

A User's Guide for Implementation of Interprofessional Oral Health Core Clinical Competencies: Results of a Pilot Project



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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.

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Executive Summary

Oral health is an integral part of overall health.¹ HRSA's February 2014 report, *Integration of Oral Health and Primary Care Practice*, states:

Lack of access to oral health care contributes to profound and enduring oral health disparities in the United States. Millions of Americans lack access to basic oral health care. In 2008, 4.6 million children—one out of every 16 children in the United States did not receive needed dental care because their families could not afford it. Children are only one of the many vulnerable and underserved populations that face persistent, systemic barriers to accessing oral health care.²

The report describes a set interprofessional oral health core clinical competencies (IPOHCCCs; also referred to throughout this guide as “oral health competencies” or “competencies”) that HRSA developed to increase integration of oral health care into primary health care and their five domains: risk assessment, oral evaluation, preventive interventions, communication and education, and interprofessional collaborative practice.

In 2013, HRSA awarded the National Network for Oral Health Access (NNOHA) supplemental funding to pilot the implementation of the IPOHCCCs in three Health Centers across the country. The goal of the IPOHCCC Pilot Project was to adopt and implement the oral health competencies using a sustainable-systems approach that results in integrating oral health and primary care through interprofessional collaborative practice, and, ultimately, to increase integration of oral health care into primary health care.

This guide provides a structure, options, and suggestions to help Health Centers develop programs to implement oral health competencies which integrate oral health care into primary health care, increasing access to oral health care, and improving the oral health status of the populations the Health Centers serve. The experiences of the three IPOHCCC pilot projects helped inform the recommendations included in this guide. These recommendations include:

- Planning
- Modifying training systems
- Updating health information systems
- Modifying clinical care systems
- Developing evaluation systems

The pilot teams encountered challenges throughout their year-long pilot period, including covering expenses associated with modifying electronic medical records, providing training, developing the work flow to integrate the oral health competencies into the primary care visit, overcoming initial resistance to system changes, and addressing competing Health Center priorities. However, all the teams agreed that establishing long-term sustainable systems changes to incorporate oral health care into primary care and, ultimately, to achieve better health for patients is worth the effort.

1 US Department of Health and Human Services, Public Health Service, Office of the Surgeon General. “Oral Health in America: A Report of the Surgeon General.” National Institutes of Health, National Institute of Dental and Craniofacial Research; 2000.

2 Health Resources and Services Administration. “Integration of Oral Health and Primary Care Practice”; 2014: <http://tinyurl.com/HRSA2014-IOH>

Background

Oral health is an integral part of overall health.³ Since the publication of *Oral Health in America: A Report of the Surgeon General* in 2000, and the *National Call to Action to Promote Oral Health* in 2003, there has been increased focus on improving the oral health status of Americans, particularly those from populations with disproportionately poor oral health. Awareness of barriers to obtaining oral health care, even for those who can access primary care, is growing.

The 2005-06 Health Resources and Services Administration (HRSA), Bureau of Primary Health Care (BPHC), Oral Health Disparities Collaborative pilot project demonstrated that education and training are key to engaging primary care health professionals (defined as physicians, nurse practitioners, and physician assistants) in integrating oral health care into primary health care. Primary care health professionals need education on the importance of oral health to overall health, as well as training on how to screen for oral health problems and how to provide initial oral health counseling.⁴ The project also demonstrated that successfully integrating oral health care into primary care requires the development of systems infrastructure to support integration activities between oral health programs and primary care programs.

The Institute of Medicine's (IOM) report, *Improving Access to Oral Health Care for Vulnerable and Underserved Populations*, recommended that HRSA convene key stakeholders to develop a core set of interprofessional oral health core clinical competencies (IPOHCCCs; also referred to throughout this guide as "oral health competencies" or "competencies") for non-oral-health professionals with the aim of increasing access to oral health care.⁵ Accordingly, in 2012, following publication of the IOM report, HRSA convened a series of meetings to (1) develop a standardized set of IPOHCCCs, (2) develop strategies to enhance oral health primary care team approaches to patient care, and (3) develop strategies for adoption and implementation of the oral health competencies in safety-net settings.

Following these meetings, HRSA developed the IPOHCCCs in 2012–13. The oral health competencies can be categorized into five domains: risk assessment, oral evaluation, preventive interventions, communication and education, and interprofessional collaborative practice. The five domains and associated competencies are presented in Table 1.

Table 1: Interprofessional Oral Health Core Clinical Domains and Competencies

Domain 1: Risk Assessment

Identifies factors that impact oral health and overall health.

Competencies: Primary care providers

- Conduct patient-specific, oral health risk assessments on all patients.
- Identify patient-specific conditions and medical treatments that impact oral health.
- Identify patient-specific, oral conditions and diseases that impact overall health.
- Integrate epidemiology of caries, periodontal diseases, oral cancer, and common oral trauma into the risk assessment.

3 US Department of Health and Human Services, Public Health Service, Office of the Surgeon General. "Oral Health in America: A Report of the Surgeon General." National Institutes of Health, National Institute of Dental and Craniofacial Research; 2000.

4 National Network for Oral Health Access. "Oral Health Collaborative Implementation Manual"; 2005: <http://www.nnoha.org/nnoha-content/uploads/2013/09/OHDC-Implementation-Manual-with-References.pdf>

5 Institute of Medicine. "Improving Access to Oral Health Care for Vulnerable and Underserved Populations." Washington, DC: The National Academies Press; 2011.

Domain 2: Oral Health Evaluation

Integrates subjective and objective findings based on completion of a focused oral health history, risk assessment, and performance of clinical oral screening.

Competencies: Primary care providers

- Perform oral health evaluations linking patient history, risk assessment, and clinical presentation.
- Identify and prioritize strategies to prevent or mitigate risk impact for oral and systemic diseases.
- Stratify interventions in accordance with evaluation findings.

Domain 3: Preventive Intervention

Recognizes options and strategies to address oral health needs identified by a comprehensive risk assessment and health evaluation.

Competencies: Primary care providers

- Implement appropriate patient-centered preventive oral health interventions and strategies.
- Introduce strategies to mitigate risk factors when identified.

Domain 4: Communication and Education

Targets individuals and groups regarding the relationship between oral and systemic health, risk factors for oral health disorders, effect of nutrition on oral health, and preventive measures appropriate to mitigate risk on both individual and population levels.

Competencies: Primary care providers

- Provide targeted patient education about importance of oral health and how to maintain good oral health, which considers oral health literacy, nutrition, and patient's perceived oral health barriers.

Domain 5: Interprofessional Collaborative Practice

Shares responsibility and collaboration among health care professionals in the care of patients and populations with, or at risk of, oral disorders to assure optimal health outcomes.

Competencies: Primary care providers

- Exchange meaningful information among health care providers to identify and implement appropriate, high quality care for patients, based on comprehensive evaluations and options available within the local health delivery and referral system.
- Apply interprofessional practice principles that lead to safe, timely, efficient, effective, equitable planning and delivery of patient and population-centered oral health care.
- Facilitate patient navigation in the oral health care delivery system through collaboration and communication with oral health care providers, and provide appropriate referrals.

In 2013, HRSA awarded the National Network for Oral Health Access (NNOHA) supplemental funding to pilot the implementation of the oral health competencies in three Health Centers across the country. The goal of the IPOHCCC Pilot Project was to adopt and implement the competencies using a sustainable-systems approach that results in integrating oral health and primary care through interprofessional collaborative practice, and, ultimately, to increase integration of oral health care into primary health care.

This guide provides a structure, options, and suggestions to help Health Centers develop programs that implement the competencies for the purpose of integrating oral health care into primary health

care, increasing access to oral health care, and improving the oral health status of the populations the Health Centers serve. The experiences of the three IPOHCCC pilot projects helped inform the recommendations included in this guide.

Overview of IPOHCCC Pilot Project

The IPOHCCC Pilot Project resulted from key stakeholders' determination that such a project, conducted in safety-net settings, would inform the implementation of the oral health competencies and the establishment of interprofessional collaboration in primary care settings.

The IPOHCCC Pilot Project objectives were as follows:

1. Increase oral health screening and preventive services.
2. Increase oral health integration in primary care practice.
3. Increase inter-professional collaborative practice.
4. Increase care coordination between medical and dental services.
5. Identification of sustainable approaches to practice changes.

The three Health Centers selected as pilot sites were chosen through a national competitive application process. The Health Centers received financial support, as well technical assistance (TA) from NNOHA staff and consultants. Descriptions of the three Health Centers appear in Table 2. NNOHA staff worked with the Health Centers for more than a year via regular correspondence, phone calls, and site visits. NNOHA enlisted Thomas Keifer Consulting as the project evaluator to compile data and evaluate the success of the pilot projects.

Table 2. Information about Health Center Pilot Sites

Health Center	Location	Description
Bronx Community Health Network, Inc. (BCHN)	New York, NY	BCHN is a Federally Qualified Health Center (FQHC) that serves over 104,000 patients per year at 15 primary care sites, 3 of which have co-located oral health clinics, in the Bronx, NY. The Comprehensive Family Care Center (CFCC) is one of the largest BCHN sites, serving 33,000 patients, and it served as the pilot site for the IPOHCCC project. The initial population of focus was children from birth through age 12 who received care at CFCC. The population of focus was later revised to 0-3 year olds.
Family HealthCare (FHC)	Fargo, ND, and Moorhead, MN	FHC is an FQHC that serves over 11,500 patients per year at 1 primary care clinic and 2 oral health clinics (one oral health clinic is co-located with the health clinic) located in Fargo, ND, and Moorhead, MN. The population of focus for the project was children from birth through age 12 receiving primary care at the Fargo, ND, site.
Health Partners of Western Ohio (HPWO)	Lima, OH	HPWO is an FQHC that serves over 14,700 patients per year at 3 primary care clinics and 2 oral health clinics (both oral health clinics are co-located with a primary care clinic) located in Lima, OH. HPWO primary care health professionals were already providing oral health services to children from birth through age 17, so they focused this new project on adults ages 18 and older at one primary care site.

After a planning period, the three selected Health Centers launched their projects in May 2013. This guide, which describes their efforts, can serve as a template for other Health Centers wishing to launch projects to implement the oral health competencies to integrate oral health care into primary care.

Readiness Assessment

Before launching a project to integrate oral health care into primary care, a Health Center should carefully consider whether it is ready. Does the Health Center possess the necessary characteristics to succeed?

NNOHA has identified common characteristics of Health Centers that successfully integrate oral health care into primary health care.⁶ The following is a list of preliminary questions to help Health Centers gauge their readiness. Answering “yes” to most questions indicates a higher probability of success. More than one “no” answer does not guarantee failure, but it suggests that systems changes need to occur before the Health Center embarks or that barriers to implementation exist that need to be addressed.

Readiness Assessment

Q: Does Health Center leadership believe in the importance of integrating oral health care into primary care?

Q: Is Health Center leadership not just supportive of such integration but also actively involved in making it happen?

- **Leadership Vision and Support**

The vision for integrating the oral health clinic and the primary care clinic originates from the executive director, the board, and other executive leaders. These leaders have long-term vision to guide the Health Center’s strategic direction and priorities. Even more than supporting a program on paper, leaders need to be involved in the process.

Q: Is there an oral health representative on the Health Center executive team?

- **Oral Health Representation on the Executive Team**

Having oral health representation on the executive team reflects a supportive environment for oral health issues and gives the oral health clinic a voice in issues that pertain to oral health. Having oral health representation on the executive management team is part of the organizational structure. The oral health clinic should be represented at all operations team meetings, on all operations team committees, and in all operations team communications, and an oral health representative should be present when planning and clinical policy and protocol decisions are made.

Q: Is the oral health clinic located in the same site as the primary care clinic?

- **Co-Location of Primary Care and Oral Health Services**

Co-location of primary care, oral health, and other services allows staff from any Health Center clinic to bring a patient directly to the oral health clinic to make an appointment and also for primary care health professionals to ask oral health professionals for quick consults. The process is bi-directional, with oral health staff able to send patients with high blood pressure or diabetes directly to the primary care clinic for same-day assessments. The “warm handoff” is an important benefit of co-location, and there are many benefits to having multiple services (e.g., nutrition, behavioral, social work) in one location.

⁶ National Network for Oral Health Access. “Oral Health and the Patient-Centered Health Home Action Guide”; 2012; http://www.nnoha.org/nnoha-content/uploads/2013/09/PCHHActionGuide02.12_final.pdf

Q: Does the Health Center promote a culture of QI?

Q: Does the Health Center currently track any oral health measures?

- **Culture of Quality Improvement**

Health Centers that are ready to launch a program to integrate oral health care into primary care tend to already have experience with quality-improvement (QI) projects. They may already have a QI team in place, use outcome measures to drive change, have in-depth knowledge of QI terminology, or have taken other measures to improve patient health, such as applying for Patient Centered Medical Home recognition. Having a culture of QI means that all levels of staff understand the value of and processes for driving improvements.

Q: Does staff understand why it is important to more fully integrate oral health care into primary care?

- **Staff Buy-In**

Changes in Health Center processes go more smoothly when staff understands the importance of the health issue at hand and the reason for the changes. The best results come not from telling staff what to do but rather from developing buy-in through explaining the why and constantly reinforcing why the changes are important.

Q: Are care coordination and other patient-enabling services available for oral health?

- **Patient-Enabling Services**

Patient-enabling staff (e.g., health coaches, patient navigators, family support workers) can both facilitate access to oral health services and make additional services directly available to oral health patients. Patient-enabling services facilitate easier navigation through the Health Center appointment-setting system and also engage patients with motivational interviewing, setting goals, and attending classes.

Q: Are EMR and EDR systems integrated?

- **Electronic Medical Record (EMR)/Electronic Dental Record (EDR) Integration**

Having integrated EMR and EDR systems means that all health professionals have access to information about patients' health concerns, histories, and medications. Having systems that communicate with each other means not only higher-quality health care for patients but also easier scheduling and data reporting.

Q: Are there clinical champions who support integration of oral health care into primary care in both the oral health clinic and the primary care clinic?

- **Clinical Champions**

Champions are individuals that believe strongly in the value of the system changes and are able to act as cheerleaders to motivate their colleagues. Champions can provide drive from within the system. Successful programs have a least one champion in both the oral health clinic and the primary care clinic.

In addition to considering these questions, Health Centers should assess whether they are able and willing to allocate the resources necessary to implement the program. Health Centers should be prepared to allocate sufficient staff time for planning and implementation as well as adequate funding for project start-up expenses, much as they would to implement a HRSA/BPHC Disparities Collaborative or prepare for National Committee for Quality Assurance (NCQA) Patient Centered Medical Home recognition.

Implementation

This section of the guide identifies five steps for implementing a program to integrate oral health care into primary care in a Health Center: planning, training systems, health information technology (HIT) systems, clinical care systems, and evaluation systems. The process flow schematic appears in Figure 1.



Figure 1. Implementation Flowchart

Step I: Planning

Establish a Team

The first step in the planning phase is to establish a planning team. This team can be a part of a QI or Patient Centered Medical Home recognition team that is already in place at the Health Center, a new team focused specifically on implementing the program, or another cross-disciplinary team. The team's role is to think through how the new program will affect the Health Center and to make preliminary decisions about how the program should be implemented. The team develops the project framework, broad strategies, and a timeline.

A sample list of planning team member staff categories follows.

- Chief executive officer
- Director of operations
- Grants & special projects director
- HIT specialist
- Medical director
- Doctor
- Nurse
- Nurse practitioner
- Medical assistant
- Dental director
- Dentist
- Dental hygienist
- Dental assistant
- Dental coordinator
- Front desk/scheduling staff
- Billing staff

Not every one of these staff categories needs to be represented on the team, but the team should include representatives of types of staff who will be impacted as the program is rolled out—not just supervisors or managers. Line staff can contribute information about potential barriers as well as practical solutions, and their involvement can create staff buy-in and help overcome barriers such as the perception that the program will create more work or that it will place staff in uncomfortable positions by expecting them to perform new clinical procedures, such as applying fluoride varnish.

It is likely that team members will be added or removed as the project moves forward. The planning team should evolve as needed.

In the early stages of project development, the team may need to meet frequently (e.g., weekly) during the initial start-up phases. Later in the process, meetings can become less frequent, (e.g., monthly). Eventually, the original planning team may disband if the systems that are developed become incorporated into Health Center operations or if the project is rolled into another Health Center committee or workgroup.

Selecting a Population of Focus

During the early phases of a program to integrate oral health care into primary care, it is recommended that the Health Center focus on a small cohort of patients. The most successful programs start with a defined population of focus (e.g., children from birth through age 5, diabetic patients, perinatal patients). Once the program is well established, the Health Center can consider expanding services to other population groups.

Timing

The time required to launch the program will depend on each Health Center's starting point. Some Health Centers may already have in place some activities that integrate oral health care into primary care, such as a fluoride varnish program in the primary care clinic, and may have some experience in oral health–primary care collaboration. Other Health Centers may be starting from scratch. Larger, more organizationally complex Health Centers may need more time to implement new activities, compared with smaller, organizationally simpler Health Centers. The three pilot sites spent an average of 3 months planning and developing systems before launching the clinical aspects of their pilot projects.

Reimbursement

Part of the process of planning a program to integrate oral health care into primary care involved determining if there are opportunities for reimbursement for oral health clinical activities that primary care health professionals may perform. The vast majority of state Medicaid programs reimburse for fluoride varnish application by primary care health professionals. Currently, only four states do not allow for Medicaid reimbursement. However, each state determines which health professionals can be reimbursed, reimbursement amount, age limits for eligible patients, number of annual applications, and required training for health professionals. Each Health Center should be aware of its state's reimbursement specifics before launching its new program. Health Centers should contact their state Medicaid office to obtain information. Information about each state's Medicaid policy on fluoride varnish reimbursement in the primary care setting can also be found on the American Academy of Pediatrics' (AAP's) website at <http://www2.aap.org/oralhealth/State.html>.

Costs

There are costs associated with developing any program. While some Health Centers can secure additional funding for new programs, many develop new programs without new funds. For projects that integrate oral health care into primary care, the costs—whether in-kind staff time or billed expenditures—fall into the following broad categories:

- Personnel time for planning, developing, testing and refining systems, and for evaluation
- Staff time for training primary care health professionals and support staff in the clinical aspects of the oral health competencies
- In-kind or contracted resources to modify the EMR system and other aspects of the data-collection infrastructure

- Clinical supplies (e.g., fluoride varnish, patient supplies, educational materials)
- Other materials

Synergy with Existing Health Center Initiatives

One strategy for lowering the costs associated with launching a program to integrate oral health care into primary care is to integrate planning activities and other activities with existing QI initiatives. Health Centers that are applying for or have NCQA Patient Centered Medical Home (PCMH) recognition can use the same methodology and tools employed in that application process to launch their program to integrate oral health care into primary care. Health Centers can also use the existing QI process.

Test Cycles

All three IPOHCCC pilot teams used repeated test cycles or Plan-Do-Study-Act cycles⁷ to implement their projects. It is far better to make adjustments after running a cycle with one health professional for one afternoon than after having initiated 20 health professionals into a new process that then must be changed. Testing may reveal that risk-assessment questions are confusing, that patient supplies are not age-appropriate, that health professionals need additional training, or other issues. Investing in test cycles will save stress and possibly resources when EMR modifications are involved. Testing can involve just one provider performing all the steps of the new process, but with paper handouts instead of in the software. Or several health professionals can follow the process, but only for half a day each. Regardless of which specific method works for particular health centers, it is best to test, adapt, test, adapt, and *then* make definitive decisions about major training, software, and clinic flow changes.

There is always resistance to change while it is happening. Using test cycles will minimize the number of staff impacted by change by gradually involving more aspects of the Health Center as test cycles reveal how systems should be modified to achieve desired results.

Champions

Identifying health professionals and support staff champions is a key component of the planning process, as these champions can lead test cycles and model Health Center implementation for other primary care clinic staff.



Health Partners of Western Ohio Implementation Team

7 Institute for Healthcare Improvement. "Plan-Do-Study-Act (PDSA) Worksheet"; N.d.: <http://www.ihl.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx>

Step II: Training Systems

While some primary care health professionals have had a certain amount of oral health training, it is usually not comprehensive enough for them to be competent in all five IPOHCCC domains, so additional training is important.

When making decisions about training, Health Centers need to keep in mind that in some states, primary care health professionals need to have completed specific courses to be eligible to receive reimbursement from Medicaid for performing oral health services. In addition, Health Center staff may need to be certified by either the state Medicaid office or the state dental association. Contact your state Medicaid offices to learn about your state's requirements.

Training for primary care health professionals in how to implement the oral health competencies is available in the form of online courses, in-person training, or a combination of the two. For initial training of primary care health professionals and support staff, all three IPOHCCC pilot sites used a combination of online and in-person training. Health Centers launching programs to integrate oral health care into primary care will need to put into place training systems for new primary care health professionals hires. Information about some specific training options is discussed in the next two sections.

Online Training

NNOHA does not recommend or endorse any particular training curriculum, but the experiences of the three pilot sites may be useful to other Health Centers as they look into the best training for their own staff. The sites all used the *Smiles for Life* online curriculum (www.SmilesforLifeOralHealth.org) as their primary source of online training. Smiles for Life is an oral health curriculum developed by the Society of Teachers of Family Medicine. The curriculum is designed to enhance primary care health professionals' ability to promote oral health to individuals of all ages. The curriculum has been endorsed by many organizations, including the National Association of Community Health Centers, the American Academy of Family Physicians, the American Academy of Physician Assistants, the National Association of Pediatric Nurse Practitioners, and the American Dental Association (ADA). The curriculum consists of eight self-paced modules that address topics such as the relationship between oral health and overall health, child oral health, acute oral health problems, and oral examinations, among others. Continuing education credits for completing the curriculum are available.

Other online curricula may be better fits for some Health Centers. Some examples include AAP's Protecting All Children's Teeth program; The Association of American Medical Colleges' oral health training program, available through MedEdPortal; and the New York University College of Nursing program which focuses on oral health. Additional information about training and resources can be found in the Resources section of this guide.

In-Person Training

Each of the pilot sites supplemented the online Smiles for Life modules with in-person training provided by Health Center oral health professionals. This activity encourages interdisciplinary collaboration and practice. After attending in-services presented by their Health Center oral health colleagues, primary care health professionals felt more comfortable calling the oral health clinic for consults, and oral health professionals were more willing to go to the primary care clinic for consults.

In-person training content can range from a verbal review of Smiles for Life topics; a more detailed, in-depth presentation of supplemental information; or instruction related to oral health topics as requested by primary care health professionals. Such topics may include oral piercings, HPV and oral cancer, smoking and oral health, and diabetes and oral health. Requested topics tend to focus on clinical recognition of oral pathology.

Trainings presented by oral health staff can vary from 10-minute mini-sessions presented during monthly primary care staff meetings to 2- to 3-hour sessions presented during the program-planning stage. In addition to the initial training, Health Centers need to provide staff with ongoing learning opportunities that allow them to grow professionally and to remain up to date on oral health issues.

One Health Center chose to have trainings at the monthly primary care staff meetings. Primary care health professionals held concurrent but separate meetings from primary care support staff, and both groups then came together for the last 10 minutes to attend the training.

While online or in-person trainings are both useful, interdisciplinary clinical observation and practice with an oral health professional can also help primary care oral health professionals gain competence in the IPOHCCC domains, especially risk assessment and oral health evaluation. Once the initial group of primary care health professionals is competent in performing the clinical procedures, they can train other primary care health professionals to do the same.

Promising Practice

As part of the IPOHCCC pilot project, one Health Center has primary care health professionals and oral health support staff complete half-day cross-observations of each other's clinics. This allows each group to see how the other functions. Developing training opportunities that involve both the primary care clinic and the oral health clinic is an excellent way to foster increased communication and collaboration.

On-Boarding New Health Professionals

Along with developing a training system for existing health professionals, Health Centers will need to develop a system to on-board future primary care health professionals in the five domains.

Strategies for on-boarding new primary care health professionals include requiring completion of an appropriate online curriculum as part of the employee orientation process. For Health Centers that use an online vendor service to manage educational and compliance training requirements for Health Center employees, oral health in-service presentations can be uploaded to serve as training and reference tools. It may be possible to link these online compliance systems to online curriculum modules, which can provide additional assurance that the materials will be viewed as part of the employee training process.

The medical director or other champions can preceptor newly hired primary care health professionals in the oral health competencies. Many Health Centers assign new employees to a peer mentor who demonstrates day-to-day clinical processes. New primary care health professionals must also understand the clinical care system that has been developed to implement the competencies during patient visits (see Step IV). A peer mentor or a nurse manager can be charged with reviewing the clinical care system, including the competencies, with new primary care health professionals.

Strategies to enable new primary care support staff to learn the clinical care systems that have been developed to implement the five domains during patients visit include orientation by a nurse manager or staff preceptor or shadowing a senior nurse.



*Bronx Community Health Network (BCHN)/
Montefiore Medical Group Team*

Promising Practice

One Health Center pilot site has each new employee spend a full day rotating through each Health Center clinic, both clinical and administrative. This rotation is completed within 30 days after the hire date. This gives every employee an appreciation for all the different clinics and individuals and creates a foundation for collaboration.

Step III: Health Information Systems

EMR Revisions

Launching a program to integrate oral health care into primary care requires Health Centers to modify existing EMR systems. Depending on the type of EMR system and the Health Center's HIT capabilities, this step is often the most difficult and costly and therefore should be discussed early in the planning process. However, while discussion should take place early in the process, changes to the EMR should not be made until the planning process is sufficiently advanced for the Health Center to clearly understand what modifications are needed.

To implement the five IPOHCCC domains, an EMR must be able to:

- Provide a risk-assessment tool—ideally one that automatically scores risk level for individual patients
- Document oral health evaluation, preventive interventions, self-management goals, and education
- Print educational handouts and post-visit instructions
- Refer the patient for oral health care
- Collect data

Two common scenarios are: (1) The Health Center has the internal resources and capability to make changes to the EMR itself or (2) The Health Center must contract with the EMR vendor to make modifications. Health Centers that can modify their own EMRs can enjoy significant cost savings, as this makes it much easier to make adjustments and run multiple test cycles. Health Centers that cannot change their own EMRs must contract with the vendor and face the additional pressure of “making it perfect the first time,” since each additional modification to the EMR will incur additional costs.

EMR-EDR Relationship

There are many ways to configure a Health Center's EMR and EDR systems. Optimally, the two should be integrated and should communicate with each other. This facilitates integration between oral health and primary care via shared appointment-making systems, ability to see patient information and visit notes across disciplines, and ability to track referrals across systems.

All other configurations require additional resources to develop workarounds to create referral and data-collection systems between the EMR and the EDR.

Step IV: Clinical Care Systems

Workflow

The most important aspect of incorporating the five IPOHCCC domains into patient clinical care visit is workflow. Evaluations of early state Medicaid programs that reimburse physicians for placing fluoride varnish identified workflow and incorporating oral health competencies into the primary care visit as top concerns:

- In Massachusetts, a survey of physicians providing services to Medicaid-enrolled children revealed that the most common barriers to fluoride varnish application were “perceived lack of time during the visit” and the “logistics associated with seamlessly integrating provision into routine practice.”⁸
- A study of pediatricians in Washington State showed that their initial concerns included that “fluoride varnish would take too much time” and that applying varnish was adding yet another task to the well-child visit.⁹
- In a North Carolina study on barriers to adoption and implementation of preventive oral health services in primary care, the most frequently reported barrier was difficulty in integrating oral health procedures into practice routines.¹⁰

Clear division of labor and development of the workflow are critical for successful implementation of a project and for support from primary care staff. In adding new patient care and documentation procedures to primary care visits, each Health Center needs to decide which team members are responsible for which tasks in the five IPOHCCC domains. Three sample scenarios based on the clinical care systems developed by the pilot sites are shown in Table 3.

Table 3. Workflow Scenarios

Domain Tasks	Scenario 1	Scenario 2	Scenario 3
Risk Assessment	100% Support staff	10% Support staff 90% Provider	50% Support staff 50% Provider
Oral Evaluation (e.g., clinical oral screening)	Provider	Provider	Provider
Preventive Interventions (e.g., fluoride varnish)	Support staff (before oral evaluation)	Support staff (after oral evaluation)	Support staff (after oral evaluation)
Communication and Education	Provider and take-home materials	Provider and take-home materials	Provider and take-home materials
Interprofessional Collaborative Practice (e.g., referral)	Provider (check-off box in the EMR), patient takes laminated “yellow tooth” reminder card to front desk	Provider (check-off box in the EMR), “passport” sheet with primary care follow-up visits (i.e., lab, radiology, dental)	Provider (check-off box in the EMR). Can print out a list of community oral health professionals from EMR

8 Isong IA, Silk H, Rao SR, Perrin JM, Savageau JA, Donelan K. “Provision of fluoride varnish to Medicaid-enrolled children by physicians: the Massachusetts experience.” *Health Serv Res*; 2011: Dec;46(6pt1):1843-62.

9 Lewis C, Lynch H, Richardson L. “Fluoride varnish use in primary care: what do providers think?” *Pediatrics*. 2005 Jan;115(1):e69-76.

10 Close K, Rozier RG, Zeldin LP, Gilbert AR. “Barriers to the adoption and implementation of preventive dental services in primary medical care.” *Pediatrics*. 2010 Mar;125(3):509-17. doi: 10.1542/peds. 2009 -1008.

Domain Tasks	Scenario 1	Scenario 2	Scenario 3
Interprofessional Collaborative Practice (e.g., appointment scheduling)	Reserved oral exam slots (4 per day) accessible by primary care front desk at checkout.	No reserved oral exam slots. Primary care front desk makes appointment at checkout.	Reserved oral exam slots (4 per day). Primary care front desk cannot access oral health appointment system. Excel spreadsheets with reserved appointments are completed in primary care and e-mailed to oral health front desk staff for entry.

No matter what workflow scenario is devised at the outset, Health Centers should be prepared to run multiple test cycles before achieving optimal integration of the IPOHCCC domains into clinical care visits. Each Health Center will have different needs.

Once the optimal workflow has been established, procedures should be documented and adopted as clinical protocols to serve as references for primary care staff and as training tools for new employees. Relying on staff to remember how to perform procedures without making them part of policy and EMR flow is often unsuccessful. Procedures tend to be performed inconsistently, and unclear division of labor can breed resentment among staff. Examples of clinical policies and protocols supporting workflow are found in Appendices A and B.

Risk Assessment

Domain 1. Risk Assessment: The risk assessment identifies the patient-centered and socioeconomic factors that impact oral and overall health.

Several oral health risk-assessment tools are available. Three well-known, referenced tools are:

1. **Caries Management by Risk Assessment (CAMBRA)**
<http://public.health.oregon.gov/PreventionWellness/oralhealth/FirstTooth/Documents/ADA-CAMBRA.pdf>
2. **American Academy of Pediatrics (AAP) Risk Assessment Tool**
<https://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf>
3. **American Dental Association Caries Risk Assessment Tool**
http://www.ada.org/~media/ADA/Science%20and%20Research/Files/topic_caries_over6.ashx

The two pilot sites that selected children as their focus populations chose AAP's risk-assessment tool as their starting point.¹¹ The site that selected adults as its focus population chose ADA's caries risk assessment tool for individuals ages 6 and above as its starting point.¹² The sites modified the tools slightly to reduce the number of items, as all the pilot teams noted that the oral health risk assessments contained a large number of questions that made them too unwieldy to incorporate into the primary care visit.

Pilot sites' recommendations are to keep risk-assessment questions brief, simple to answer, and consistent in the use of positive or negative language so that the health professional or support staff member can quickly conduct the assessment without having to pause to reread questions.

Screenshots of the three EMR risk-assessment tools developed by the pilot teams are available in Appendix C.

11 American Academy of Pediatrics. "Oral Health Risk Assessment Tool"; 2011: <https://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf>

12 American Dental Association. "Caries Risk Assessment Form (Ages >6)"; 2011: http://www.ada.org/~media/ADA/Science%20and%20Research/Files/topic_caries_over6.ashx

Promising Practice

One pilot site configured its risk-assessment template to present a drop-down menu of medications with dry mouth side effects to help primary care health professionals complete this part of the risk assessment. The screen question is “does the patient take medications that can cause dry mouth? Yes/No.” If the answer is yes, the screen in Figure 2 appears:

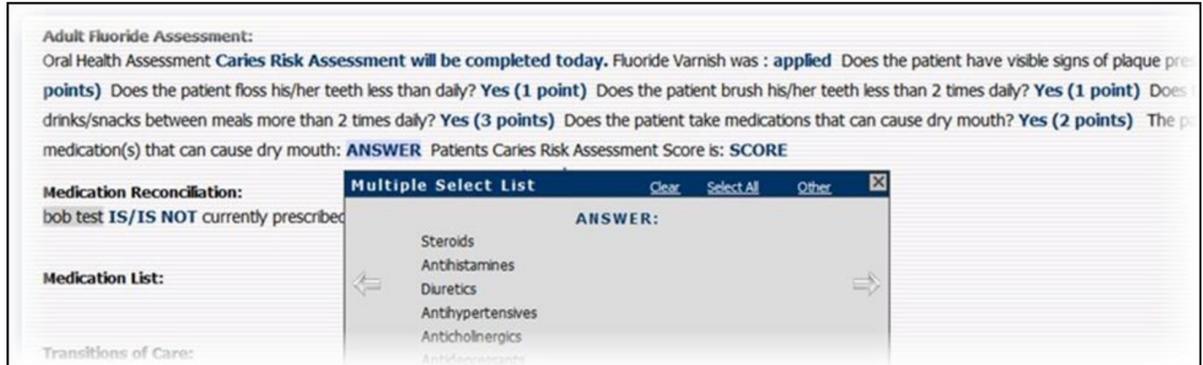


Figure 2. Medications with Dry Mouth Side Effects

If the Health Center’s EMR system has the capability, the risk-assessment tool can be configured to automatically score risk once all questions have been answered. One pilot site weighted responses to certain questions higher as part of the automatic scoring. It was also possible to configure the EMR so that a risk-assessment result of “moderate” or “high” risk automatically triggered an order for a fluoride varnish application. An example of auto scoring is shown in Figure 3.

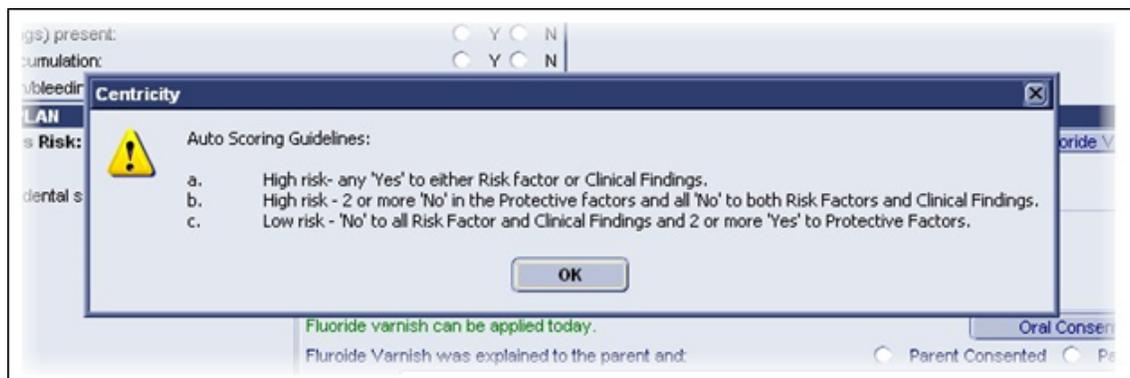


Figure 3. Risk Assessment Auto Scoring

Oral Health Evaluation

Domain 2. Oral Health Evaluation: The oral health evaluation integrates subjective and objective findings, based on completion of a focused oral health history, risk assessment, and performance of a clinical oral screening.

The clinical oral screening, along with the health history and risk assessment, informs the level of intervention needed for prevention, education, and referrals.

Primary care health professionals learn how to properly perform clinical oral screening during the training phase of the project. Providers can learn how to do a screening through an online course, instructions from an oral health professional, dental clinic observations, observed practice on actual patients, or a combination of all these methods. Primary care health professionals are generally not familiar with the “knee-to-knee” examination technique frequently used by oral health professionals to perform oral exams and administer preventive interventions such as fluoride varnish application for

young children. In-person instruction in this technique is beneficial.

After primary care health professionals received training in the knee-to-knee technique at one pilot site, support staff expressed that the chairs in the primary care exam rooms had arm rests that limited movement and would create safety issues if used for knee-to-knee examinations. The Health Center resolved this concern by purchasing armless exam room chairs for primary care patients.

Preventive Intervention

Domain 3. Preventive Interventions: Preventive interventions include options and strategies that address oral health needs identified by a comprehensive risk assessment and health evaluation.

National organizations recommend that infants and children from birth through age 5 who are at high risk for oral disease receive fluoride varnish application.¹³ Fluoride varnish is a concentrated topical fluoride (usually 5% sodium fluoride) that is painted onto the teeth. Regular application has been shown to inhibit caries and tooth decay.^{14,15}

Fluoride Varnish

The average cost of one single-use fluoride varnish application is between 50 cents and 4 dollars, depending upon the brand. All major dental suppliers carry varnishes (see the Resources Section for more information about fluoride varnish suppliers).



Fluoride Varnish Applicator

The pilot sites recommend conducting small-scale tests of varnishes before committing to one brand or flavor. The sites found that flavor variations can impact patient receptiveness. Testing also allowed primary care staff an opportunity to experience what the varnishes looked, felt, and tasted like so that they would be better prepared to address patient concerns about issues like temporary staining and stickiness against their lips. Health Centers are encouraged to set up small test groups comprising volunteer staff or patients, either as part of the test cycles or as a preliminary step before widespread implementation.



Fluoride Varnish Card

Test cycles at one pilot site revealed that adults were more receptive to varnish that is white or clear, rather than yellow. The Health Center also planned on letting adult patients self-administer the varnish during the visit to increase patient comfort and receptiveness.

In Health Centers where the EMR and EDR do not communicate, there may be concern about how the primary care clinic and the oral health clinic will be able to keep track of when fluoride varnish was applied. One pilot site resolved this concern by creating a fluoride card—a credit-card-sized card similar to the organization’s immunization card—that they gave to parents and used to keep track of fluoride varnish applications.

13 U.S. Preventive Services Task Force. “Prevention of Dental Caries in Children from Birth through Age 5 Years”; 2014: www.uspreventiveservicestaskforce.org/uspstf12/dentalprek/dentchfinalrs.htm#summary

14 American Dental Association. “The Use of Fluoride Varnishes in the Prevention of Dental Caries: A Short Review”; 2001: <http://ebd.ada.org/en/evidence/evidence-by-topic/cariology-and-caries-management/the-use-of-fluoride-varnishes-in-the-prevention-of-dental-caries-a-short-review>

15 Centers for Disease Control and Prevention. “Other Fluoride Products”; 2013: http://www.cdc.gov/fluoridation/fluoride_products/

Communication and Education

Domain 4. Communication and Education: Communication and education is targeted to individuals and groups regarding the relationship between oral and systemic health, risk factors for oral health disorders, effect of nutrition on oral health, and preventive measures appropriate to mitigate risk, on both individual as well as population level.

Primary Care Visit Education

Education and communication can take many forms, including one-on-one discussions with a health professional, support staff member, or health coach; reviewing models; viewing visual aids or posters in the exam room; viewing videos in the exam room; and reviewing take-home materials.

Ideally, education is targeted to the individual patient's risk factors for oral disease as determined by the risk assessment and oral evaluation. Topics include tooth-brushing and flossing instruction, food choices, use of bottles or sippy cups, daily fluoride exposure, and attending regular oral health visits.

The pilot sites found that brushing and flossing instruction was most successful when toothbrushes and toothpaste (and floss when age-appropriate) were given out with the instruction.

Take-Home Materials

The pilot teams used various take-home materials, including materials about brushing and flossing techniques and fluoride varnish and self-management goal sheets as shown in the photo. Materials were written at low literacy levels and relied heavily on visuals. Sites obtained their take-home materials from different sources. One site developed its own materials. Others found materials online (see the Resources Section for more information about obtaining take-home materials).



Take-Home Materials

One pilot site served individuals who spoke languages for which there are few translated oral-health-education materials available, including Somali, Nepalese, Arabic, and Bosnian. The Health Center had on-site staff that could translate existing materials. Health Center project staff identified materials on the Smiles for Life website, and NNOHA contacted the National Interprofessional Initiative on Oral Health, the organization that maintains the Smiles for Life curriculum, to request permission for the Health Center to use and translate the materials.

The pilot sites included educational materials with self-care supplies given out at primary care visits. One site was able to print out educational materials and the fluoride varnish information sheet from the EMR in the exam room during the visit. At another site, oral health instructions are part of the patient primary care visit summary that the patient receives at the end of each visit, as highlighted in Figure 4.

Instructions

****SELF-CARE ACTION PLAN****

- Physical Activity 30 minutes 5 times a week
- Diet: Increase my fruits and vegetables, and decrease my salt, sugar, and caffeine
- Prescriptions were e-prescribed to the pharmacy listed in your chart. Please check with your pharmacy to make sure they are ready.
- HPWO Pharmacy offers sliding fees for prescriptions, accepts most insurance plans. Please stop by the pharmacy at your health center.
- **Remember to bring in all your pill bottles every visit, it is very important for you to have an updated medication list.**
- Patient was given a printed copy of the following items and verbalized understanding:
- ----Clinical Summary and Current Medication List----
- Patient verbalized understanding and denies any questions at the time regarding the following: use, side effects, importance of taking medications, and potential interactions with food and/or other medications.
- ****DENTAL INSTRUCTIONS****
- Brush teeth at least 2 times daily along with flossing
- Decrease the amount of sugary snacks/drinks daily

Figure 4. Primary Care Visit Summary

For samples of take-home materials in English see Appendix D.

Motivational Interviewing: A Communication Technique

When possible, using motivational interviewing techniques to determine self-management goals to improve oral health is recommended. Health Centers are familiar with motivational interviewing techniques if they provide smoking-cessation or diabetes self-management services, and these techniques can be applied to oral health services as well. The pilot sites noted that some patients respond better to negative imagery and consequences of poor oral health, while others need more positive reinforcement. Determining which approach works best for each patient is important (see the Resources Section for more information about motivational interviewing).

Waiting Room Education

Pilot sites also provided education sessions in primary care waiting rooms. Sample topics included the effect of diet on oral health, diabetes and oral health, oral cancer and smoking cessation, and fear of dental visits. The sessions included short two- to three-question post-tests.



Interdisciplinary Waiting Room Education

Promising Practice

Two staff members, one from the primary care clinic and one from the oral health clinic worked together to design the waiting room educational intervention. The purpose of this structure is to encourage interdisciplinary collaboration. Staff received dedicated time to work on this activity. One primary care support staff member reported that after reading information on oral cancer and smoking cessation for the presentation she was co-developing with oral health staff, she decided to quit smoking.

Interprofessional Collaborative Practice

Domain 5. Interprofessional Collaborative Practice: Interprofessional collaborative practice is shared responsibility and coordination among professionals in the care of patients and populations with, or at risk for oral disorders to assure optimal health outcomes.

Referrals

All of the pilot sites had oral health clinics* located in the same facility as the primary care clinics and stated that even before the pilot project was initiated, primary care staff could call the oral health clinic for urgent consults or send a patient urgently in need of care to the oral health clinic for evaluation. However, once the project was under way, primary care staff felt more comfortable taking a patient directly to their oral health colleagues because they were more familiar with the oral health professionals at the Health Center and had more contact with them.

* In this section, the words “oral health clinic” and “dental clinic” are interchangeable when referring to primary care staff making follow-up appointments.

All the pilot sites had a check-off box in the EMR where the primary care health professional could document that a patient had received a referral to the oral health clinic. The check-off entry allowed referrals to be tracked after the primary care visit. An example of an oral health referral screen in the EMR is shown in Figure 5.

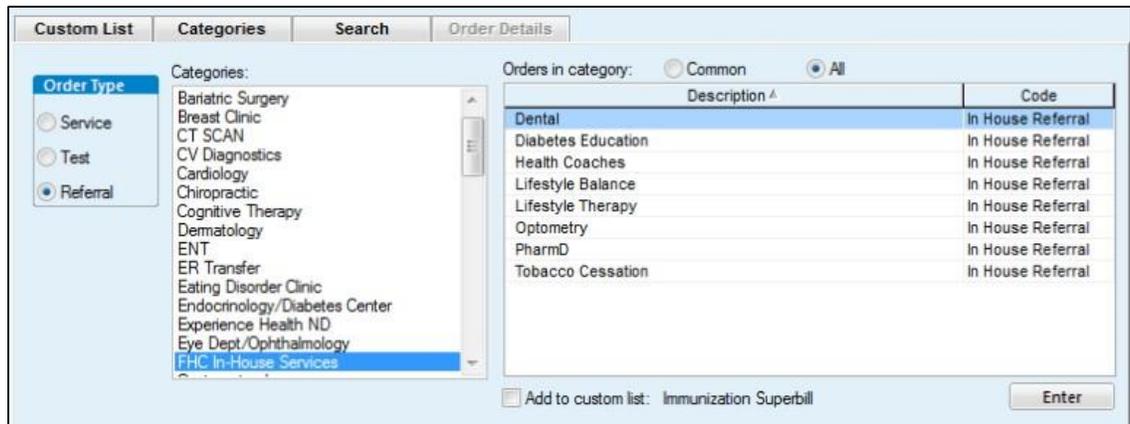


Figure 5. Dental Referral

Primary care patients had different options for making oral health appointments. They could go to the oral health clinic themselves and schedule appointments, or primary care staff could schedule appointments for them.

Sites either instituted dedicated dental exam slots for primary care patients that schedulers could access, or schedulers could access the entire dental exam appointment schedule.

When the EMR allows, if an oral health referral is checked off in the EMR, it appears on the summary that the front desk sees when the patient is leaving and alerts schedulers that the patient needs an appointment for a dental exam, as shown in Figure 6.

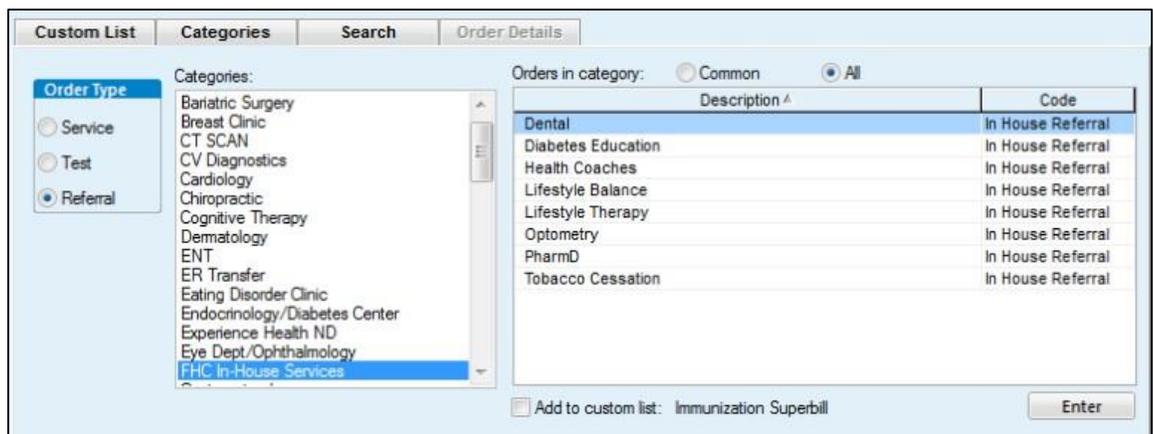
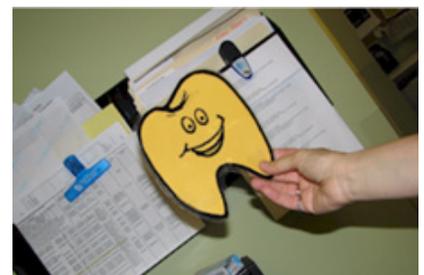


Figure 6. Referral in Visit Summary

Visuals can be easier to remember than text. Other strategies for communicating to primary care schedulers that a patient needs an appointment for a dental exam include developing a visual reminder—a big tooth that patients carry to checkout. Another site developed a passport sheet that included all follow-ups needed after a primary care visit, including a dental exam, that patients present to the front desk to schedule appointments. A portion of the passport is shown in Figure 7.



Reminder to Schedule a Dental Appointment

Before you leave the clinic ...

Make an appointment for:

_____ A Specialist

_____ An Imaging Study

_____ Your provider: _____

When:

_____ Eye doctor

X _____ Dentist

_____ Nurse Only Visit

_____ Lifestyle Medicine

Reason:



Figure 7. Patient Passport

For clinics that do not share appointment-making systems, alternative systems can be developed. The oral health clinic can dedicate exam slots, which primary care schedulers can record and document on paper or in an Excel file. Once appointments are filled, the primary care clinic can e-mail or fax the schedule to the oral health clinic for entry. This is not ideal, as it requires additional staff time, but duplicate entries are necessary when systems do not communicate with one another.

Primary care health professionals discuss with parents and caregivers during well-child visits that it is recommended that children visit a dentist and establish a dental home by age 1 and that establishing a dental home is an important part of lifelong health.

Follow-up

One ongoing challenge for pilot site teams was low rates of attendance at follow-up dental appointments. One site had both primary care and oral health support staff make reminder calls in an effort to increase attendance.

The sites with children as their focus populations wanted primary care staff to walk patients directly to the oral health clinic for an immediate visit, avoiding some of the challenges of return visits such as transportation, child care, or work barriers. However, the oral health clinics struggled with demand and capacity issues, and offering same-day access was not always feasible.



Signage for a Dental Clinic

The HIT system plays a key role in follow-up, as the EMR can run reports on which primary care patients have been referred to the oral health clinic and then determine if they attended an oral health appointment. For integrated EMR and EDR systems, this is feasible, but for Health Centers with separate EMRs and EDRs, information-technology strategies for interfacing the two systems must be developed (e.g., using a tracking program such as i2i) as a bridge between the two systems.

Other Collaborative Activities

The pilot sites developed strategies for increased interaction and collaboration between their primary care clinic and oral health clinic. These strategies included providing training to primary care staff by oral health professionals, two-person workgroups developing and presenting educational materials together, having a shared break room to encourage staff to work together and socialize and to provide opportunities for unstructured discussion and connections, and implementing half-day cross-observations of each other's clinics as part of training for new hires. One site is considering integrating a dental operatory within the primary care clinic in a future expansion design, and another site is considering adding a dental hygienist to the primary care team.

Step V: Evaluation Systems

Each Health Center will need to determine which data it wants to collect and what information is important to drive the system changes necessary to implement a program to integrate oral health care into primary care as well as to evaluate the program's success. Most data will be collected through the EMR, but there are also opportunities to include patient surveys in the primary care setting, the oral health care setting, or the waiting room. As a starting point, Table 4 lists the measures that experts developed for the IPOHCCC pilot project with input and guidance from HRSA:

Table 4. IPOHCCC's Minimum Core Set of Measures

<ol style="list-style-type: none"> 1. Number and percentage of oral health assessments or screenings performed by primary care medical providers. 2. Number and percentage of fluoride varnish applications for high-risk patients. 3. Number and percentage of patients receiving oral health preventive interventions. 4. Number and percentage of patients referred from medical to dental. 5. Number and percentage of patients that are linked to definitive oral health care and treatment (e.g. through care coordination, patient navigation services). 6. Changes in quality of care/outcome indicators. 7. Knowledge and skills of primary care medical providers. 8. Patient experience and knowledge of oral health. 9. Factors and barriers for: <ol style="list-style-type: none"> a. Uptake of the oral health core clinical competencies b. Enable primary care medical providers to perform core oral health competencies c. Sustainability of systems changes.

The outcome indicators developed by the pilot teams included:

Phase 1** treatment completion for members of target population
Number of members of the target population with new cavities
Number of diabetic patients enrolled in the dental clinic
Visits to local ERs for oral emergencies by members of target population
DMFTS and dmft*** in members of target population

**Phase 1 Treatment= Prevention, maintenance and/or elimination of oral pathology that results from dental caries or periodontal disease.

This includes oral cancer prevention and early diagnosis, prevention education and services, emergency treatment, diagnostic services and treatment planning, restorative treatment, basic periodontal therapy (nonsurgical), basic oral surgery that includes simple extractions and biopsy, nonsurgical endodontic therapy, and space maintenance and tooth-eruption guidance for transitional dentition.

***"Decayed, Missing, Filled Teeth/Surfaces" for permanent teeth and "decayed, missing, filled teeth" for primary teeth.

Throughout pilot testing, one common theme emerged: data collection was the most cumbersome aspect of the project. For effective evaluation, Health Centers should focus on collecting data to drive system change and to determine if the project is successful.

One method to assess compliance with new policies and protocols is peer review. One Health Center incorporated oral health criteria into the primary care provider peer review tool as shown in Figure 8. This ensures that staff recognizes that oral health is a priority for the Health Center and for each health professional's job performance.

21	Proper immunizations given when indic. (Flu/Pne)				
22	Problem list is updated (has recent dx listed)				
23	Documentation supports code assigned to visit				
24	Chart signed off at time of visit (within 24 hours)				
25					
26	Integrated Care: BH/Dental/CPS Referrals				
27	Patient referred to Dental if no screening on chart				
28	Patient referred to CPS for >5 meds				
29	Patient referred to CPS for A1C >9				
30	Patient referred to CPS for Asthma/Spirometry				
31	Patient referred to CPS for Lipids if >100				
32	Patient seen by BH at least annually				
33	Seen by BH if psych med. prescribed/changed				
34	Seen by BH for uncontrolled chronic illness				
35	Signature of reviewer doing the Audit: _____		Printed Name _____		
36	Signature of Clinical Director: _____		Printed Name _____		

Figure 8. Peer Review Tool

Challenges

Even Health Centers with motivated staff, abundant resources, and a clear vision are likely to encounter challenges on the path to implementing programs that integrate oral health care into primary care. The pilot teams encountered a variety of challenges. Table 5 lists common challenges and possible mitigation strategies.

Table 5. Challenges

Challenge	Strategies
Staff resistance to change.	<ul style="list-style-type: none"> • Allow sufficient time and provide training to make staff feel comfortable. Recognize that changing patterns and behavior take time. • Allow for staff participation and questions. Provide opportunities for primary care staff and oral health staff to talk about workflows and interactions. • Make sure any changes are supported by official policies and procedures. • Be open to listening to challenges; experiment • Identify health professional and support staff champions to promote change. • Consider incentive programs.

Challenge	Strategies
Adding time to the already full primary care visit.	<ul style="list-style-type: none"> • Emphasize proper use of support staff and the success of similar programs in other Health Centers. • Use repeated test cycles to optimize the patient flow. • Streamline workflow as much as possible by implementing a concise risk assessment.
Primary care staff does not value oral health.	<ul style="list-style-type: none"> • Continue educational in-services. • Allow for multidisciplinary training like the two-person waiting room education development experience described on page 18.
Oral health clinic lacks capacity to accommodate referrals.	<ul style="list-style-type: none"> • Ensure that oral health staff are practicing to their full licensed capacity, follow best practices for efficient operations, and build oral health needs into any future expansions. • Create protocols to triage urgency of oral health referrals.
State dental association conflicts.	<ul style="list-style-type: none"> • Comply with all state requirements for performing and billing oral health procedures in the primary care setting.
Oral health clinic territorialism.	<ul style="list-style-type: none"> • Continue to emphasize integration as a Health Center-wide value, encourage oral health staff to participate in primary care staff training, and act as preceptors for primary care staff.
Need for new supplies.	<ul style="list-style-type: none"> • Budget funds for additional supplies as needed. • Apply for grants to offset start-up costs. • Look for donated supply opportunities. • Start with the minimum new supplies necessary.
Patient resistance.	<ul style="list-style-type: none"> • Emphasize the importance of oral health to general health at every visit. • Ensure that staff is prepared to respond to all patient concerns. • Make the same educational materials available in the primary care and dental clinic waiting rooms so there is consistent messaging.
Time required for training.	<ul style="list-style-type: none"> • Leverage existing training opportunities available at Health Centers, such as general staff meetings and primary care health professional meetings. Tailor length of training sessions to work with staff schedules.

Challenge	Strategies
Funding external vendor HIT modifications.	<ul style="list-style-type: none"> To minimize costs, run test cycles before making permanent changes. If necessary, use paper to test proposed changes.
Different HIT systems for primary care and oral health care—lack of interoperability.	<ul style="list-style-type: none"> Develop alternative methods to make and track referrals. Document needs for future HIT purchases.
Diverse language needs.	<ul style="list-style-type: none"> Use online resources and knowledge libraries to obtain multi-lingual materials. Use handouts that rely heavily on visuals. Consider group education visits to minimize use of translators.
Patient resistance to tooth discoloration from fluoride varnish.	<ul style="list-style-type: none"> Train primary care health professionals to assure patients that discoloration is temporary and time before eating is allowed is minimal. Use white or clear fluoride varnish.
Patients unwilling to spend time taking follow-up surveys. Difficult to monitor success.	<ul style="list-style-type: none"> Keep surveys brief (three to four questions), and have patients complete them before leaving. Give small incentives like sugar-free gum. Consider conducting verbal in-person surveys.
Cost of implementing program.	<ul style="list-style-type: none"> Leverage resources (e.g. time, staff) allotted to other multi-disciplinary initiatives, such as PCMH. Explore whether primary care health professionals can be reimbursed for performing oral health services.
Project started by departmental staff without adequate understanding of project scope and the need for support from Health Center administration.	<ul style="list-style-type: none"> Conduct a thorough readiness assessment to determine a Health Center's ability to successfully implement an IPOHCCC project. Promote high involvement of Health Center administration through frequent communication. Require regular, objective, data-driven reporting of project results instead of relying on project staff's subjective opinions. Encourage involvement of Health Center administration through frequent communication and regular reporting.

Challenge	Strategies
<p>Perception of organizational status quo as permanent.</p>	<ul style="list-style-type: none"> • Create a safe environment where staff can question institutional barriers, processes, workflows, and systems. • Acknowledge that processes that “have always been this way” might not be the best way to operate today. • Understand that changes takes time, and build in additional time when developing project timelines. • Encourage breaking the organizational change into small steps.
<p>Lack of executive buy-in and project support.</p>	<ul style="list-style-type: none"> • Ensure that Health Center administration thoroughly understands project scope and support needs. Focus on small changes that initiate integration, but hold off on system-wide changes until executive support is achieved.

“Any change, even a change for the better, is always accompanied by *drawbacks and discomforts*.” Arnold Bennett

Summary

Increased interest in patient-centered health homes and integrated care has resulted in the expectation that more and more health professionals will be collaborating to achieve improved patient care. As part of this movement, Health Centers can provide opportunities for primary care health professionals to address patients’ oral health needs and to more fully integrate with their oral health colleagues.

To increase access to health care among vulnerable populations, in 2012-13, HRSA developed a set of IPOHCCCs that can be categorized into five domains: risk assessment, oral evaluation, preventive interventions, communication and education, and interprofessional collaborative practice. Health Centers can improve the oral health and overall health of the populations they serve by developing programs that implement the oral health competencies using a sustainable-systems approach that results in integrating oral health and primary care through interprofessional collaborative practice.

This guide is one tool to help Health Centers develop such programs to increase access to oral health care and improve the oral health status of the populations they serve. The guide provides background on how the competencies and the corresponding five domains were developed, an overview of an IPOHCCC Pilot Project involving three pilot sites, a discussion of how Health Centers can determine whether they are ready to begin their own project, and detailed information about five planning steps:

1. **Planning**—including developing a team and identifying a focus population
2. Implementing **training systems** to enhance primary care health professionals’ oral health skill set
3. Updating **HIT systems** to allow for additional clinical care tracking, data collection, and oral health referrals

4. Modifying **clinical care systems** to include risk assessments, oral health screenings, and fluoride varnish applications
5. Developing **evaluation systems** to ensure program success

As with any new project, there will be challenges. The specific nature of the challenges depends on factors such as state regulations, Health Center size, current levels of program integration, health professional skill sets, available funding, executive support, and current EMR system capabilities. Despite challenges, all pilot teams agreed that embarking on their IPOHCCC projects was a positive step toward improving patient care. One pilot project participant stated that, “more than anything the project has brought oral health to the awareness of medical providers and patients. We catch a lot of patients that we might have missed otherwise.”

In addition to reviewing HRSA’s *Integration of Oral Health and Primary Care Practice*¹⁶ report and this guide, Health Centers interested in launching programs to integrate oral health care into primary care are encouraged to make use of the many resources listed at the end of the guide.

NNOHA would like to express its appreciation to all Health Center staff for the work they are doing done to ensure healthy citizens and healthy communities. For additional information on important issues related to Health Center oral health programs, please visit us at www.nnoha.org.

**“Every tooth in a man’s head is more valuable than a diamond.”
Miguel de Cervantes, *Don Quixote*, 1605**

¹⁶ Health Resources and Services Administration. “Integration of Oral Health and Primary Care Practice”; 2014: <http://tinyurl.com/HRSA2014-IOH>

Resources

For additional information or to access some of the resources mentioned in the guide, please follow the links provided in Table 6.

Table 6. Resources

General	
Resource	Link
NNOHA	www.nnoha.org
“Integration of Oral Health and Primary Care Practice” (2014 HRSA report)	http://www.hrsa.gov/publichealth/clinical/oralhealth/primarycare/integrationoforalhealth.pdf
American Academy of Pediatrics (AAP)	www.aap.org
Oral Health Collaborative Pilot Implementation Manual	http://www.nnoha.org/nnoha-content/uploads/2013/09/OHDC-Implementation-Manual-with-References.pdf
Bright Futures Oral Health Curriculum	http://brightfutures.aap.org/
NNOHA’s Patient-Centered Health Home Action Guide	http://www.nnoha.org/nnoha-content/uploads/2013/09/PCHHActionGuide02.12_final.pdf
Training	
Resource	Link
AAP’s Protecting All Children’s Teeth	http://www2.aap.org/ORALHEALTH/pact/index.cfm
Association of American Medical Colleges MedEdPortal	https://www.mededportal.org/
California First Five Program	http://www.cffc.ca.gov/
National Maternal and Child Oral Health Resource Center (OHRC)	http://www.mchoralhealth.org/materials/DL.html
NYU Teaching Oral-Systemic Health program	http://www.nyu.edu/
NYU Oral Health Nursing Education and Practice Program	https://nursing.nyu.edu/OHNEP
National Interprofessional Initiative on Oral Health	http://www.niioh.org/
Smiles for Life	www.smilesforlife.org

Risk Assessments	
Resource	Link
AAP's Risk Assessment Form	http://www2.aap.org/oralhealth/docs/riskassessmenttool.pdf
CAMBRA	http://public.health.oregon.gov/PreventionWellness/oralhealth/FirstTooth/Documents/ADA-CAMBRA.pdf
ADA's Risk Assessment Tool for Individual Over Age 6	http://www.ada.org/~media/ADA/Science%20and%20Research/Files/topic_caries_over6.ashx
Prevention/Fluoride	
Resource	Link
ADA Fluoride Guidelines	http://www.aapd.org/media/Policies_Guidelines/G_fluoridetherapy.pdf
Fluoride Varnish Manufacturers	http://www2.aap.org/oralhealth/docs/fluoride-varnish-manufacturers.pdf
OHRC's Fluoride Varnish	http://www.mchoralhealth.org/Topics/flvarnish.html
North Carolina's Into the Mouths of Babes PROGRAM	http://www.ncdhhs.gov/dph/oralhealth/partners/IMB.htm
Prevention Task Force Summary	www.uspreventiveservicestaskforce.org/uspstf12/dentalprek/dentchfinalrs.htm#summary
NYU Oral Health Nursing Education and Practice Program	https://nursing.nyu.edu/OHNEP
National Interprofessional Initiative on Oral Health	http://www.niioh.org/
Smiles for Life	www.smilesforlife.org
Education and Communication	
Resource	Link
Cavity Free at Three	http://www.cavityfreeatthree.org/
OHRC's Spanish-Language Patient-Education Materials	http://www.mchoralhealth.org/highlights/spanish.html
Minnesota Head Start's Tooth Book	http://www.mnheadstart.org/toothbooken.pdf
2min2x	http://www.2min2x.org/
Motivational Interviewing	http://www.integration.samhsa.gov/clinical-practice/motivational-interviewing http://chcact.org/resources/PCMHMotivationalInterviewing.pdf
Health Information Technology	
Resource	Link
NNOHA's Health Information Technology Guide	http://www.nnoha.org/nnoha-content/uploads/2013/07/HIT-Part-2.pdf

* NNOHA does not endorse content provided at these sites. All links were functional at the time of this guide's release.

Example of Clinical Policy

IPOHCCC Project **Primary Care Clinic Procedures**

Oral Hygiene Kit (Nursing)

- There are two kits available, the 0-18mon, and 2-5 years.
- Give first bag with first visible tooth in the mouth, and then give dental hygiene kit at each well child visit after that.
- Let dental know when we need more kits.

Oral Health Education (Nursing)

- Give the oral health education at the same time as you give the oral hygiene kit.
- Remember that the oral health education is available in Bosnian, Nepali, Somali, Spanish, and Arabic.

Patient Satisfaction Survey (Nursing)

- Give to all parents at the well child exams 0-5 year olds.
- Have interpreters help parents complete the survey
- Place in envelope

Referral to Dental (Nursing)

- Nursing is going to put in the dental referral.
- Put the dental referral in at the child's first tooth well child appointment.
- We will need to do some catch up for those children that are older but have not had the dental referral placed.
- When chart prepping you can look at orders to see if there has been a dental referral placed.
- Give the parents a laminated tooth as a reminder to stop at the referral desk to make the dental appointment the same day as the well child appointment.
- If nursing is the last one in the room, please escort the patient to the referral desk to tell the referral coordinator that this is an IPOHCCC patient.

Oral Risk Assessment

- Done at every well child visit 0-5 years old.

Fluoride Varnish (Providers)

- Done at each well child visit there are teeth present from 0-5 years old.

Referral to Dental (Providers)

- If a provider or a nurse could walk the patient to the referral desk to make sure the referral coordinator knows that this is an IPOHCCC patient. One of the goals of the project is that a dental appointment is made the day of the well child exam.

Example of Fluoride Varnish Policy

SUBJECT: Fluoride Varnish Application During a Medical Visit	Page 1 of 2
DEPARTMENT: Medical – 10.0.23	

POLICY:

Tooth decay is the most common chronic disease of children and adults. Caries can lead to extreme pain, spread of infection, difficulty chewing, poor weight gain, extensive and costly dental treatment, and risk of dental decay in adult teeth, and crooked bite. In order to reduce the proportion of people who have dental caries in the primary teeth and permanent teeth, ****Sample Health Center staff **** will apply fluoride varnish to children's and adults' teeth during medical visits and refer them to our dental department to establish a dental home.

PROCEDURE:

Fluoride varnishes contain high concentrations of fluoride ion in a resin or polyurethane carrier. This forms a sticky layer on the tooth following application which hardens on contact with saliva. Fluoride is then absorbed into the enamel of the tooth. Fluoride varnishes have received approval as cavity varnishes and desensitizing agents; however, one of the most promising uses for fluoride varnishes is in the prevention of tooth decay. Fluoride varnish is indicated for infants, children, and adults with a moderate or high risk of developing caries. A patient is considered at risk if he/she:

- Has a history of caries (or has caregivers and/or siblings with caries)
- Has visible dental caries, white spots, or plaque
- Frequently drinks sugary drinks (soda, Gatorade, Energy Drinks, etc.)
- Eats sugary snacks
- Chronically uses high-sugar oral medications
- Has a special health care need
- Continues to use the bottle past one year of age
- Sleeps with a bottle containing liquids other than water
- Breastfeeds on demand at night
- Engages in prolonged use throughout the day of a bottle or sippy cup containing liquids other than water.

Supplies needed:

- 2 x 2-inch gauze sponges, fluoride varnish kit including small brush, and latex/vinyl gloves.

Position the child:

- For an infant, use the knee-to-knee position and have the caretaker lower the child's head onto the assistant's/nurse's lap. Treat the child from above.

- Or, place an infant or young child on an exam table and work from above and behind the head.
- Or, adapt a method that works for you.

Position of Adult:

- Adult patient can remain seated for Fluoride Varnish application

Apply Fluoride Varnish:

- Complete the Caries Risk Assessment & Oral Health Screening in the EHR system.
- Using gentle finger pressure, open the child's mouth.
- Remove excess saliva and plaque from the teeth with a gauze sponge. The teeth should be as dry as possible.
- Use your fingers and sponges to isolate the dry teeth and keep them dry. Work on one quadrant of teeth at a time, but with younger children (age 6 -18 months) you will have fewer teeth to work with.
- Apply a thin layer of varnish to all surfaces of the teeth. The varnish will set upon contact with saliva.
- Adult patients can be instructed to apply Fluoride Varnish themselves using a mirror, gauze, and Fluoride Varnish applicator.
- LPN or MA must observe patient putting on the Fluoride Varnish.
- Repeat the varnish application every 3-4 months for children and one year for adults.

Post-Application Instructions:

- Eat a soft, non-abrasive diet for the rest of the day.
- Do not brush or floss until the next morning
- Tell patient (or guardian) the teeth may not be white and shiny until the next day.
- Give education information on fluoride varnish and oral health.

Referral:

- If the patient does not have a regular dentist, the patient will be immediately referred to the dental department, or medical front desk will make a dental appointment.
- The medical staff will contact the dental staff to facilitate a dentist to come to the patient's medical exam room to complete a dental exam.
- Or, the patient may be walked over to the dental area and signed in to see the dentist.
- Patients that are unable to stay to complete a dental visit will schedule an appointment to see the dentist to establish regular dental care.

APPROVAL:

Appendix C

Risk Assessment Screen Shots

Risk Assessment Example 1

Risk Factors TB Scrn Lead Scrn Devt1 Scrn Lipid/DM Sx Checklist Adolescent **Oral Health**

Only for CFCC use **Oral Health Assessment Plan**

Oral Health Risk Assessment completed

RISK FACTORS	PROTECTIVE FACTORS
Mother or primary caregiver had active decay in the past 12 months: <input checked="" type="radio"/> Y <input type="radio"/> N	Drinks fluoridated water: <input type="radio"/> Y <input type="radio"/> N
Continual bottle/sippy cup use with fluid other than water: <input type="radio"/> Y <input type="radio"/> N	Had fluoride varnish in the last 6 months: <input type="radio"/> Y <input type="radio"/> N
Frequent snacking of sugar/processed carbohydrates: <input type="radio"/> Y <input type="radio"/> N	Brushes teeth with fluoride toothpaste twice daily: <input type="radio"/> Y <input type="radio"/> N
Special health care needs: <input type="radio"/> Y <input type="radio"/> N	

Performed by >> _____

CLINICAL FINDINGS
White spots or visible decalcifications: <input type="radio"/> Y <input type="radio"/> N
Obvious decay: <input type="radio"/> Y <input type="radio"/> N
Restorations (fillings) present: <input type="radio"/> Y <input type="radio"/> N
Visible plaque accumulation: <input type="radio"/> Y <input type="radio"/> N
Gingivitis (swollen/bleeding gums): <input type="radio"/> Y <input type="radio"/> N

ASSESSMENT PLAN

Caries Risk: Low High

Referred to dental service

[Print Dental Clinics](#)

Fluoride Varnish

Please offer fluoride varnish to **high risk patients** between 9 months and 47 months

Date Last Fluoride Varnish Completed: _____

[Administer Fluoride Varnish](#)

Fluoride varnish can be applied today.

Fluoride Varnish was explained to the parent and: Parent Consented Parent Declined

Comments: _____

[Oral Consent Verbiage](#)

[Print Fluoride Varnish Handout](#)

Patient Instructions:

This will translate into the Patient Instructions.

<input type="checkbox"/> Regular dental visits	<input type="checkbox"/> Wean off bottle	<input type="checkbox"/> Drink tap water
<input type="checkbox"/> Brush twice daily	<input type="checkbox"/> Less/No juice	<input type="checkbox"/> Healthy snacks
<input type="checkbox"/> Use fluoride toothpaste	<input type="checkbox"/> Only water in sippy cup	<input type="checkbox"/> No soda

Print Oral Health risk assessment tool

Performed by >> _____

Risk Assessment Example 2

Oral Health Risk Assessment	
<input type="checkbox"/> Oral Health Risk Assessment completed	
RISK FACTORS	
Mother or primary caregiver had active decay in the past 12 months	<input type="radio"/> yes <input type="radio"/> no
Mother or primary caregiver does not have a dentist	<input type="radio"/> yes <input type="radio"/> no
Continual bottle/sippy cup use with fluid other than water	<input type="radio"/> yes <input type="radio"/> no
Frequent snacking	<input type="radio"/> yes <input type="radio"/> no
Special health care needs	<input type="radio"/> yes <input type="radio"/> no
Medicaid eligible	<input type="radio"/> yes <input type="radio"/> no
PROTECTIVE FACTORS	
Existing dental home	<input type="radio"/> yes <input type="radio"/> no
Drinks fluoridated water or takes fluoride supplements	<input type="radio"/> yes <input type="radio"/> no
Fluoride varnish in the last 6 months	<input type="radio"/> yes <input type="radio"/> no
Has teeth brushed daily	<input type="radio"/> yes <input type="radio"/> no
CLINICAL FINDINGS	
White spots visible decalcifications in the past 12 months	<input type="radio"/> yes <input type="radio"/> no
Obvious decay	<input type="radio"/> yes <input type="radio"/> no
Restoration (fillings) present	<input type="radio"/> yes <input type="radio"/> no
Visible plaque accumulation	<input type="radio"/> yes <input type="radio"/> no
Gingivitis (swollen/bleeding gums)	<input type="radio"/> yes <input type="radio"/> no
Teeth present	<input type="radio"/> yes <input type="radio"/> no
Healthy teeth	<input type="radio"/> yes <input type="radio"/> no
Carries Risk <input type="radio"/> Low <input type="radio"/> High	
Anticipatory Guidance	
<input type="checkbox"/> Oral health education provided	
<input type="checkbox"/> Discussed importance of regular dental care	
<input type="checkbox"/> Nutritional counseling provided	
<input type="checkbox"/> Fluoride varnish applied to patient	
<input type="checkbox"/> Oral Hygiene kit given to patient	
Comments:	<input type="text"/>
Entered By	<input type="text"/>
Reviewed By	<input type="text"/>
Prev Form (Ctrl+PgUp)	Next Form (Ctrl+PgDn)

Risk Assessment Example 3

Caries Risk Assessment

Oral Health Assessment Flag

Note Date: 04/23/2

Adult Fluoride Assessment:

Has the patient been seen by a dentist within the last 12 months? **No, since the patient has not have a dental evaluation in the past 12 months, he/she will receive a caries risk assessment at todays visit.**

Does the patient floss his/her teeth less than daily? **ANSWER**

Does the patient brush his/her teeth less than 2 times daily? **ANSWER**

Does the patient have sugary drinks/snacks between meals more than 2 times daly? **ANSWER**

Does the patient take medications that can cause dry mouth? **ANSWER**

Based on the following assessment the patient is **RESULT**

Select List Other

ANSWER:

Yes
No

Caries Risk Assessment-all questions answered

Orders for tracking

- ophthalmologist or optometrist documented and reviewed assessment. (DM) (2022F) **Plan**
- Colonoscopy, flexible, proximal to splenic flexure; diagnd with or without collection of specimen(s) by brushing o washing, with or without colon decompression (separat procedure) (45378)
- obtain colonoscopy records (COLRS)
- NNOHA - Caries Risk - Assessment completed. (NNOH1)
- NNOHA - Fluoride Varnish Applied. (NNOH2)
- NNOHA - Oral Health Kit Given. (NNOH3)
- NNOHA - Oral Education Given. (NNOH4)
- NNOHA - Referral to dental for exam. (NNOH5)
- NNOHA - High Risk for dental caries. (NNOH6)
- NNOHA - Low/Moderate risk for dental caries. (NNOH7)

Instructions

- Call or make an appointment with HPWO Lipid Clinic: Please bring
- Call or make an appointment with HPWO MTM clinic for medicati appointment.
- Please schedule your mammogram and have results sent to you
- Please schedule a PAP test and have results sent to your provid
- Please call the OSU Physician Financial Assistance Program at 1-6 then be able to schedule your appointment with the correct OSI
- Please schedule a yearly Health Check-Up.
- Make and keep appointment for Dental exam
- Make and keep appointment for teeth cleaning
- Start flossing teeth daily
- Brush teeth at least 2 times daily
- Decrease the amount of sugary snacks/drinks daily

Appendix D

Patient Take-Home Materials

Take-Home Materials Example 1: Self-Management Goals

SELECT TWO GOALS

ROUTINE CARE



Set up Dental Home



Brush Twice a Day with Fluoride Toothpaste



Floss Nightly

DIET



Choose Healthy Snacks Like Fruits and Vegetables



Limit Soda/Sports Drinks to 1 Time Per Day



Less/No Sugared Candy & Junk Food

HABITS



Quit Smoking



Limit # Alcoholic Beverages



Chew Xylitol Gum/Mints



Drink Tap Water

Fluoride Varnish Protecting Your Child's Teeth

Fluoride Varnish

Fluoride varnish is applied to the teeth two to four times a year. It strengthens the teeth and protects them from cavities.

Both medical and dental offices can apply fluoride varnish. It is okay for your child to receive fluoride varnish from both places.

Who Needs Fluoride Varnish?

A child who has any of the following:

- Cavities or white spots
- Defects of the teeth
- Red or puffy gums
- Difficulty keeping their teeth clean
- Two or more drinks or snacks containing sugar between meals
- The habit of sleeping with a baby-bottle
- No fluoridated drinking water
- No regular dentist
- Family members with dental decay
- Special health care needs

What Do I Do After the Varnish Has Been Applied?

Your child's teeth will be a light yellow color for the rest of the day.

Your child can eat but avoid hard foods and hot drinks for the rest of the day.

Do not brush the teeth until the next morning. The teeth will then return to their normal color.

Applying Fluoride Varnish

Applying fluoride varnish is easy and will take only a few minutes.



Your child will be laid back onto the doctor's lap.



The teeth will be dried with gauze.



The varnish will be painted on.



Developed by JM Douglass, BDS DDS,
University of Connecticut School of Dental Medicine
Funded by Connecticut Department of Social Services



Nanosenje Fluorida Zastita zuba vasega djeteta

Nanosenje Fluorida

Fluoride se nanosi na zube 2 do 4 puta godisnje. Ono jaca zube i stiti ih od supljina.

Fluorid moze da se nanese i kod doktora opste prakse a i kod zubara. Znacni uredu ja da se vasemu djetetu nanese u bilo kojem od ta dva ureda.

Kome je potrebno nanosenje Fluorida?

Djetetu koje ima bilo koje od sljedecega:

- Supljine ili bijele fleke
- Defektne zube
- Crvene ili natecene desni
- Probleme sa odrzavanjem cistoce zuba
- 2 ili vise uzina ili napitak sa sadrzajem secera izmedzu obroka
- Navika spavanja sa flasicom
- Voda bez fluoridnog sadrzaja
- Neredovno posjecivanje zubara
- Clanovi porodice sa truhlim zubima
- Djeca sa specijalnom zdravstvenom njegom

Sta ciniti nakon nanosenja Fluorida

Zubi vasega djeteta ce biti blago zuti ostatak dana.

Vase dijete moze da jede ali treba da izbjegava tvrdnu hranu i tople napitke ostatak dana.

Nemojte da perete zube vasega djeteta do sljedecega dana. Do tada ce se boja zubi vasega djeteta vratiti u normalnu boju.

Nanosenje Fluorida

Nanosenje Fluorida je jednostavno i traje smao par minuta.



Vase dijete je u lezecem polozaju doktorovoga krila..



Zubi se posuse sa suhom gazom.



I tada se nanosi Fluoride.

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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.