Case Studies of 8 Federally Qualified Health Centers: Strategies to Integrate Oral Health With Primary Care

Margaret Langelier, MSHSA, Jean Moore, DrPH
Oral Health Workforce Research Center, Center for Health Workforce Studies, School of Public Health, University at Albany

ABSTRACT

Access to oral health services is especially limited for underserved populations that receive primary care services from safety net providers. As the medical home for many people who lack access to oral health services, federally qualified health centers (FQHCs) are well positioned to also provide a dental home for their patients.

Objective: The objectives of this study were to identify the most effective workforce models used by FQHCs to provide oral health services to patients, including their roles and functions, to describe the delivery of oral health services, and to identify barriers and facilitators of integrating primary care and oral health services.

Methods: This qualitative research used a case study methodology.

Results: Oral health service delivery program design in FQHCs varied depending on local need and the populations served. FQHCs were engaging primary care clinicians and dental professionals in efforts to integrate service delivery. FQHCs used existing workforce in innovative ways and also used new workforce models in oral health to engage and serve patients.

Limitations: Because the number of case studies was small, findings from this qualitative work may not be generalizable. Although geographic locations, patient populations, and local health care needs varied by FQHC, recurrent themes identified from the research suggested underlying commonalities in FQHCs drawn from a strong commitment to serving high-need populations in their communities.

Conclusions: FQHCs provide examples of the opportunities for and benefits from integrated care delivery as well as the difficulties inherent in changing professional siloes in care delivery systems that impede integration.

CONTACT

Oral Health Workforce Research Center
Center for Health Workforce Studies
University at Albany, School of Public Health

518-402-0250
info@oralhealthworkforce.org
www.oralhealthworkforce.org

METHODS

OHWRC researchers completed case studies at 8 FQHCs headquartered or operating satellite clinics in 9 states (CA, CT, ME, MN, NH, NY, PA, RI, WI) to understand selected workforce and team configurations to deliver oral health services.

The health centers for the case studies were selected based on 1 or more of the following criteria, including that the FQHC:

- Used team-based approaches to provide oral health services
- Implemented policies to support oral health assessments of patients in primary care clinics and routine referrals to the FQHC dental clinic
- Used technology to improve access to oral health services
- Employed new oral health workforce models to expand access to oral health services

Informants included medical and oral health professionals, pharmacists, behavioral health specialists, information technology (IT) staff, operations and financial management, and executive leadership. Interviews lasted between 30 minutes and several hours, depending on the number of participants in each group and relevancy of questions.

RESULTS

Themes drawn from the case studies about delivery of oral health services in FQHCs included:

- **Oral health service delivery that is designed to meet local need is the most effective way of improving access and utilization of oral health services by the local population.**
- **Demand for oral health services was high in FQHCs, while the oral health literacy of patients was relatively low.**

  Demand for emergency oral health services among at-risk populations was a direct indicator of a lack of population oral health literacy.
- **FQHCs employed a variety of strategies to integrate oral health and primary care service delivery.**

Table 1. Strategies Used to Achieve Integration of Primary Care and Oral Health

Using the EHR bidirectionally to exchange information and effect referrals
Requiring that all patients receiving services in the dental clinic at the FQHC also be primary care patients at the clinic
Including oral health services from dental hygienists in the services scheduled for periodic pediatric visits
Engaging primary care clinicians in the FQHC to provide oral health screening and referral services
Embedding oral health services in school-based health clinics managed by the FQHC
Embedding a dental hygienist in the off-site primary care practices affiliated with the FQHC to provide oral health preventive and educational services
Using new patient information forms that contain questions about oral health history

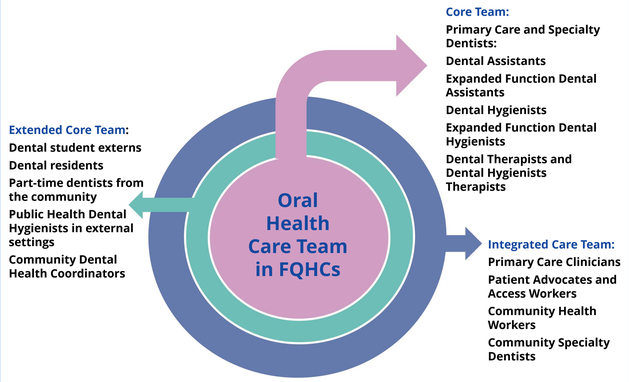
RESULTS (cont.)

- **FQHCs generally recognized that technology was a facilitator to integration of primary care and oral health, but some health centers had resource limitations that prohibited full engagement with available or emerging technologies to improve care transparency.**

  FQHCs utilizing integrated electronic health records (EHRs), portable/mobile dental equipment, and teledentistry clearly demonstrated the benefits of using IT to enable patient care.

  Integrated EHRs in FQHCs:
  - Facilitated bidirectional information exchange and referral within clinics
  - Aided consultations with other professionals in the FQHC in real time
  - Improved efficiency and quality in care delivery
  - Permitted interface with patients in community settings through patient portals
  - Connected clinicians with other health care providers in the community who were treating mutual patients
  - Enabled monitoring of outcomes from selected clinical interventions
- **FQHCs embraced team-based approaches to delivering oral health services and were successful in using teams to meet patient demand for dental care.**

Fig 1. Teams Used in Oral Health Service Delivery in FQHCs



- **FQHCs used existing oral health workforce in innovative ways and also engaged with new oral health workforce models to improve care delivery.**

  FQHCs in the case studies:
  - Provided dental residents and dental student externs with clinical rotations at the FQHC
  - Encouraged private-practice dentists from the community to work on a part-time basis at the dental clinic
  - Recruited dentists through state and federal loan repayment programs
  - Enabled dental assistants and dental hygienists to obtain further training to support expanded capabilities
  - Employed new categories of oral health professionals, such as extended function dental assistants, public health dental hygienists, community dental health coordinators, and dental therapists, that were recognized by the state in which the FQHC was located

CONCLUSIONS

FQHCs are structured to provide a comprehensive array of health services in an integrated ambulatory care setting. As a result, FQHCs have the potential to seamlessly provide primary care, oral health, behavioral health and ancillary health services in their health centers.

The major conclusions from this study were:

- FQHCs are uniquely positioned to provide health care services that are inclusive and patient centered.
- FQHCs experience common problems with the oral health literacy of patients and with building sufficient capacity to meet high demand for services.
- FQHCs have exceptional opportunities to engage with innovation, especially novel local workforce solutions that increase access to oral health services for underserved populations because many of these models are designed to meet the needs of the underserved.

FQHCs recognized that technology was a facilitator of integration of primary care and oral health, but some health centers had resource limitations that prohibited full engagement with available or emerging technologies to improve care transparency. Finding local, state, federal, and other funding to support the cost of building both electronic and clinical infrastructure to deliver oral health services is critical to sustain the contributions of FQHCs to improvements in access to oral health services.

DISCUSSION

Strategies to blend service delivery are confronted with distinct primary care and oral health care delivery systems that make integration challenging even for FQHCs. Co-location of services in FQHCs is not equivalent to integration but it is a facilitator of integrated service delivery.

FQHCs are ideally structured to provide patient-centered services using an array of multidisciplinary providers to improve overall health outcomes. The co-location of dental care with the medical clinics in FQHCs provided many benefits in terms of assessment and referral for care.

FQHCs recognized their important contributions to oral health service delivery in their local communities and acknowledged that engagement with clinical and social service providers in the larger community was important to the success of improvements in population oral health.

FQHCs worked well with local hospital systems, other neighborhood clinics, and clinicians in private practices, especially specialty providers, in planning for and implementing programs to improve the health and oral health of their patients. Participation in regional and state health information exchanges and in referral networks that included community clinicians was tangible evidence of the recognition that clinics are partners in health care delivery and that community linkages are essential to meet the need of FQHC patients for access to a comprehensive care delivery system.