- Dental department screens for mental health or substance use challenges and refers to mental health or substance use treatment providers, as appropriate.
- Providers co-manage patients using a shared treatment plan.

Administrative integration:

- Provider develops specific policies and procedures for screening and referring patients across departments, as well as for tracking and following up on those referrals.
- Providers regularly conducts joint meetings across dental, mental health and substance use treatment department staff that include case presentations on related topics (e.g., discussing impact of opioid prescriptions, how or why patients might self-medicate because of dental pain).
- Behavioral health and oral health departments each have an identified “champion” to help advocate for and implement integration activities.
- Provider governing structure includes representation from mental health and substance use treatment providers and dental departments.

Potential funding approaches: This type of model may be most appropriate for larger, integrated provider organizations, such as FQHCs or ACOs. These organizations may be able to cover integration-related activities under prospective payment system rates or other alternative payment models. Integration across other health care sectors has shown to demonstrate a positive return-on-investment, such as integration of mental health and substance use services into primary care, so integration may also be an appealing option for providers operating under any kind of value-based payment or total cost of care arrangement.

Data monitoring:

- Assess number and percent of mental health and substance use screenings completed in dental department and number and percent of oral health screenings completed in behavioral health department.
- Assess number of patients referred from dental to mental health or substance use treatment services and number of patients referred from mental health and substance use treatment services to dental.
- Assess number of referred mental health and/or substance use treatment patients with a completed dental visit and number of referred dental patients with a completed behavioral health visit.
- FQHCs may want to track any changes in the three relevant Uniform Data System measures prior to and after oral, mental and substance use treatment services integration: 1) tobacco use screening and cessation intervention, 2) screening for depression and follow-up plan and 3) dental sealants for children between 6–9 years.
- Stratify (separate) data by social risk factors, race/ethnicity and gender to identify and address disparities in care.
- Health systems that include emergency departments may want to expand data capabilities for tracking and monitoring emergency room visits for dental pain or other non-traumatic oral health-related issues.

Tools and resources: Virginia Health Catalyst developed an Oral Health Integration Toolkit that includes case studies related to oral and behavioral health integration. The National Network for Oral Health Access piloted the Integration of Behavioral and Oral Health (IBOH) learning collaborative with 12 participating health centers. The aim of IBOH is to use a systems-based integration implementation model to increase the number of health center dental patients receiving depression screenings and referral to mental health and substance use treatment services when appropriate. The IBOH learning collaborative will be offered again in the Fall of 2021 and 2022.

Example from the Field: Integration of Oral and Behavioral Health – Community Health Centers of South-Central Texas. The health center has a behavioral health consultant embedded at all seven sites, either in-person or via telehealth. The behavioral health consultant, medical and dental provider have a morning huddle to review mutual patients on the schedule and discuss possible need for a mental health or substance use consultation, referral or follow-up. All patients aged 12 and above at the medical and dental clinics receive a PHQ-9/A form for depression screening at every visit. This form also has CAGE alcohol questionnaire included for assessment of substance use. Elevated scores of 10 or higher are reported to the behavioral health consultant and intervention is provided, as needed (either the same day or as scheduled appointment) depending on the urgency. The behavioral health consultant also addresses patient dental anxiety as needed. Moving forward, the health center plans to incorporate oral health screenings at intake on mental health and substance use treatment patients, including questions about past dental experiences and associated anxiety.



CONCLUSION

There are a multitude of connections between oral health, mental health and substance use challenges. Oral, mental and substance use conditions have historically been undertreated in the United States, often with stark disparities in access to care. Availability of mental health, substance use treatment and dental health care has been further imperiled by the COVID-19 pandemic, as offices have limited in-person service provision and, in some cases, shut their doors completely because of lost revenue. Systems of care that are more coordinated and integrated hold promise to not only increase access to needed care, but also to improve outcomes and potentially reduce health care costs. This introductory toolkit seeks to help oral health, mental health and substance use treatment providers and organizations increase coordination and integration by offering practical suggestions, resources, strategies and on-the-ground examples for implementation of new care models across a continuum, ranging from cross-sector provider and patient education to full system integration. It provides innovative examples from leading-edge programs across the country about how to reengineer traditional care pathways, especially given broader adoption of telehealth. While this document outlines many new and innovative care model ideas, the continuum structure is designed to enable all interested providers, regardless of size or resources, to begin taking steps to increase coordination and integration, with the long-term goal of expanding access to needed oral health, mental health and substance use treatment for all Americans.



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