

Oral Health: An Essential Component of Primary Care

Case Examples



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Case Example 1: Providing Comprehensive Care for Patients with Diabetes: Experience from Marshfield Clinic

The Marshfield Clinic is the second largest private group medical practice in Wisconsin with over 700 physicians, 50 locations, and 380,000 patients. In this case example, Dr. Eric Penniman, DO, a Medical Director for Primary Care, describes the experience of three sites pilot testing integrated oral healthcare for adult patients with diabetes.

The impetus: “A member of our research team, who was trained as a dentist and has diabetes, took our clinic’s diabetic education class. He noticed that in seven hours, no one talked about the importance of good oral health. At the end, he asked us why. Everyone was left scratching their head with no good answer. Frankly, I was embarrassed that as a family doctor I’d been ignoring this important piece of healthcare,” admitted Penniman. “Once we saw this gap, we knew we needed to address it.”

The process: Attention to patients’ oral health begins at the very start of the clinical visit. “When a patient checks in for an appointment, the clerk asks who their dentist is, and enters that information into the patient’s health record,” explained Penniman. Marshfield Clinic developed a standard oral health collection tool for its EHR, Cattails. This tool guides the care team through a series of risk assessment and screening questions, helps them record findings from the brief oral exam as structured data, and flags patients overdue for a dental exam. “During the rooming process, the medical assistant asks the patient about the last time they saw a dentist; or if they don’t have a dentist, if they’d like one. The medical assistant also introduces the importance of oral health for patients with diabetes,” explained Penniman. After the care team completes other preventive and chronic care activities, they return to the oral exam and look into the patient’s mouth for signs or symptoms of oral disease, such as bleeding gums, lesions and decay. If a patient is identified to be in need of dental care, the provider orders a referral. “If they don’t have a dentist, then we refer them to our local Federally Qualified Health Center’s (FQHC’s) dental clinic, or a Marshfield dental clinic if they live near one. If they already have a dentist and just haven’t been lately, then it’s a matter of encouraging them to get an appointment,” explained Penniman.

At the end of the visit, the provider reinforces the importance of oral health. “If we can consistently get providers to share that it’s especially important for patients with diabetes to take care of their oral health, then that’s a win,” shared Penniman. “We want providers to weave oral health messages in to what they are already talking about with their diabetic patients; for example, that poor oral health contributes to coronary disease, kidney disease, and other complications.” An important component of Marshfield Clinic’s oral health program is its commitment to proactive care. “For patients that have teeth, we want a dentist to check their mouth every 6 months,” explained Penniman. “We review data from the oral exam tool and when we identify patients that have not seen a dentist within 12 months, or not seen us, we call them and encourage them to make an appointment with their dentist or help them find a referral source if they don’t have a dentist,” explained Penniman.

“If we can consistently get providers to share that it’s especially important for patients with diabetes to take care of their oral health, then that’s a win.”

Patient reactions: Reactions from patients have been positive, shared Penniman. “They appreciate that their doctor cares about their mouth.” He continues, “You can see the light bulb come on for patients, not dissimilar to the light bulb that came on for us doctors when we realized we were leaving oral health out.”

Building buy in: “There were concerns about adding one more thing to an already packed visit and concerns about how adding time to clinical visits might impact patient access,” shared Penniman. “There is so much to do in primary care, we need to make sure that whatever we add is efficient. So we set it up so everything we do for oral health doesn’t add more than 30–60 seconds to the overall visit.” Penniman explained: “When we created the risk assessment and screening tool, we tried to pare down the questions to the very minimum. To get people over the time concern, we modeled the process live in a staff meeting and had someone time it. We proved that you could get through the oral health risk assessment and screening piece in about 12 seconds. Once people saw that, they felt they could do it.”

Impact: Marshfield Clinic expects all patients with diabetes to receive oral health risk assessment, screening, education, and referral from their primary care team. As a process measure, they track the number of patients who receive an oral exam in primary care and the number who report receiving care from a dentist within the past 6, 9 or 12 months. “We expect to see improvements in these process measures within the next year,” shared Penniman. “A next step will be outcome measures.” Marshfield Clinic has been able to add the oral exam as a component of routine care for patients with diabetes without added reimbursement from Medicaid or private payers. “We haven’t seen any negative financial impact—our doctors still see the same number of patients,” explained Penniman. “We’re focused on the whole patient, on closing the gap. You don’t always have to provide a financial incentive for a primary care provider; they have a mindset, a commitment to the patient.”

What advice does Marshfield offer to other practices interested in supporting patients’ oral health?

- **Cultivate champions:** “I’m a huge believer that when you’re going to launch something new, have a local champion,” shared Penniman. “I reached out to some of our providers who I thought would be interested in oral health, and asked them to take this on and figure out how it could be done. Rather than me telling the troops to do one more thing, they presented the work at provider meetings. That was key.”
- **Focus on the ‘why’:** “The real key is to focus on the ‘why.’ Talk to those people who have already stepped up from a quality improvement perspective and show them the research. If you can point out the huge gap between what we know is important and what we are actually doing, they will be motivated to change.”
- **Take an incremental approach:** The Marshfield Clinic has been thoughtful in scaling its oral health integration efforts. “You have to take this work in chunks to get people used to it,” explained Penniman. “We purposefully chose to start with diabetic patients. As a disease, it is the most expensive. Secondly, there’s already so much we’re trying to do, and the research supported focusing on oral health.”
- **Balance standardization and flexibility:** While Marshfield Clinic has carefully standardized the oral exam process, they provide each care team the flexibility to assign tasks to staff. Some providers conduct the oral exam, while others delegate to a member of their team, typically a medical assistant. “Providers can choose whether they delegate or not, but the message from the leadership team is that the oral exam should be done,” explained Penniman.
- **Recruit partners:** The Marshfield Clinic knew that many of its patients did not have dental insurance and would not be able to pay for dental care out of pocket. To overcome this potential access barrier, Marshfield Clinic developed a relationship with its local FQHC, which has a co-located dental practice. “I went to talk to the FQHC dentists about our program. They were thrilled that doctors considered them part of the health community and respected the role they have.” A next step for Marshfield Clinic is to develop referral relationships with local private practice dentists.

Figure 1: Oral Health Template Tool

Workflow

- Weight: 58.06 kg (128 lbs)
- Height: 157.48 cm (62 in)
- Pulse: 72 bpm
- Blood Pressure: 132/74 mmHg
- Tobacco Use: Never, No sec
- Body Mass Index: 23.4 kg/m²
- Oral Exam

Collection

Oral Exam:

- ✓ **Collected Date Time:** 03/20/2015, 09:40 [Current Time]
- * **Last visit to a dental provider (required):**
 - ☐ Date: / /
 - ☐ In the last year
 - ☐ In the last 6 months
 - ☐ More than a year
 - ☐ In the last 3 months
 - ☐ In the last 9 months
 - ☐ Unsure
- ✓ **Last periodontal exam/teeth cleaning:** [Clear]
 - ☐ Date: / /
 - ☐ In the last year
 - ☐ In the last 6 months
 - ☐ More than a year
 - ☐ In the last 3 months
 - ☐ In the last 9 months
 - ☐ Unsure
- ✓ **Does the patient have any natural teeth present?:** [Clear]
 - ☒ Yes
 - ☐ No
- ✓ **Did you conduct a visual oral examination today?:** [Clear]
 - ☒ Yes
 - ☐ No
- Visual Oral Exam Observations (optional):**
 - ☐ Bad Breath
 - ☐ Swollen gums
 - ☐ Bleeding gums
 - ☐ Redness of the gums
 - ☐ Ulcers in the mouth
 - ☐ Red/White lesions in the mouth
 - ☐ Tooth decay
 - ☐ Broken teeth
 - ☐ Missing teeth
 - ☐ Other:
 - ☐ None
- Refer to (optional):**
 - ☐ Internal Dentist (FHC)
 - ☐ External Dentist
 - ☐ Advised the patient to follow-up with their Dentist
- Education Provided (optional):**
 - ☐ Resources provided

Favorites

- Patient Health Questionnaire
- Asthma Control Test for 12 y
- Childhood Asthma Control T
- Menstruation
- Blood Pressure
- 000 Adult Planned Visit
- 00 tobacco counseling 3-10
- 00 tobacco counseling > 10
- adolescent vitals
- 000 infant vitals
- adult vitals: respiratory
- child vitals: respiratory
- Oral Exam

Buttons: Done, Add Comment

Case Example 2:

The Child and Adolescent Clinic: Engaging Patients and Staff in Oral Health

The Child and Adolescent Clinic (CAAC) is a 13-provider, two-site private pediatrics practice in southwestern Washington State. Seventy percent (70%) of CAAC's patients are covered by Medicaid. CAAC launched its oral health integration program in 2009 and today provides family oral health education, oral exams, fluoride varnish, and coordinated referrals for patients birth through age 21. "We have seen huge improvements in the oral health of our patients and the oral health of our community as a whole," stated Kimberley Robbins, CAAC's Administrator. In this case example, Robbins describes how CAAC was able to engage staff in developing an effective and sustainable oral health program.

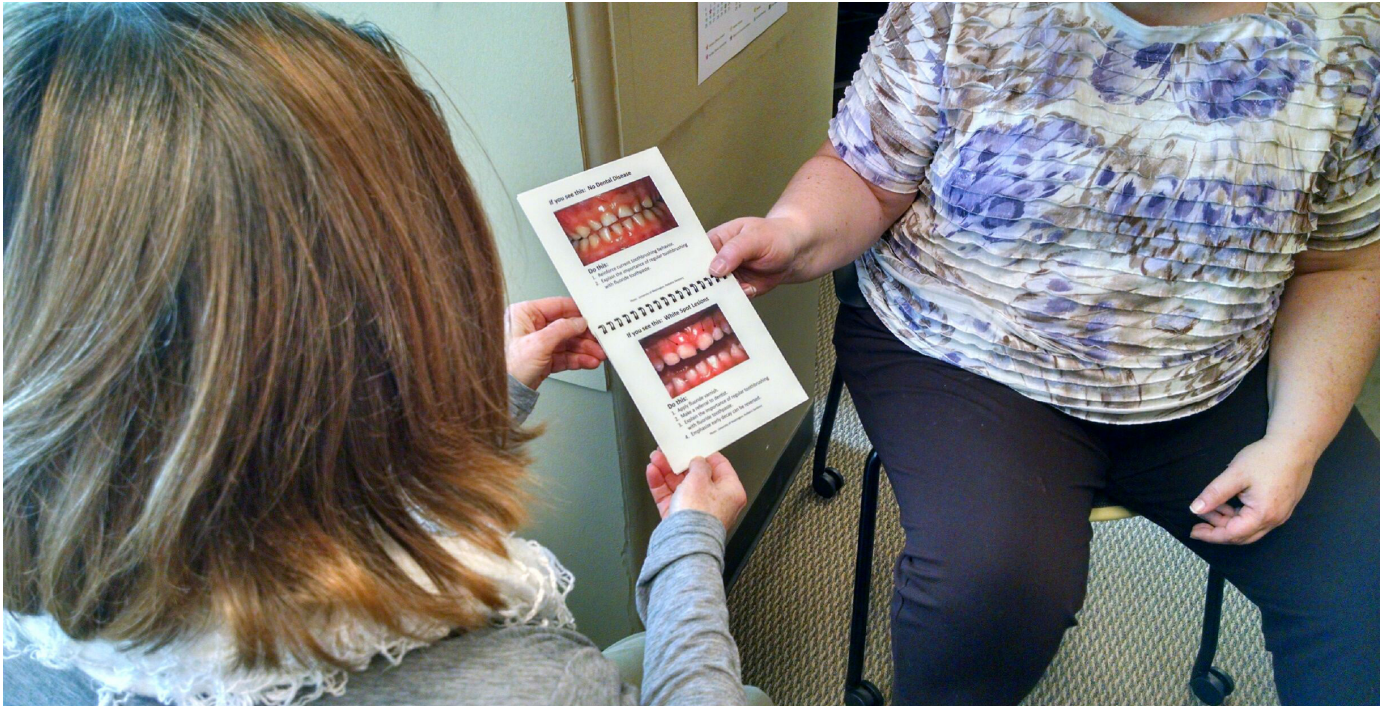
Program Overview

At check-in, patients and families are given a flyer that describes CAAC's oral health program, the importance of good oral health, and the recommended schedule for fluoride varnish. The flyer also includes a few brief screening questions to help the primary care team understand the patient's risks for oral disease. Family oral health education is provided at the very beginning of the visit by the medical assistant. Each exam room includes a flip chart with images of common problems parents should look for (e.g., white spots) and how fluoride varnish is applied. Medical assistants use this resource to engage families in a discussion on oral health self-care, and then demonstrate good brushing and flossing techniques. The medical assistant also asks each family if they have a dental home. "If not, we enter 'lack of dental care' as part of the chief complaint," noted Robbins.

"When our commercial patients ask 'who should we see?' we recommend the same dentists that take our Medicaid patients. We do not refer to dentists who do not take Medicaid. In fact, most of our staff won't see a dentist who doesn't take Medicaid patients, even for their own oral health...Dentists have reacted well to having a balanced mix of patients coming from us. We have heard from the dentists we refer to that they are appreciative that we are actively referring commercial patients to them."

CAAC serves a high percentage of Medicaid and uninsured/self-pay patients, as well as many non-English speaking families. To remove barriers to self-care, CAAC provides education through a medical interpreter, and offers free toothbrushes. After the medical assistant has answered the family's questions, the provider enters, completes the oral exam and remaining well-child care services, discusses the importance of fluoride varnish, and orders it to be applied by the medical assistant. The provider also determines whether the patient needs a referral to a dentist. If the family does not already have a relationship with a dentist, she gives the family a business card for CAAC's referral coordinator. Referral coordinators provide support to ensure families have what they need in order to access care. This includes identifying a dentist that will take the patient's insurance, making an appointment for the patient, and arranging for transportation and medical interpreters, if needed.

Figure 2: Patient Education Flip Chart for Caregivers



CAAC struggled to find referral resources for patients in need of dental care and without private dental insurance. “We used to have just one dentist in the community who would accept Medicaid patients; now we have two,” noted Robbins. What helped CAAC elicit local support? “When our commercial patients ask ‘who should we see?’ We recommend the same dentists that take our Medicaid patients. We do not refer to dentists who do not take Medicaid. In fact, most of our staff won’t see a dentist who doesn’t take Medicaid patients, even for their own oral health,” shared Robbins. “Dentists have reacted well to having a balanced mix of patients coming from us. We have heard from the dentists we refer to that they are appreciative that we are actively referring commercial patients to them.” CAAC also works with a local dental foundation and community partners to support a mobile dental unit, SmileMobile, to provide access for patients without insurance. The mobile van is available twice per year at the clinic site and is able to provide dental cleanings, restoration and other services.

Improving Patient Health, Improving Community Health

“Our county was notorious for having the worst child oral health in the state. In the years since we implemented this program, we have turned that around,” noted Robbins. “We’ve seen a decrease in the number of days our local dentist spends in the hospital doing restoration under anesthesia. He used to be in the hospital 4–5 days a month, but now it’s only 1–2 days, because there are so many fewer patients that need surgical intervention. That’s success.”

“This work is meaningful to the team, meaningful to the pediatrician, and best for our patients. It’s that simple.”

Strategies for Building and Spreading an Effective Program

CAAC successfully spread its oral health program to all 13 providers in both clinic locations over a period of about 15 months. “The most challenging aspect of this work has been getting the process right and then getting that process to stick,” explained Robbins. “We had to keep coming back to it over and over again. When it wasn’t working for some reason, or when a service was only being offered a minor percent of the time, we had to assess why—what’s the hold up? And then we had to figure it out.”

First, CAAC invested time in staff training and engagement. “Initially there were concerns from staff,” admitted Robbins. CAAC arranged for training to help staff members gain confidence in providing oral health preventive care, and they trained entire pods together meaning physicians, nurse practitioners, and medical assistants received the same information at the same time, and had the opportunity to ask questions and share experiences with one another. Robbins credits this team approach as a key determinant in their success.

Second, CAAC made the expectation that all patients receive oral health preventive care explicit, and then provided transparent data to allow care teams to monitor their own performance and the performance of the practice as whole. CAAC produced a quarterly report to show the percentage of patients eligible for an oral exam, family education, and fluoride varnish, and the percentage that received those services in the given time period for each provider and team. Refer to Figure 8 for an example. CAAC also used standing Quality Assurance weekly meetings as a forum for communication and engagement—first for planning the oral health integration program and then for improving specific processes. “We also used these meetings as time to share what was working well and share tips,” explains Robbins. “Every provider has a different style and they can teach each other.” Reviewing data at the team level, and with an eye for improvement, created a culture of shared accountability and a willingness to identify and solve process challenges head-on. “Getting and taking input from staff was essential,” noted Robbins.

Figure 3: Transparent Data on Provider and Team Performance, Preventive Oral Health Care for Children 1–5 Years of Age

	Dr. John Doe			Dr. Jane Doe		
	Jan-Mar 2013	Apr-Jun 2013	Jul-Sep 2013	Jan-Mar 2013	Apr-Jun 2013	Jul-Sep 2013
1–5 yr WCC Visits	116	116	92	68	89	74
	Units Delivered					
Family Ed (\$27.58) ^A	6	59	63	12	65	76
Periodic Oral Eval (\$29.46)	9	57	65	10	68	78
FI Varnish (\$13.25)	55	62	77	32	53	58
	Percentage (Goal is to achieve >100% by applying fluoride varnish at opportunities other than at well child exams)					
% FI Varnish 1–5 yr	47%	53%	84%	47%	60%	78%
% Oral Eval 1–5 yr	8%	49%	71%	15%	76%	105% ^B

A 2013 Medicaid reimbursement rates in Washington State.

B Some percentages exceed 100% because services can be provided outside of well-child visits.

For example, initially CAAC provided information on fluoride varnish during the family education portion of the visit. Staff noticed that some parents were refusing fluoride because they did not have enough time to learn about fluoride and its benefits before being asked to give permission for application. This finding led the practice to include basic information about fluoride varnish and the application schedule in the oral health education flyer given at check-in so that parents had time to process the information before being asked to make a decision.

Similarly, initially medical assistants applied the varnish at the very beginning of the visit, concurrent with family education. However, the application process upset some children, making subsequent interactions between the child, parent, and provider more challenging for other important well-child visit activities, such as developmental screening; and this led some care teams to skip applying varnish. Care teams then experimented with applying varnish at the very end of the visit (after the provider had left the room) and after immunizations or other services had been completed. However, this approach proved to be problematic—too many families left before the fluoride varnish could be applied. After team brainstorming and small tests of change, CAAC settled on a process that worked well for patients and providers: medical assistants would apply fluoride varnish after the provider completed the well-child care exam, but before immunizations and other after care services.

Both changes resulted in an increase in the proportion of eligible patients receiving family oral health education, an oral exam, and fluoride varnish at well-child care visits.

What was the turning point in getting the process to stick? “Ultimately, what made it work was building the entire process [education, evaluation, varnish] into the template for the well child visit and then tasking each activity, so the medical assistant rooming the patient has the task of doing the oral health family education. She can’t check off that task until it is done. The discipline of the EHR was key,” explained Robbins. “Today our program is self-sustaining. Medicaid and private insurance reimbursement amounts are sufficient to cover the cost of our time and equipment, including self-care products for patients who cannot afford them.”

What comes next for CAAC? “I’m excited to see what this looks like in another generation,” Robbins shared, “getting these parents and children oral health education, and then seeing what happens when they pass it along to their children.”

“Assess the caries rate of your Kindergartners, and then do it again in four years. You will see an impact within just a few years, and you’ll have all the validation you need to keep going.”

Case Example 3:

Understanding Oral Health as Core Preventive Care: Lessons from Confluence Health's Wenatchee Pediatric Clinic

Confluence Health is an 11-site, 300+ provider healthcare system with locations throughout north central Washington State. The Wenatchee Clinic's Pediatric Department, which serves primarily Medicaid patients, began delivering integrated preventive oral health care in 2014. Today, they provide fluoride varnish for patients birth through 18 as well as oral health evaluation and family education for patients 5 and under. In this case example, John Donaghy, Practice Manager for Wenatchee Clinic's Pediatric Department, shares his practice's motivators, success factors, and plans for spread.

Motivation

"A key motivator for our organization is preventive care, and we saw integrating oral health as a way to help our youth," explains Donaghy. "A significant number of our patients don't receive basic oral health services, so we are the starting point for good oral health." Providers were initially concerned about the time required to add oral health preventive care to the primary care visit, so the Wenatchee Pediatric Clinic selected a pilot team (one provider and one medical assistant) to test the process. After just a few weeks, this team had fine-tuned a workflow adding only 2–3 minutes to the typical well-child care visit. "The concerns the providers and department had were washed away. They had testimony from a provider and a staff member who shared how easy this was to do," recalled Donaghy.

"A significant number of our patients don't receive basic oral health services, so we are the starting point for good oral health."

Success Factors

Donaghy credits clinical and administrative leadership and Confluence's prevention-focused culture as key factors in the clinic's success. "We stand by our mission statement to deliver innovative ways to improve the delivery of excellent, high-value care. When we identified oral health as something we could provide to our patients, I didn't have to make the staff do it; they wanted to do it, and they were willing to be accountable without needing an incentive. A lot of our staff have children, and they know exactly what they would want if they were going to come to an office," shared Donaghy.

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What else helped?

- **Engaging patients and families:** Before implementing their integrated oral health program, Wenatchee Pediatric Clinic asked patients if they would be interested in receiving oral health services in the primary care setting. “We received 60 responses to our survey and 90% of our families responded positively. This became a motivator for us,” shared Donaghy.
- **Setting the course:** “This was a learning process for all of us. We had to understand the Medicaid reimbursement model and figure out specific processes,” shared Donaghy. “Because we were able to clearly articulate a goal and cultivate clinical champions, we had a strong sense of ‘why’. The ‘how’ followed.” Donaghy recommends other sites be realistic in their implementation planning process, and engage staff in the planning process. “You have to have everyone on board. Be transparent about what you are doing and why.”
- **Creating standard work and formal documentation:** “We were able to design and implement our program in 6 months,” recalled Donaghy. “Once we identified a process that worked, we formalized it and created supporting tools. We added a Dot Phrase Oral Health Template to our EMR (EPIC) to guide our team through the process and make sure nothing is missed.” (Refer to Figure 9 for a sample EPIC Template). “All providers do it the same way now,” explained Donaghy, “Oral health is standard work.”
- **Using data to drive change:** The Wenatchee Pediatric Clinic collects and transparently reports data to help care teams understand the impact of the oral health program, and identify opportunities to improve and expand services. “We have an RVU report that shows how many patients are eligible for oral health services, how many actually receive them, and the breakdown per provider of the costs of their supplies and the value of their reimbursements,” explained Donaghy. “We use this report to show providers if they are meeting the goal of 100% of eligible patients receiving oral health care, and to demonstrate the revenue they are bringing into the practice to keep our program sustainable.”

Based on the success of the Wenatchee Pilot, Confluence Health is exploring options to spread the work, including expanding their pediatric program to children with commercial insurance. “When you have your staff and providers on board to do this, you can go as far as you want. There’s a ton of potential,” shared Donaghy.



Figure 4: EPIC Oral Health Template

Provider Section:

Oral Disease Prevention

- I have performed a screening examination of the teeth and gums.
- Teeth have erupted and appear normal in shape, size, color, and location. Areas of concern include {specify}
- White spots or decay {are/are not} present.
- Redness or swelling in the gums {are/are not} present.
- Other areas of concern include: {specify}.

Assessment

- {Child/Adolescent Oral Disease Assessment}
- Patient {has/has not had} previous dental disease.
- If previous dental disease, please specify ***
- Patient {is/is not} at risk for dental disease.

CMA Section:

Education

- {Child/Adolescent Oral Health Education Conf}
- Fluoride varnish {was/was not} applied.
- Fluoride supplements {WERE / WERE NOT} prescribed.
- Referral to dentist {was/was not} made.
- Time spent with patient ***