Health Workforce Policy Brief

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

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I. Introduction/Background

There is increasing evidence of important linkages between oral and physical health. Researchers report that periodontal disease and dental caries are associated with coronary artery disease, diabetes, pre term birth and substance abuse, among others. While the value of integrated medical and oral health service delivery is generally acknowledged, structural barriers such as the separation of dentistry and medicine within the larger health care delivery system often impede effective integration efforts. This separation limits opportunities for better communication and collaboration in support of optimal patient-centered care.

Federally Qualified Health Centers (FQHCs) are a notable exception in that they are vertically integrated organizations that typically provide primary care, oral health, and behavioral health services to underserved populations. In addition, FQHCs use multi-disciplinary teams that facilitate communication across service lines. Service integration in the safety net has the potential to improve clinical outcomes and provide a comprehensive health home for underserved populations.

II. Methods

The Oral Health Workforce Research Center conducted eight case studies of FQHCs operating in nine states to identify the specific strategies used by these safety net providers to successfully integrate primary care and oral health services. FQHCs selected for the case studies were based on whether the FQHC: used team-based approaches to provide oral health services; implemented policies that support oral health assessments in primary care clinics and routine referrals to the FQHC dental clinic; used technology to improve access to oral health services (eg, integrated EHRs and tele-dentistry); and used new oral health workforce models to increase access to oral health services (eg, dental therapist, community dental health coordinator).

III. Findings

Despite differences among FQHCs regarding patient populations and strategies employed to integrate services, four key themes emerged, including:

Conclusions & Policy Implications

1) FQHCs that understand the limitations in local resources for their patients including gaps in care, reimbursement, and workforce availability, often use this information to develop strategic plans to address local oral health access issues.

2) FQHCs use electronic health records (EHRs) to better connect oral health and primary care providers. Their use increases opportunities to exchange information, provide referrals, and monitor patient outcomes. Integrated medical and dental EHRs also improve patient-provider interactions as well as the delivery of health and oral health services.

3) FQHCs use innovative workforce strategies such as cross-training oral health and primary care providers to identify/assess patients' oral and primary health conditions; these integrated approaches support providers' ability to respond to patients' unique needs.

4) Oral health team configurations in FQHCs vary, based on local circumstances including worker availability and scope of practice requirements for oral health professionals in the state.

- The use of interoperable electronic medical and dental health records was key to successful integration and facilitated communication and collaboration between primary care and oral health providers.

- Workforce strategies used by FQHCs emphasized team-based approaches to care, including providers who were trained to assess both medical and oral health issues. In some instances, primary care providers engaged in oral health assessments and oral health providers conducted basic medical assessments, facilitating bi-directional referrals for necessary services.

- FQHCs used their existing oral health workforce in innovative ways, including placing dental hygienists in primary care practices and pediatric clinics. FQHCs also embraced new oral health workforce providers to improve care delivery, including community dental health coordinators and dental therapists. Other oral health team members included general and specialty dentists, part-time community dentists, dental assistants in basic and extended functions, dental hygienists in basic and expanded roles, dental therapists, community dental health coordinators, dental residents, and student externs.

- FQHCs also recognized the importance of engaging with clinical and social service providers in local communities to improve access to care for underserved patients. These organizations built relationships with local hospital systems, neighborhood clinics, and private practice clinicians to plan for and implement integrated programs to improve overall patient health. They participated in regional and state health information exchanges and referral networks that connected with local providers. These novel approaches to integrated care developed by FQHCs reflected a solid understanding of local community need, which in turn informed the development of tailored strategies to improve access to oral health services and clinical outcomes.

III. Conclusions

The FQHCs that participated in this study embraced opportunities for workforce innovation and demonstrated the benefits of integrated care delivery models. While these health centers fully understood the challenges associated with the prevailing silos within care delivery systems, they demonstrated the benefits of successfully integrating oral health and primary care services.

The case studies focused on the importance of building integrated oral health and primary health care services, using innovative and culturally competent team-based models. The most successful FQHCs focused on integrated teams with access to patients' dental and medical records, and training workforce to identify oral health and primary care issues. These coordinated approaches to care better informed and connected providers and patients, and helped improve patients' health outcomes.

V. Policy Implications

FQHCs have a unique opportunity to expand access to oral health services for the underserved and to provide patients with a comprehensive health home. While FQHCs recognize that technology is a facilitator of integration of primary care and oral health, some face resource limitations that prohibit full engagement with available or emerging technologies. FQHCs are essential providers of oral health services. HRSA is awarding grants to FQHCs to expand oral health infrastructure and programs. Finding local, state, federal, and other funding to support the cost of building infrastructure and delivering oral health services, such as HRSA's oral health expansion grants, is critical to sustain the contributions of FQHCs to improvements in access to oral health services.

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