Expanding Oral Health Access for Children:
Early Experience from the Bluegrass Community Health Center

The Bluegrass Community Health Center [BCHC] is a federally qualified health center [FQHC] and a Level 3 patient-centered medical home sponsored by Eastern Kentucky University. Established in 2001, BCHC was originally funded to serve local farm workers. In 2007, additional funding allowed expansion to serve the greater community, including low-income families, the homeless, and Medicaid and Kentucky Children's Health Insurance Program recipients. BCHC became a center for refugee screening and primary care in 2011. In this case example, Dr. Steve Wrightson, MD, medical director; and Donna Agee, clinic nurse manager describe the early experience of oral health integration and BCHC's experience as a leader in the field.

The history

"My work in this area started in 2001, when HRSA [Health Resources and Service Administration]released the grant to educate primary care providers about oral health, inspired by the Surgeon General's report in 2000 about the state of oral health." explains Wrightson. " I was working locally with the University of Kentucky School of Public Health-Dentistry, and nationally I was part of the development of the Smiles for Life curriculum. I was in the residency program at the University of Kentucky, on faculty, and I tried to implement things like fluoride varnish for children in the residency program, but there wasn't a lot of buy-in from other faculty members."

"Bluegrass CHC was just starting, and Susan Fister, a PhD nurse, came onboard as the CEO. She knew of my work through mutual colleagues, and came to a lecture I gave at the University of Kentucky on oral health and children. Afterwards, she said offering fluoride varnish to children in BCHC was a no-brainer, and wouldn't be difficult to do," explains Wrightson. "Susan got fluoride varnish from the health department for free, but she couldn't get her providers at the time to apply it to the patients. Even though it was freely available, their fluoride varnish application rate was less than 1%". percent

The evolution

In 2010, Dr. Wrightson joined the providers at BCHC as the medical director. "I brought my interest and passion in the topic of oral health with me, and when I arrived I said, 'Well, where do you keep your fluoride varnish?' and they said, 'Um, we have it here somewhere' and dug it out," Wrightson describes. "It's clear that if you don't have anyone in the clinic who is interested in it, it won't happen. Initially we put it in the hands of the clinicians and there was a slow uptake—10 percent application rate one year, 20 percent the next. So I conferenced with the nurses and asked them how we could make this happen."

"This increased our fluoride varnish rate up to 50 percent, where it has remained consistently since then. Making it a standing order was key—having it in our system where it was easily performed, and part of the flow of the workday."

The nurses recommended creating a standing order—a policy that dictates that any child under the age of 6 who hasn't had fluoride varnish in the previous 6 months will get fluoride varnish at their primary care appointment, regardless of the reason for the visit.

Key motivators

Dr. Wrightson has found that key motivators for clinicians include having an internal champion, providing education so providers understand why they're being asked to do the work, and having the ability to track progress through the electronic medical record (EMR). "Ultimately, particularly to sustain it, you need to feel like you're having success. People need to see how they're doing with the initiative. If you're not tracking it, you're not likely to improve on it—that's why an EMR makes it easier," explains Wrightson. "We don't have an internal IT department, but we were able to put prompts in the EMR. The oral health screen and varnish comes up as an alert if it has been more than 6 months since it was recorded." Donna Agee, clinic nurse manager shares,

"We made the Smiles for Life curriculum required for staff as part of their onboarding, and then annually for all staff. We also focus on celebrating the work we do, and celebrating Steve's work nationally."

Other factors for success

"We don't have a lot of staff turnover, and we have the nurses there as part of the team to make sure the standing orders are done. The special populations we serve (the homeless, migrant farmworkers, refugees) inspire passion in those who work here," explains Wrightson. "When I asked the nurses what they like best about this program, they shared that they are most proud of the children who come in who are refugees who are in pain, or embarrassed because of the state of their oral health. One child came in recently and just wouldn't open his mouth despite lots of coaxing, until the nurse had to draw blood; then he opened his mouth to cry in pain and they saw his mouth was in bad shape! He was referred to dental care, and when he came back in and smiled, proudly I would say, the clinicians saw they had changed his life," shares Agee.

Data collection

As an FQHC, BCHC is required to report an oral health measure to HRSA. "We choose to report fluoride varnish application as one of the uniform data system [UDS] measures we report to HRSA, to meet that oral health requirement. I would love to see all community health centers be required to use that as their UDS measure.
If HRSA says it's important enough to be required, then it would become standard," shares Wrightson. "As with all of our UDS measures (including pap screens, immunization rates, etc.), we share that information with clinicians, both our clinic-wide rates and our per/clinician rate. Clinic-wide measures are posted on the wall of every exam room so patients can also see that information. We run the data reports quarterly, because we want to know why the people who are doing well are doing so well-—what is that provider doing with her team that makes it happen? And if someone else is not doing as well with fluoride varnish, we want to ask why it isn't being done, to know why we're missing it," explains Wrightson.

Financing

"In Kentucky, Medicaid does pay for fluoride varnish application at a rate of about $15 per application. However, it is not in addition to your prospective payment system [PPS] rate. If we provide fluoride varnish for a patient who has Medicaid (and most children we see do), we get our PPS rate but nothing in addition for providing fluoride varnish," explains Wrightson. "Basically we're just paying for it and see it as part of the service we offer, because we feel it's part of the mandated care we're

obligated to provide to patients. It's not expensive, just $1.50 per application for the varnish. It takes 10 seconds to apply. It takes more time to do some of the counseling that goes along with it, though some of the counseling is similar to what we need to do anyway, like nutrition counseling. But basically we just pay for that. In the scheme of things, if you realize that you're doing this a couple of times a year for patients, and if you're reducing the caries rate by one to three caries per child, that's ultimately a big cost savings for the system."

Patient education

"We give all children the Bright Futures oral health education materials. For older kids and adults, if they're not seeing a dentist regularly, our clinical assistants are trained to show them how to floss and how to brush," explains Wrightson. "We create care plans for patients who need additional support (like adults with diabetes), and oral health is part of that care plan. So the nurse will spend time counseling them about oral health and seeing a dentist as part of that care plan."

Patient response

"Clinical assistants have to do a lot of education about fluoride varnish, since a lot of people initially refuse, saying things like, 'I see a dentist' or 'I don't have time today,'" admits Agee. Wrightson explains "Often when the fluoride varnish rates were low initially, it was due to a clinical assistant who was not as comfortable convincing the patient to let them apply the fluoride varnish. Now, they have learned from each other and they are more confident doing the education, and if they still face resistance, the nurse and then the clinician can go in and explain the benefits. One of the biggest challenges the providers face is if someone doesn't want fluoride varnish. Refusal usually comes from a lack of understanding about what fluoride varnish is, and what benefit it provides. Some patients may still harbor the old notion about fluoride being dangerous." This is a familiar situation for clinicians, with patients often initially refusing other procedures like HIV testing. "Patients initially refuse, the clinical assistant provides additional education, and if they still refuse the clinician can go in and give them their information about the importance. That usually works," describes Wrightson.

"Some people are taken aback when you talk about oral health in the primary care office. But it's a much smaller percentage than I expected when we started out. Most patients appreciate it, and feel like 'Thank goodness someone asked me about that because nobody ever has.'"

"We do an outreach clinic at a homeless day center in Lexington, and the first time I went to the center, I think I saw maybe 10 people that day. At least half of them, their primary reason for wanting to see the doctor that day was they were having problems with their teeth. The good thing about that is we were able to directly help
90 percent of them," describes Wrightson. "One patient, we had to do some creative things to try to get him help (he had Medicare, so he didn't have access to dental insurance immediately). The other four patients were all able to get in to see a dentist; we just had to smooth the pathway for them. Some of the people with the most significant problems we were still able to help."

"I can't say that we're touching all of our patients' oral health needs. However, since we focus on children, diabetic patients, the homeless, and refugees, that is a pretty big percentage of our patients we see!" exclaims Wrightson. "And by process of osmosis, it goes to the rest of the patients as well. If we're paying this much attention to 75 percent of our patients for oral health, why wouldn't we address it with the rest? It engenders growth in that area for clinicians, nurses, clinical assistants. If you're not doing much at the beginning, once you start and pick your target groups and expand on that, it does grow."

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.

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