



## Oral Health Integration in the Patient-Centered Medical Home (PCMH) Environment: Case Studies from Community Health Centers

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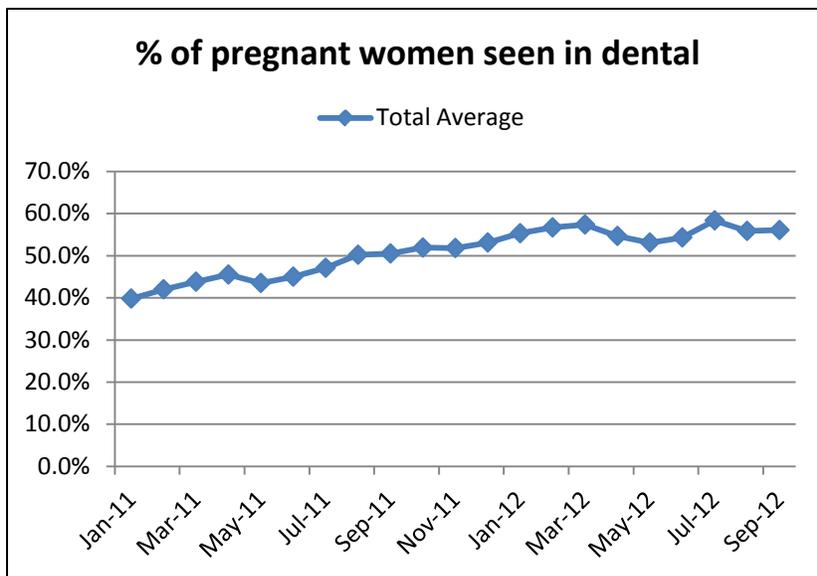
This article advances the case for bringing oral health into the realm of the PCMH by featuring four community health centers where changes have been made that address the opportunity for prevention and the interplay between oral diseases and other systemic conditions so as to improve health outcomes and reduce costs. The underlying report on which this article is based was commissioned by the Funders Oral Health Policy Group, with additional funding from the REACH Healthcare Foundation. This group of national, state, and local funders is aware that the current health system fails to reach the population where dental diseases are most prevalent. Report author Bonni Brownlee, Director of Quality Improvement and Compliance Consulting for Qualis Health, boldly states:

*“Embracing comprehensive care, the PCMH model provides the perfect environment for strengthening access to oral health care, improving provider and patient understanding of oral health and providing the needed oral health care screening, preventive and restorative services that are essential to optimal health status.”*

The four community health centers featured in this report are: Neighborcare Health, Seattle WA; Dorchester House Multi Service Center, Boston MA; The Marshfield Clinic, Marshfield, WI; and Terry Reilly Health Services, Boise, ID.

In each center, medical and dental leadership sees the importance of taking a population health management approach to oral disease prevention and management. Patient populations commonly targeted are: young children, pregnant women, patients with diabetes and other chronic diseases. Training of medical providers is a strategy used to generate buy-in. With a basic understanding of the oral disease process, interventions to prevent and/or manage it and the impact of oral diseases on overall health, medical staffs demonstrate a willingness to address the oral health needs of their patients.

In some cases, the health centers used quality improvement processes to monitor and trend oral health metrics, e.g. the percent of pregnant women receiving dental care prior to delivery (see chart at right). In one case, a health center used its oral health improvement project as an example of continuous quality improvement in its application for NCQA PCMH recognition.



Bi-directional communication (from medical to dental and from dental to medical) is supported by electronic medical record systems in some centers, where visibility of patient health information is provided to both medical and dental providers. Dental providers seeing a high blood pressure reading or incomplete immunization status refer patients to medical services. Medical providers whose patients have elevated HbA1c levels are prioritized for dental treatment. In some cases, prompts are designed into the EHR to initiate referrals and the ensuing referral requests are initiated as an order in the EHR system.

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## Oral Health Integration in PCMH...continued

Published data cited in this report indicates that the need for improvements in our approach to oral health service availability and delivery is profound:

- The American Dental Association has estimated that around 30% of the population has difficulty accessing dental services through the current private dental care delivery system<sup>1</sup>
- The California Healthcare Foundation reported in 2008 that 24% of all children ages 0-11 in California had never seen a dentist<sup>2</sup>
- A national analysis by the GAO in 2010 revealed that only about one-third of children enrolled in Medicaid received any dental service during the 2008 fiscal year<sup>3</sup>
- Forty-four percent (44%) of 5 year olds already have cavities<sup>4</sup>

The approach to improvements implemented in the case study health centers involves, to varying degrees, the primary care medical team members performing risk assessments, providing anticipatory guidance or patient self management counseling on diet and hygiene, applying fluoride varnish, and consulting with and/or referring to the dental service high risk patients from the target populations. Report interviewee and Terry Reilly Health Services Dental Director, Dan Watt, DDS states:

*"I see a day where the primary care provider has a team that looks at the risks, scores and targets, and applies interventions including oral health care to reduce the rate of heart disease, improve blood glucose control and achieve other improvements for specific sub-populations."*

The case studies shed light on the financial impacts of integrating oral health into primary care. Health centers report that increasing the number of young children receiving dental services increases health center revenues, since these populations are likely to be covered by Medicaid. By contrast, there is a lack of financing for the oral health care needs of adults. Health center interviewees also note the need for reimbursement (billable codes) for the provision of oral health preventive services provided in the medical clinic by primary care medical staff.

Non-financial barriers to implementation of integration strategies that are commonly cited include the lack of:

- health center leadership or advocacy
- training of medical staff on oral health care
- medical/dental health information system interoperability
- on site (co-located) dental service.

Federal and other national initiatives that are supportive of incorporating oral health in the medical home are referenced, including a 2011 CMS Oral Health Strategy indicating that CMS is assessing opportunities "to ensure that oral health is included in the medical home initiative and the ACO demonstration as required by the Affordable Care Act."<sup>5</sup> The report synthesizes the case study findings into "Lessons Learned" relating to infrastructure, program design and reimbursement. It also provides funders with suggestions for how philanthropic investments can be made to support integrated service programs, advancements in health professional education, development of pilot projects, and advocacy.

This report provides an efficient way for readers to learn more about an aspect of comprehensive care that is often overlooked during PCMH planning and improvement processes. The case for including oral health in patient-centered primary care is made. Specific practice models, integration strategies, and implementation issues are provided in the four case studies.

### References:

1. The American Dental Association "Report of the Dental Workforce Taskforce 2006. HOD Resolution 3. 2006
2. Nadereh Pourat, Ph.D. Haves and Have-Nots: A Look at Children's Use of Dental Care in California. The California Healthcare Foundation, 2008
3. U.S. Government Accountability Office. "Oral Health: efforts Underway to Improve Children's Access to Dental Services, But Sustained Attention Needed to Address Ongoing Concerns." 2010
4. Iida, Hiroko. Pediatrics Vol. 120 #4, October 2007
5. CMS Oral Health Strategy. "Improving Access to and Utilization of Oral Health services for Children in Medicaid and CHIP Programs" April 11, 2011

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