Implementation of the Oral Health Delivery Framework
at Dimock Community Health Center

The Dimock Community Health Center (Dimock CHC) is a federally qualified health center (FQHC) located in an urban community in Boston. Dimock CHC provides access to high-quality, low-cost healthcare and human services for adults and children. Dimock CHC previously integrated behavioral health into its practice and took the opportunity to participate in the Oral Health Delivery Framework field-testing initiative. With support from the Massachusetts League for Community Health Centers and their coaches, the staff at Dimock CHC focused on integrating oral health into its practice using the Oral Health Delivery Framework. In this case example, Nandini Sengupta MD, medical director of Health Services; Katie Dolan, MSN, CPNP, pediatric nurse practitioner; and Chenelle Norman, MPH, quality improvement analyst, share their experience as an oral health integration field-testing site.

The history

Dimock CHC received a grant a few years ago to implement fluoride varnish application in children ages 0–5. Dr. Nandini Sengupta shares, "That initiative was successful at first, but then rates dropped off because competing priorities came up. When this opportunity came up, we wanted to dive in again to figure out how to make it more sustainable and go beyond fluoride varnish and develop the referral piece."

Provider motivation

"We hold regular staff meetings, and that engages all of the staff throughout the clinic. We focus on a variety of topics, including oral health. We have three large quality improvement initiatives (oral health, asthma, and nutrition), and we report out on all three regularly. We discuss the rates, analyze what happened when rates drop, share how things are going, and celebrate successes. We print the run charts and post them in places the staff will be able to see them," explains Sengupta.

"When you're in our clinic and you see all those children with caries or crowns, that's pretty motivating! Initially we didn't know what to do about it, and now we have something we can actually do to address it."

The Framework in action

Sengupta describes, "We focused on a pediatric population between 6 months and 6 years. If a patient in this demographic

comes in for a well-child check, they are given the screening questionnaire while they are being roomed. Some patients opt to fill it out online, which they can do before a visit, or in the room, but more people prefer to do the paper form. When they are roomed and handed the questionnaire, the clinical assistant explains that it is to understand how the child is doing with oral health, and that sometimes generates a question or conversation right then."

Sengupta continues, "When the clinical assistant leaves the room, she hangs a goodie bag with a toothbrush and toothpaste on the handle of the door, which serves as a visual cue and reminder for the provider when they come in. Then the visit with the clinician happens the usual way. There is a standing order for fluoride varnish, so at the end of the visit the clinical assistant goes in to administer it, unless the clinician says it is not indicated for some reason. When the clinical assistant is doing the fluoride varnish, she gives three standard oral health handouts and goes over them. They talk about baby bottles and nutrition, visiting the dentist, and oral hygiene, and that also gets documented in the chart so we can track that. The risk assessment and oral health screen are all templated into the progress note, which serves as another visual reminder to the provider to document."

Starting small

Sengupta explains, "We held a workflow optimization workshop with a pilot team and developed a future state workflow with oral health integrated. We then presented it at a staff meeting, tried it with all pediatric clinicians at once, got feedback from the clinical assistants, and did 2–3 PDSA [Plan, Do, Study, Act] cycles. All together it took about two months to get it solid. We started with just fluoride varnish, then we spread to risk assessment, then to oral health education."

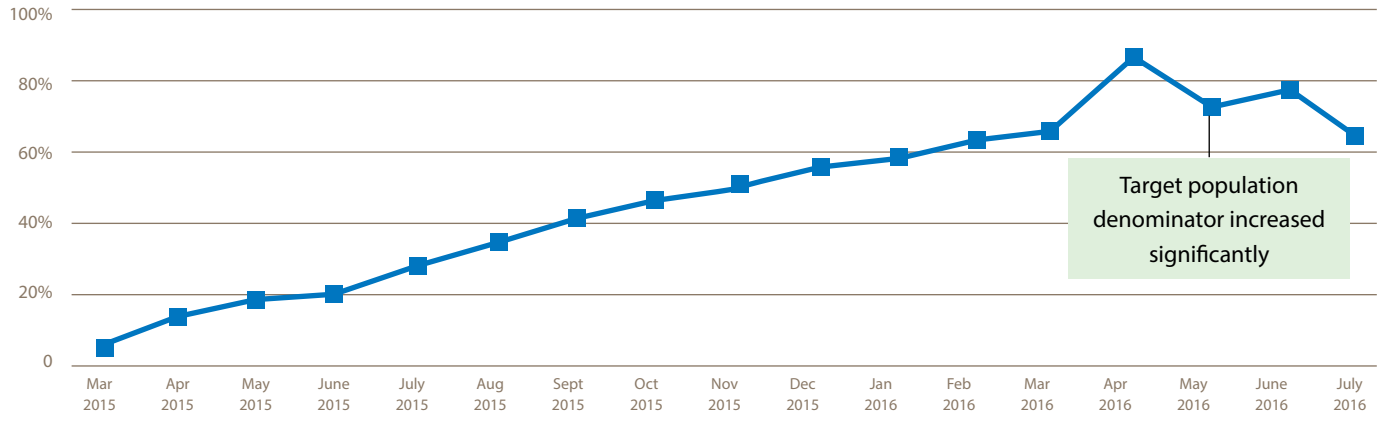
Risk assessment and referral

"We use two screens, one for children ages 0–3, and the other for children older than 3. Each is just three questions, adapted from the AAP [American Academy of Pediatrics] screening tool. Initially we used the screen and then got feedback from the clinical assistants about language difficulty so we adapted the language. We try to make sure all the reading materials we offer are at a third-grade level. About 40 percent of our patients prefer a language other than English, mostly Spanish," explains Sengupta.

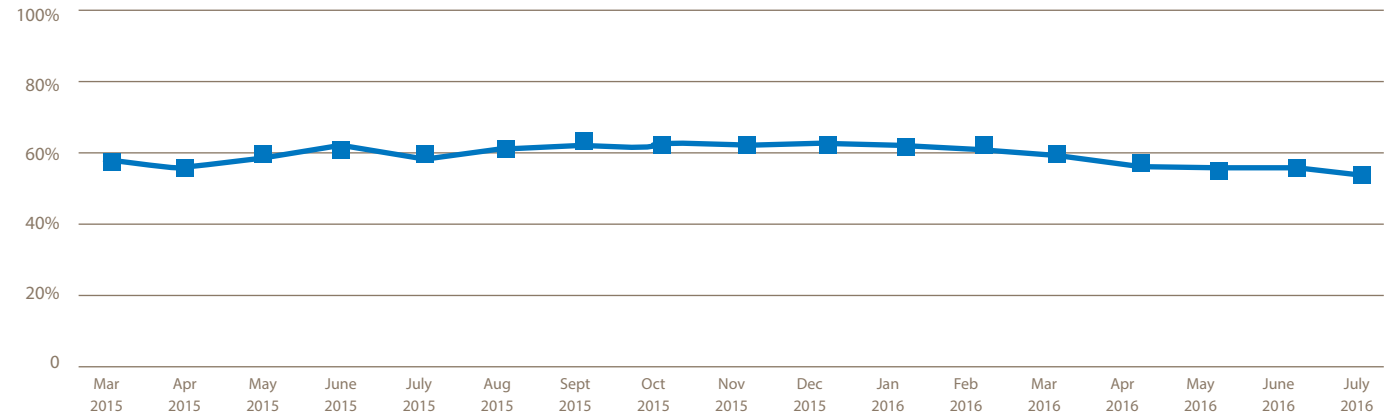
Figure 1: Percentage of target population given oral health assessment (ASK and LOOK)

Data Collection

Chenelle Norman, quality analyst, collects all of the screens done in the previous month, totals them in Excel, and populates the Oral Health Data Reporting Template and Run Chart tool. Norman explains, "The data is structured data in the electronic

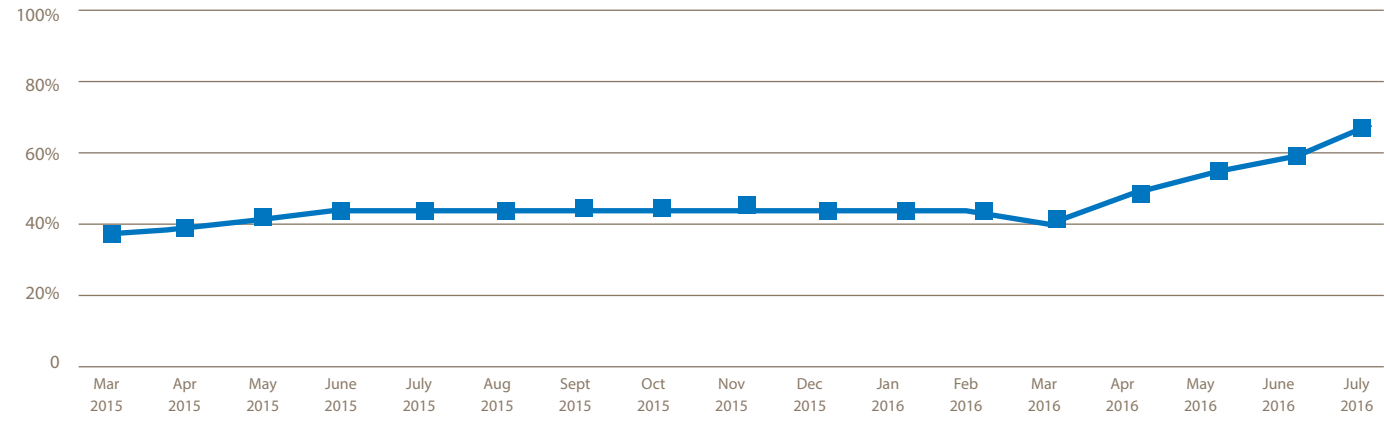


Target population with high-risk oral health profile



health record [EHR], but our information technology [IT] department needs to develop a special report to pull that data automatically, and they haven't done that yet. We pulled an initial automated report, but when we went to validate it, we saw that the report wasn't capturing all of the data. We'd like to have it all be automated in the long run. I spend about three hours a month putting reports together using the manual review process, which is manageable for now." Looking back at the previous year, the fluoride varnish application rate before beginning the field-testing work was about 27 percent.

Figure 3: Percentage of target population patients given fluoride varnish at a well-child visit



Advice for other practices

"We were big on data right from the beginning—we didn't say we'll try it and then start documenting, we set up the documentation in a measureable way right from the beginning," shares Sengupta. "That has kept us on track so we know how we're doing and can see what needs to be improved. We also started with paper documentation while our IT department

figured out how to get the EHR up to speed. Sometimes people get so focused on how to leverage the EHR that the work never gets done, and we wanted to avoid that."

"Clinical assistants have really made this successful. Everyone is always overwhelmed in a CHC, but if you can find a group or team other than clinicians to really own the work, it allows it to be more sustainable."

In the future

"We have a referral module within our EHR, but we haven't implemented it yet because our dental department has recently adopted the same EHR that we all use in Health Services at Dimock CHC, and both operational and clinical staff are not quite ready to accept electronic referrals. We can tell patients to go to the dentist, but we have no way to electronically track the referral and be sure they went. Once the dental department is ready to accept our referrals electronically, we will use the referral system that we use for medical referrals. Our dental department is on the same EHR, so we anticipate that we will be able to communicate," shares Sengupta. "Moving forward, we would like to prioritize strengthening the referral process, and then look at expanding the age range we offer the risk assessment and interventions to. In the future we'd like to be able to look up quickly who has seen the dentist and access the results of that visit."

About the Oral Health Integration in Primary Care Project

Organized, Evidence-Based Care Supplement: Oral Health Integration joins the Safety Net Medical Home Initiative Implementation Guide Series.

The goal of the Oral Health Integration in Primary Care Project was to prepare primary care teams to address oral health and to improve referrals to dentistry through the development and testing of a framework and toolset. The project was administered by Qualis Health and built upon the learnings from 19 field-testing sites in Washington, Oregon, Kansas, Missouri, and Massachusetts, who received implementation support from their primary care association. Organized, Evidence-Based Care Supplement: Oral Health Integration built upon the Oral Health Delivery Framework published in Oral Health: An Essential Component of Primary Care, and was informed by the field-testing sites' work, experiences, and feedback. Field-testing sites in Kansas, Massachusetts, and Oregon also received technical assistance from their state's primary care association.

The Oral Health Integration in Primary Care Project was sponsored by the National Interprofessional Initiative on Oral Health, a consortium of funders and health professionals who share a vision that dental disease can be eradicated, and funded by the DentaQuest Foundation, the REACH Healthcare Foundation, and the Washington Dental Service Foundation.

The guide has been added to a series published by the Safety Net Medical Home Initiative, which was sponsored by The Commonwealth Fund, supported by local and regional foundations, and administered by Qualis Health in partnership with the MacColl Center for Health Care Innovation.