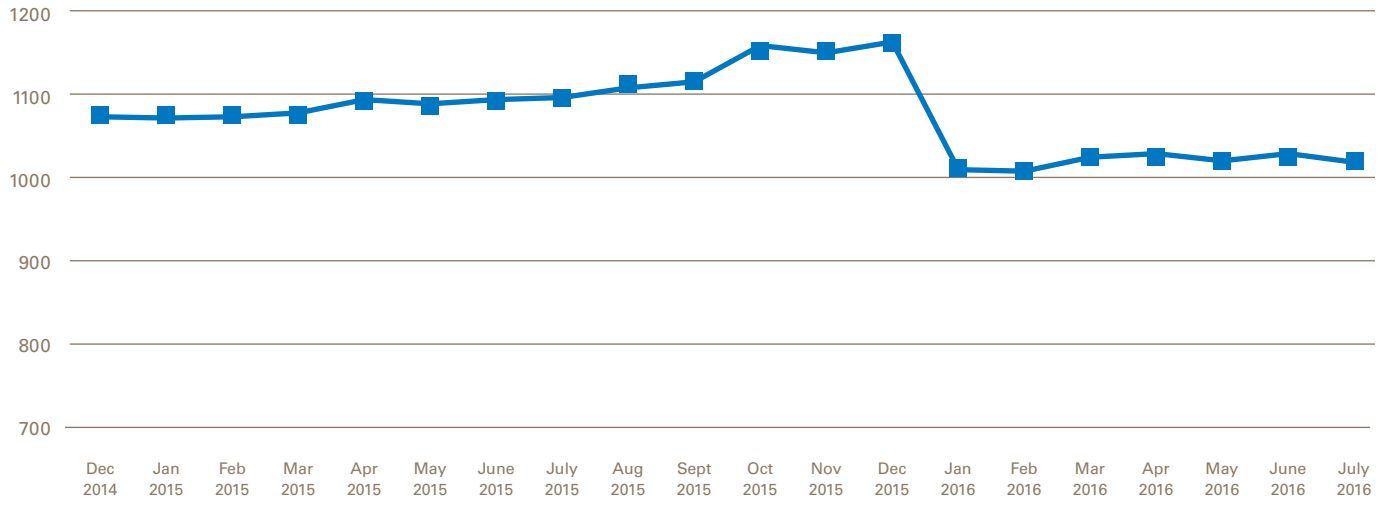
Sound Family Medicine Integrates Oral Health into Primary Care for Adults with Diabetes

Sound Family Medicine is a private primary care practice with four clinic locations situated south of Seattle. The Sunrise clinic was chosen as a pilot site, and the initial workflow was developed in November 2014 and piloted by a single clinician, focusing on his panel of patients with diabetes. In this case example, medical director Marc Aversa, MD, and quality improvement manager Beth Thurman share their experience as an oral health integration field-testing site.

Getting started

Sound Family Medicine was recruited to participate as a field-testing site by the Washington Dental Service Foundation. An initial meeting was held with the leadership team to get the program started. "When the 'why' of oral health integration was presented at the kickoff meeting, there were staff who had not really heard of the idea, and were unaware of the role they could play in helping us to screen and identify oral health issues in patients, and that was where we saw an a-ha moment," said Dr. Marc Aversa. "Staff recognized this was something they could help with. The medical case for integrating oral health is strong, and our medical assistants in particular got excited to take this on."

Figure 1: Total number of target population patients at the Sunrise clinic (nine clinicians)

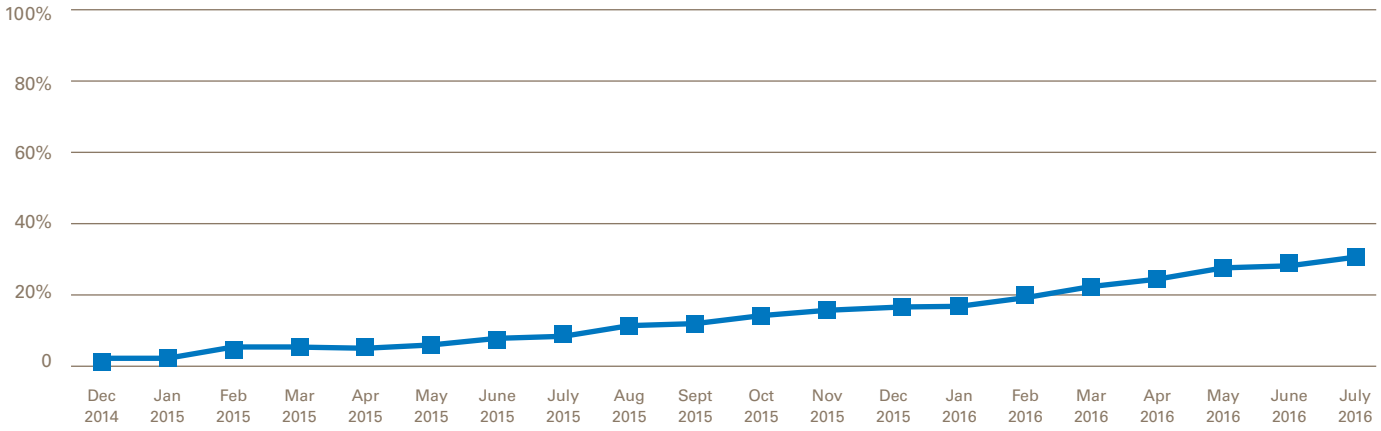


Key elements of success

"It's very clear that the key to success was to be able to figure out how to make room for a project like this. In primary care we've continued to add things to the plate without any real change in financing, or to the support system or tools. To make room for this new work, our medical assistants took responsibility for the pilot," explains Aversa. "Making room in the workflow by modifying the electronic health record [EHR] and automating things that clinicians had to pay attention to helped as well."s

A particular concern was that the volume of patients would be overwhelming, so Sound Family Medicine chose to start small, by focusing on a single clinician team and the patients in their panel with diabetes. "We're only really seeing one to two patients a day who are due for screening for each clinician, maybe up to four," Aversa observes. "I don't think we're seeing any slowing of patient flow in any of the settings. We haven't made anything worse in terms of the time impact, but we are doing more, so that's pretty cool."

Figure 2: Percentage of target population that received an oral health assessment at the Sunrise clinic (nine clinicians)



After running the pilot for several months, the medical director shared the information more broadly with other clinicians, and they began to spread the program to other teams at the same clinic. Team workflow and distribution of oral health tasks varies somewhat. "In most cases where the workflow is working well, the medical assistants are doing the bulk of the work—they're screening by asking the questions, they're doing an initial look in the mouth, and they're giving the educational messages. The clinicians also look in the mouth, especially looking for dry mouth, and they look at the medication list and think about if there are meds that might be causing problems," explains Aversa. "The medical assistant response has been positive. They were given good education about the patient impact, they were given tools to make the visit more efficient, and in making it more efficient they could do more for their patients. They've been given tools for how to counsel about oral health and how to share education resources with patients. They feel like they've developed some competency with oral health, and they know that many other practices aren't doing this, so they are the pioneers."

Figure 3: Percentage of target population that received an oral health assessment–pilot clinician care team

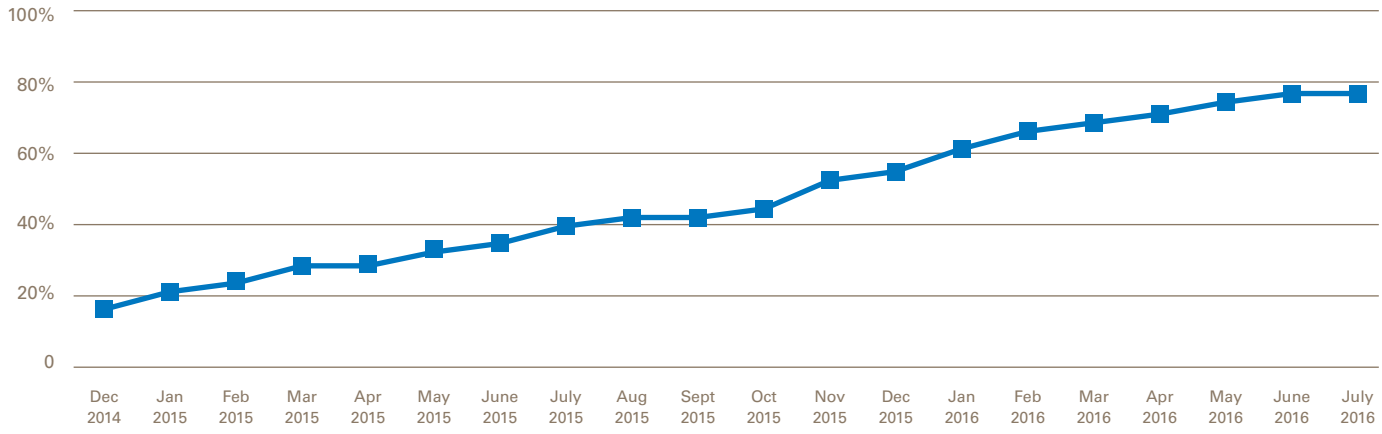


Figure 3 reflects the progression of the pilot clinician care team in assessing their target population of adults with diabetes. Figures 4 and 5 show two different examples of the spread trend within the Sunrise clinic location. In Figure 4, the clinician care team did not begin assessing patients for oral health until May of 2015, at which point their curve initially grew steeply before leveling off. In Figure 5, the clinician care team began slowly, assessing a few patients each month initially, before making workflow adjustments that increased their rate of assessment more dramatically, growing from 18% to 56% of the target population assessed in the last eight months.

Figure 4: Percentage of target population that received an oral health assessment–spread clinician care team example 1

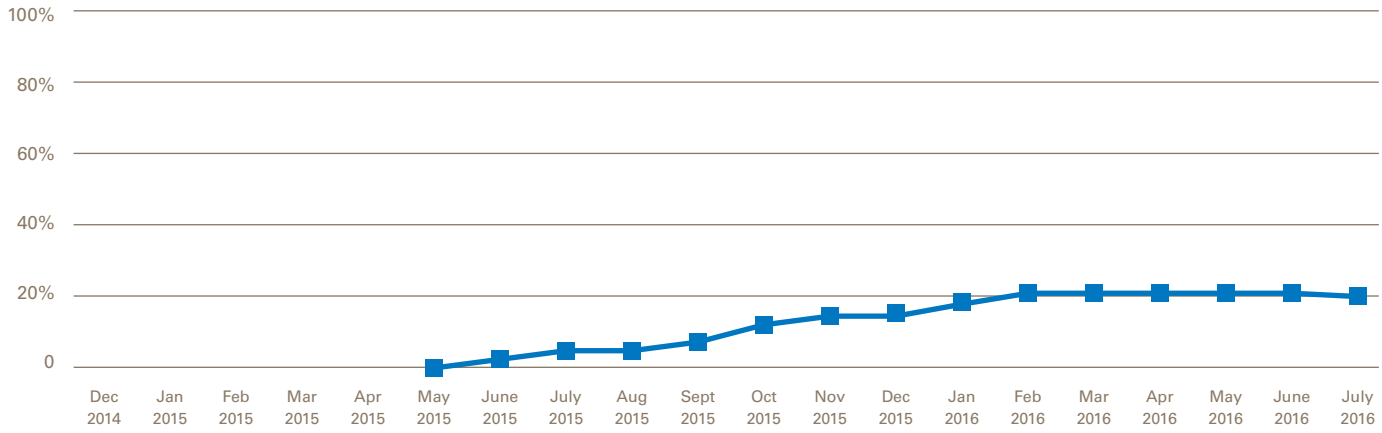
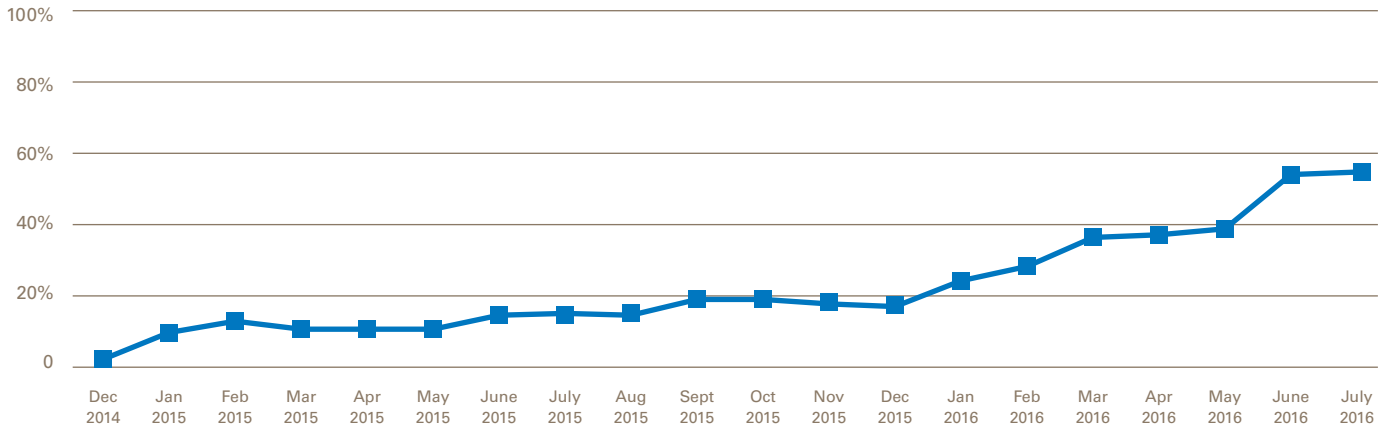


Figure 5: Percentage of target population that received an oral health assessment–spread clinician care team example 2



Electronic health record modification

Beth Thurman was instrumental in modifying the EHR and setting up reporting early in the program development. She explains, "Early on, some clinicians were slower to adopt the new workflow, and I was giving more regular feedback with the data. If I noticed a trend with one team, like no education handouts were being given, I'd reach out and ask them what was going on." Thurman was able to create a custom template in the EHR to record when a patient was assessed, the answers to the screening questions, and a referral order to dentistry. Aversa adds, "Once the order button is clicked in the EHR it generates a referral, which gets printed and handed to the patient. Then our referral coordinator follows up." Sound Family Medicine uses a proprietary health information exchange to manage their referrals. "The referral order gets sent out, and then the referral coordinator follows up to make sure the patient gets an appointment. At the beginning I had more active referrals to make, but over time that has dropped off since patients got dental care established," observes Aversa. "Once you have seen your whole patient panel, you're doing less work because you've set them up with regular dental care. That's good because it means they have the care they need."

Referrals

Sound Family Medicine established referral relationships with two local community dental partners with the assistance of the Washington Dental Service Foundation. One is a community health center dental practice; the other is a private community dental practice that accepts all patients regardless of insurance status. "The private dental practice has worked well for most of the patients we needed to refer to them, but with the community health center the patient volume was so low we didn't have a chance to work out a good workflow," comments Aversa. Thurman suggests, "One thing we could have done better was the coordination with the dental practices early on. We were initially receiving too much information back from the dentist, and the lead clinician at the time just wanted a snapshot of what happened. We worked that out, but having that conversation with the dental team in advance, and the referral workflow process established prior to going live, would have been helpful."

Figure 6 displays the run chart for referral to dentistry for the pilot clinician team, while Figure 7 shows the run chart for the 12 clinicians referring to dentistry across the Sound Family Medicine system.

Figure 6: Percentage of patients screened given a referral to dentistry–pilot clinician team

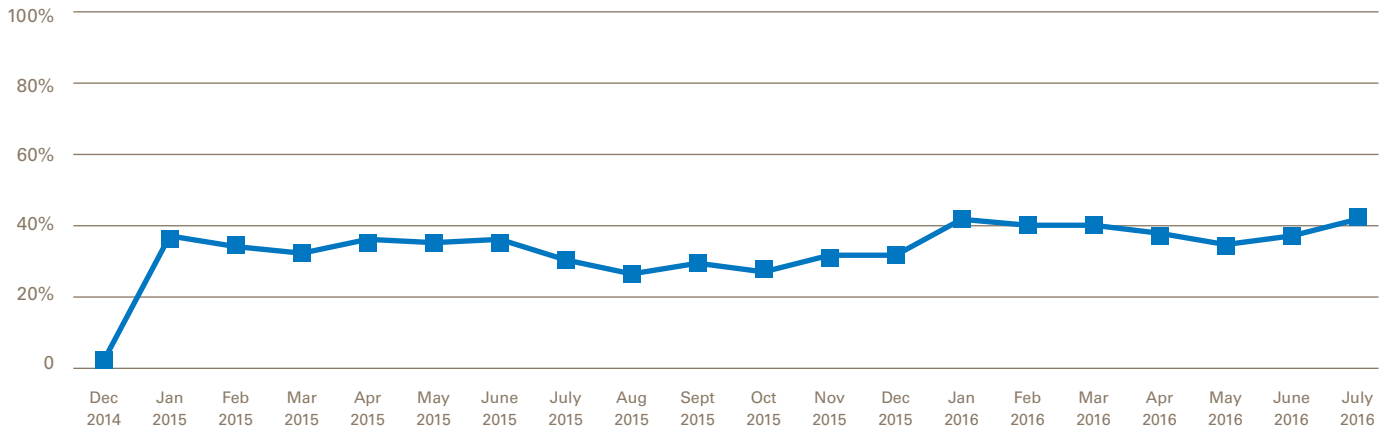
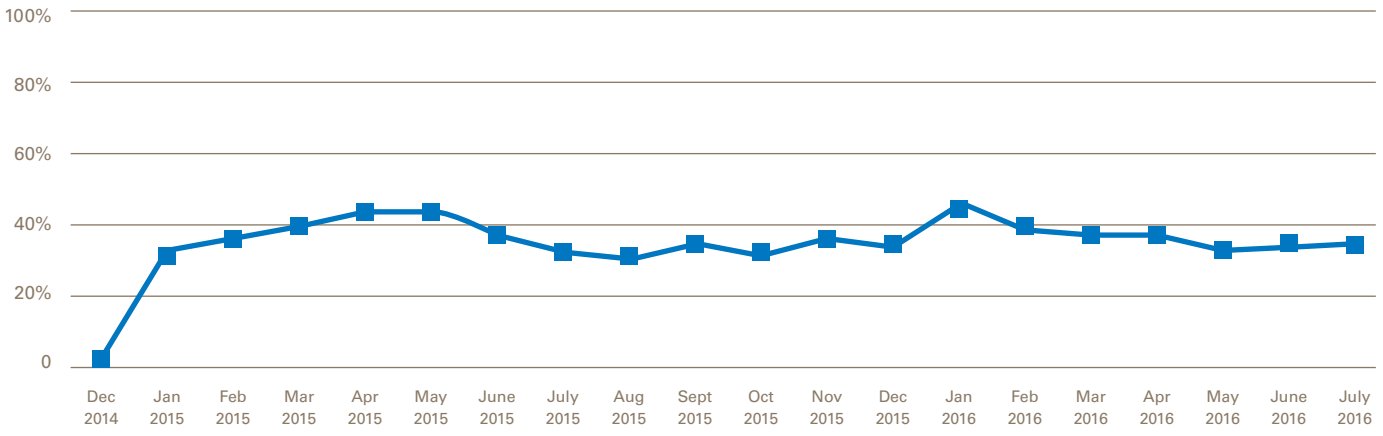


Figure 7: Percentage of patients screened given a referral to dentistry: twelve Sound Family Medicine clinicians combined



Lessons learned

Aversa says, "Right now primary care clinicians are under stress with the amount of work we're trying to manage in the current environment. The only path forward is to figure out how to reduce the workflow overhead by using more intelligent systems, and getting the information in front of clinicians in useful ways. It's critical to build systems that make it faster for clinicians to do what they should be doing. Oral health integration is a good example of trying to do things that way. It was a nice vehicle for us to look at how to work more efficiently. Our challenge now is to take the learnings from this and apply them to the other workflows our clinicians have."

Spreading

Aversa explains, "The main thing we've done with the data is to look at it in terms of spread. When we first looked at the overall clinic data we thought our pilot clinic was doing well and we were ready to spread to our other clinic locations. Then we decided to look within the pilot clinic and saw that there was a lot of variation from clinician to clinician." The decision was made to delay spreading to other clinics and focus first on getting all clinicians within the original pilot site to a more stable level of implementation. "We shared the data with our clinicians, and our floor supervisor is looking at ways to standardize and improve. Once we get the workflows sorted out, we'll spread to our other three clinic locations and would look at adding other target populations," predicts Aversa.

About the Oral Health Integration in Primary Care Project

Organized, Evidence-Based Care Supplement: Oral Health Integration joins the Safety Net Medical Home Initiative Implementation Guide Series.

The goal of the Oral Health Integration in Primary Care Project was to prepare primary care teams to address oral health and to improve referrals to dentistry through the development and testing of a framework and toolset. The project was administered by Qualis Health and built upon the learnings from 19 field-testing sites in Washington, Oregon, Kansas, Missouri, and Massachusetts, who received implementation support from their primary care association. Organized, Evidence-Based Care Supplement: Oral Health Integration built upon the Oral Health Delivery Framework published in *Oral Health: An Essential Component of Primary Care*, and was informed by the field-testing sites' work, experiences, and feedback. Field-testing sites in Kansas, Massachusetts, and Oregon also received technical assistance from their state's primary care association.

The Oral Health Integration in Primary Care Project was sponsored by the National Interprofessional Initiative on Oral Health, a consortium of funders and health professionals who share a vision that dental disease can be eradicated, and funded by the DentaQuest Foundation, the REACH Healthcare Foundation, and the Washington Dental Service Foundation.

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

- National Interprofessional Initiative on Oral Health: www.niioh.org.
- DentaQuest Foundation: www.dentaquestfoundation.org.
- REACH Healthcare Foundation: www.reachhealth.org.
- Washington Dental Service Foundation: www.deltadentalwa.com/foundation.

QUALIS HEALTH

National Interprofessional Initiative on Oral Health
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eradicating dental disease

DentaQuest FOUNDATION

REACH healthcare foundation

Washington Dental Service Foundation
Community Advocates for Oral Health

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For more information about the Safety Net Medical Home Initiative, refer to www.safetynetmedicalhome.org.