SECTION 5

Staffing Options and Workflow

Introduction

The Oral Health Delivery Framework (the Framework) defines what can be done in primary care to protect and promote oral health. Exactly what this looks like in any given practice will depend on the staffing model in the practice and the processes by which care is delivered. This section will first review the range of staffing options available to a primary care team. This is followed by a description of how the Framework can be included in the primary care workflow so that it:

- Aligns with practice transformation in preparation for value-based reimbursement.
- Works with all staffing models.
- Can be used with any target population.
- Supports small steps in oral health integration.

"Clinicians see the importance of oral health—we haven't had to convince anyone that it is important. The challenge for clinicians is time and competing interests. The more that we can do to make oral health integration just a part of the regular process and the more we can do to simplify it, the better."

—Samantha Jordan, DMD, MPH, Lowell Community Health Center

Staffing

Terms used to describe different staffing roles and their scope of practice vary from state to state. The terms used and their intended meaning within this implementation guide are shown in Table 5.1.

Table 5.1: Terms used to describe roles in the typical primary care team

Term	Title
Clinician	Physicians: Medical Doctor, Doctor of Osteopathic Medicine Other Clinicians: Physician Assistant, Nurse Practitioner
Nurse	Registered Nurse Licensed Practical Nurse
Clinical Assistant	Medical Assistant
Clinic Personnel Supporting All Teams	Pharmacist, Lab/Imaging Technician, Social Worker, Referral Coordinator, Patient Educator, Reception Staff, Billing, Patient Service Representative, Community Health Worker/Promotora, Dental Hygienist*

*The presence of a dental hygienist in a primary care clinic is not typical of primary care practices unless the clinic contains a co-located dental practice. None of the supporting roles for clinic personnel listed here are required for a primary care practice to address oral health, yet for clinics in which these roles are present they offer opportunities for an expanded oral health program (e.g., offering dental sealants) depending on scope of practice laws that vary from state to state.

The staffing models described here represent the spectrum of care team compositions observed in the field-testing sites. They are presented as a way to discuss advantages, disadvantages, and work-arounds for various staffing options, and are not intended to advocate any particular model as a "best practice" for integrating oral health into primary care. Oral health integration has been successful across a variety of staffing models. The key is for a team to determine the best utilization of the staffing resources they have for addressing oral health. For example, a pediatrician may decide to apply fluoride varnish while examining a child because it works best for that clinic's workflow.

Staffing model option one—clinician/clinical assistant dyad

The most common structure in many settings is a single clinician working with a single clinical assistant, whose job is primarily to manage patient flow.

Advantages

The advantage of this "teamlet" is that it is often stable and based on a close working relationship. In this setting, parts of the Framework can be relatively simple to implement if the clinical assistant asks the oral health questions and looks in the patient's mouth while the clinician reviews the clinical assistant's work, verifies positive findings, and makes the clinical decisions. A stable teamlet can identify patients who are overdue for an oral health assessment and take advantage of all opportunities to address oral health, such as conducting the risk assessment during an episodic care visit if the patient has not been coming to their well visits.

"Don't overcomplicate the work, keep it simple, and keep your goals within reach. Make sure you get staff buy-in—not just from clinicians but also from the clinical assistants. If the clinical assistant doesn't start the screening and remind the clinician, it won't happen, so they play an important role."

—Benjamin Lightfoot, MD, Brockton Neighborhood Health Center

Disadvantages

- If visit times are short (15–20 minutes), the clinical assistant will frequently be multitasking. This generally means little capacity to add work while rooming patients, and no time at the end of a visit for coaching. A teamlet may need to limit its oral health focus to simply identifying patients with active oral disease and referring them to a dentist. This disadvantage may be overcome by using non-care team clinical personnel (e.g., a Women, Infants, and Children [WIC] nutritionist) to perform educational tasks or apply fluoride varnish.
- If the teamlet relationship is unstable, it may be impossible for a clinician to be comfortable delegating oral health tasks to the clinical assistant.
- In this structure, if the dyad does not have the support of a referral coordinator, care coordination may be a challenge. Care coordination is most effective if a designated individual on the team or in the clinic is responsible for following clearly defined procedures.

Leveraging the clinician/clinical assistant teamlet for oral health integration

For clinician/clinical assistant teamlets, the volume of work clinical assistants do while rooming patients is often a bottleneck, which may be worsened with additional tasks. There are several useful tactics for minimizing this risk:

- Limit oral health assessment in young children (under age six) to well-child exams, and to a yearly basis for older children, adolescents, and adults.
- Configure clinical decision support in the electronic health record (EHR) to make it easy for the care team to identify patients on the schedule who are due for an oral health assessment while reviewing a chart in the huddle.
- Use the huddle to prioritize tasks to be completed while rooming each patient on the schedule. Create an expectation that while rooming a patient, the clinical assistant will work his or her way down the priority list as far as possible without negatively impacting patient flow.
- Limit the oral health assessment to four questions. Script the clinical assistant to ask the questions using a language level appropriate for the patient in order to minimize time spent explaining a question.
- Limit the scope of oral health integration (at least initially) to activities requiring minimal additional clinical assistant work. Focus efforts on identifying patients with active tooth decay and gum inflammation, and referring those patients to a dentist. Leave assessment of behavioral risk factors, coaching on diet/oral hygiene, and fluoride varnish for later.
- Create a protocol by which the clinical assistant can enter an order for a referral to dentistry for the clinician to sign based on a positive response to the pain and bleeding question or suspected oral disease on visual exam, or if the patient would simply like a referral.

"The clinical assistant goes through the charts for the day and determines who is due for an oral health assessment. We're focusing on patients with diabetes and have tried doing the screening at different visits—figuring out the best visit to do the assessment during has been a bit of a challenge. The clinical assistant asks five questions, and a positive answer to any of them triggers an oral exam by the clinician. A positive answer to any of the screening questions and/or an abnormal exam generates a referral. Oral health education brochures get printed from the EHR."

—Michael Purdy, MD, Hilltown Community Health Center

Limit the job of the clinician to:

- Reviewing the clinical assistant's findings.
- Looking at the patient's teeth and gums.
- Following up on oral dryness as a possible side effect of a medication.
- Underscoring and reinforcing oral health messages delivered by the clinical assistant.
- Reviewing and signing (if appropriate) orders placed and pended by the clinical assistant.

Summary of staffing model one

Clinician/clinical assistant dyads are a common care team structure that frequently offer stability and close working relationships. However, there are disadvantages to this structure, which can be minimized by deliberate attention to decreasing the impact of oral health integration on the jobs of the clinical assistant and clinician. This can be accomplished by limiting the frequency of the oral health assessment, the number of assessment questions, or the scope of oral health integration; configuring the EHR to support clinical decision-making; and using the huddle to prioritize tasks.

Staffing model option two—advanced primary care teams

Increasing the size and complexity of the team expands the potential for preventive and chronic illness care, including oral health, during and in between office visits. There are numerous potential configurations for multidisciplinary care teams.

One clinician/multiple clinical assistants

Care teams with two clinical assistants (medical assistant and/or LPN) have greater capacity to integrate oral health into their workflow:

- With this configuration, the clinical assistants can improve preparation for the visit by scrubbing the chart for care gaps that can be closed during the visit, and then work with the clinician to prioritize them during the huddle.
- The work of rooming patients is less likely to compete with other care team tasks. This decreases pressure on the clinical assistant to omit the Framework while rooming patients, and allows more time to engage patients in conversations about oral health.
- The team has the capacity to organize end-of-visit activities to include oral health risk factor coaching, application of fluoride varnish, and setting up of referrals.

Patient educator role

The presence of a nurse, dietician, or diabetes educator will enable a practice to provide coaching on oral hygiene and diet with minimal impact on workflow. Practices without health education staff can devote a clinical assistant to this work or, if staffing resources are unavailable, use print or media resources instead. Refer to Summary of Patient Education Resources for oral health education materials in a variety of languages that can be shared with patients. Refer to Summary of Primary Care Clinical Interventions for a summary of techniques for more robust oral health hygiene and dietary counseling.

Complex teams

Larger interdisciplinary teams comprising, for example, a clinician, an NP/PA, a nurse, and multiple clinical assistants have sufficient depth and flexibility to address the components of the Framework during an office visit through task sharing and cross coverage. A model for oral health integration for multidisciplinary teams to consider for the future would be one that includes a dental teamlet in the care team, for example, a dentist and/or dental hygienist, and multiple dental assistants.

Advantages

- Well-resourced teams can unload many tasks from busy clinicians, allowing them to focus on complex clinical issues and increasing the likelihood that preventive and chronic illness activities will be completed.
- Non-clinician staff often find greater satisfaction as they are given larger roles in patient care.
- Clinicians frequently experience greater professional satisfaction working in complex teams.
- Clinical protocols, which are necessary for delegation of tasks to non-clinician care team members, are an opportunity to make standards of care explicit and based on clinical evidence.
- A care team member can be given responsibility for care coordination, resulting in a more personal referral connection for the patient.

Disadvantages

- Many clinicians have little experience working in interdisciplinary teams and have not developed some of the necessary skills to do so. For more information on team-based care and team skills development, refer to the Continuous and Team-Based Healing Relationships Implementation Guide. Practices that are newly working in teams may find that engaging in oral health integration work helps build teamwork skills.
- Successful delegation of clinical tasks requires reliable and skilled team members, which may not be available.
- Fee-for-service reimbursement, which limits revenue to office visits with the clinician, may be insufficient to support a complex care team.

Summary of staffing model two

Advanced primary care teams, which come in several configurations, allow more flexibility in integrating oral health into the workflow and offer the clinician more opportunities to focus on complex clinical issues, while offering non-clinicians greater job satisfaction as they assume more responsibility for patient care. Disadvantages include potential lack of experience with interdisciplinary teamwork and delegation and fee-for-service reimbursement limitations.

Staffing model option three—population health personnel

A number of different types of skilled personnel (nurse, dietician, social worker, pharmacist) are capable of playing essential care management roles in population health. When primary care teams are given additional resources, often shared across several teams, there is an opportunity to expand the expertise of these highly trained team members to include activities that support oral health integration:

- Care team members can provide additional capacity for behavior modification coaching.
- Oral health can be incorporated into other disease management activities that entail patient engagement and self-management support.
- Oral health can be part of condition-specific events such as planned diabetes visits, prenatal groups, or group visits for frail elderly.
- Outreach activity for population health can be expanded to include contacting patients in target populations due for oral health assessment.
- Pharmacists can play an important role by counseling patients about sugar in liquid medications, and about oral dryness as a potential side effect of medications.
- There is growing experience in select populations utilizing community health workers (CHWs) and promotoras for community needs assessments, patient engagement, and patient education.

"I work with the patients with diabetes, and I'm enjoying the new oral health program—it's something good for my patients and my community. I have a close relationship with my patients, so I explain that this is a new service for them that is available here. Part of my vision for the future is to see more community health workers working with patients and educating them. This community has limited education, they have a lot of barriers, and I can help with that. I didn't have a lot of education about oral health, and I am part of the community. After I learned about it, I understand how important oral health is for all of my patients, and for all of the One Community Health patients." — Alicia Sandoval, Community Health Worker, One Community Health

The advantages and disadvantages for staffing model option 3 are nearly identical to those for staffing model option two listed on page 59–60.

The availability of additional care team members increases the ability of the team to provide the oral health assessment to its entire panel of patients instead of limiting its effort to one or two target populations. It also increases the ability of the team to expand the scope of their efforts to identifying behavior-mediated oral health risk factors such as diet and oral hygiene. The role of the clinician would not be expected to expand, remaining limited to the actions described above on page 58.

Summary of staffing model three

A staffing model offering greater numbers of skilled personnel in management roles creates greater opportunity to support oral health integration. Advantages and disadvantages of this model closely parallel those of the advanced primary care team model.

Workflow Structure

The general structure of a primary care office visit is shown in Figure 5.1. Primary care clinics have all developed workflows within this structure based on their staffing model and influenced by a number of additional factors that will vary from clinic to clinic:

- Clinician level of comfort with clinical task delegation.
- The skills and abilities of available support staff.
- Reimbursement considerations.
- Additional considerations for practices with co-located dental services.

It is possible to fit some of the Framework actions into existing preventive and chronic care visits for both children and adults, with minimal impacts on workflow.

Clinician comfort with delegation of clinical tasks

Clinicians vary in their willingness to delegate clinical tasks to support staff. There are many reasons:

- Clinicians may be concerned that adding more tasks for their clinical assistant means it will take longer for them to room patients.
- Clinicians may not trust their clinical assistant's ability to perform the tasks reliably.
- Clinicians may have a culture of working alone and be new to the concept of teamwork.

Skills and ability of available support staff

Clinical support staff often vary in their ability or willingness to adopt new skills or manage new tasks. Commonly, complex new tasks, e.g., pulmonary function testing or phlebotomy, are embraced by some clinical assistants and avoided by others. In comparison, preventive oral health tasks, such as fluoride varnish application, are relatively simple, and in the field-testing sites, many found that clinical assistants were eager to perform this skill. It is important to decide for oral health what constitutes a core competency checklist for all clinical support staff and then develop standardized training and procedures, so that all clinical support staff members develop competence and confidence. As with any clinical task, there must be a mechanism for monitoring how oral health tasks are

being performed. Many of these core competencies can be maintained with online training, such as Smiles for Life, as an adjunct to in-service training, which, although developed for clinicians, is reasonable for clinical support staff as well. Refer to the clinical content training developed for the field-testing sites and described in Section 4: How to Prepare for Successful Implementation. Clinics with co-located dental practices may be able to get dental hygienists or dental assistants to lead onsite training to update the skills of clinical assistants.

Case Vignette: Integrating a Co-located Dental Hygienist at Community Health Centers of Benton and Linn Counties

At Community Health Centers of Benton and Linn Counties, a multi-site federally qualified health center located in and around Corvallis, OR (population 54,000), the leadership team chose to begin its oral health integration pilot with a new clinician who has a single clinical assistant and a small total patient panel. "I've gone through all of our patient panel—about 150 patients—and put a private sticky note in the patient chart that says 'needs dental assessment' because there's no easy way to enter it in the EHR. We're a new practice with a small panel, so it's relatively easy to manage it this way," shares Sheila Lien, the clinical assistant for the pilot clinician. Initially, the leadership team thought they would focus just on the patients with diabetes on the panel, but they realized that scale would be too small, and it would create additional work to determine who was due for a screen. Lien explains, "When a patient comes in who has that sticky note, I ask them the screening questions including whether they would like a referral to the dental hygienist. If their answers indicate they are high risk, then I look in their mouth as well. I ask everyone if they would like a referral to the co-located dental hygienist for a cleaning and evaluation, and I schedule them directly before they leave the appointment. I give out toothbrushes and toothpaste, and if they have an outside dentist that they already see, then I make a referral to that dentist and I call their office to get the scheduling process underway." Using the co-located dental hygienist in this way maximizes efficiency within a small team. Patients who do not have an existing relationship with a dentist will get referred if necessary by the dental hygienist.

Practices with co-located dental facilities

Medical practices in facilities with co-located dental practices have additional opportunities for workflow innovation to integrate oral health into primary care:

- For patients referred to dentistry, the clinical assistant can make the dental appointment during the end-of-visit segment of the primary care visit in the exam room, and can make a warm handoff directly to a member of the dental care team. Although a referral order is still important for communication and referral tracking, co-located practices may be able to minimize the administrative work necessary for dental referrals.
- Dental personnel are available to monitor, provide oversight, and improve the primary care team's clinical skills in interpreting the answers to oral health questions and identifying subtle findings on examination.
- Clinicians on both medical and dental teams are available to each other for informal, real-time clinical advice.
- Dental assistants can be trained to monitor blood pressure, check for overdue screening or chronic care monitoring needs, and pay attention to immunization schedules, including giving influenza vaccines during flu season.

To read more about an innovative co-located education and practice model, refer to the Interprofessional Education and Care at the New York University Nursing Faculty Practice case example.

The availability of a dental assistant or dental hygienist within the primary care practice and/or a co-located dental practice does not diminish the importance of integrating oral health preventive services into the primary care workflow. In order to expand access for the entire panel and emphasize the centrality of oral health in overall health, it is important for the primary care team to create and maintain a focus on integrated oral health. In a co-located practice, the emphasis can shift to reinforcing a common message collaborating on a common approach to population management for oral health. For example, a dental hygienist shared across multiple primary care teams might support a clinic-wide initiative to ensure that children receive sealants and older adults at risk for caries receive fluoride varnish. Both of these efforts would be carried out in the primary care setting with dental leadership. The ability of a clinical setting or delivery system to pursue any of these opportunities will depend upon the stability of the clinic as a whole, the level of interdisciplinary collegiality, and the presence of adequate resources for each side to take on additional tasks to assist in the effort.

Reimbursement opportunities

One of the reasons it is important to have the chief financial officer or office manager on the program team is that quality improvement initiatives are most likely to be sustained when they are responsive to the financial realities of the organization. Given the limited financial reserves with which most primary care practices operate, it may be necessary to limit initial services to those that are associated with at least some level of reimbursement (e.g., fluoride varnish for children), those for which there is a clear business case under alternative payment models, and those deemed to have no negative financial impact on the organization (e.g., provisioning of patient education resources).

When considering reimbursement opportunities, the chief financial officer will be considering the following:

- The value of developing population management competency and whole-person care in preparation for value-based reimbursement.
- Projected revenue from reimbursable services*:
  - Fluoride varnish.
  - Oral health screening and family education.
- Costs of applying a single care standard to all patients, regardless of coverage or reimbursement, that includes:
  - Fluoride varnish.
  - Documenting clinical information for reimbursement.
  - Additional staff, if any required, to support the workflow.

For more information on reimbursement opportunities and issues, refer to Section 8: Leveraging Success: Spreading and Sustaining.

"We can get reimbursed for the assessment and the fluoride varnish. Due to an insurance company requiring an additional form be filled out in order to be reimbursed for the oral health assessment, we decided to just go forward and do the assessment knowing we may not get reimbursed. We're trying to make the process as seamless and simple as we can for staff, and adding one more form for staff to complete increases the change that the workflow won't work. Reimbursement is important, but we're not going to not provide oral health services because of that."

—Aron Goffin, MPH, Multnomah County Health Department–East County Health Center

*The American Academy of Pediatrics (AAP) Oral Health Reimbursement Chart maintains state-specific information on delegation of oral health activities and reimbursement rates.

A common-sense workflow for oral health integration

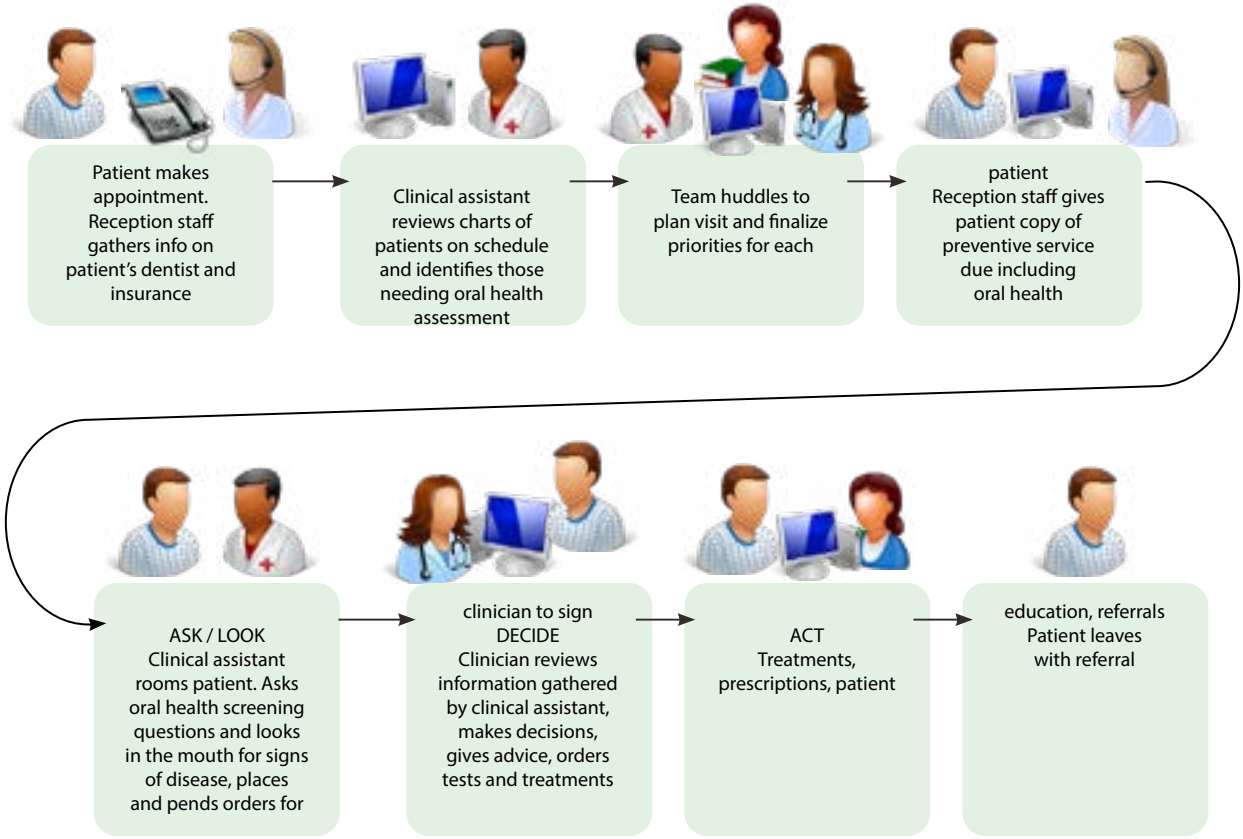
Figure 5.1 graphically depicts a workflow in which the Framework is integrated into the primary care office visit, applying the principles that have been stressed in this implementation guide so as to maximize the benefit to patients with the minimum disruption of the underlying workflow. These principles include:

- Sharing the work of gathering and organizing clinical information across the care team.
- Creating protocols for clinical decisions that require minimal clinical judgment and are algorithm driven, so they can be delegated to clinical support staff.
- Configuring clinical decision support within the EHR to present information necessary for decision-making to the person responsible for a decision, so that the right decision can be made with the least amount of effort.

Before the visit

- The reception staff has an opportunity both as the patient makes an appointment and in preparation for the appointment to update dental insurance and the name of the patient's dentist.
- The clinical assistant reviews the charts of all patients on the schedule in preparation for the huddle prior to the first patient appointment. Among the purposes of this activity is to make a list of all preventive actions that are necessary for each patient. The clinical assistant will bring this list, including the oral health assessment, to the huddle where it will be prioritized for each patient.
- In the huddle, the care team prioritizes the list of tasks the clinical assistant will try to do while rooming the patient.

Figure 5.1: A common-sense approach to integrating oral health into the primary care workflow





During the visit

- As the patient arrives at the clinic for the visit, the reception staff gives the patient a list of the screening and preventive services that are due, including oral health assessment.
- As the patient is roomed, the clinical assistant asks the age-appropriate questions that are part of the Framework, and performs a look in the mouth to identify signs of oral disease. Based on the result of this screening assessment, the clinical assistant may set up an order for a preventive intervention or referral corresponding to the findings in the patient's chart.
- The clinician reviews the clinical assistant's findings, checks positive findings, and signs the orders. For any findings that require advanced clinical judgment, including acid reflux and oral dryness, the clinician gathers the information necessary for diagnosis/treatment and develops a treatment plan.
- At the end of the visit, the orders for the actions are carried out by one of the care team members. This includes orders for fluoride varnish, coaching, and referral to dentistry.

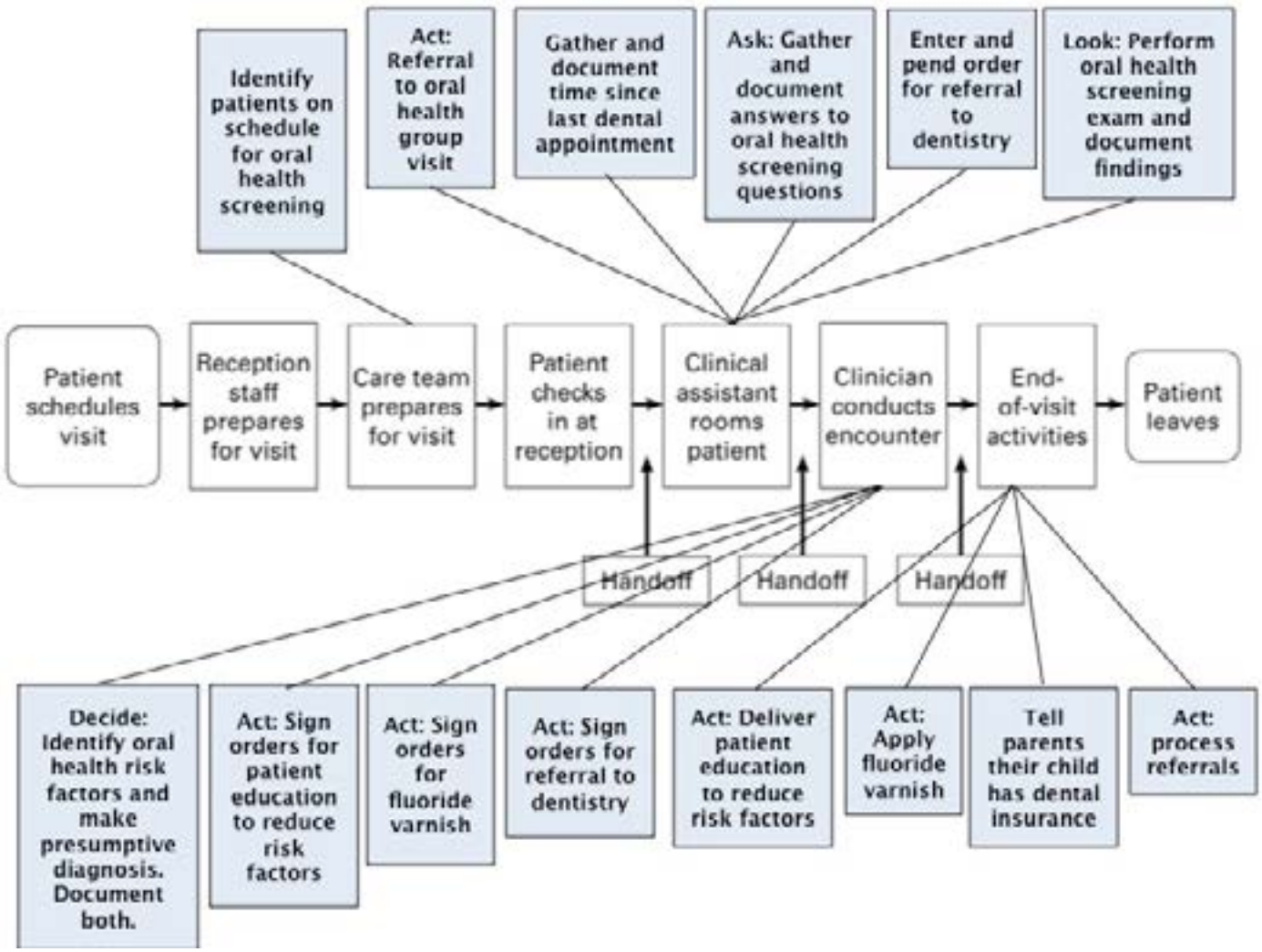
On the following pages are two examples of primary care workflows from field-testing sites that were optimized to include portions of the Framework.

"This has been really good for me, as a clinician, to remind me of the importance of oral health and how easy it is to incorporate it into the practice, and the benefit for my patients. I've had a small handful of patients who have had important significant dental issues that got addressed, and they wouldn't have been addressed otherwise."

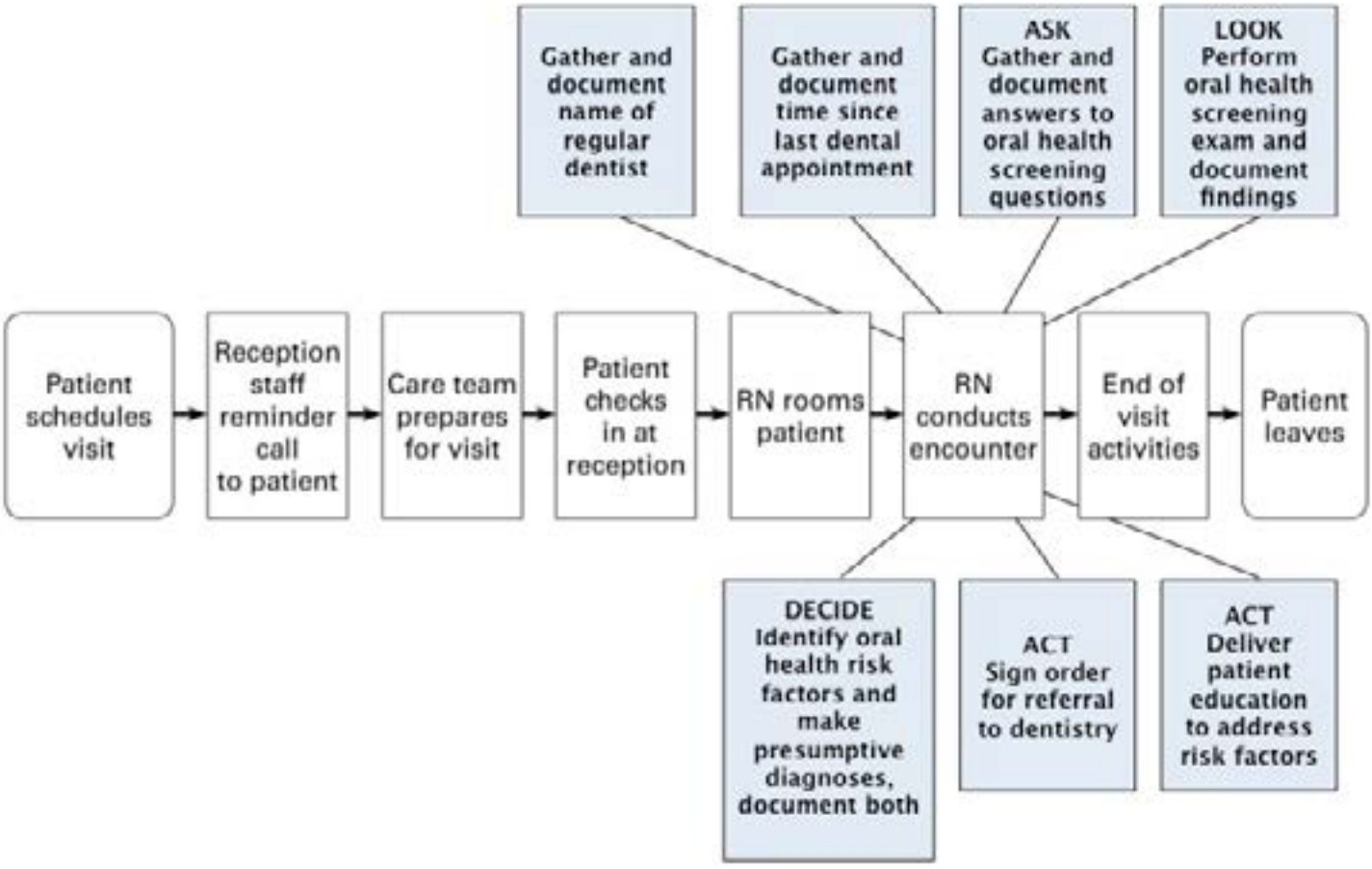
—Deborah Nalty, MD, Providence Medical Group–Monroe Clinic

Figure 5.2: Examples of workflows successfully used by field-testing sites

Well adult visit—Rodger's Health
This field-testing site found that by moving the information-gathering steps earlier in the workflow to be completed by the reception staff at check-in, efficiencies were created that freed up other staff later in the workflow to perform other actions as needed.



Prenatal visit—Harborview Medical Center
This field-testing site found that having the nurses be responsible for addressing oral health during the first new OB visit was the most efficient and effective way to accomplish the work, because the nurses played such an important role in patient education.



Health Information Technology

Use of Health Information Technology Within the Optimized Workflow

The role of health information technology (HIT) in developing a streamlined process to fit oral health into the busy primary care workflow is to match the tools available in the EHR to the unique characteristics of the micro-environment in which a care team is working, as determined by the team configuration, the patient population, and countless other factors. This means that the HIT tools for entering and using information pertaining to oral health should be designed so that potentially any care team member could use them. This gives the care team maximal flexibility with different staffing models and workflow innovations. Potential ways to support oral health integration using HIT could include:

- Creation of a tool or field to display the date of the most recent oral health assessment, which informs the clinical assistant whether a patient is due for an assessment or not.
- Utilization of the specifications for data entry fields to accept information gathered in the ASK and LOOK parts of the Framework described in Section 4: How to Prepare for Successful Implementation. These have been kept as simple as possible to allow their use by anyone on the primary care team.
- Orders for actions defined by a written protocol placed using the order set, by any care team member, and then signed by the appropriate person depending on the order.

Administrative data

HIT pertaining to the Framework focuses on clinical information that is used for making clinical decisions. There is also a set of administrative data that practices will need to consider how to manage that includes the name and contact information of the patient's dentist as well as dental insurance information:

- Most EHRs have a place to keep contact information for medical and surgical specialists. The identical information for dentists should be kept in the same place.
- The practice will need to decide where in the workflow to collect and record dental insurance information to help determine where to refer the patient if needed. The two choices are to collect, verify, and record it prior to the visit of every patient, or to only collect it on those patients for whom a referral to dentistry has been made.

Integrated workflow optimization

A representative of the HIT department or the local HIT staff member is an essential member of the workflow optimization team. The care team members will do most of the work in the workflow mapping; however, questions will arise that only the HIT staff member can answer. It is during the second part of the mapping, when the Framework is being translated into tasks that are to be performed at specific points in the future state workflow by designated individuals, that someone who understands the HIT perspective needs to be present. The care team may or may not understand the limitations and the potential of different EHR features, and the HIT staff member's role is to help find solutions to the challenges the care team may face. The following are examples of the types of questions that can arise:

- What are the options for quickly identifying patients on the schedule who should have their oral health assessed during the visit?
- How can the system be set up to print the oral health questionnaire to give to a patient at reception when checking in?
- How can information that a clinical assistant enters into the chart be incorporated into the clinician's note?
- What are the options for a clinical assistant to communicate a positive finding to the clinician?
- What decision support tools are available to ensure that a patient with a modifiable oral health risk factor receives all the corresponding interventions?
- What are the options for documenting coaching for diet/oral hygiene that takes place during the office visit?
- What are the options for maintaining oral health education handouts and tools in the EHR?
- What are the options for separating internal referrals from external referrals to dentistry in the order menu?
- What features does the EHR have to track referrals, and can they be configured to track dental referrals?

At the end of the workflow optimization mapping, many of the tasks to be completed before the future state can be tested are likely to involve HIT, and the person who is responsible for such tasks will need to fully understand the context of the request. The HIT staff member will need to work with the leadership of the workflow optimization group to make sure that the HIT modifications are made to meet the needs of the care team.

Click here to jump to Section 6: HIT: Support for Structured Referrals