Integrating Oral Health into Primary Care: Lessons Learned from Rodgers Health

Rodgers Health is a multisite federally qualified health center (FQHC) located in Kansas City, MO. Services offered include medical, behavioral, OB/GYN, and dental healthcare for patients from newborns to seniors. Rodgers Health consists of a large downtown location, in Kansas City, and three smaller clinics in the surrounding area. They operate with a centralized referral system and health information technology (HIT) department that serve all four clinic locations. Rodgers Health selected the Lafayette Family Medicine clinic, located in a more rural setting in Missouri, for their pilot team, and began oral health integration in November 2014. The pilot team at Lafayette consisted of Tina Moore, APRN, FNP-C; Brenda Lierman, practice manager; Jamey Onnen, DDS; Nadia Douglas, patient care representative; Teresa Rogers, patient care representative; and Stephanie Cole, certified medical assistant. They were supported by Patricia Beatty, MBA, quality improvement coordinator; and Jeffrey Draper, CHTS, NCP, systems application manager.

Getting started

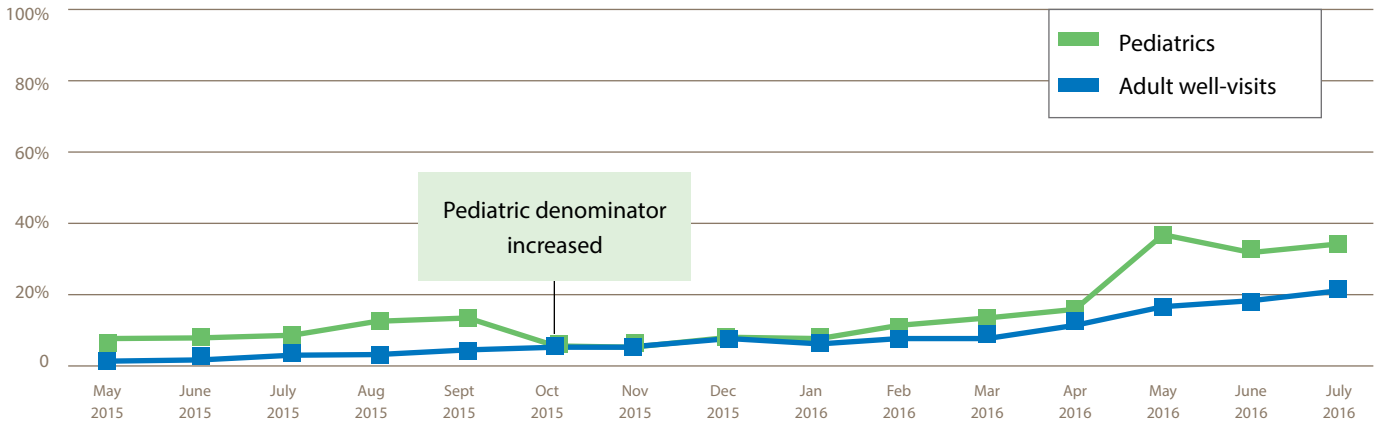
Tina Moore, APRN, FNP-C, describes what initially engaged Rodgers Health in oral health integration. "The management team at Rodgers Health elected to be part of a project to integrate oral health into the medical model of care. When the chief medical officer presented the idea to me, I was excited to be a part of the project because I knew this was a new and evolving area of medicine. We started with my patient panel, focusing on adult and pediatric well visits," explains Moore. "We knew that the biggest challenge would be time management—this was adding one more thing to the already full patient appointment. We mapped out exactly, to the smallest detail, what the patient was doing from start to finish. That helped us take a look at the reality of an appointment, and then we worked out exactly where we could implement the Framework, and who would do what. Being that detailed in the planning up front helped us be successful in implementation," Moore shares.

"We all thought we'd have to give something up to fit in oral health, but once we got the workflow worked out we were all surprised to see it really didn't take that much time, and we didn't have to lose anything to get it done."
The Oral Health Delivery Framework in Action

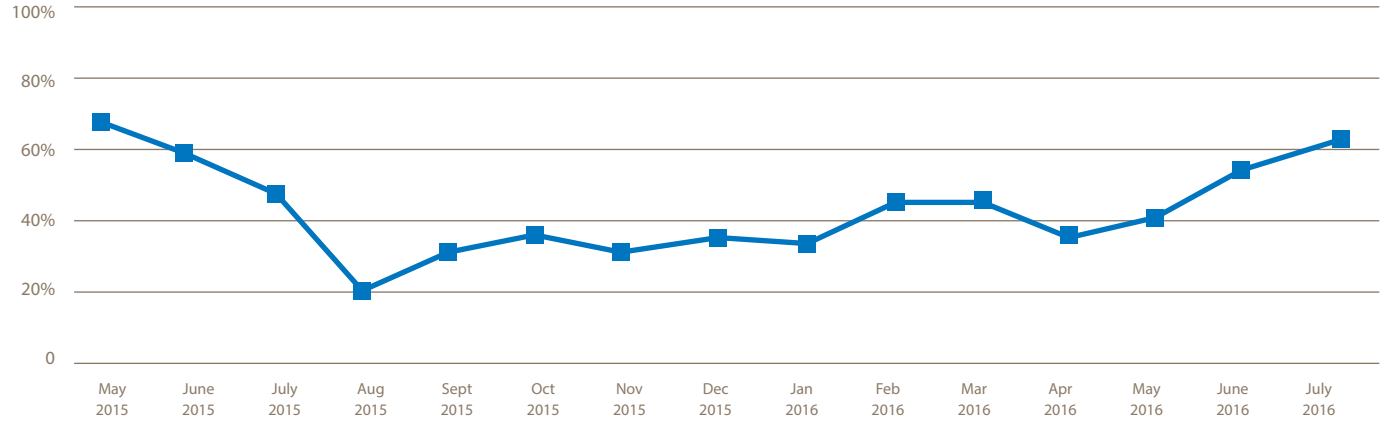
When a patient is due for an oral health assessment, they are asked if they have dental insurance while checking in with the reception staff. Brenda Lierman, practice manager, explains, "The clinical assistant takes them back to the room, does vital signs, and does the screening assessment. When the clinical assistant lets Tina know the patient is ready, they also give her the information they've gotten from the patient—whether there are any signs of caries or any patient complaints about oral health." Moore shares, "The HIT department has come up with a very nice oral health template, so I can pull up the template and see what has been recorded. When I go in I talk about the importance of oral health, and the importance of having a dental home if they don't have one. I order fluoride varnish and a referral to dentistry if it's needed. Then the nurse comes in and provides more oral health education, and we give them a toothbrush and toothpaste."

Patient Reaction

Percentage of adult well-visit and pediatric patients who received the oral health screening assessment



Percentage of adult well-visit patients screened high risk on oral health assessment at the Lafayette Family Medicine clinic



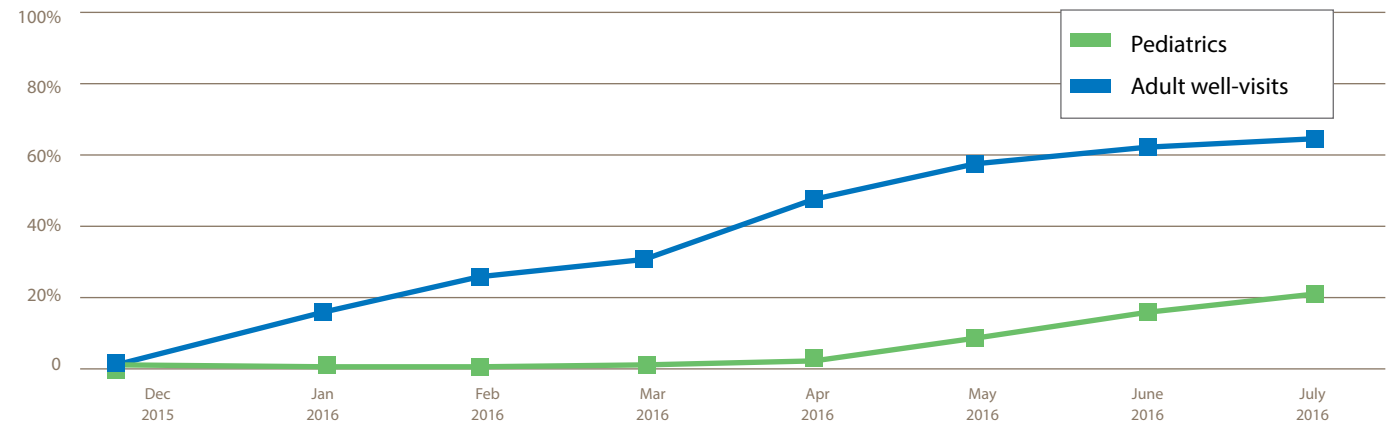
their oral health addressed—they like to learn about it and it makes them feel like they're getting more comprehensive care. Surprisingly, a fair number will refuse the referral to dentistry," shares Moore. "The culture has been that you only go to the dentist when you really need to because you're in pain; preventive services aren't the norm. A lot of the refusals are probably due to financial challenges or lack of education. The leadership team is working to figure out how to remove the lack of dental insurance barrier, but we haven't figured that out yet. The majority of our patients don't have dental insurance," explains Moore. "Most children do have dental coverage, so the percentage of that population who follow up on referrals is higher."

Spreading the Pilot

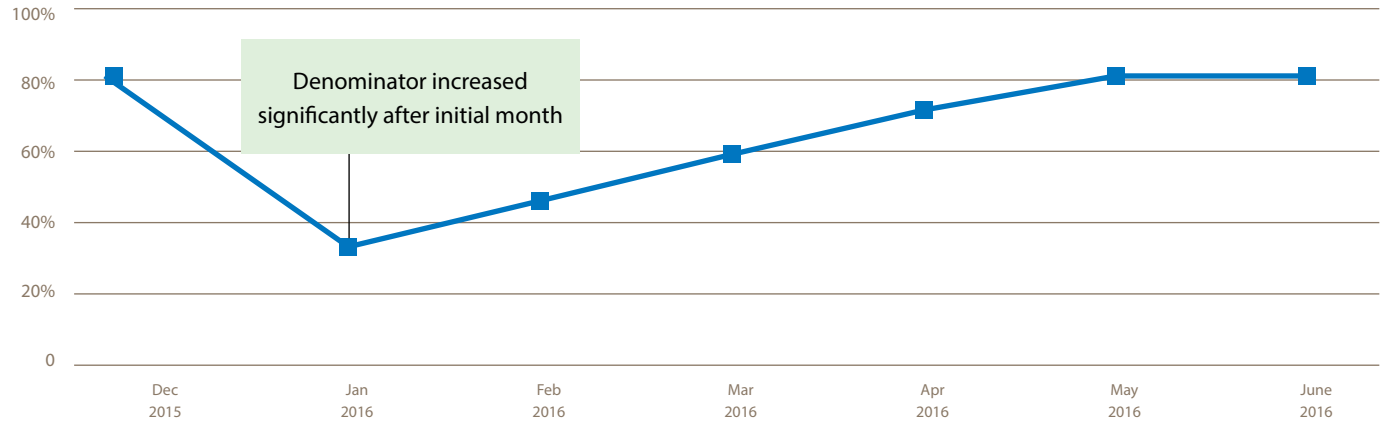
After beginning with well visits for adults and pediatrics, the pilot team spread to all obstetric patients, and then added patients with diabetes. That process took seven months, at which point the leadership team decided to spread to the other clinic sites in the Rodgers Health system. Beatty shares, "It took longer to get up and running at the new sites than it originally did at the Lafayette clinic. Lafayette is small, and the medical and dental are located around the corner from each other on the same hallway. We thought we would start with that team and develop a process that we could roll out to everybody." Beatty explains, "When we started to spread to the Cabot Westside Medical clinic, we realized that every site was a little different, so there was going to need to be some variety in the implementation. It was a little more involved than we originally anticipated, and we had to take a step back and look at the workflow at the new site." The team decided that they did not need to start from scratch at the Cabot clinic, or at the Clay County Family Medicine clinic, which was their third site in the spread process. "We started with the Lafayette clinic's workflow and wound up taking some of it and then creating some new components based on feedback from the new teams. When we spread to the Cabot clinic and the Clay clinic we spread to all clinicians at the site at the same time," explains Beatty. When the team prepared to spread to the largest site in downtown Kansas City, they felt the workflow process would be different enough that they started with just one department (pediatrics) before spreading to the others.

Clay County Family Medicine Clinic had a unique challenge in beginning oral health integration. After initial training and implementation, their sole physician provider was temporarily re-located to another clinic site for several months. The provider who delivered locum services during this period of time was not trained in oral health integration. Although staff members continued to try to assess patients, the number of adults and children with completed assessments increased only slightly.

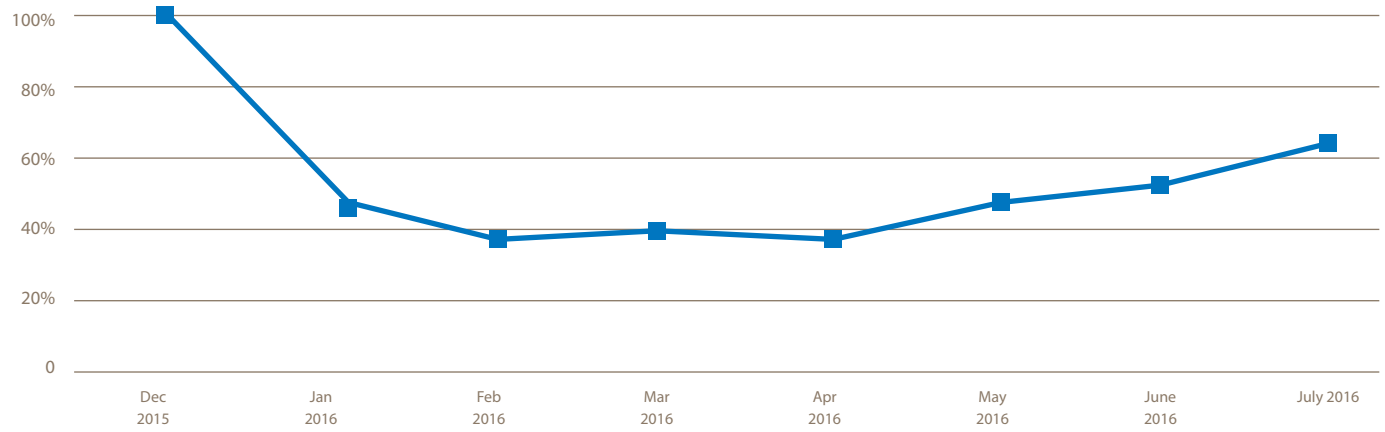
Percentage of adults with diabetes and pediatric patients who received the oral health screening assessment at the Cabot clinic



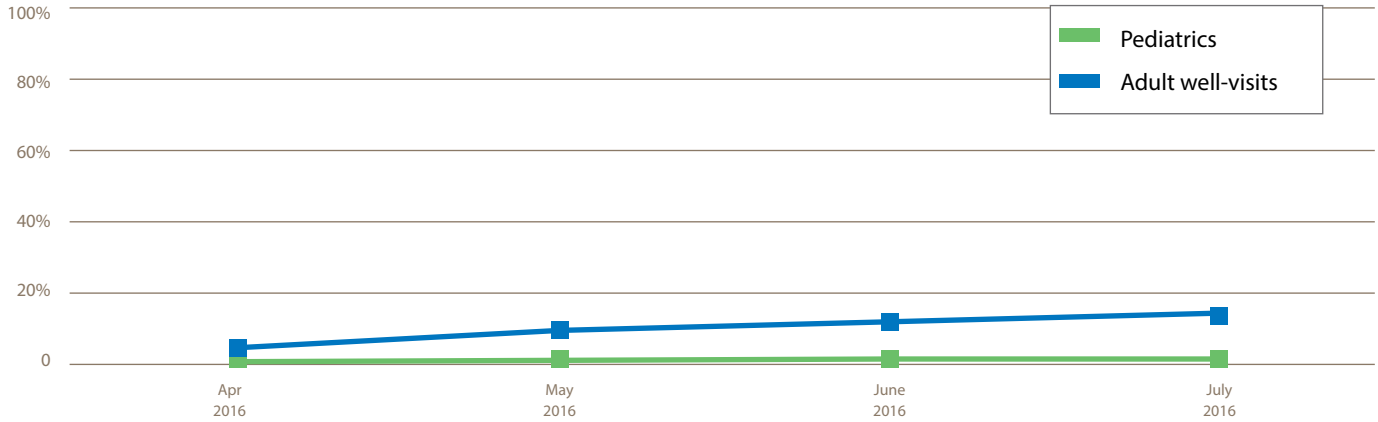
Percentage of patients with an oral health issue identified on screening assessment who were referred to a dentist at the Cabot clinic



Percentage of adults with diabetes receiving fluoride varnish for high risk oral health screen at the Cabot clinic



Percentage of adults with diabetes and pediatric patients who received the oral health screening assessment at the Clay County Family Medicine clinic



Now that the physician care team leader is back at Clay County Family Medicine Clinic, Rodgers Health plans to re-train members of the care team and provide monthly data feedback, and anticipates seeing numbers increase as they have at other clinic sites.

Referrals

While the Lafayette clinic has a co-located dental clinic and a pre-existing centralized referral department, they did not have a structured internal referral process from medicine to dentistry prior to this project. "Initially, we put together a good referral process for our clinic," explains Moore. When the pilot began to spread to the other clinics in the Rodgers Health system, however, unexpected challenges with the referral process arose. "As we spread to the next clinic, we received some pushback from some of the clinicians because we were asking them to do more work with the referral forms and the oral health template. So we modified the process a little bit, and changed the template in the electronic health record [EHR]," shares Moore. Patricia Beatty, quality improvement coordinator, explains, "After a couple of months when we checked the data reports, we found that some referrals weren't getting through to our referral coordinators, so referrals were being placed but the patients hadn't been contacted to schedule an appointment. We had to go back and reach out to all of those referrals to make sure they got scheduled." The referral process has since been corrected. "We didn't monitor the process closely enough when we spread to Cabot," admits Beatty. "I was focused on UDS reporting, and by the time we realized and re-grouped, we had lost two months of referrals." Their lesson learned is that close monitoring of the process and data is key when changing a process and/or spreading to a new team or location.

The referral process has evolved over time as well. "Ideally a referral goes into the EHR, and the referral coordinator receives it and calls to schedule an appointment with the patient. The referral coordinator then monitors the referral to see when the patient comes in for an appointment, ensures a report is generated for the patient's record, and then closes out the referral once the clinician has the report in the record," explains Beatty. "We are still working on refining the internal process to make sure we get a report back from dentistry. We need to work out a standard note template so that the report that comes back to

primary care is standardized. We're talking about how to make something pop up in the EHR when the dentist is entering his notes that would remind him this is a referred patient and something needs to go back to the primary care clinician."

For more stories of referral processes and data from field-testing sites, see the Oral Health Integration Referral Experiences Case Example.

Electronic Health Record Modification

One key element to the successful implementation across the Rodgers Health system is their EHR and ability to modify it. Moore explains, "We worked with the EHR department so we have just one template that all team members can record information in. Once we went live, we wound up altering the template on several occasions as we made sure our workflow process worked, so we had to work with the EHR department which we share across the system." The HIT department was able to build the necessary reports to extract the oral health data that the clinicians record. Beatty shares, "Data is reported and shared monthly with the key players. We have a general quality improvement process where we review the data to look at care gaps and talk about how we can close those gaps." The data extraction and reporting process had its share of challenges, too. "One of the initial challenges was just how do we get the data out of the EHR system, especially in a way where we could look at it by clinician panel, and then how to look at just the target populations within that panel. We did figure out a way to do that," shares Beatty. Initially, reports looked at discrete visits within a month, and the process of building reports to look at the data from a population health perspective took some time. "Population health management was a new concept, so it took a while to figure out how to do that, and we still have to go back and check the numbers, and sometimes revise the reports," admits Beatty. "I think we will use population health management in many ways going forward."

> "For the Lafayette clinic, being as small as we are, it's not often we get an opportunity to do something like this, and it was a good team-building effort for us. Everyone was on board; everyone was pulling their weight to make it happen."

Additional benefits have been seen across the system as well. Beatty explains, " The referral process benefited from the oral health work. We knew we needed to work on it before, and it's still not exactly where we want it to be, but taking on oral health integration really highlighted how we needed to streamline our process and created improvement in the system."

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.