TABLE OF CONTENTS

1. INTRODUCTION

2. METHODS

3. ORGANIZATIONAL CHARACTERISTICS OF EARLY ADOPTERS

4. BARRIERS TO INTEGRATING ORAL HEALTH INTO THE PATIENT-CENTERED HEALTH HOME

5. PROMISING PRACTICES

6. CONCLUSION

7. LINKS

9. APPENDICES

10. CREDITS
The Patient-Centered Health Home (PCHH)* can be defined as a place where all aspects of patient care between healthcare providers—for example dental, medical and behavioral care and community resources—are integrated and coordinated, with the goal of improving health care quality and outcomes and lowering health care costs.

The PCHH is an emerging concept being implemented through a variety of approaches including full integration, co-location, shared financing, virtual linkages and facilitated referral and follow-up. Health Homes are an important approach for helping to ensure that Health Center populations have access to comprehensive health care services, including dental care.

The Health Resources and Services Administration (HRSA) has embarked on several PCHH initiatives within Health Centers, including encouraging organizations to apply for NCQA Patient-Centered Medical Home recognition, and covers the cost of recognition through its Patient-Centered Medical/Health Home Initiative (http://bphc.hrsa.gov/policiesregulations/policies/pal201101.html). As part of a cooperative agreement with HRSA, NNOHA conducted a needs assessment of Health Center Dental Directors and follow-up interviews with nine “early adopter” organizations that have made substantial progress integrating oral health into the PCHH.

The needs assessment and follow-up interviews revealed characteristics and organizational factors of the early adopter Health Centers that facilitated medical-dental integration and the establishment of the PCHH, along with barriers that hinder this achievement.

Lastly, promising practices conducted in the responding Health Centers related to integrating oral health with other Health Center services were identified and categorized for review and consideration by other Health Centers.

While the results of this project are based on a limited survey sample, NNOHA hopes the information provided will encourage and inform efforts to integrate oral health into the Patient Center Health Home with the goal of improved health outcomes for the populations we serve.

* NNOHA recognizes the current national movement of patient-centered medical homes. However, while NNOHA supports the concept, this term’s focus on medical care is exclusive of other health care disciplines, such as oral health and behavioral health. As a result, NNOHA has chosen to advocate the more inclusive term “patient-centered health home” throughout this Action Guide.
An online assessment was sent to 270 current self-identified Health Center Dental Directors. The assessment contained questions about both practices indicative of progression towards medical-dental integration, as well as common barriers to incorporating dental component into the PCHH in Health Center settings. The assessment can be found in Appendix A. A total of 77 responses were received for a response rate of 28.5%.

The results of the assessment revealed what the respondents felt were common barriers to incorporating dental into the PCHH in Health Center settings. The “early-adopter” Health Center dental programs that routinely performed practices indicative of progression towards medical-dental integration were also identified through the assessment responses.

Follow-up structured interviews were conducted with the Dental Directors of nine early-adopter Health Center oral health programs, who stated that they “routinely” performed at least 6 out of 9 practices indicative of progression towards medical-dental integration and the existence of the PCHH. The interview guide can be found in Appendix B. The interviews revealed characteristics and organizational factors of the early adopter Health Centers that facilitated medical-dental integration and establishment of the PCHH.

Established promising clinical and administrative practices from all Health Centers responding to the online assessment and the follow-up interviews were collected and categorized into the six domains of the Chronic Care Model of Health Care Management, in order to facilitate review and consideration of relevant practices by other Health Centers.

The results of this project presented in this Action Guide are based on a limited survey sample, not a representative sample, and conclusions about the entire Health Center universe should be drawn carefully.

**ORGANIZATIONAL CHARACTERISTICS OF EARLY ADPOTERS**

During interviews with the nine early-adopter dental programs, respondents were asked to describe the reasons why they felt their Health Center had achieved a high level of medical-dental integration. As a result, seven common themes emerged:

**1. Leadership Vision and Support**

The Executive Director (ED/CEO) of the Health Center is the prime force behind efforts to achieve medical-dental integration, even more than the Medical Director.

The vision for incorporation of dental and other departments into the PCHH cascades down from the ED/CEO. These leaders have long-term vision and guide the strategic direction of the Health Center. They ensure that the same message is given out throughout the organization – that treating the patient as a whole is part of the mission and culture of the Health Center, and that the Health Center has a whole population of patients that have a whole constellation of needs.
2. Dental Integration Into the Health Center Executive/Management Team

The dental department is included in the Health Center administrative structure, and is present and “in the room” as each phase of integrating services with the medical department is planned and discussed.

The integration of dental services into Health Center management is not based on personal relationships – it is part of the organizational structure. The dental department is completely integrated into the administrative structure of the Health Center, with dental included in all operations team meetings and communications, and the Dental Directors having close working relationships with other departmental directors. The dental department participates in Health Center committees (quality improvement, clinic flow etc.) and is present when planning and clinical policy and protocol decisions are made to advocate for dental and give dental input and perspective. The dental department has access to the marketing and development staff at the Health Center, to help dental complete any funding opportunities.

The governing Boards of early-adopter Health Centers support for dental and other services through policy. Some Boards have the goal of having each clinical and enabling service available at each HC site. Other boards include dental services in every expansion grant application, with emphasis on targeted special populations that require medical collaboration to access. In some Health Centers integration is an organizational core principle but not unless right-sized capacity exists (facilities, staffing) because medical providers cannot refer patients to the dental (or other) department if there is no available capacity. Therefore, in these organizations, appropriate Health Center expansion adds equivalent amounts of dental and medical capacity.

A Health Center has 14 Quality Improvement (QI) measures. The measures are split amongst the Executive Team members including the Dental Director. Each Team member is responsible for making sure the work on making progress in the measures gets done in the organization. Each Team member may not be assigned measures that relate to their clinical or organizational area of expertise, so they can understand how the other aspects of the organization operate.

3. Co-location of Medical and Dental Services

Co-location of medical, dental and other services at the same site allows staff from any Health Center department to both bring a client directly to dental department to make an appointment, and also allows medical providers to ask dentists for quick consults. The process is bi-directional with dental staff able to send patients with high blood pressure or potential uncontrolled diabetes directly to medical for same day assessment. The “warm handoff” is an important benefit of co-location, and there are positives to having multiple services (e.g. nutrition, behavioral, social workers etc.) in one location.

A rural new start Health Center hired the management team including the medical and dental directors, three months before the Health Center opened for clinical services. As the Health Center clinical and administrative infrastructure was being created, individuals bonded during planned activities, including building parts of the clinic together. This communication is part of the culture now- new staff accepts close relations between departments as normal.
4. Organizational Culture of Quality Improvement

The Health Center embraces a culture of quality improvement. Dental Directors of early-adopter organizations tend to display an in-depth user's knowledge of the terminology and methodology of quality improvement. This culture permeates all levels of the Health Center and is part of how the dental program conducts its daily functions.

There is a focus on outcomes – of using outcome measures to drive change, of improvement from a baseline, and that these concepts can be used for all aspects of clinic operations. As members of the Health Center management team, the Dental Directors view their efforts in the dental program with their own departmental measures such as the percentage of diabetic or perinatal clients with a dental visit, as contributing to improvement in center-wide outcome measures such as controlled diabetic patients and low rates of adverse birth outcomes.

5. Staff Buy-in Through Understanding the “Why”

Progress in integrating oral health into the PCHH is the result of a continuous process, with many changes and new concepts introduced along the way. When confronted with resistance from staff to change, especially the introduction of new patient populations not previously seen in the dental clinics, the approach is not telling staff what to do, but rather of developing buy-in through explaining the why, constantly reinforcing why things are being done a certain way.

Frequently-stated reasons articulated to staff as rationale for change tend to fall into two categories, the first being that proposed changes achieve good patient outcomes, provide the best care for patients and prevent disease. The other rationale relates to the benefits to clinics of seeing certain patient populations in terms of generating revenues and maintaining financial sustainability.

6. Utilization of Patient Enabling Services

Early-adopter Health Centers utilize patient support staff to both facilitate access to dental services and make the support staff services directly available to dental clients. These employees have different names: health coaches, patient navigators, family support workers, etc. In any case, their functions include assisting patients navigating the Health Center appointment system, as well as engaging patients with motivational interviewing, setting goals, running classes. These staff members float in the Health Center and are utilized as needed by different departments including dental.

A dental hygienist, after completing a prophy, was discussing lowering caries risk through diet choices with a patient. The topic of soda consumption came up and the hygienist mentioned that reducing soda intake could lower caries risk as well as calorie intake for weight reduction.

The conversation continued with the patient then expressing a desire to engage in weight reduction. The dental hygienist was able to get up from the dental operatory and go out into the clinic hallway and flag down a health coach that was circulating in the medical clinic. The health coaches were available for dental providers also, and had previously assisted dental patients with smoking cessation efforts. In this instance the health coach was able to take the patient right away and in the health coach office, discussion began on weight reduction goals.
7. Dental Director Leadership

Dental Directors in the early-adopter Health Centers, regardless of length of tenure, are proactive individuals, with strong leadership skills and sure of the importance of oral health to improving the general health status of the patients they serve. This gives them the confidence to advocate for oral health with other Health Center administrators. They have a long-term horizon, take the time to develop influence, develop relationships and grow credibility, to develop “Purposeful Leadership” – transforming vision into reality in a way that helps others.

“Meet the Medical Director, push prevention and oral health as part of general health...you need to be a champion yourself.”

“Dental staff tries to always be present in Health Center life.”

“Remember the reason for doing this is not for a piece of paper of recognition but to better serve our patients and improve their quality of life.”

BARRIERS TO INTEGRATING ORAL HEALTH INTO THE PATIENT-CENTERED HEALTH HOME

Lack of necessary infrastructure was identified as the biggest barrier to integration of oral health with other Health Center services to create the PCHH. Infrastructure was further described as lack of capacity in dental programs compared to medical programs and issues with interoperability between medical and dental IT systems.

Co-location of Medical and Dental Services On-site

Of the Health Centers that responded to the needs assessment, a significant percentage (28.9%) stated that medical and dental services were co-located at all sites. However, the majority of Health Centers reported that not all medical sites had a co-located dental clinic, with 31.6% stating that more than 50% of the medical sites had a co-located dental clinic, 34.2% stating that less than 50% of the medical sites had a co-located dental clinic and 5.3% stating that none of the medical sites had a co-located dental clinic.

Since co-location was identified as one on the enabling characteristics of high-performing Health Centers, the fact that the majority of Health Center medical care access points do not have a co-located dental clinic, may create a barrier to integration of the two disciplines.
Electronic Health Record (EHR) Issues

Of the Health Centers that responded to the needs assessment, only 23% of the respondents indicated that they practiced in an environment where the medical and dental systems were interoperable. The vast majority of respondents either practiced in a Health Center where the Electronic Medical Record (EMR) and Electronic Dental Record (EDR) were not interoperable or one of the two systems was lacking.

A detailed description of the HIT configurations between medical and dental in the nine high-performing Health Centers, obtained during the follow-up interviews, highlights the configurations available and the differences between configurations.

### Table: HIT Configurations of Interviewees

<table>
<thead>
<tr>
<th>System</th>
<th># using</th>
<th>Issue/notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>1</td>
<td>Will be getting EMR soon</td>
</tr>
<tr>
<td>EMR only</td>
<td>1</td>
<td>Interoperable after Dental Director created dental templates for the EMR - dental is using/ integrated into the medical EMR - one program.</td>
</tr>
<tr>
<td>Interoperable EMR/EDR</td>
<td>2</td>
<td>Selected by the Health Center precisely because it is interoperable - there are 2 separate programs that do communicate.</td>
</tr>
<tr>
<td>Sep EMR + Sep EDR + HL7 bridge</td>
<td>2</td>
<td>The clinics contract with a Health Center management network and as part of the services, they pay for the proprietary software HL7 bridge that allows EDR to be interoperable with the medical program. There are 2 separate programs.</td>
</tr>
<tr>
<td>Sep EMR + Sep EDR</td>
<td>3</td>
<td>Non-interoperable - 2 separate programs.</td>
</tr>
</tbody>
</table>

Blue= interoperable  Red= Non-interoperable

Having a truly interoperable EHR facilitates PCHH activities. Although all the Health Centers interviewed have achieved a great deal, the programs with interoperable HIT systems are able to access much more data, both clinical and administrative, much faster than programs without interoperable systems, and are able to use this data for clinical decision making, follow-up, quality improvement and other functions that contribute to increased integration and better patient outcomes.

Any Health Center that has a separate, non-interoperable EDR and EMR will usually have dental providers able to access the EMR, but medical providers may not be able to see the EDR. Prescription writing is a tremendous issue in this situation because medical providers have no way of knowing if a patient has received a prescription in the dental clinic. Since chronic drug-seeking behavior can be an issue that health care providers face in Health Centers, some organizations have the dental provider check the EMR first for the medical prescription history as well as double enter the prescription into both the EDR and the EMR, using additional provider time.

Health Centers that are members of a Health Center Controlled Network (HCCN) pose an interesting solution to the interoperability issue. HCCN’s developed to improve operational effectiveness and clinical quality in Health Centers through the provision of management, financial, technology and clinical support services. HCCN initiatives are typically focused in functional areas requiring high-cost and/or highly specialized trained personnel, procurement of large infrastructure systems or in functional areas where operational mass drives economies of scale. One of the services available to Health Centers in a HCCN is access to software that creates an interoperability bridge between EDR and EMR software.
HIT is an evolving issue in health care in general, as well as in Health Centers. For more information on HIT and Health Centers, and Health Center Controlled Networks, see the LINKS section.

Training Issues

In general, medical providers and patient support staff are open to educational efforts about oral-systemic topics. Once the evidence base is presented, medical providers are willing to refer specific patient populations (HIV, diabetic, perinatal, young children) to dental department. Respondents provide training to medical staff through Health Center in-service presentations, journal articles and online resources such as the Smiles for Life curriculum (http://www.smilesforlifeoralhealth.org).

Some early-adopter respondents mentioned resistance from some dental providers and staff to expand services, especially to infant and perinatal populations. This could be due in part to a lack of training and familiarity serving these populations during dental school and in previous clinical practice. Many organizations provide training for providers and staff to begin to feel comfortable treating these populations. Training could be a combination of didactic and hands-on experience, provided at the Health Center or at offsite CE courses.

Support Needed to Move PCHH Initiatives Forward

Some respondents felt that a lack of funding hampers furthering PCHH efforts, stating that increased funding to expand dental capacity to more closely match medical capacity would allow more patients to access dental services. Also that funding gaps exist that might not allow for some individual Health Centers to undertake all the activities needed to establish a PCHH environment.

There are also systemic funding issues. Under the current health care payer system, patient support staff such as health coaches, family support workers and patient navigators, critical to integration efforts between health center departments, perform non-billable services. Health Centers currently fund these positions through grants and other means, which are not stable long-term funding streams.

PROMISING PRACTICES

Promising practices were solicited in the online survey from all participants and additional practices were identified during interviews with the early adopter programs. The promising practices are categorized here under the six aspects of the Chronic Care Model, since this is a well-known paradigm for change utilized in most HRSA/BPHC Health Centers.

Clinical Information Systems

Health Centers use their IT system patient databases to identify targeted populations for integration efforts. Lists of specific age ranges or medical conditions within the Health Center medical patient or Women, Infants, and Children (WIC) populations are developed. Common age cohorts are very young children 0-5, children or adults. Medical conditions include pregnancy, diabetes and HIV.

Once specific population lists are developed, strategies are devised to guide patients into dental care.
Strategies include sending targeted mailings and having staff directly contact potential patients. Programs with advanced HIT systems utilize the software capabilities to identify and alert medical providers about special populations such as perinatal, diabetic and HIV/infectious disease patients that need a dental referral in real time during the primary care visit. HIT systems can also be used to generate direct referrals from the medical department to the dental clinic.

Information systems are also used to track progress in achieving access to dental care for the specific populations. Cross matching the initial population lists with dental encounter data provides a baseline of those patients that have already achieved dental access and allows continuous monitoring of efforts to reach the rest of the population. An enhanced reporting system derived from EHR is a key factor that allows progress evaluation that is accessible to all providers.

Clinically, examples of HIT strategies include dental providers accessing diabetic patient's HBA1c levels and medical appointment attendance records and referring patients back to medical if they have not been back for regular recalls. Another Health Center configured the EHR to create a health summary form - one page of information that dental providers want to see in the health record. As the medical history is being filled out in the medical department, certain fields will populate a summary form of data that dental providers have decided is critical for dental care, such as medications, key social/medical history items, etc. The dentist then accesses the health summary during dental visits.

**Decision Support**

Early-adopter Health Centers provide continuous education and training of both medical and dental staff. Nationally recognized resources such as the Society of Teachers for Family Medicine (STFM) Smiles for Life online curriculum are utilized at all levels of the organization to teach non-dental staff about clinical oral health. Various venues for training are used including yearly training for non-dental staff on oral health topics, "lunch and learn" sessions, and the dental department contributing to "grand rounds" - the Health Center’s internal education program.

Medical providers are reminded at monthly meetings about the administrative and recordkeeping procedures associated with integration efforts, for example, the global alert system at one Health Center that flags medical patients in special populations that need a dental referral.

Dental staff also receives training in the clinical guidelines and procedures specific to dental care for the targeted populations, such as clinical procedures for infant oral care visits and perinatal treatment guidelines. Dental staff are also provided training in the Health Center HIT system and the specific dental clinic procedures and systems for recordkeeping and data entry.

To facilitate integration, processes have been implemented such as developing specific forms for the referral of patients, such as perinatal patients to the dental department and integrating dental-specific referral language into Health Center obstetric patient and diabetic patient clinical protocols.

Minimum bureaucracy, having the ability to get a form or protocol approved and implemented in a few days; a belief in “why delay an improvement” encourages implementation of processes. Also, the ability to use the word mandatory in relation to specific procedures and protocols that have been developed facilitate adoption of change.
Delivery System Design

Many innovative modifications to health care delivery have been made by Health Centers to facilitate integration between medical and dental programs. Some Health Centers dental programs choose to give priority access to targeted populations. Examples include "fast-tracking" perinatal dental exam appointments within two weeks, having dental staff "case manage" perinatal patients in an attempt to complete treatment prior to delivery, and providing "open access", usually to pediatric primary care patients, by allowing them to drop-in to the dental department for an exam on the same day as a primary care visit.

Other strategies include "max-packed visits" such as scheduling immunizations with the physician and dental check-up with the dentist all in one visit, or a "well child visit" for ages 0-5 that includes a medical, dental and behavioral encounter at one visit, and providing adjunct services such as HIV diagnostic swabbing as a part of routine care in dental clinic visits.

In some Health Centers, non-dental department staff have access to the electronic dental department schedule to make exam appointments. When combined with utilization of patient support staff such as family support workers, patient navigators, health coaches or perinatal outreach workers to make dental appointments for clients from other parts of the Health Center, this can reduce barriers to access substantially. Programs that use a centralized call center for appointments, have given call center staff the ability to see both medical and dental schedules simultaneously.

At sites where medical and dental services are both available at the same location, informal enhanced access is available for unusual circumstances. For example, dentists are available for consults (a quick look at an unusual oral lesion) for primary care providers and drop-in appointments are available for dental patients with abnormal blood pressure readings.

Self-Management Support

To facilitate self-management of health, the Health Centers focus on patient literacy and having appropriate educational materials. There is cross-pollination with dental education brochures provided for medical clinic waiting rooms, and materials on topics such as diabetes and obesity available in the dental waiting room.

Looking at the future Health Centers envision giving patients access to their health records over the internet/phone – giving the patients control of their results, by following lifestyle recommendations, proper medication usage. This feedback communicates the relationship between lifestyle and results.

Health System/Organization of Health Care

Many programs have developed innovations in physically integrating dental providers into medical clinics and other Health Center departments. One Health Center will have a one-chair dental clinic embedded in the new medical clinic that will use a handheld x-ray and portable dental unit. The plan is to use this facility primarily for children but adult emergencies will also be seen. Other sites have located a dentist or dental hygienist in the medical and/or pediatrics clinics and in the WIC department. Services provided include exams, assessments, education and fluoride applications on younger children depending on state dental practice regulations.
Programs are also looking at staff attitudes towards integration and the PCHH concept. Understanding that a new concept is being introduced and that there is sometimes resistance to change, education and training of existing staff is the first step to overcoming change. As an additional motivator, some Health Centers are compensating staff based on patient outcomes. In hiring new staff some programs are focusing on applicants that understand Health Center culture including the recent emphasis on the PCHH, and may have had some exposure to Health Center practice through rotations, residencies or externships.

Early-adopter programs emphasize institutionalizing processes. Otherwise the process will stop as soon as someone leaves the organization. As an example, policies and procedures for referrals across departments have been developed and documented. Another aspect of this is institutionalizing the inclusion of oral health in Health Center quality improvement activities. Some Health Centers have a dentist as a permanent member of the Clinical Quality Improvement (CQI) group or committee. Others have developed and utilize quality improvement measures relating to medical-dental integration to drive change and improve care.

**Community Resources and Policies**

Health Center dental program staff engage in community outreach and education on the efforts to integrate medical and dental in patient care, starting with presentations made to the Health Center Board. In some locations, annually (in February- National Children’s Dental Health Month) staff makes presentations to the county social services office and department of public health staff. In another site the dental hygienists developed a presentation for the local dental hygiene and local dental society components to increase awareness of Health Center programs.

Another early adopter employs a bilingual dental outreach worker, who works full time and goes to Head Starts, schools, homeless shelters, La Leche league meetings, Hispanic community groups and other events. The Outreach Worker is self-supporting through generating new clients and acting in an advertising capacity for the Health Center.

Some Health Centers are part of networks participating in PCHH/meaningful Use Learning Collaborative activities sponsored by the state Primary Care Association. Both medical and dental staff are included in these planning committees and are able to share promising practices with peers.
To determine the current status of oral health in Health Center’s Patient Centered Health Home (PCHH) efforts, NNOHA conducted an online assessment and follow-up interviews of early adopter oral health programs. Though the results of this project are based on a limited survey sample, not a representative sample and conclusions about the entire Health Center universe should be drawn carefully, there are many findings that have relevance and immediate applicability.

Seven key factors that facilitate medical-dental integration and the inclusion of oral health into the PCHH were identified. Most are organizational in nature and can be duplicated in other Health Centers if there is the vision and will to do so.

Lack of infrastructure is the primary identified barrier to development of the PCHH, as revealed in two dimensions by this assessment. The majority of Health Center medical sites do not have a co-located dental clinic making physical integration and access more difficult. A lack of HIT infrastructure and lack of interoperability between the medical and dental HIT systems (when present) impedes efforts to access clinical data in a timely manner, and hinder the integration of referrals, appointment tracking and other systems that facilitate the creation of a PCHH.

The early-adopter Health Centers and other respondents have already developed many promising practices and innovations, especially in the areas of Clinical Information Systems, Delivery System Design and Health System/Organization of Health Care, that facilitate medical and dental integration.

Over ten years ago the Surgeon General’s Report on Oral Health popularized the phrase “oral health is part of general health.” The journey to translate that phrase into clinical practice continues. Hopefully the information contained in this Action Guide can assist Health Centers on their journeys to integrate oral health with medical care and other disciplines to create the Patient-Centered Health Home with the goal of improving health for the populations served by safety-net oral health programs.
Patient-Centered Medical/Health Home Initiatives:

- HRSA Patient-Centered Medical/Health Home Initiative Program Assistance Letter 2011-11
  http://bphc.hrsa.gov/policiesregulations/policies/pal201101.html

- National Center for Medical Home Implementation
  http://www.medicalhomeinfo.org/

- National Committee for Quality Assurance Patient Centered Medical Home recognition

Health Information Technology and Health Centers:

- HRSA Oral Health IT Toolbox

- Tips for the Safety Net Community on Using Health IT within a Patient Centered Medical Home

Health Center Controlled Networks:

Health Home Needs Assessment Questions

1. The health home is a model of patient-centered and value-driven healthcare emphasizing coordination and communication among all healthcare professionals that can lead to higher quality and lower costs and improve both the patients’ and providers’ experiences of care. Please indicate whether or not your Health Center(s) or dental clinic(s), as specified below, "Routinely", "Sometimes", or "Never" engage in these practices.

<table>
<thead>
<tr>
<th>Question</th>
<th>Routinely</th>
<th>Sometimes</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental providers have immediate access to the patient’s current medication and problem list</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specific policies and procedures exist for referral, tracking and follow-up of diabetic patients into dental care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specific policies and procedures exist for referral, tracking and follow-up of dental patients into behavioral health care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specific policies and procedures exist for follow-up and tracking of dental patients with abnormal BP readings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early Childhood Caries risk assessment is incorporated into well-child visits for ages 0-5 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>An oral health measure has been incorporated into the Health Center’s Diabetes or Prevention collaborative.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The percent of perinatal patients that receive a dental exam while pregnant is reported on a monthly basis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Center clinical staff is able to access the scheduling system to coordinate dental appointments with other care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental leadership participates in strategic planning for the organization</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Each Health Center site where medical services are provided has a co-located dental clinic.
   a. All sites
   b. 50% of sites
   c. <50% of sites
   d. No sites have co-located dental services

3. The following is a list of potential barriers that might interfere with or prevent a clinic from integrating and coordinating patient care (i.e. establishing a health home) between a dental program and other healthcare providers. Please indicate whether or not each potential barrier would be viewed as a "definite barrier", "possible barrier", or "not a barrier" for your dental clinic when considering the integration and coordination of patient care.
4. Which of the following does your Health Center utilize?

<table>
<thead>
<tr>
<th></th>
<th>Definite Barrier</th>
<th>Possible Barrier</th>
<th>Not a Barrier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unfamiliarity with the health home concept.</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Lack of training for Health Center clinical staff (medical and dental) or guidelines for care.</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Lack of knowledge of resources available to support integration of oral health into other Health Center services (e.g. best practices, etc.).</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Lack of clear incentives to integrate/coordinate oral health into other Health Center services.</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Lack of necessary infrastructure, especially IT systems, to facilitate integration of oral health with other health center services.</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Reluctance of dental staff to integrate and coordinate care.</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Reluctance of non-dental Health Center staff and administrators to integrate and coordinate care.</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Reluctance of the patients themselves due to potential lack of understanding of the value of the integration and coordination of patient care.</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Lack of sufficient oral health workforce to hire, contract with, or refer patients to.</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

5. Please briefly share what is working well/best practices for your site regarding any of your current Health Home initiatives.

6. If you are willing to have NNOHA contact you for follow-up on any items, please enter your name and Email address below:
APPENDIX B

Interview Guide for Oral Health Programs Leading Patient Centered Health Home Initiatives

Questions about your Health Center oral health/dental program:

- What is the number of medical/dental sites?
- What is the number of medical/dental users?
- What % of medical users are also dental users?
- How long have you been Dental Director at this program?
- How long have you worked with the current Medical Director?
- How long have you worked with the current Executive Director/Chief Executive Officer?

1. Has your organization achieved National Committee for Quality Assurance (NCQA) Patient Centered Medical Home designation or are you currently working towards that?
   a. If yes, do you feel the designation has had an effect on the high level of integration demonstrated by your scores?
   b. How/why? Give some examples…

2. What are some of the reasons that you feel that you have been able to achieve the level of medical-dental integration that you have?

3. Who have been the champions of this integration at different levels of your organization?

4. What types of training/education had to take place in order to make integration work? Dental staff? Non-dental staff? Patients?

5. Your survey showed that you do/do not have an EDR and that it is/is not interoperable with the EMR. How has this impacted your ability to achieve the level of integration you have?
   a. What EMR and EDR vendor is used in your HC?

6. Give me an example of something that you have not been able to implement or really had challenges with.

7. What advice would you give a program that is just starting a Health Home initiative?

8. What support do you wish was available for strengthening Health Home initiatives?

9. We are going to distill the best practices from these interviews and make them available to NNOHA members and others so they can learn from your successes and challenges. Do you have anything you wish to add?
CREDITS

NNOHA staff:

Colleen Lampron, MPH
Former NNOHA Executive Director

Irene V. Hilton, DDS, MPH
NNOHA Dental Consultant (Primary Author)
Irene@nnoha.org

Mitsuko Ikeda
NNOHA Project Director
mitsuko@nnoha.org

Jennifer Hein
Operations Manager
jennifer@nnoha.org

Thank you to:

Lisa A. Wald, MPH
NNOHA Project officer
Public Health Analyst
Office of Training and Technical Assistance
Coordination
Bureau of Primary Health Care, HRSA

Wendy Mouradian, MD, MS
Special Adviser
Office of Strategic Priorities, Office of Special Health Affairs
Health Resources and Services Administration

Special Acknowledgement:

Think2 Consulting, LLC

Erie Family Health in Chicago, Illinois, for generous use of many patient photographs.

Terry Hobbs

Dental Directors and/or Dental Managers in the following Health Centers:

Community Health of South Florida, Inc.
Community Healthcare Network
Crescent Community Health Center
Family Health Centers of Southwest Florida
Healthpoint Community Health Center
High Plains Community Health Center
La Clinica de la Raza, Inc.
Primary Health Care, Inc.
Solano County Public Health Dental Services
The mission of the National Network for Oral Health Access (NNOHA) is to improve the oral health of underserved populations and contribute to overall health through leadership, advocacy, and support to oral health providers in safety-net systems.

The National Network for Oral Health Access (NNOHA) is a nationwide network of Health Center dental providers. These providers understand that oral disease can affect a person's speech, appearance, health, and quality of life and that inadequate access to oral health services is a significant problem for low-income individuals. The members of NNOHA are committed to improving the overall health of the country's underserved individuals through increased access to oral health services.

For more information on NNOHA, visit www.nnoha.org, send an email to info@nnoha.org, or call 303-957-0635.

This publication was supported by Grant/Cooperative Agreement No. #U30CS09745 from the Health Resources and Services Administration Bureau of Primary Health Care (HRSA/BPHC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA/BPHC.