SECTION 9

Field-Testing Results and Case Examples

Introduction

The Oral Health Delivery Framework (Framework) was successfully field-tested by 19 diverse primary care practices in Washington, Kansas, Missouri, Massachusetts, and Oregon between 2014 and 2016. These sites included urban, suburban, and rural practices. Collectively, they focused on four unique target populations for their initial pilots and utilized five different electronic health records (EHR). The sites varied in size, and included both private practices (hospital-based, independent, and part of a large integrated delivery system) as well as community health centers (most of which are federally qualified health centers). Summary results and impact data are included in this section, as well as annotated links to in-depth case studies.

Overall Intervention Distribution

Implementation of the Framework varied across the 19 sites, as practices customized the model to fit their circumstances, resources, and clinician interest. Some practices had the resources necessary to fully implement the Framework from the beginning, but as Table 9.1 illustrates, most field-testing sites did not do every possible component of the Framework. Several sites chose to do some additional activities like prescribing chlorhexidine rinse for patients with periodontal disease. All sites focusing on a pediatric target population chose to offer fluoride varnish as a preventive intervention (though the age-range parameters varied), and three sites focusing on an adult population with diabetes also chose to offer fluoride varnish.

Table 9.1: Oral Health Framework Components implemented by field-testing sites by state

Framework Components	Washington field-testing sites	Kansas/ Missouri field-testing sites	Massachusetts field-testing sites	Oregon field-testing sites
	N=4	N=5	N=5	N=5
Screening Assessment: ASK and LOOK	4	4	5	5
Preventive Intervention:	3	5	4	
Changes to the Medication List		2	2	
Fluoride Varnish		4	2	3
Chlorhexidine Rinse			2	
Oral Health Counseling		1	2	
Education Handout	3	2	4	2
Referral	4	3	4	5
Referral Tracking	3	3	1	2

Framework Component Run Charts

Field-testing sites used the Oral Health Data Reporting Template and Run Chart tool to visually display the different components of the Framework that they implemented. Tracking these trends over time allowed sites to follow their progress, determine when their process was stable enough to begin to spread, and in some cases to motivate teams to continue to improve their workflows. This section shows some of the data trends observed among the field-testing sites.

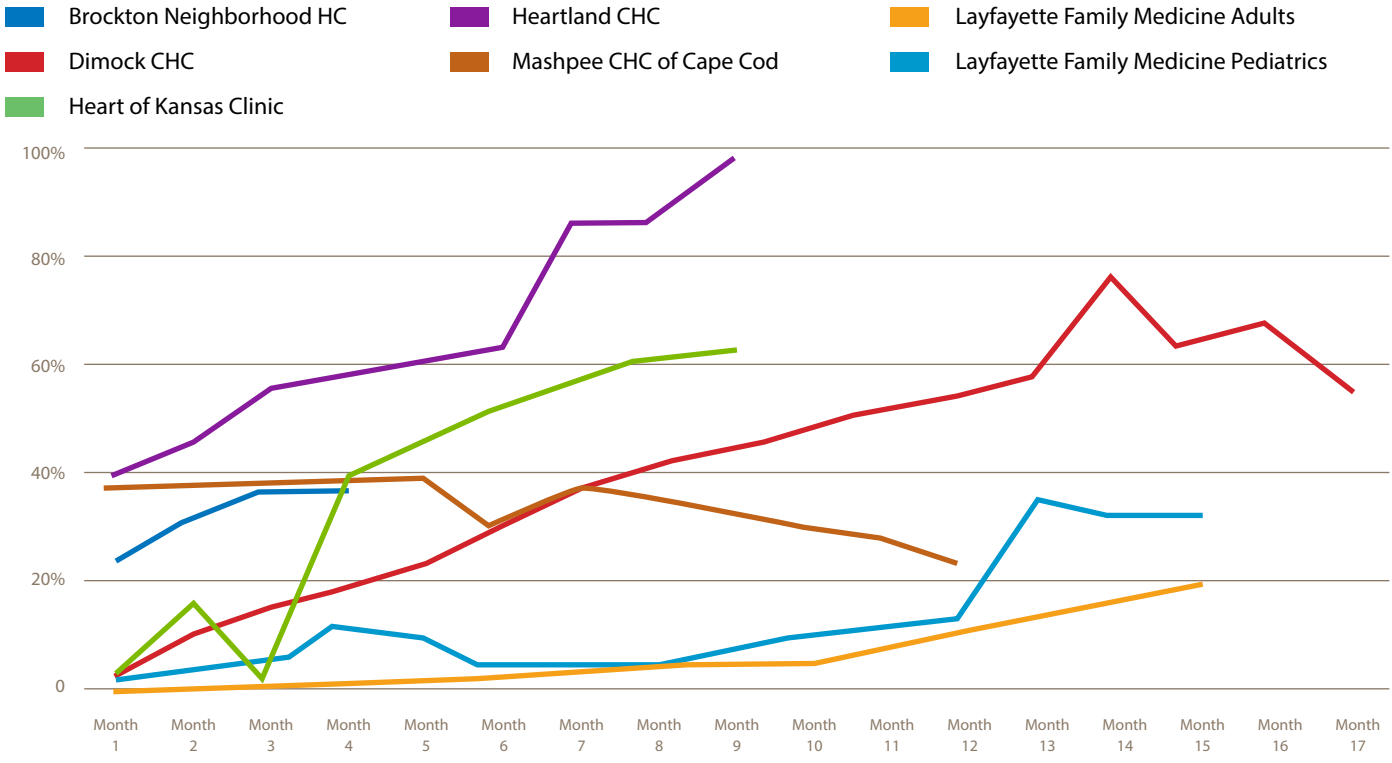
Patient impact

13,771 patients were given the oral health screening assessment during the 20 months of field- testing, across 17 of the 19 sites. Two sites were unable to report this data.

4,518 patients had fluoride varnish applied during the 20 months of field-testing, across eight of the nine sites that selected that preventive intervention. One site was unable to report this data.

1,255 patients were referred to a dentist during 20 months of field testing, across 13 of the 16 sites making dental referrals. Three sites were unable to report this data. This is an under-representation of the actual number of patients connected to dentistry, as additional sites reported making referrals but were unable to capture their referrals to dentistry as structured data in their EHR. Additionally, some sites reported only new dental referrals, and did not track the times where a patient had an existing dental relationship and the primary care clinician referred them for a current concern.

Figure 9.1: Percentage of target population assessed by month of project

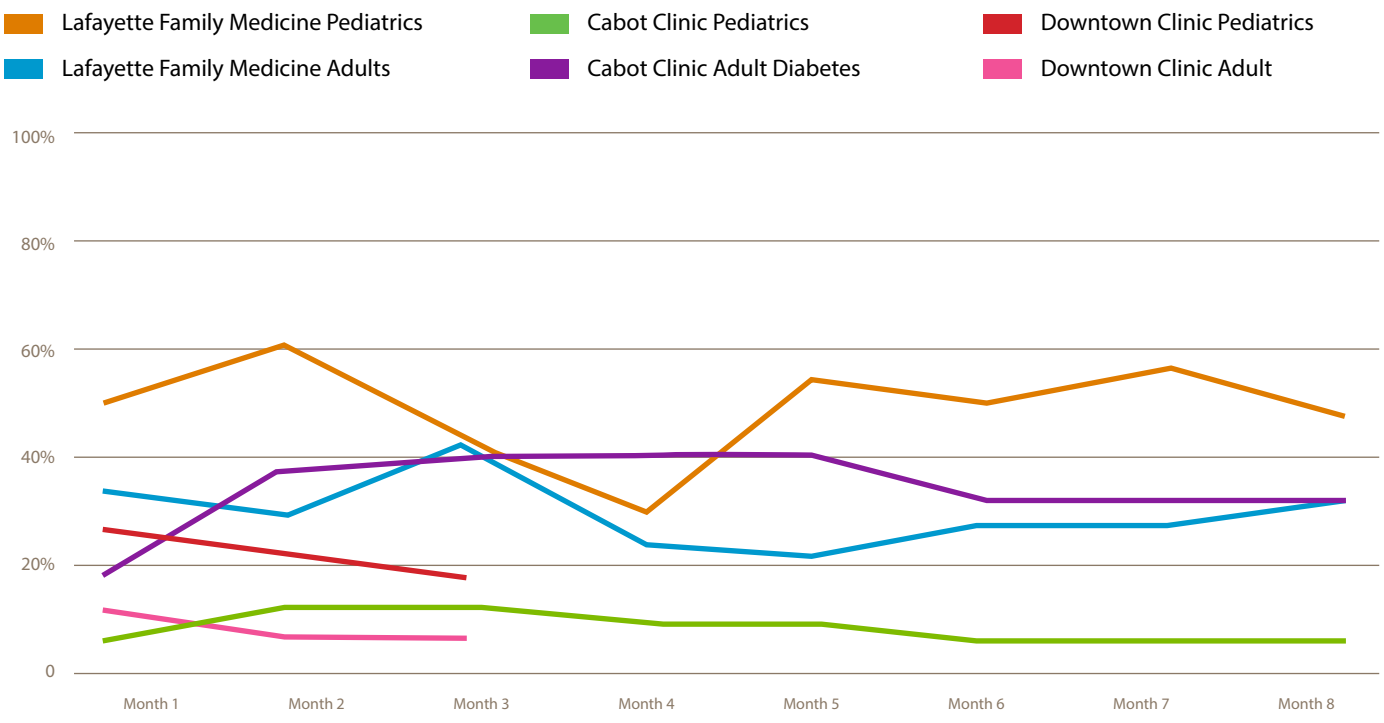


Field-testing sites started the oral health integration work at different times, so Figures 9.1, 9.2, and 9.3 use Month 1, 2, 3 in the x-axis to denote the progress of the sites over time.

Figure 9.1 displays run chart lines for oral health assessments given by pilot teams at a number of different field-testing sites. Some sites were able to progress through the implementation phase rapidly resulting in a steep upward curve as their target population was assessed. Others progressed more slowly. A downward trend, and dips in the upward trend, can occur when the denominator (all patients in the target population) increases significantly from one month to the next without a corresponding increase in oral health screening. At the one year mark, the trends start to shift as patients screened at the beginning of the pilot no longer appear in the numerator of the one year look-back report.

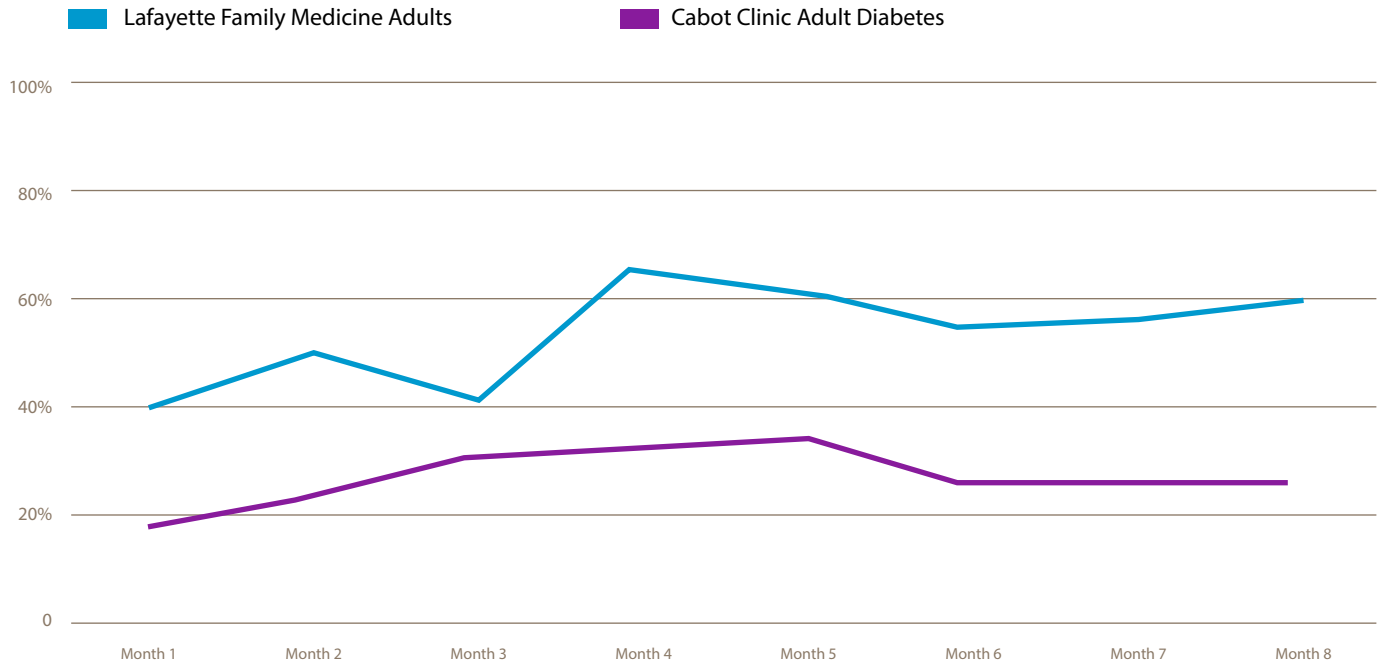
Some sites chose to track the prevalence of signs of oral disease in their patient population. This can be useful to help focus patient education efforts, and to motivate care team members. Other sites were unable track this information as structured data and report it. Sites engaging in an oral health integration program will need to evaluate their report writing resources and prioritize those reports that will be of greatest value to the care teams and their patients. See Section 7: Using Data for Quality Improvement for more information on this process. Figures 9.2 and 9.3 below show the variation in prevalence of signs of disease among different clinics in the Rodgers Health system in different target populations.

Figure 9.2: Prevalence of signs of caries among patients screened at three different practice sites in the Rodgers Health system



It is interesting that Lafayette Family Medicine shows a high rate of suspected tooth decay in the pediatric population compared to the two urban pediatric sites. Lafayette Family Medicine is located in a county in which a significant percent of the population lacks fluoridated water, whereas the populations served by the other pediatric sites have fluoridated public water. It is difficult to know whether this finding represents an accurate reflection of caries prevalence, or whether other factors may be at play such as a small sample size and variation in clinician sensitivity to identifying signs of oral disease.

Figure 9.3: Prevalence of signs of periodontal disease among patients screened at two different practice sites in the Rodgers Health system



Early months of reporting tend to be outliers due to the small number of patients screened as the pilot is beginning. As the program grows and a larger percentage of the population is screened, trends tend to even out and more accurately reflect a stable observed prevalence in the community.

Figure 9.4: Fluoride varnish rate for pediatric patients at Dimock Community Health Center

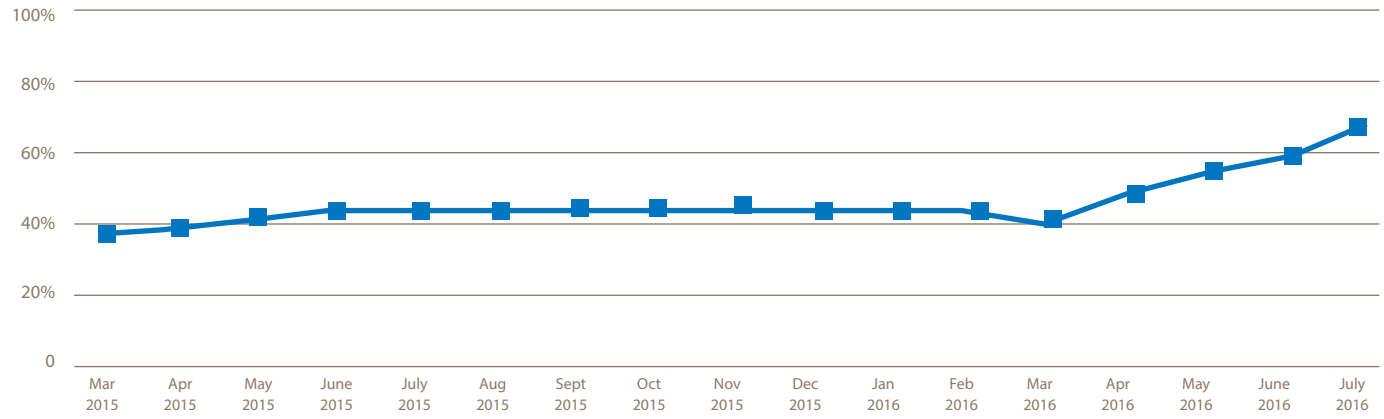


Figure 9.4 is an example of a typical run chart for a preventive intervention offered in the primary care setting. Some field-testing sites chose to offer fluoride varnish to pediatric patients as a preventive intervention, adult patients who screened high risk for oral health problems, or adults who were found to have signs of caries on exam. As the pilot test went on over time, the workflow process improved and the percentage of the screened population receiving fluoride varnish increased.

Figure 9.5: Referral rate to dentistry for signs of gum inflammation at Rogers Health

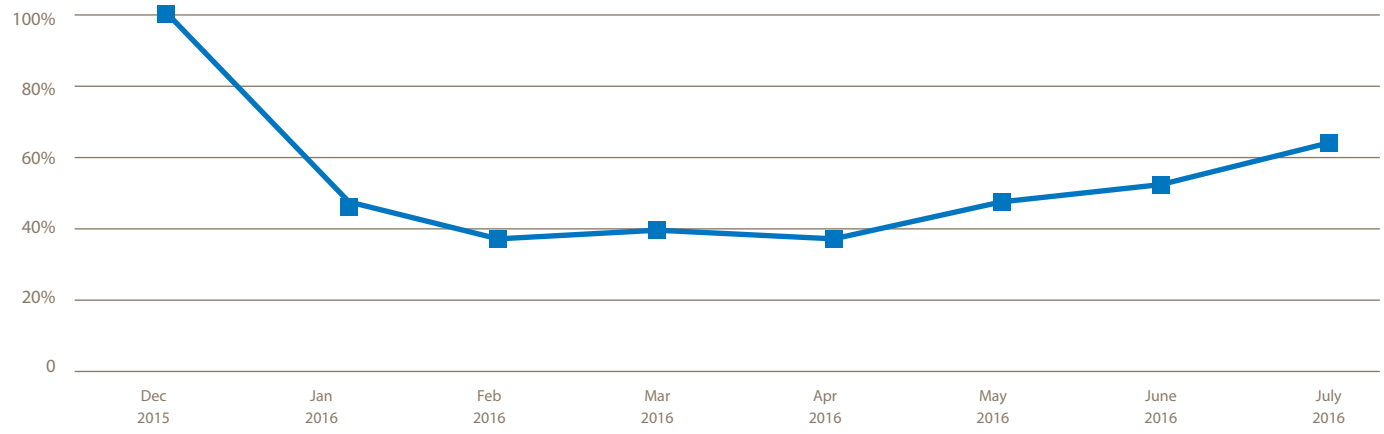


Figure 9.5 shows a common trend among field-testing sites. At the beginning, when the denominator (patients given an oral health assessment and found to have signs of an oral health problem) is small, all patients may receive a referral. Then, as the denominator grows but the workflow processes are still being refined, the referral rate is likely to decrease as patients who should receive a referral do not. Over time, as the workflow processes stabilize, the referral rate will also stabilize around a percent reflecting the reliability of the workflow. The referral rate is unlikely to ever be 100% since some patients may decline a referral and others are likely to already be under the active care of a dentist when the finding is noted on the screening exam.

Reporting the number of patients with a completed dental referral was a far greater challenge for the field-testing sites, and only a few were able to accurately track that information. The barriers included variation in how incoming consultation reports are managed, such as whether the report is attached to the referral order or simply scanned into the EHR as a separate document. In addition, dentists do not normally share consultation reports for their patients with primary care and field-testing dental partners frequently found it a challenge to identify referred patients at the time they were seen. Finally, information exchanged with consultants was, in some cases, stored in a separate database from the EHR in which the referral was ordered, making reporting all the more challenging. Field-testing sites that had an established process for following up on external referrals, and who had staff resources (such as a dedicated referral coordinator) who could regularly communicate with a dedicated contact in the dental office were more likely to be able to follow up on referrals and ensure they were tracked and completed.

Clinician impact

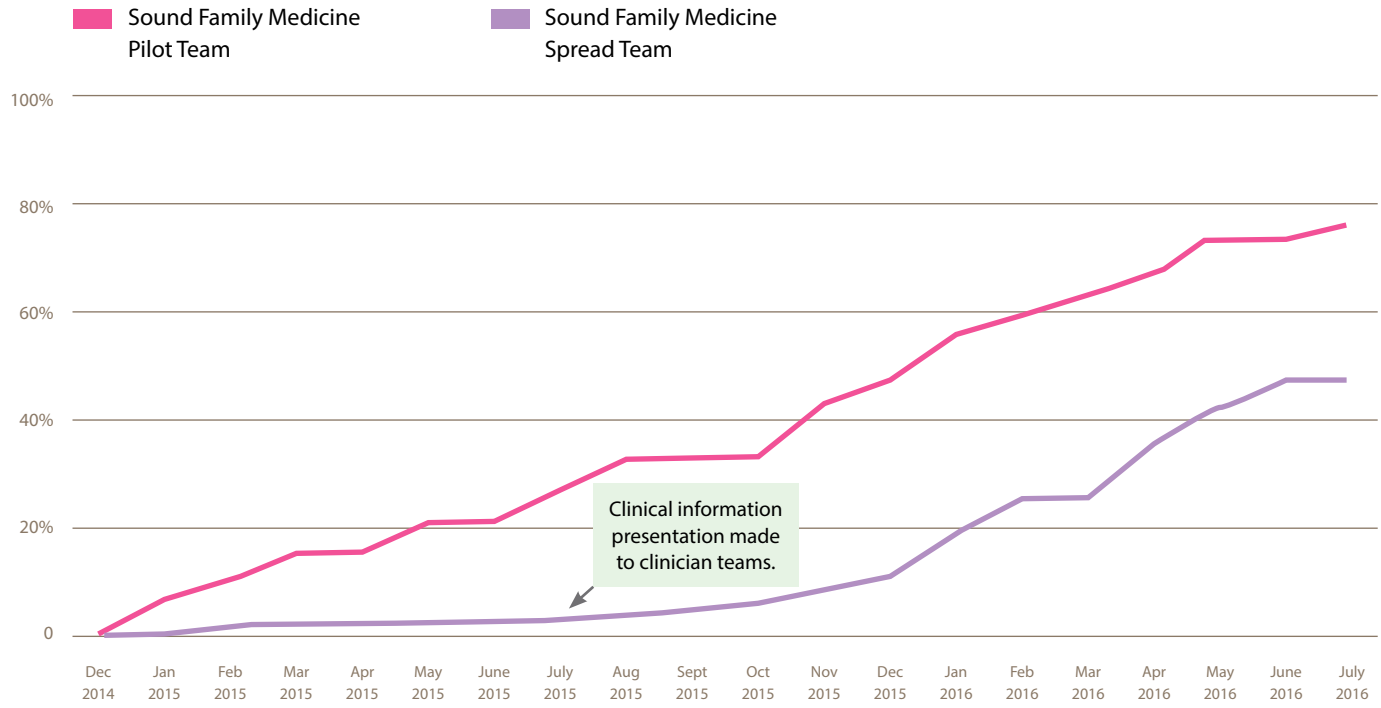
At the outset 27 clinician teams across the 19 field-testing practices engaged in the initial workflow training and piloted the oral health integration program at their practice site. After 20 months of field-testing, 80 clinician teams were engaged in the delivery of oral health preventive services. Spread took place in a variety of ways including:

- From a single target population to multiple target populations.
- From a single care team to other care teams within the same practice site.
- From care teams at one practice site to other sites within the system.
- From a single component of the Framework to multiple components.

Some sites approached spread in a formal manner, utilizing an internal clinical champion (often the medical director or the pilot clinician) to offer oral health clinical content training to other clinicians, sharing the pilot team workflow with other teams, and monitoring data over time to evaluate adoption of the oral health integration components. Other sites saw spread happen more organically, as clinicians and clinical assistants shared their work with colleagues and as EHR changes made decision support and clinical data gathering tools available to all users. One site created a custom EHR template and observed that once it was present in the EHR, some clinicians began to ask the oral health assessment questions during some visits without any formal request to begin assessing oral health.

Figure 9.6 shows two oral health assessment trend lines. One line represents the pilot clinician who participated in the initial clinical content presentation and the workflow optimization work. The other represents a clinician who began assessing oral health status by asking the screening questions for a handful of patients simply because the oral health questions were integrated in the diabetes template. In month 8, the medical director presented the results of the pilot and the clinical information to the EHR remaining clinician teams in the site, and the rate of screening increased rapidly.

Figure 9.6: Two oral health assessment run charts at Sound Family Medicine



Field Testing Results

Overall, there was a high degree of success in implementing the Framework across the 19 field-testing sites. While implementation varied depending on variables such as location, available community dental partners, internal staff resources, and patient population, all 19 sites were able to implement at least three aspects of the Framework and many implemented all five. All of the field-testing sites are currently focusing on spread and sustainability, with a significant degree of clinician support for the idea that oral health integration is a key component of whole-person care.

All 19 field-testing sites experienced challenges during the course of implementation, and creative solutions and work-arounds were often needed. These ranged from small workflow adjustments, such as deciding to hang an oral health "goodie bag" on the doorknob of the exam room when a patient was due for an oral health exam to help the clinician remember to look in the mouth, to more significant actions such as requesting an EHR vendor to build a specialized oral health template. Detailed stories of selected site experiences are shared in the case examples described below, and quotes and case vignettes can be found throughout the Oral Health Integration Implementation Guide.

Annotated case examples

Early leaders

Expanding Oral Health Access for Children: Early Experience from the Bluegrass Community Health Center: In this case example, Dr. A. Stevens Wrightson, MD, describes the early experience of oral health integration and Bluegrass Community Health Center's (BCHC) experience as a leader in the field. BCHC has been integrating oral health into the primary care of their pediatric population since 2010.

Interprofessional Education and Care at the New York University Nursing Faculty Practice: In this case example, Judith Haber, PhD, APRN, BC, FAAN and Madeleine Lloyd, PhD, FNP-BC, MHNP-BC, describe their experience in an innovative interprofessional teaching practice.

Field-testing sites

Integrating Oral Health into Primary Care: Lessons Learned from Rodgers Health: In this case example, Tina Moore, APRN, FNP-C; Brenda Lierman, Practice Manager, and Patricia Beatty, MBA, Quality Improvement Coordinator share their experience as an oral health integration field-testing site which began with a single rural practice site with two patient populations and spread to three additional urban locations and three patient populations.

Sound Family Medicine Integrates Oral Health into Primary Care for Adults with Diabetes: In this case example, Marc Aversa, MD, Medical Director and Beth Thurman, Quality Improvement Manager share their experience as an oral health integration field-testing site which began with a single suburban practice site focusing on adults with diabetes, and spread to additional practice sites and additional clinicians within the original site.

Implementation of the Oral Health Delivery Framework at Dimock Community Health Center: 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 which began with the entire pediatric department focusing on offering fluoride varnish as a preventive intervention.

Common topics of interest

Field-testing sites identified two primary areas of common interest which are discussed in the following case examples.

Oral Health Integration Referral Experiences: A critical component of the Oral Health Delivery Framework (the Framework) is the development of a dental referral network so that as oral health issues are uncovered in the primary care setting, there is a clear protocol to follow to ensure those patients are seen, diagnosed, and treated by a dentist. This case example shares the experience of field testing sites, including those that needed to create a community referral network of dental partners, and those who were able to leverage co-located dental clinics as a referral resource.

Electronic Health Record Use in Oral Health Integration: Every field-testing site struggled with the challenges of modifying their user interface to accept new information as structured data, optimizing decision support features, and creating accurate reports. One of the most important findings was the range of creative solutions that practices were able to devise in order to overcome the barriers they encountered in adapting their HIT to support oral health integration. This case example shares stories from three of the 19 field-testing sites, including EHR challenges encountered and work-arounds developed.

Appendix A: Annotated Oral Health Integration Toolset

Section 2: The Case for Change: Delivering Preventive Oral Health Services in the Primary Care Setting

- The Case for Change: Incorporating Oral Health in Routine Medical Care: This modifiable slide deck can be used by a champion in your practice organization to educate and inspire others. It includes basic information on the burden of oral disease and why oral health is an important component of comprehensive care. There are also spaces and directions for customizing messages for your community and audience.

Section 3: The Oral Health Delivery Framework

- Summary of Patient Education Resources: This PDF tool contains links to a variety of patient education materials including handouts, posters, flyers, videos, and websites. The resources are organized by topic, and when available in other languages, the languages are listed.
- Rapid Oral Health Screening and Risk Assessment: This PDF tool is a handout intended for members of the clinical care team. It succinctly summarizes the Framework components, and notes where information can and should be entered into the EHR.
- Summary of Primary Care Oral Health Interventions: This PDF tool is designed for members of the clinical care team. It details the oral health interventions that can be offered in the primary care setting, and provides supporting evidence and references. Links are provided to additional resources that describe coaching techniques that can be applied to oral health topics such as dietary and oral hygiene risk reduction.
- Recommended Oral Health Screening Questions: This PDF handout summarizes the recommended questions a practice can select from to use as the oral health screening and risk assessment questions. Four questions are provided for pediatrics, and six questions are provided for adults and adolescents. A practice may want to use all the questions, or they may select a smaller set, depending on their target population and workflow.

Section 4: Planning for Successful Implementation

- Oral Health Practice Readiness Assessment: This PDF tool walks through the key practice components that are necessary to support oral health integration, and describes conditions that may support full implementation, as well as conditions that may indicate that additional technical assistance may be required to achieve full implementation.
- Sample Oral Health Integration Kickoff Meeting Agenda: This modifiable Word tool presents a draft agenda used by field-testing sites to guide the kickoff meeting for the oral health integration program. The agenda suggests timing and topics for discussion, and includes resources to share with attendees.

These clinical content presentations were designed for the sites field-testing the Framework with the goal of providing the necessary information a primary care practice would need to understand the anatomy and physiology of the mouth, teeth, and gums; the pathophysiology of oral disease; and the actions a primary care team can take to protect and promote oral health. They are designed for a clinical champion to provide to a care team at the beginning of the oral health integration work, and they include two case studies on each topic that can be used to engage a care team and begin the conversation about how the work can be done.

- Clinical Content Presentation and Case Studies: Pregnancy
- Clinical Content Presentation and Case Studies: Diabetes
- Clinical Content Presentation and Case Studies: Pediatrics

- Oral Health Integration Workflow Optimization: A Streamlined Guide for Primary Care Practices: This PDF tool provides a detailed guide to anyone who is planning to conduct a workflow optimization mapping session to integrate oral health into primary care. It reviews the seven key steps in the workflow optimization process, and describes in detail how to execute each step including time commitment, supplies needed, and tools to support the mapping.
- Workflow Optimization for Oral Health Integration: This interactive PowerPoint tool was developed to streamline the traditional workflow redesign process. It allows a practice to walk through the standard steps of a primary care practice visit and determine where to fit in the components of the Framework they plan to implement, and determine who should carry out each component.
- Oral Health Information Technology Assessment: This PDF tool guides a practice through the process of identifying their practice's technical capabilities and organizational willingness to modify their EHR to support oral health integration. Assessing existing barriers is helpful to determine what work-arounds may be needed.

Section 6: Structuring Referrals to Dentistry

- Referral Agreement Template: This modifiable form walks a practice through the content that might be included in a referral agreement. Practices can use the form as a prompt for discussions with referring partners, and remove, modify, or add elements they agree upon. A good practice is for both the primary care practice and dental practice to sign and retain copies of the agreement to refer back to as the referral workflow and processes are worked out.
- Referral Template for Primary Care Referrals to Dentistry: This modifiable Word form provides a template for a primary care practice and dental practice to use to communicate the essential information back and forth. The top half is intended to be filled out by the primary care practice and then sent to the dental practice (via secure email, fax, etc). After the patient is seen, the dentist completes the bottom half and sends it back to the primary care practice's designated contact.
- Sample Completed Referral for Primary Care Referrals to Dentistry: This is a sample completed referral form from a fictional practice to show what the information might look like when completed.
- Oral Health Referral Workflow Optimization: This PowerPoint presentation is designed to be conducted as a 60–90-minute webinar with the primary care and dental staff involved in the referral process. It is based on the overall oral health workflow mapping process, and focuses specifically on the steps involved in making a referral to dentistry, and communicating the results of that referral back to primary care for referral tracking purposes. This "micro" workflow within the larger oral health integration workflow may need some adjusting and refining as referrals start to happen, including regular check-ins between the staff designated as the primary referral contacts.

Section 7: Using Data for Quality Improvement

- Recommended Oral Health Integration Metrics: This PDF tool details the recommended oral health measures used by the oral health integration field-testing sites. The denominators and numerators are defined for each measure. This tool includes the recommended screening questions for adults and pediatrics.
- Oral Health Data Reporting Template and Run Chart: This modifiable Excel tool supports oral health integration data reporting. The first tab provides a description of the recommended measures for adults and pediatrics and instructions for using the tool. The second tab is where a practice can enter the numerators and denominators for the oral health data they are reporting. Subsequent tabs automatically generate run charts to show progress over time.

References

1 Jeffcoat MK, Jeffcoat RL, Gladowski PA, Bramson JB, Blum JJ. Impact of periodontal therapy on general health evidence from insurance data for five systemic conditions. Am J Prev Med. 2014;47(2):166–174.

2 Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. Oral Health at a Glance: 2011. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Pub no. C5217229-AK. 2011.

3 Institute of Medicine (IOM). 2011. Advancing Oral Health in America. Washington, DC: The National Academies Press.

4 Dye BA, Li X, Smith V, Beltran-Anguilar ED. 2012. Selected oral health indicators in the United States, 2005-2008. Hyattsville, MD: United States Department of Health and Human Services, National Center for Health Statistics.

5 Griffin SO, Jones JA, Brunson D, Griffin PM, Bailey WD. Burden of oral disease among older adults and implications for public health priorities. Am J Public Health. 2012;102(3):411-418.

6 Seirawan H, Faust S, Mulligan R. The impact of oral health on the academic performance of disadvantaged children. Am J Pub Health. 2012;102(9):1729-1734.

7 Jackson SL, Vann WF, Kotch JB, Pahel BT, Lee JY. Impact of Oral Health on Children's School Attendance and Performance. Am J Public Health. 2011; 101(10):1900-1906.

8 Health, United States, 2015 with Special Feature on Racial and Ethnic Health Disparities. Hyattsville, MD: United States Department of Health and Human Services, National Center for Health Statistics.

9 Eke PI, Dye BA, Wei L, Thornton-Evans GO, Genco RJ. Prevalence of periodontitis in adults in the United States: 2009 and 2010. J Dent Res. 2012;91:914-920.

10 Mealey BL. Periodontal disease and diabetes: A two-way street. J Am Dent Assoc. 2006; 137 Suppl: 26S-31S.

11 Casanova L, Hughes FJ, Preshaw M. Periodontitis and Diabetes – a two-way relationship. Diabetologia. 2014;55(1):21-31.

12 Schenkein HA, Loos BG. Inflammatory mechanisms linking periodontal diseases to cardiovascular diseases. J Clin Periodontol. 2013; 40(Suppl. 14):S51–S69.

13 Jeffcoat M, Parry S, Sammel M, Clothier B, Catlin A, Macones G. Periodontal infection and preterm birth: successful periodontal therapy reduces the risk of preterm birth. BJOG. 2011; 118:250-256.

14 Guimaraes AN, Silva-Mato A, Siqueira FM, Cyrino RM, Cota LOM, Costa FO. Very low and low birth weight associated with material periodontitis. J Clin Periodontol. 2012;39:1024-1031.

15 Michaelowicz BS, DiAngelis AJ, Novak MJ, Buchanan W, Papapanou PN, Matseoane S. Treatment of periodontal disease and the risk of preterm birth. NEJM. 2006;355(18):1885-1894.

16 Polyzos NP, Polyzos IP, Zavos A, et al. Obstetric outcomes after treatment of periodontal disease during pregnancy: systematic review and meta-analysis. BMJ. 2010;341.

17 Tinanoff N, Reisine S. Update on early childhood caries since the Surgeon General's Report. Acad Pediatr. 2009;9:369-403.

18 Bouchery E. Medicaid Policy Brief: Utilization of dental services among Medicaid-enrolled children. Washington, DC: Mathematica Policy Research. October 2012.

19 National Health Expenditure Accounts (NHEA). National Health Expenditures by type of service and source of funds, CY 1960-2013. Full data set. Available at: www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical.html. Accessed July 11, 2016.

20 Wall T, Nasseh K. Dental-related emergency department visits on the increase in the United States. Health Policy Institute Research Brief. American Dental Association. May 2013. Accessed July 11, 2016.

21 National Center for Health Statistics. Health, United States, 2012: With Special Feature on Emergency Care. Hyattsville, MD. 2013.

22 National Association of Community Health Centers. Integration of Oral Health with Primary Care in Health Centers: Profiles of Five Innovative Models. Accessed July 11, 2016.

23 Reinertsen JL, Bisognano M, Pugh MD. Seven Leadership Leverage Points for Organization-Level Improvement in Health Care (Second Edition). IHI Innovation Series white paper. Cambridge, MA: Institute for Healthcare Improvement; 2008.

24 Health Resources and Services Administration. Integration of Oral Health and Primary Care Practices. Rockville,MD; U.S. Department of Health and Human Services: February 2014.

25 Haber J, Hartnett E, Allen K, et al. Putting the Mouth Back in the Head: HEENT to HEENOT. Am J Public Health. 2014;105(3):437-441.

26 U.S. Preventive Services Task Force. Prevention of dental caries in children younger than 5 years: screening and treatment: U.S. Preventive Services Task Force recommendation statement. 2021.

Recommended citation: Safety Net Medical Home Initiative. Hummel J, Phillips, KE, Holt B, Virden M. Organized, Evidence-Based Care Supplement: Oral Health Integration. Seattle, WA: Qualis Health; 2016.

Featured in: Safety Net Medical Home Initiative Implementation Guide Series. 2nd ed. Seattle, WA: Qualis Health and the MacColl Center for Health Care Innovation at the Group Health Research Institute; 2013.

Acknowledgements

Primary Author Jeff Hummel, MD, MPH (Medical Director for Health Informatics, Qualis Health) gratefully acknowledges the contributions of the Key Stakeholder Group: Marcia Brand (Executive Director, National Interprofessional Initiative on Oral Health), Mike Monopoli (Vice President of Foundation Programs, DentaQuest Foundation), Diane Oakes (President and CEO, Washington Dental Service Foundation), Glenn Puckett (Program Manager, Washington Dental Service Foundation), Brenda Sharpe (President and CEO, REACH Healthcare Foundation), Dawn Downes (Senior Program Officer, REACH Healthcare Foundation), Kathryn E. Phillips (Senior Program Officer, California Health Care Foundation), Bre Holt (Program Director, Qualis Health), Mary Virden (Senior Consultant, Qualis Health) Karen Vest-Taubert (Senior Consultant, Qualis Health), and Kelley Carnwath (Quality Improvement Principal).

Reactor Panel: A reactor panel provided valuable feedback and improvement ideas on the Oral Health Integration Implementation Guide. Reactors included representatives from leading medical and dental associations, community health centers, academic institutions, policymakers, and patient and family advocates. Lauren Barone, MPH (Manager, Oral Health, American Academy of Pediatrics), Anne Clancy, RDH, MBA (Manager, Council on Access, Prevention, and Interprofessional Relations [CAPIR], American Dental Association), Amos Deinard, MD, MPH (Pediatrician; Associate Professor, Epidemiology and Community Health, University of Minnesota School of Public Health), Nadeem Karimbux, DMD, MMSc (Associate Dean for Academic Affairs, Tufts School of Dental Medicine), Ellen Sachs Leicher, MA (Principal, ESL Associates), Amy Brock Martin, DrPH (Director, Division of Population Health; Associate Professor, Department of Stomatology, James B. Edwards College of Dental Medicine), Hannah Maxey, PhD, MPH, RDH (Director, Health Workforce Studies; Assistant Professor of Family Medicine, University of Indiana), Mary Minitti, BS, CPHQ (Senior Policy and Program Specialist, Institute for Patient- and Family-Centered Care), Karen Pastori, CPM (Practice Facilitator, Pediatric TCPI Grant, Washington State Department of Health), Vy Nguyen, DDS, MPH (Dental Officer, Office of Quality Improvement, Quality Division, Bureau of Primary Health Care, Health Resources and Services Administration), Laurie Norris, JD (Senior Policy Advisor for Oral Health, Division of Quality and Health Outcomes, Children and Adults Health Programs Group, Centers for Medicare and Medicaid Services), Eve Rutherford, DDS (General Dentist, Snohomish County, Washington), Dixie Schroeder, MBA (Administrator, Institute for Oral and Systemic Health, Marshfield Clinic Research Foundation, Marshfield Clinic), Steve Shannon, DO, MPH (President and CEO, American Association of Colleges of Osteopathic Medicine), Hugh Silk, MD (Associate Clinic Professor, University of Massachusetts Medical School, American Academy of Family Medicine), Amy Whitcomb Slemmer, JD (Executive Director, Health Care for All), Melinda Thomas, PA-C (Associate Medical Director, Boston Healthcare for the Homeless), Libby Thurman (Health Policy Director, Tennessee Primary Care Association), Sarah Vander Beek, DMD (Chief Dental Officer, Neighborcare Health), Donald L. Weaver, MD (Associate Medical Officer, National Association of Community Health Centers).

Primary Care Associations partnered with Qualis Health to support field-testing in Kansas, Massachusetts, and Oregon.

Kansas Association for the Medically Underserved, Denise Cyzman, Executive Director
Coach: Susan Wood (Director of Clinical and Quality Programs)

Massachusetts League of Community Health Centers, James W. Hunt Jr, President and CEO
Coaches: Shannon Wells (Oral Health Affairs Manager), Rebekah Fiehn (Public Health Program Coordinator)

Oregon Primary Care Association, Irma Murauskas, Director of CHC and OPCA Operational Excellence
Coaches: Mohamed Alyajouri (Healthcare Integration Manager), Krista Collins (Performance Improvement Manager), and Akira Templeton (Quality Initiatives Specialist)

Field Testing Sites:

Qualis Health, the primary care associations, and project sponsor and funders acknowledge the field-testing sites and their implementation team leaders for their contributions to this guide and the associated toolset.
Brockton Neighborhood Health Center (Benjamin Lightfoot), Community Health Center of Cape Cod (David Tager), Community Health Centers of Benton and Linn Counties (Molly Perino), Dimock Community Health Center (Nandini Sengupta), Grand Coulee Medical Center (Cheri Gregson), Harborview Medical Center–Women's Clinic (Leondra Weiss), HealthCore Clinic (Diane Peltier), Heart of Kansas Clinic (Heather Hicks), Heartland Community Health Center (Allie Nicholson and Lanaya Henry), Hilltown Community Health Center (Michael Purdy), Lowell Community Health Center (Samantha Jordan), Multnomah County Health Department–East County Health Center (Aron Goffin), Neighborhood Health Center (Alynn Vienot), One Community Health (Elizabeth Aughney), Providence Medical Group–Monroe Clinic (Deborah Nalty), Rinehart Clinic (Jane Dageenakis), Rodger's Health (Hilda Fuentes), Sound Family Medicine (Marc Aversa), and Turner House Children's Clinic (Janet Burton)

Additional Interviews:

Bluegrass Community Health Center (A. Stevens Wrightson), Light Dental Studios (Angie Dunn), Nursing Faculty Practice, New York University (Judith Haber and Madeleine Lloyd)

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.

For more information about the project sponsors and funders, refer to:

- National Interprofessional Initiative on Oral Health: niioh.org.
- DentaQuest Foundation (now CareQuest Institute for Oral Health): carequest.org.
- REACH Healthcare Foundation: reachhealth.org.
- Washington Dental Service Foundation (now Arcora Foundation): arcorafoundation.org.











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.