America’s Voice for Community Health Care
The integration of oral health into the Patient Centered Medical Home (PCMH) and larger healthcare delivery system is a priority for improving access and health. Through their PCMH practice transformation efforts, health center care teams have developed a skill set, including workflow revisions and maximizing the use of technology, that can be adapted to integrating oral health with primary care. The interprofessional oral health core clinical domains are defined in the Health Resources and Services Administration's (HRSA) 2014 "Integration of Oral Health and Primary Care Practice" report. The groundwork has been laid. Now how can your health center, primary care association (PCA), or health center controlled network (HCCN) take the next steps? This Educational Session will feature the findings from NACHC’s monograph, "Integration of Oral Health with Primary Care in Health Centers: Profiles of Five Innovative Models"; the lessons learned by a health center in their oral health integration journey; and the results to date from a national effort to integrate oral health in the PCMH. Learn how health centers, PCAs, and HCCNs are strategically positioned to integrate oral health with primary care.
Learning Objectives:

Upon participation in this Education Session, participants will be able to:

1. Assess the current implementation status of the five interprofessional oral health core clinical domains in your health center.

2. Discuss three resources available to assist your health center, PCA, or HCCN in your work to integrate oral health with primary care in PCMHs.

3. Describe how your organization is strategically positioned to integrate oral health with primary care.
Moderator:
Donald L. Weaver, M.D.
Associate Medical Officer
National Association of Community Health Centers

Speakers:
Hannah L. Maxey, PhD, MPH, RDH
Assistant Professor and Director of Health Workforce Studies
Indiana University School of Medicine, Department of Family Medicine

Lisa Kearney, DDS
Clinical Director of Oral Health
Erie Family Health Center

Rebekah Fiehn
Public Health Program Coordinator
Massachusetts League of Community Health Centers
Hannah L. Maxey, PhD, MPH, RDH:

Dr. Hannah Maxey, Assistant Professor and the Director of Health Workforce Studies at Indiana University School of Medicine, is actively involved in health workforce policy and research at the state and national level. She received her PhD from the Department of Health Policy and Management at the Indiana University Richard M. Fairbanks School of Public Health in August of 2014, and her dissertation work examined the effect of state regulation of the dental hygiene workforce on dental service delivery, access to care, and the oral health status of patients at Federally Qualified Health Centers from 2004 to 2012. Prior to pursuing graduate education, Dr. Maxey spent seven years providing preventive oral health care to underserved populations at Indianapolis area community health centers.
Lisa Kearney, DDS:

Dr. Lisa Kearney starting working as a staff dentist at Erie Family Health Center in Chicago, Illinois in March 2007. She became the Clinical Director of Oral Health at Erie in August 2012 and manages Erie’s four dental clinics. Dr. Kearney also works as an adjunct faculty preceptor for the UIC College of Dentistry. She strongly believes in Erie’s mission to make quality healthcare a right, not a privilege.
Rebekah Fiehn is the Public Health Program Coordinator at the Massachusetts League of Community Health Centers. She has focused her work on providing training and technical assistance to community health centers who are integrating oral health and primary care. Prior to working at the PCA she was the coordinator for the Better Oral Health for Massachusetts Coalition. She holds a Master of Science degree in International Relations and Public Affairs from the University of Massachusetts Boston. She is a graduate of the Women in Politics and Public Policy Program at the University of Massachusetts Boston. She received her B.A. in Political Science from Rockford College.
HEALTH CENTERS AS LEADERS FOR ORAL HEALTH AND PRIMARY CARE INTEGRATION

Hannah Maxey, PhD, MPH, RDH
Assistant Professor and Director of Health Workforce Studies
Indiana University School of Medicine
Department of Family Medicine
PRESENTATION OBJECTIVE

• Describe oral health and access to care as a national issue/priority

• Discuss integration of oral health with primary care as a strategic initiative to improve access and address disparity

• Explain how health centers are positioned to lead integration efforts

• Describe the innovative models for integration at five health centers
ORAL HEALTH
DEFINING ORAL HEALTH

• Oral health: aspect of overall health broadly defined as a state of being free from pain, diseases, and disorders
ORAL HEALTH: DISEASE AND DISPARITY

- 50% of children age 12-15 suffer from tooth decay\(^1\)
- 25% of adults (age 20-64) have untreated caries
- In 2010, there were 2.1 million ED visits for dental conditions (costing ~$867 million to $2.1 billion)\(^3,4\)

REFERENCES

ORAL HEALTH: A NATIONAL PRIORITY

2000, Oral Health in America: A report of the Surgeon General ¹

2011, Institute of Medicine’s Call to Action: Advancing Oral Health in America ²,³

2014, Health Resources Services Administration, Integration of Oral Health and Primary Care Practice (IOHPCP) initiative ⁴

2015, Integration of Oral Health with Primary Care in Health Centers ⁵ & Oral Health: An Essential Component of Primary Care ⁶

REFERENCES
5. Available at: https://www.nachc.com/clinicalnewnews.cfm
6. Available at: http://www.safetynetmedicalhome.org/resources-tools/white-papers
INTEGRATION: ORAL HEALTH WITH PRIMARY CARE
## ORAL HEALTHCARE VS. DENTAL CARE

<table>
<thead>
<tr>
<th>Oral Healthcare</th>
<th>Dental Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What?</strong></td>
<td><strong>What?</strong></td>
</tr>
<tr>
<td>• part of overall patient care, including</td>
<td>• critical component of oral healthcare, including</td>
</tr>
<tr>
<td>• Risk assessment</td>
<td>• Specific services focused on maintaining, attaining or restoring oral health</td>
</tr>
<tr>
<td>• Health promotion and education</td>
<td></td>
</tr>
<tr>
<td>• referral</td>
<td></td>
</tr>
<tr>
<td><strong>Who?</strong></td>
<td><strong>Who?</strong></td>
</tr>
<tr>
<td>• Everyone’s (the entire health care team) responsibility</td>
<td>• Members of the healthcare team with specific training/qualifications/etc</td>
</tr>
</tbody>
</table>
HEALTH CENTERS AS LEADERS IN INTEGRATION
HEALTH CENTERS AND ORAL HEALTH

• FQHC Preventive Dental Service Requirement

• Under current funding agreements, health center grantees are required to deliver “primary health services,” which are defined in the statute to include “preventive dental services.” (42 U.S.C.§254b (a) (1) and §254b (b)(1)(A)(i)(III) (hh)). “Preventive dental services” are further defined by regulation (42 C.F.R.§51c.102 (h) (6)) to include “services provided by a licensed dentist or other qualified personnel, including: (i) “oral hygiene instruction; (ii) oral prophylaxis, as necessary; and (iii) topical application of fluorides, and the prescription of fluorides for systemic use when not available in the community water supply.”
STRATEGICALLY POSITIONED FOR IMPACT

• Major healthcare provider for underserved/vulnerable communities
• Co-located medical and dental services

Health Centers are here to help!
STRATEGICALLY POSITIONED FOR INTEGRATION

• Patient Center Medical Home Model (PCMH)
  • Comprehensive
  • Patient-centered
  • Coordinated
  • Accessible
  • Quality and Safety
Integration of Oral Health and Primary Care Practice

U.S. Department of Health and Human Services
Health Resources and Services Administration
February 2014
1. RISK ASSESSMENT

- Identify factors
  - Individual
    - Medical
    - Oral
  - Population
    - Epidemiology
2. ORAL HEALTH EVALUATION

- Review risk assessment
- Perform oral screening
- Treatment planning
3. PREVENTIVE INTERVENTIONS

Recognize strategies to address oral health needs
- Deliver patient-centered preventive interventions
- Mitigate risk factors
4. COMMUNICATION AND EDUCATION

- Provide targeted patient-centered communication and education strategies
5. INTERPROFESSIONAL COLLABORATIVE PRACTICE

Shared responsibility in patient care
- Information exchange
- Interprofessional practice
- Care coordination
FIVE SUCCESSFUL MODELS
BLUEGRASS COMMUNITY HEALTH CENTER

• **Model Type:**
  - Physician-led

• **Features:**
  - Ongoing training
    - Smiles for Life (SFL) Curriculum
  - Deliver preventive oral healthcare as a part of routine primary care
  - Dental referrals/vouchers program
• **Strategic Factors:**
  - Dr. Steve Wrightson as a founder of SFL and champion for integration

• **Financing Mechanism:**
  - Funded by overall budget
  - Estimated cost: $1/patient
HOLYOKE HEALTH CENTER

Model Type:
- Administration-driven

Features:
- Interoperable EHR
- Strong Dental Programming
- Outreach to underserved populations (HIV, veterans, developmental disabilities)
HOLYOKE HEALTH CENTER

• **Strategic Factors:**
  - Jay Breines, CEO, champion of integration

• **Financing Mechanism:**
  - “built-in” to primary care visit cost
SALINA FAMILY HEALTHCARE CENTER

- Model Type:
  - Interprofessional Team

- Features:
  - Inreach Program: dental hygienists serve as dental care coordinators
  - Training: All care team members with SFL training
**Strategic Factors:**
- Custom equipment: dental hygiene cart (pictured)

**Financing Mechanism:**
- RDH salaries funded through Medicaid reimbursements
- Bill visits as dental encounters
SALUD FAMILY HEALTH CENTER

- Model Type:
  - Culture of integration

- Features:
  - Open communication
    - Impromptu consults
  - Interprofessional care team
Strategic Factors:
- Open door policy between medical and dental

Financing Mechanism:
- RDH salaries funded by Medicaid reimbursement for fluoride varnish
YAKIMA VALLEY FARM WORKERS CLINIC

• **Model Type:**
  - Dental Outreach Coordination

• **Features:**
  - Mobile units
  - WIC
  - Same-day dental appointments
YAKIMA VALLEY FARM WORKERS CLINIC

- **Strategic Factors:**
  - Dental outreach coordinator

- **Financing Mechanism:**
  - Outreach budget
SUMMARY

- Millions of underserved American struggle with poor oral health
- Integrating oral health with primary care is a national priority
- Health centers are strategically positioned and are blazing a trail integration
- Successful models provide insight for other organizations
“They (the care team at Salina Family Health Center) did not make me feel ‘less than’ because my family has Medicaid. I go to other doctors and feel like a burden, but at the health center I feel like a priority.”

-30 year old male and father of 4 small children
Medical and Dental integration efforts at Erie Family Health Center

LISA KEARNEY
CLINICAL DIRECTOR OF ORAL HEALTH
Erie Family Health Center

- Founded in 1957
- FQHC in Chicago, Illinois
- Provide comprehensive care to 62,000 patients annually at 12 sites
  - 7 primary health care centers
  - 5 school based health centers
  - 4 integrated dental centers serving over 9,500 patients

At Erie Family Health Center, we believe health care is a right, not a privilege. Our mission is to provide accessible, affordable and high quality health care for those in need.
Erie Family Health Center
Brief Overview of Project

- With the establishment of our new site management teams, the clinical director of oral health and the Foster site operational director decided to work collaboratively to implement pilot projects designed to improve medical and dental integration at Erie Family Health Center.
Rationale for Project

- Until this project started, the dental clinic had been its own separate entity at Erie Family Health Center. There was very little communication or collaboration between the medical and dental teams. We hoped that with this project, we would break down established barriers between the medical and dental teams in an effort to improve patient care and overall patient health.
Project Objectives

- Increase medical and dental collaboration to improve clinical care and overall patient health
- Implement operational changes to improve patient access, improve utilization of shared services, and improved quality of care provided
- Increase the number of patients receiving both medical and dental care at Erie Family Health Center
Timeline

- **Operational changes**
  - Hours of operation – same as medical
  - Changes in DA/Dentist ratios and Dentist/chair ratios

- **Physical Changes**
  - Co-location of front desk staff for medical and dental teams

- **Trainings**
  - Trainings for front desk team to make dental appts in Centricity
  - Training for front desk team to verify codes and send claims to billing
  - Training for billing team to process dental claims

- **IT changes**
  - HL7 interface – link between EMR and EDR
  - All teams scheduling in Centricity
Timeline continued

- **Integrated service changes**
  - Integrated front desk
  - Front desk at non-dental sites making initial dental appointments
  - Health promotions team making dental appointments at VOP appointments
  - Coordinated group visits – Centering and Parenting groups
  - Coordinated well-child visits
  - Medical residents rotating through dental clinics
  - Call center taking on Dental calls
  - Case management scheduling 6 month and 1 year dental appointments
  - Site management team – new Erie management model
Implementation Process - operational changes

- Back to the Basics: Operational changes to improve access, improve provider efficiency and productivity and improve quality of care
- NOHLI Project (National Oral Health Learning Institute)
- Objectives:
  1. Implement new hours of operation to increase access to dental services
  2. Implement new scheduling model for dental providers to improve efficiency
  3. Implement new standard chair dentist ratios and dental assistant/dentist ratios to improve efficiency and quality of care
Outcomes of Operational changes

- Improved provider and staff satisfaction with new scheduling template, DA/Dentists ratios, and chair/provider ratios
- Overall visit volume increase with extended hours
- Improved patient satisfaction with extended hours
- Extended hours are the first appointments booked
- Extended hours also have highest no-show rates
- Implemented operational changes leads easier implementation of integrated front desk

[Graph showing total visits from Sep-12 to Sep-13]
Implementation process physical changes

- Co-located front desk: physically moving dental front desk to the same place as the medical front desk
  - Evanston clinic was opened in July 2013 with co-located front desk
  - When AP clinic was moved to larger EFA location in July 2013, the new site was built with a co-located front desk
  - Dental PBAs in HP location were moved to medical front desk check in on the first floor
  - Required collaboration of medical and dental directors and front desk supervisors to make room for the dental team in the medical space
Implementation Process - Trainings

- Trainings for all medical and dental front desk on how to make dental appointments in Centricity
- Training on how to schedule dental appointments (how much time per appointment type, what types of procedures can be scheduled together, etc.)
- Training for dental team - changes to the system and what to expect
- Training for all front desk staff to send dental claims to billing department and to verify dental codes
- Training for billing team to send dental claim
- Trainings for call center to take dental calls
- Trainings were given by dental clinical supervisor, front desk supervisors, clinical director of oral health, billing supervisor
Implementation process – IT changes

- **HL7 interface**
  - Bidirectional interface that links Dentrix and Centricity
  - Scheduling and billing done in Centricity rather than Dentrix
  - Timeline for interface: Jan 2014 – April 2014
    - Building and testing interface
    - Training, Training and more Training
    - Go-live: April 1st, 2014
Outcomes

**HL7 Interface successes**
- Front desk able to make medical and dental appointments for all patients that present at the clinic
- Medical sites without dental center able to make initial dental appointments
- Able to fill cancellations and no-shows in dental schedule with medical patients
- Better utilization of shared services – do not need separate front desk staff for medical and dental clinics
- Better communication between medical and dental teams
- Created potential for other integrated services
Coordination with Women’s Health Team

- Women’s health promotions team were trained to make dental appointments in Centricity.
- At verification of pregnancy visit, patient is scheduled an appointment with an Ob/Gyn and also scheduled an appointment with a dental provider.
- Ability to capture all pregnant patients presenting to medical clinic at early stage in their pregnancy.
- Dental clinics have seen huge increase in amount of pregnant women presenting for treatment.
- 91% of pregnant medical patients have a dental appointment at Erie.
Coordinated Group Visits

Centering group

- Worked with women’s health team to be part of week 2 centering group
- Provide group presentation on oral health and infant oral health
- Make dental appointments for centering group patients at the end of the session
- If appointments are available in the dental center, centering group patients can be seen the same day
Coordinated Group Visits
Parenting group

- Worked with nurse practitioner to be part of 6 month and one year parenting group sessions
- Dentist provides group presentation on infant oral health
- Patients are given vaccines, have 6 month or 12 month well child check-up with medical provider and dental check-up with the dentist
- Follow up visits are scheduled in dental clinics
- Parents are encouraged to schedule dental appointments also
Coordinated Well-child Visits

- Dentist on-site at medical clinics that do not have dental center
- Provides knee-to-knee exams and oral health education to all medical patients 2 and under presenting for medical well-child visits
- Able to schedule follow up visits in the dental centers
Medical residents rotate through dental clinic

- Erie has a Family Practice Residency at our HP clinic
- As part of the residents training, they spend a day with the dental providers in the dental clinic
- Gives the dental providers a chance to talk to new medical providers about the importance of oral health and systemic disease and vice versa
- Improves collaboration between medical and dental providers
- Significant increase in dental “referrals” from medical residents that rotate through the dental clinic
Call Center taking all dental calls

- September 2014 – the call center started taking all dental calls
- Call center able to make medical and dental appointments for any eligible patients calling into Erie
Case management making appointments

- Case management team trained to make dental appointments
- Making appointments for 6 month and one year olds that have not had a dental appointment
Each site has a health center operations director and medical director that work as a team to manage the clinic.

In sites with dental, I am part of the site management team.

Behavioral health director is also included in the site management team.

The Executive Leadership Team is present at these meetings.

All aspects of the site are discussed at the meeting, including the budget, productivity, current challenges.

The site management team along with the leadership team work to resolve the challenges.
Challenges

- Patient wait times – longer lines for medical registration than dental registration
- IT – new technology, still working out bugs
- Data collection – working on best ways to collect data now that we are using two different systems
- Making sure everyone understands and feels comfortable with new responsibilities and roles
Contact Information:
Email: lkearney@eriefamilyhealth.org
Phone: 312 432 4545
Integration of Oral Health With Primary Care in Patient Centered Medical Homes

Massachusetts and the Qualis Health Framework
What About Massachusetts? (2011 data)

- 31,000 unique adult patients; half age 22-34
- 29.2% had 3 or more ED visits
- ED utilization highest among non-Hispanic blacks

Cost to MassHealth: $2.6 million

Source: Massachusetts Division of Health Care Finance and Policy. December 2012.
An imperfect solution to a big problem

- There are over 700,000 Medicaid Eligible adults in MA
- Only 54 CHC dental sites that can provide restorative care
Access and Affordability Challenges

40% of the population lacks dental insurance

2.5x the % who lack medical insurance

- Even with insurance, dental care is often not affordable

- 47 million live in dental professional shortage areas- In MA, Hilltown and Mashpee are just two.

Dental care is the most common unmet health need
## Findings From Lowell Community Health Center:

### Comparisons for key indicators of oral health and access to care

<table>
<thead>
<tr>
<th>Indicator</th>
<th>United States</th>
<th>Massachusetts</th>
<th>LCHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental decay experience (ages 2-4)</td>
<td>22%</td>
<td>28%</td>
<td>38%</td>
</tr>
<tr>
<td>Dental decay experience (ages 6-8)</td>
<td>51%</td>
<td>58%</td>
<td>82%</td>
</tr>
<tr>
<td>Untreated decay (ages 2-4)</td>
<td>17%</td>
<td>15%</td>
<td>28%</td>
</tr>
<tr>
<td>Untreated decay (ages 6-8)</td>
<td>28%</td>
<td>17%</td>
<td>64%</td>
</tr>
<tr>
<td>Adults with no tooth loss (ages 31-44)</td>
<td>38%</td>
<td>67%</td>
<td>39%</td>
</tr>
<tr>
<td>Dental visits in Past 12 months (children &amp; adults)</td>
<td>44%</td>
<td>76%</td>
<td>55%</td>
</tr>
<tr>
<td>Dental Sealants (age 8)</td>
<td>35%</td>
<td>46%</td>
<td>NED*</td>
</tr>
<tr>
<td>Dental Sealants (age 14)</td>
<td>19%</td>
<td>52%</td>
<td>NED*</td>
</tr>
</tbody>
</table>

* Not Enough Data
Oral Health in Primary Care Project

**Goal**: Equip primary care practices with the information and tools they need to deliver preventive oral health care and coordinate referrals to dentistry.

**Sponsor**: National Interprofessional Initiative on Oral Health

**Consultant**: QUALIS Health

**Funders**: DentaQuest Foundation, Washington Dental Service Foundation, REACH Healthcare Foundation
So How Do We Get There?

Step One: Utilize Qualis Health’s Oral Health Delivery Framework
Oral Health Delivery Framework

5 actions primary care teams can take to protect and promote their patients’ oral health. Within the scope of practice for primary care; possible to implement in diverse practice settings.

Preventive interventions: Fluoride therapy; dietary counseling; oral hygiene training; therapy for drug, alcohol, tobacco use.

Developed in Partnership with a Technical Expert Panel

Primary care and dental providers; leaders from medical, dental, and nursing associations; payors and policymakers; a patient and family partnership expert; oral and public health advocates

Endorsed by:

American Academy of Pediatrics,
American Association for Community Dental Programs,
American Association of Public Health Dentistry,
American College of Nurse Midwives, American Public Health Association – Oral Health Section, Association for State and Territorial Dental Directors,
Institute for Patient- and Family-Centered Care,
National Association of Pediatric Nurse Practitioners,
National Network for Oral Health Access, National Organization of Nurse Practitioner Faculties, Physician Assistant Education Association
Field-Testing a Conceptual Framework

16 diverse healthcare delivery organizations: Private practices, Federally Qualified Health Centers; medical only and on-site dental

Patient groups: Adults with diabetes, pediatrics, pregnant women, high-risk adolescents
Goals: In summary, this project will result in

- Improved access to primary care oral health services in at least 5 CHCs;

- Increased access to dental care through improved collaboration and communication with community-based dentists;

- Increased awareness among primary care teams and leaders of the importance of oral health care;

- Enhanced PCMH implementation, resulting in improved quality, efficiency, and patient experience.
Partners

- DentaQuest Foundation
- Massachusetts League of Community Health Centers
- Community Health Center of Cape Cod
- CHC
- Brockton Neighborhood Health Center
- The Dimock Center
- National Interprofessional Initiative on Oral Health
- Qualis Health
- Lowell Community Health Center
- Hilltown Community Health Centers
How Does a CHC Incorporate the Framework Into Primary Care?
Outline of Steps at each CHC:

1. Leadership Meeting
2. Selection of Practice Improvement Team
3. Kick Off Meeting
4. Sites Select Population of Focus
   - Adults with diabetes
   - Pediatrics
5. Conduct Workflow Mapping
   - Current State- map out from the time a patient enters the clinic to the time they leave.
   - Future State-where the OH framework is incorporated into the workflow and Health IT is modified to support it.
Examples of Workflow Mapping
Pediatric Oral Health Project
Data for May 2015

Percent of Eligible Patients Receiving Oral Health Screen

<table>
<thead>
<tr>
<th>Month</th>
<th>Num</th>
<th>Denom</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar-15</td>
<td>40</td>
<td>62</td>
<td>65%</td>
</tr>
<tr>
<td>Apr-15</td>
<td>98</td>
<td>105</td>
<td>93.33%</td>
</tr>
<tr>
<td>May-15</td>
<td>54</td>
<td>67</td>
<td>80.60%</td>
</tr>
</tbody>
</table>

Percent of Eligible Patients Administered Fluoride

<table>
<thead>
<tr>
<th>Month</th>
<th>Num</th>
<th>Denom</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar-15</td>
<td>40</td>
<td>62</td>
<td>65%</td>
</tr>
<tr>
<td>Apr-15</td>
<td>85</td>
<td>105</td>
<td>80.95%</td>
</tr>
<tr>
<td>May-15</td>
<td>42</td>
<td>67</td>
<td>62.69%</td>
</tr>
</tbody>
</table>

Comparison of FV administration rates:
3/12/14 -3/20/14 : 27% received Fluoride
3/12/15-3/20/15 : 73% received Fluoride

Dimock Community Health Center
Roxbury, MA
Additional Information Learned

• Patients 2 and younger:
  ▪ 73% fall asleep with a bottle containing juice or milk
  ▪ 69% screened in as high risk

Patients 3 years and older:
  ▪ 63% have seen a dentist within the past six months
  ▪ 36% screened in as high risk
After Workflow Mapping Comes:

Plan → Do → Study → Act → Plan → Do → Study → Act

‘What’s next?’
- Plan:
  - Objective
  - Questions & predictions
  - Plan to carry out: Who? When? How? Where?

‘What will happen if we try something different?’
- Act:
  - Ready to implement?
  - Next cycle

Did it work?
- Study:
  - Analyse data
  - Compare to predictions
  - Summarise

‘Let’s try it!’
- Do:
  - Carry out plan
  - Document problems
  - Spot new ideas
### Clinical Process Measures
*Required*
- Percentage of patients given:
  - A written or verbal risk assessment or screening questions
  - An oral exam
  - A referral to a dentist, if indicated based on findings

### Intervention Measures
*Required*
- Percentage of patients in need given:
  - Dietary counseling
  - Oral hygiene training
  - Risk behavior education
  - Fluoride varnish, or other fluoride therapy
  - Medication adjustment to address dry mouth

### Care Coordination and Referral Process Measures
- Number of referral agreements in place with local dental partners
- Percentage of referred patients with a completed dental referral—*required*

### Patient Experience Measures
- Percentage of patients satisfied with the oral health preventive care offered, or coordinated by primary care
- Percentage of patients who received useful oral health information, dietary counseling, or oral hygiene training

### Practice Experience Measures
- Percentage of staff trained to deliver oral health preventive services
- Percentage of staff with demonstrated knowledge of oral health clinical content
- Percentage of staff satisfied with dental referral process
Key Points: Teamwork is Essential

- Use Health IT to identify chronic care gaps
- Involve the whole team in clinical care
  - Everyone working at top of licensure
  - Identify potential care gaps before the visit
  - Verify the care gaps while rooming the patient
  - Set up orders for the provider to sign
  - Arrange for activities at the end of the visit
- Allow the provider focus on acute episodic care needs
The Role of the Coach
What is Practice Improvement Coaching?

- The practice coach helps physicians and their staff gain knowledge and skills in the science of improvement so that they can continue to improve long after the coach is gone.

- Coaching isn’t about making improvement for the health centers, instead its about helping the centers do it themselves!
Process vs Content Experts

- Rely on the CHC team as technical experts, they will know their roles and the culture of the CHC best.
- Coaches can assist by asking questions and challenging resistance.
- Coaches promote teamwork and help define goals.
- As a coach you can provide the tools to help make the project successful.
Lessons Learned
Be Prepared!

• Know your audience
  ▪ Think about the culture of the health center
  ▪ What is their experience with QI/PCMH?
  ▪ Each practice will have its own unique advantages and challenges (Rural vs. Urban)
Listening

• Ask Questions:
  ▪ What are the staff strengths and weaknesses?
  ▪ What are the capabilities of the staff?
    o IT
    o Scope of Practice
    o Languages
  ▪ What is the staff’s comfort level with oral health?
Staying Focused

• Accountability
  ▪ WWW
  ▪ Follow up calls
  ▪ Agendas

• Time
  ▪ Everyone is busy, what is achievable? Breakdown into small tasks.

• QI projects open a Pandora’s Box of “things we need to do” use a Parking Lot to avoid getting off track
Most important...

- The CHC is the **owner**! Focus on coaching and avoid enabling!

- The goal is to give the CHC the skills to continue to do QI projects and make them sustainable!
Resources to Guide the Way

**Oral Health: An Essential Component of Primary Care**
(white paper, June 2015)

- Oral Health Delivery Framework
- Practical model for collaboration with dentistry
- Case examples from early leaders

Available at: [www.QualisHealth.org/white-paper](http://www.QualisHealth.org/white-paper)

**Implementation guide** (toolkit, 2016)

- Sample workflows
- Referral agreements
- Patient education strategies
- Case studies and impact data
Questions?
Contacts

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