ECOH Implementation Guide

Keeping Us on the Right Track

ECOH

Early Childhood Oral Health

Acknowledgements

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Community Health Centers of Greater Dayton
Family Health Care of Northwest Ohio
Family Health Services of Darke County
Health Partners of Western Ohio
HealthSource of Ohio
Neighborhood Health Care
Ohio Hills Health Center
ONE Health Ohio
Rocking Horse Center
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"All aboard the CHEW CHEW Express!"

The vision for the Early Childhood Oral Health (ECOH) program is to improve oral health outcomes for Ohio's youngest and most vulnerable citizens by integrating preventive oral health practices within the primary care setting.

With vision comes change and system-wide change is never an easy undertaking. Therefore, teamwork is a very important component of the ECOH initiative. **A team is a group of people working together to achieve a common purpose.** Effective teamwork results from a mutual understanding of the organization's vision and values and a shared commitment to the ECOH initiative. To assist health centers with this change and to best prepare them for adoption of a new standard of care, the ECOH Implementation Guide was developed. The purpose of the ECOH Implementation Guide is to clearly define the goals and objectives of this initiative and provide the strategy to achieve them. The guide will establish who we are, where we want to go and how we are going to get there. Let's say it will help keep us on the "RIGHT TRACK"!

How to use the ECOH Implementation Guide

This guide is intended to "conduct" the health center through the various stages of the ECOH program while remaining flexible enough for adaptation by each organization. Some ideas that work for one health center may not work for another; but the framework still remains the same. As a result, the guide should continually be modified as the organization gains knowledge and experience and identifies alternatives to complications. Not only will these three tracks prepare the team for implementation, they will also assist with the establishment of timelines and goals. By sharing this guide with the entire ECOH team it will help to build the foundation for a cohesive group and set the stage for a successful implementation strategy and long-lasting sustainability. The three tracks are divided into two sections: Health Center Operations and Health Center Clinical. The Operations section is intended for the key management staff, while the Clinical section is intended for the medical/dental staff. So, let's keep "chugging" along!

The ECOH Implementation Guide is divided into three tracks.

TRACK 1: Preparation & Buy-in (1-3 months prior)

TRACK 2: Preparation for Start-up (0-4 weeks prior)

TRACK 3: Implementation (Days 1-60)
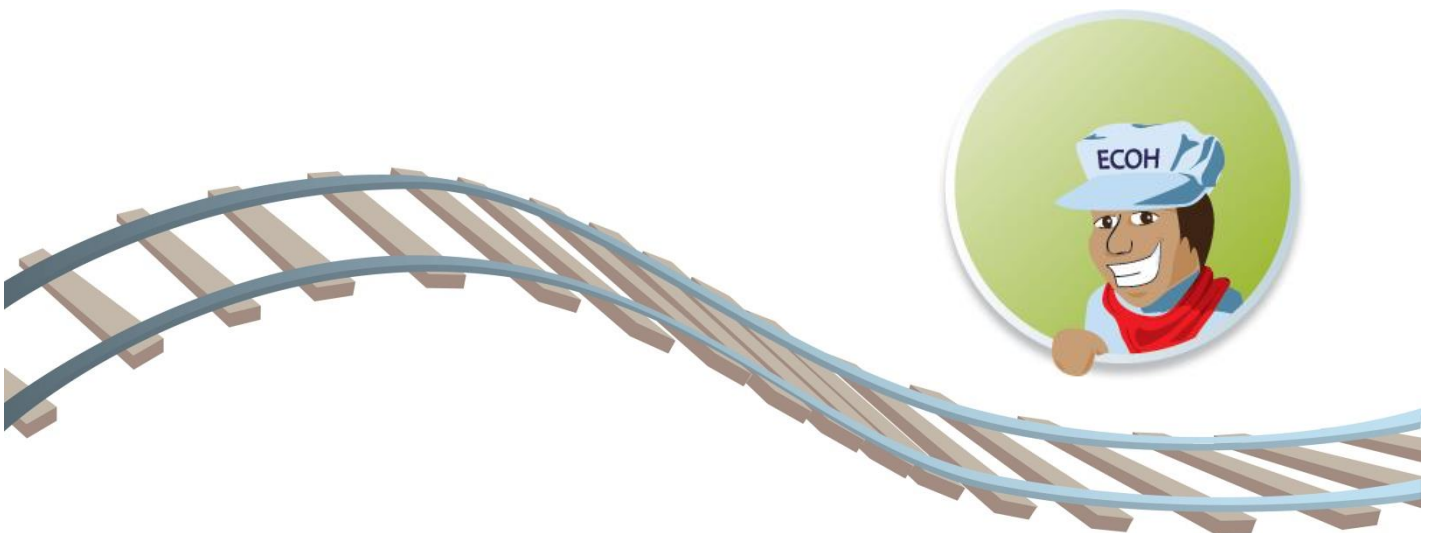
ECOH: A Historical Perspective

The Early Childhood Oral Health (ECOH) Initiative is a quality improvement initiative focused on Federally Qualified Health Centers (FQHC) and Look-Alike (FQHCLA) networks with sites that are located within the HealthPath Foundation of Ohio's (HPFO), previously Anthem Foundation of Ohio, 36 counties service area.

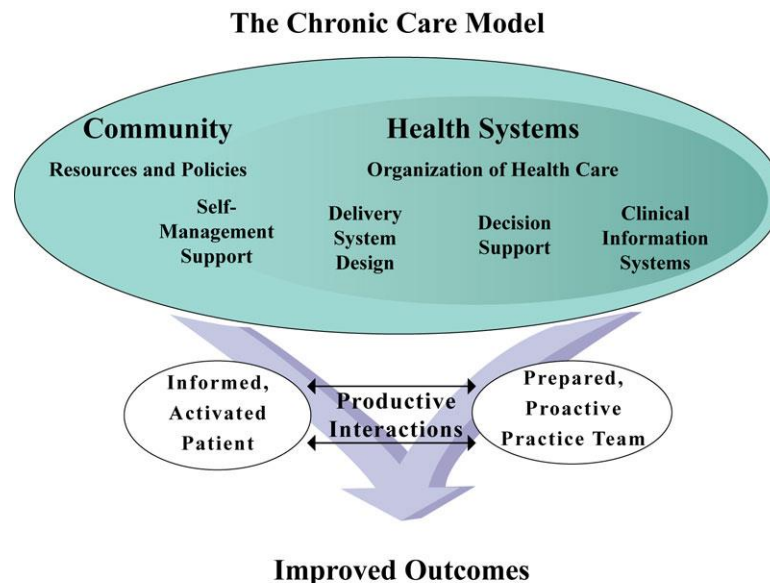| *ECOH Mission Statement*	*ECOH Vision Statement*
The mission of the Early Childhood Oral Health (ECOH) initiative is to enable access and integrate preventive oral health screenings as a standard of care during well-child checks for children 9-36 months of age within community health centers in Ohio and to develop community based referral partnerships between medical and dental providers.	The vision for the Early Childhood Oral Health (ECOH) initiative is to improve oral health outcomes for Ohio's youngest and most vulnerable citizens by enabling access and integrating preventive oral health practices within the primary care setting.

The ECOH Initiative builds on pilot work conducted by the HealthPath Foundation of Ohio in conjunction with the University Of Cincinnati, Department Of Public Health Services. The Ohio Association of Community Health Centers (OACHC) built upon the lessons learned and best practices developed through participation of Ohio's health centers in the Health Disparities Collaborative (HDC). The HDC model is broken-down into two phases of program implementation. Phase 1 is the initial learning that teams used as the framework to implement the ECOH initiative as the standard of care. Phase 1 allowed the health centers to view current problems in operational systems and look at ways to overcome these identified barriers to streamline processes to effectively transition into a more effective model for quality improvement. The objectives of Phase 2 were for health centers to spread the model to all providers and sites and to sustain the operational changes that were completed in Phase 1 activities.   OACHC planned to utilize the work done with the initial health centers as a model that could be duplicated for all of Ohio's health centers and become the standard of care for well-child visits within the target population of the initiative.

The HDC utilized the framework of **The Chronic Care Model**, developed by the MacColl Institute, to guide centers through the process of an integrated, collaborative care model. There are six components that promote an organizational approach to providing planned, proactive care for people within a primary care setting. The six concepts include Health Care Organization, Community Resources and Policies, Self-management Support, Decision Support, Delivery System Design, and Clinical Information Systems.

For information on **The Chronic Care Model**, please go to *www.improvingchroniccare.org*.

ECOH in Ohio

According to the 2008 Ohio Family Health Survey, dental care is the #1 unmet health care need for children in Ohio. To add to the problem, there is a shortage of dentists in the state of Ohio; the ratio of dentists to population is one dentist to every 1,654 Ohioans (Ohio Oral Health Surveillance System, 2010). Because of this shortage, many patients turn to the emergency room for treatment, which is very costly. "Research shows the average cost of a Medicaid enrollee's inpatient hospital treatment for dental problems is nearly 10 times more expensive that the cost of preventative care delivered in a dentist's office", according to a study by E. Pettinato, M. Webb and S.N. Seale, Pediatric Dentistry 22, (2000). Too many children have their first dental encounter in the emergency room, where nothing can be done except treat the pain since dentists are not typically on staff in emergency rooms.

Ohio health centers are an ideal venue for reaching Ohioans with limited access to oral health care. In 2011 alone, the Uniform Data System (UDS) reported that the health centers in Ohio cared for a total of 32,007 patients under the age of three. These health centers also reach a diverse cultural and socioeconomic population as well. According to a 2005 General Accounting Office report, poor children have 5 times more untreated dental caries than children in higher-income families. (U.S. Dept. of Health and Human Services Oral Health in America: A Report of the Surgeon General. Rockville, Maryland. 2000). Based on the most recent 2011 UDS report, the patient population served by health centers in Ohio is reflected in the following diagrams:

Income (as % of FPL)

- 100% and Below
- 101-150%
- 151-200%
- Over 200%
- Unknown

41% | 41% | 10% | 4% | 4%

Patients by Race

- Asian
- Hawaiian/Pacific Islander
- Black
- American Indian/Alaska Native
- White
- More than one race
- Unreported

1% | 0% | 1% | 11% | 29% | 58% | 0%

Insurance Status
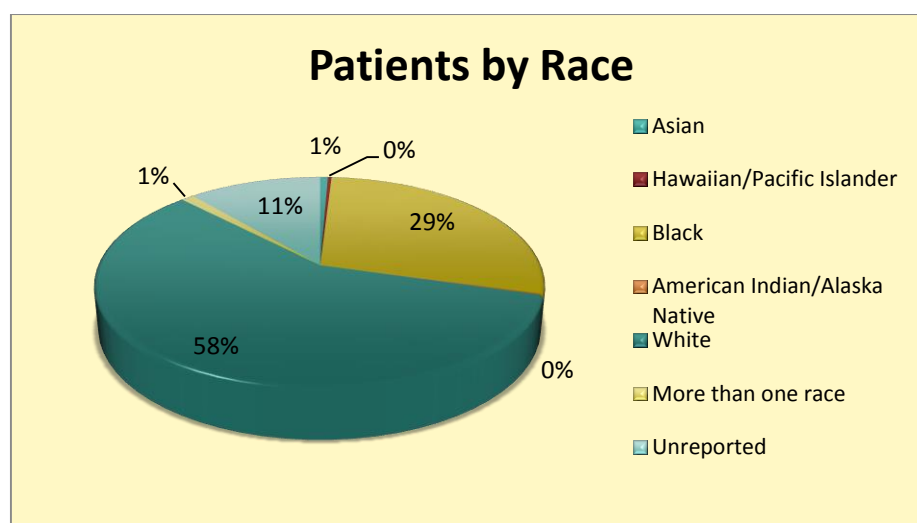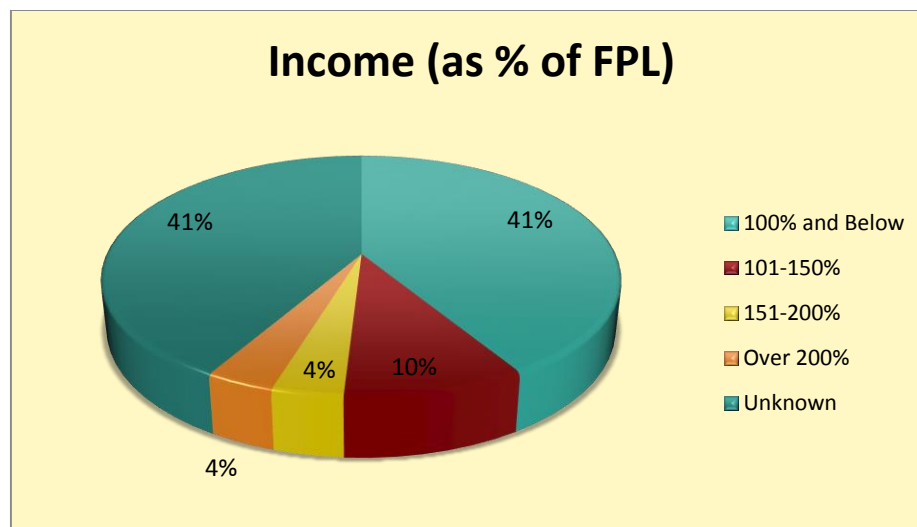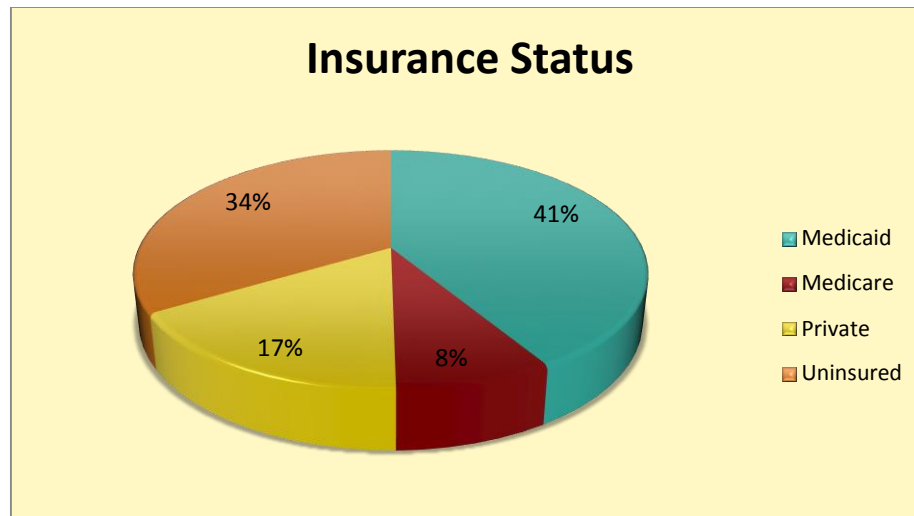
The goals of the ECOH program include:

- The establishment of dental homes and regular dental care for children by 1 year of age.
- The establishment of oral health screenings, caries risk assessments, fluoride varnish applications, appropriate referrals, caregiver education and anticipatory guidance as components of the expected standard of care provided during routine well-child and minor illness primary care visits within participating community health centers.
- An increase in the number of general dentists providing care to pediatric patients.
- A significant reduction in the incidence of oral health problems among children under 36 months of age over the course of the initiative.

Implementing a fluoride varnish program into a health center is literally adding a new procedure for the medical provider. **This is NOT something they have been trained to do.** To address this issue OACHC utilized a set of Critical Success Factors developed by Dr. Ludke from the University of Cincinnati, Department of Public Health Sciences, as a guide throughout the implementation process.

For the complete list, please click *Critical Success Factors.*

| Strong Physician Commitment | Culture that Values Oral Health | Integration into Existing Patient Care Process | Team Leader | Staff Training | Data Collection | Referral System |

The following is a subset of those success factors:

Strong Physician Commitment/ Strong Administrative Commitment

It is important to have a strong commitment from not only the Physician, but the CEO, COO, CFO, CMO, and CDO. Each health center must have a Program Champion. Again, each health center is different, so saying a Physician should be the Program Champion is restrictive. A Program Champion can be a Physician, CEO, Dentist, Physician's Assistant, etc. anyone who will take the responsibility of ensuring that EVERY child has an oral examination and is provided a fluoride varnish application along with anticipatory guidance to the caregiver.

Clinic Culture Must Value Oral Health

Every clinic employee must value the importance of good oral health, not only for patients, but also for themselves. It is important to address any dental phobias that staff may have and how their attitudes, fears, and misconceptions may be transferred, even inadvertently, to patients and their families. Establishing a culture based on teeth and gums being as important as every other body part helps to ensure that patients receive appropriate oral health care, and also communicates to parents and caregivers that good oral health is a vital part of one's overall health. In this environment, parents and caregivers are more likely to be willing to participate in the program, adopt good oral health behaviors for their children as well as themselves, and comply with patient referrals to a dentist.

Integration into Existing Patient Care Process

The conduct of the oral exam, the application of the fluoride varnish, the provision of anticipatory guidance, and the collection of the necessary informed consent, patient information, and documentation must be well-integrated into the practice's patient care processes. Because these are activities being added into an already busy practice, they must be efficiently and effectively incorporated into existing policies and procedures. Failure to do so will result in the activities either not being performed routinely or being conducted in a less than high quality manner. This integration requires a careful examination of the practice's patient flow patterns and a modification of those patterns to adopt the added responsibilities. This may also include examining current staff roles, as well as practice act regulations, regarding staff responsibilities, use of standing orders, and dental referral policies and practices. In addition, decisions must be made regarding the location of supplies needed for the program as well as the flow and processing of the required information.

Team Leader

A staff member should be designated as the coordinator for the program. This person should be responsible for working with other staff in developing and implementing the plan for integrating the program into the clinic, making parents and caregivers aware of the program and addressing their questions and concerns, and addressing operational issues that arise. Most importantly, the team leader should monitor the implementation of all aspects of the program and establish quality control and improvement policies and procedures.

Staff Training

Staff must be appropriately trained to provide the necessary anticipatory guidance to parents and caregivers regarding good oral health behaviors, conduct the oral health examination on the child and correctly identify and document any oral health problems, correctly apply the fluoride varnish to the child's teeth and address any parent or caregiver questions or concerns, and make the appropriate dental referral decisions. The trainer should be available for follow-up questions and technical assistance (via phone or site visit), especially in the early stages of implementation. Follow-up training sessions are important for any new staff members, and can be an effective way of re-energizing or engaging existing providers.

Data Collection

A system for recording the clinical findings of the oral health examination, the application of the fluoride varnish, and the anticipatory guidance provided to parents

and caregivers must be effectively integrated into existing documentation policies and procedures to minimize data collection burden on staff, while providing the necessary data for continuity of oral health care. Any additional data collection efforts established for evaluation purposes, which is an important component for on-going program quality monitoring and improvement, must also be designed to minimize staff and parent/caregiver burden as well as be culturally sensitive. Procedures should be established for not only the collection of evaluation data, but also the processing, analysis, and review of the data to provide timely feedback on the level of success of the program and areas of potential improvement.

Referral System

Because oral health problems may be identified that are beyond the practitioner's scope of practice, an effective system must be established to refer patients to the dental community. The implementation of the program in the practice must have the support of the local dental community and members of that community must be willing to accept referrals of (a) young children and (b) children with the particular type of payment source. It is very important to establish a relationship with private dentists in your area.

Did You Know?

- Dental Caries is the most common chronic childhood disease in America
- Dental caries is 5x more common than Asthma
- Low-income children are especially vulnerable to Dental Caries; 5x more likely to develop it than children from families with higher incomes
- Oral health is a key determining factor in the condition of a child's overall health
- Dental disease has the potential to cause serious infection, pain and dietary problems, leading to 51 MILLION hours of missed school time
- Dental disease and medical health are interrelated: Periodontal disease is linked to…
    - Diabetes, Cardiovascular Disease, Alzheimer's, Hypertension, Respiratory Disease, HIV, Pre-term low birth weight babies
- Caries are CONTAGIOUS
- Early Childhood Caries is a PREVENTABLE disease

TRACK 1

Preparation and Buy-in

Health Center Operations

Health Center Clinical

Preparation and Buy-in

- *1-3 months prior*

TRACK 1: Preparation and Buy-In

As we start this process, it is important to first state the obvious, CHANGE is difficult! Add to that, no two health centers, CEOs of health centers or even providers at health centers are at the same level of readiness for program adoption and integration. It is because of these discrepancies that each health center and leadership team must spend a significant amount of time assessing their level of readiness. OACHC recommends this process take place at least one to three months prior to program implementation.

TRACK 1: Preparation and Buy-in allows for health centers to take a look at their clinical and operational capacities and arrange for adjustments to "the way we do things" in order for a new procedure and process to be adopted by all levels of the organization. Successful change is difficult and must follow a logical and orderly sequence in order to thrive. One key piece of TRACK 1 is to not underestimate the importance of communication. Innately, people are resistant to change, especially if they have no involvement or say in the process. Therefore communicating why the change is important is essential for it to be effective and sustainable.

Health Center Operations

The entire organization must be engaged in the improvement effort. Senior leadership must identify the effort to improve oral health services as important work, and translate that into clear goals reflected in the health center's policies, procedures, business plan, and financial planning. Health center administrators (CEO, CFO, and Office Manager) along with clinical leaders (CMO, QI Manager, Clinical Coordinator, CDO) must be visible and committed members of the team and give personnel the resources and support they need to pursue ECOH the initiative.

Health Center Clinical

Physicians (and dentists if applicable) must not simply endorse the concept, but must be dedicated to improving oral health of the children seen within the clinic and serve as program champion. As a program champion, each physician or clinician must assume the responsibility of ensuring that every child has an oral assessment and an oral health risk assessment, is provided fluoride varnish at the appropriate time and that the child's caregivers are provided with basic oral health information and anticipatory guidance. Research shows that dental disease and medical health problems are interrelated. Periodontal disease is linked to diabetes, cardiovascular disease, Alzheimer's, hypertension, respiratory disease, HIV, and even pre-term low birth weight babies. Following the recommendation of the American Academy of Pediatrics and the American Dental Association, patients who are at increased risk of developing dental caries should be directed to establish a dental home by age 1. However, since many dentists do not feel comfortable treating the little ones (ages 1-3) and many dentists do not participate in Medicaid, the number of dentists willing to see very young children is quite low. Given these barriers it becomes even more critical for physicians to be screening and applying fluoride varnish to these little ones, who will see them up to 11 times for well child check-ups before they will see their dentist.

> **American Academy of Pediatrics, Policy Statement**
>
> "To prevent caries in children, high-risk individuals must be identified at an early age (preferably high-risk mothers during prenatal care), and aggressive strategies should be adopted, including anticipatory guidance, behavior modifications (oral hygiene and feeding practices), and establishment of a dental home by 1 year of age for children deemed at risk."
>
> *For the full article please click **here**.*

TRACK 1 - Tools and Resources

Health Center Operations

- Implementation Readiness Questionnaire
- Health Center Leadership In-service
- Cost Analysis for Fluoride Varnish
- ECOH Measures

Implementation Readiness Questionnaire

This questionnaire should be used as a preparation tool to determine if the health center is ready to implement this program. Use each question as a conversation starter to be sure your health center's culture is one of preventative measures. These are the questions that we found critical when introducing the program to new participants but can be altered to best suit your needs. This can be conducted during a staff meeting by show of hands and will most definitely lend itself to a rich discussion. It is essential to involve all members of the health center team because a truly integrated program will need support from leadership, front line staff, providers, operational staff, and clinical support staff.

Please click the following links to be directed to the Implementation Readiness Questionnaire and the accompanying Introductory Letter.

Sample questions from the Questionnaire include:

Does the HC environment embrace learning and continuous improvement?

Are members of your dental community willing to accept referrals?

Does the HC have a culture that values oral health and sees it as an integral part of holistic health?

Do you think the ECOH program will be perceived as another thing to do that can be eliminated if the HC gets busy or is short-staffed?

Health Center Leadership In-service

OACHC developed an in-service training with health center leadership in mind. This presentation is intended to be a quick, fifteen to twenty minute introduction to the ECOH Initiative and should be presented to the decision makers of the organization; the CEO, CFO, CMO and CDO. Without their leadership and buy-in it becomes difficult for the program to succeed. The presentation outlines the hot topics that health center leadership will want to know prior to implementation including the overall concept of the ECOH Initiative, the time involved for the procedure, cost, and any associated training that is necessary.

Please click Health Center Leadership In-service to be directed to the presentation.

Cost Analysis

The cost-benefit of adding this preventive procedure during a pediatric visit for an at-risk child is priceless. However, OACHC prepared a basic cost analysis to show how very little expense is involved in the program. The analysis for fluoride varnish was calculated based on prices from a 2012 dental supply catalog, and although prices vary slightly from suppliers this is an average cost a health center may expect to incur.

Please click Fluoride Varnish Cost Analysis to be directed to the document and for a comprehensive list of dental suppliers that carry fluoride varnish, please click the Fluoride Varnish Supply List.

Safety Net Solutions Financial Model

The DentaQuest Institute's Safety Net Solutions (SNS) program was funded by the HealthPath Foundation of Ohio to review the ECOH business plan, develop a financial model showing the cost/benefit of implementation for health centers with either onsite or offsite dental services and demonstrate various models of success. OACHC is pleased to be able to provide this invaluable expertise as part of the ECOH Implementation Guide.

Safety Net Solutions' Financial Model for Implementation for Health Centers

The comprehensive health care system supports dental collaborations/integration that treats the patient at the point of care where the patient is most comfortable and applies a patient-centered approach to treatment. We know that dental disease and medical health problems are interrelated. Periodontal disease is linked to Diabetes, Cardiovascular Disease, Alzheimer's, Hypertension, Respiratory disease, HIV, Pre-Term Low Birth Weight Babies. When Oral Health Prevention and Early Intervention become part of routine primary care there are many advantages for both Medical and Dental. Some of those advantages are: better communication, more efficient coordination of policies and referral process, sharing of information, collaborative care, and single point of contact, patient centered care, comprehensive and coordinated care.

There is a shortage of Dentists; especially dentists that will treat children under the age of three and are on Medicaid. The Primary Care Workforce can make a difference! It just makes sense to use these providers to screen and oversee the patient's oral health needs until they find a Dental Home.

Primary Care Workforce (Nationally)

- 70,000 — 17%
- 105,000 — 26%
- 36,000 — 9%
- 45,000 — 11%
- 150,000 — 37%

Legend:
- Family Medicine
- Nurse Practitioners
- Pediatrics
- Physician Assistants
- General Internists
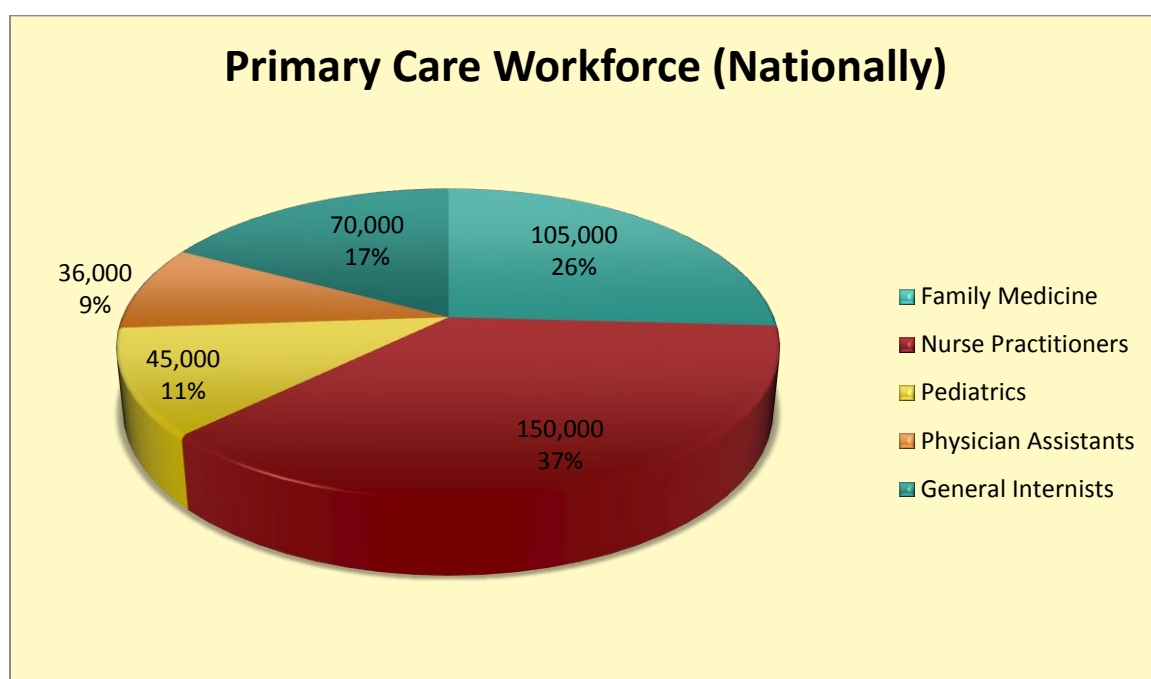
Financial Modeling:

Suggested Starting Phase - Create a sound financial base upon which to expand the integrated model.

- Populations of Focus:
- Children 0-5
- All Children
- Pregnant Women
- Medically compromised patients with high risk for dental problems:
- Diabetics
- Cardiovascular patients
- Patients with HIV
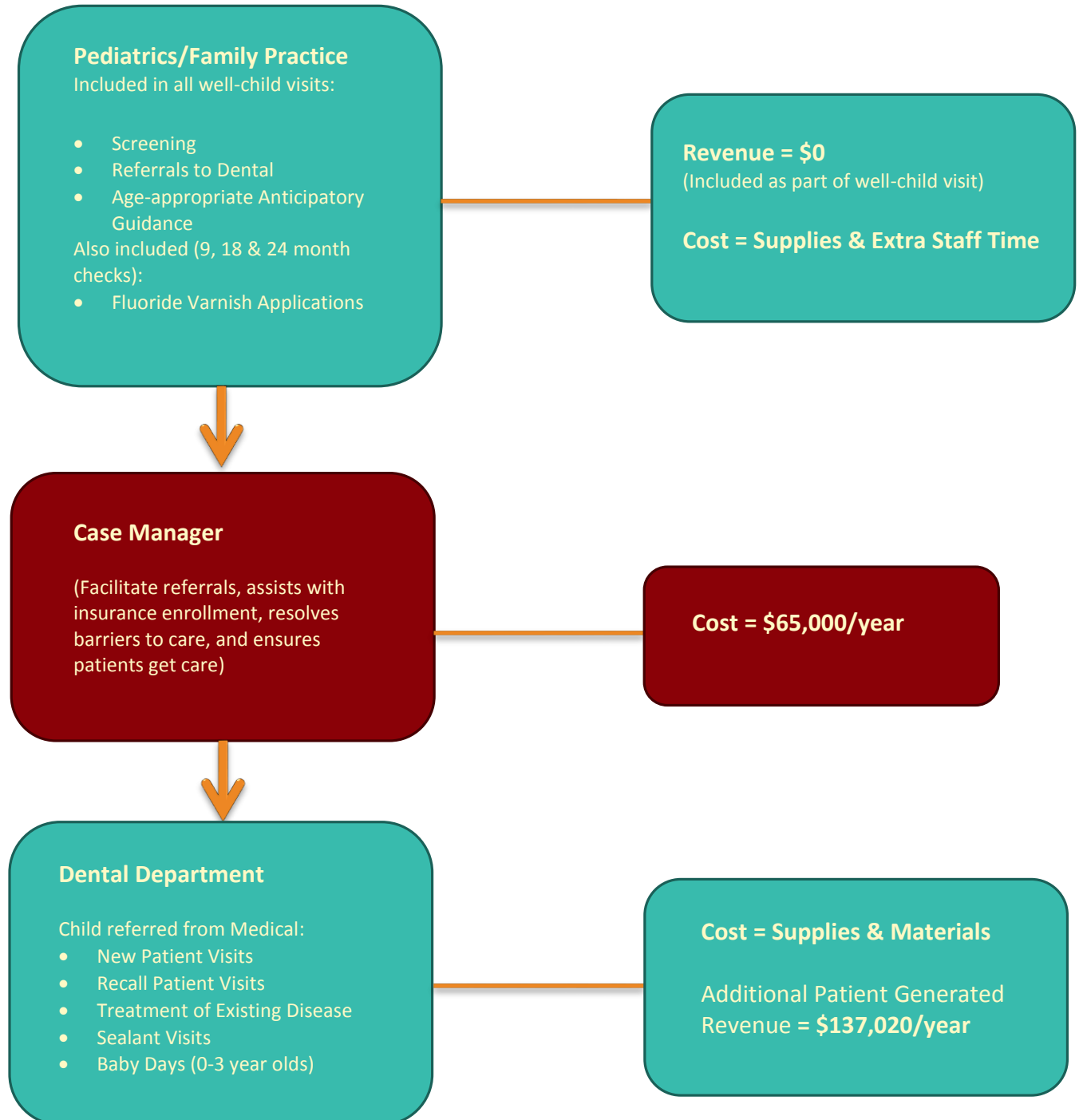
More Fully Integrated Model Feature:

- Patient experiences oral health as a key component of a routine primary care visit
- Primary care team incorporates oral health into disease management processes of delivery system; entire patient population is the target
- Primary care team treats ordinary oral health conditions in their practice, consult with dentist if patient does not improve, refers patients with treatment needs to dentists; retains responsibility for routine care
- For those at risk, primary care team delivers brief, focused interventions
- Primary care team has comfort level with oral health

Sustainability of the ECOH initiative will not come from the application of preventive oral health practices within the primary care setting as Medicaid will not reimburse for these services as a separate visit apart from the well-child visit. **Sustainability will be achieved by the increase in dental revenue that will result from referrals of children of all ages from pediatrics and family practice to the dental clinic.** To facilitate medical referrals to dental, ensure that children get the care they need and maximize dental revenue, health centers participating in the ECOH program are strongly encouraged to include a case management component.

An effective and accountable case manager will be able to cover his or her salary several times over through the additional dental revenue that will result from his or her efforts.

Case Managers:

- Facilitating referrals
- Help parents enroll in publicly available insurance programs
- Assist in removing barriers to care

- Referral follow- up
- Track and report the results of the initiative

Pediatrics/Family Practice
Included in all well-child visits:

- Screening
- Referrals to Dental
- Age-appropriate Anticipatory Guidance

Also included (9, 18 & 24 month checks):

- Fluoride Varnish Applications

Revenue = $0
(Included as part of well-child visit)

Cost = Supplies & Extra Staff Time

Case Manager

(Facilitate referrals, assists with insurance enrollment, resolves barriers to care, and ensures patients get care)

Cost = $65,000/year

Dental Department

Child referred from Medical:
- New Patient Visits
- Recall Patient Visits
- Treatment of Existing Disease
- Sealant Visits
- Baby Days (0-3 year olds)

Cost = Supplies & Materials

Additional Patient Generated Revenue **= $137,020/year**

Vision:

- Improvement in payer mix through referral of more children of all ages to dental (50% Medicaid to 62% Medicaid)
- Increased revenue for dental as a result of change in payer mix (+$137,020)
- Dental invests $65,000 in case manager/coordinator (salary plus fringe)—critical to program success
- Dental reimburses medical $18,842 to reimburse medical for supplies and staff time to do screenings, referrals, AG and FL varnish
- "Baby Days" in dental one day per week generates 736 additional visits to dental for children <age 3
- Investment generates nearly $53,000 in additional revenue for dental AFTER all costs

ECOH Program Assumptions	
Program w/o ECOH Integration	**Program with ECOH Integration**
Clinic operates 46 weeks/year	Clinic operates 46 weeks/year
4 operatories	4 operatories
Total visits: 5,313	Total visits: 6,049
Hours: M-F 8-5	Hours: M-F 8-5
Staffing: 1 FTE dentist/clinical director 2 FTE dental assistant 1 FTE hygienist 2 FTE reception/registration clerks	Staffing: 1 FTE dentist/clinical director 2 FTE dental assistant 1 FTE hygienist 2 FTE reception/registration clerks 1 FTE case manager
	ECOH program adds 736 additional visits to the dental program (ages 0-3)

ECOH Financial Model:

Dental Program Without ECOH & Integration			Dental Program With ECOH & Integration		
REVENUE	Year 1	5,313 visits	REVENUE	Year 1	6,049 visits*
Self-Pay (35%)	$74,400	$40/visit	Self-Pay (23%)	$55,640	$40/visit
Medicaid (50%)	$345,410	$130/visit	Medicaid (62%)	$487,500	$130/visit
Commercial Insurance (10%)	$98,235	$185/visit	Commercial Insurance (10%)	$111,925	$185/visit
Free care patients (5%)	$0	$0	Free care patients (5%)	$0	$0
Total Patient Net Revenue	$518,045		Total Patient Net Revenue	$655,065	
Grant Revenue			Grant Revenue		
330 Allocation	$250,000		330 Allocation	$250,000	
Total Revenue	$768,045		Total Revenue	$905,065	
Direct Expenses			Direct Expenses		
Personnel Related			*Personnel Related*		
Salaries	$322,400		Salaries	$374,400	
Fringe Benefits (25%)	$80,600		Fringe Benefits (25%)	$93,600	
Malpractice Insurance	$0		Malpractice Insurance	$0	
Subtotal Personnel Costs	$403,000		Subtotal Personnel Costs	$468,000	
Support costs			*Support costs*		
Dental Supplies	$42,504	$8/visit	Dental Supplies	$42,504	$8/visit
Dental Lab Services	$20,000	130 patients @ $150/patient	Dental Lab Services	$11,250	75 patients $150/patient
Equipment Repair/Maintenance	$9,500		Equipment Repair/Maintenance	$9,500	
Housekeeping	$6,000		Housekeeping	$6,000	
Conference/Travel	$2,000		Conference/Travel	$2,000	
Office Supplies	$3,000		Office Supplies	$3,000	
Computer Maintenance, License Fees	$12,000		Computer Maintenance, License Fees	$12,000	
Books & Subscriptions	$1,000		Books & Subscriptions	$1,000	
Fees & Dues	$3,500		Fees & Dues	$3,500	
Recruitment Expenses	$3,000		Recruitment Expenses	$3,000	
Insurance	$10,000		Insurance	$10,000	
Printing	$2,000		Printing	$2,000	
Postage	$2,000		Postage	$2,000	
Depreciation	$30,000		Depreciation	$30,000	
Bad Debt	$11,500		Bad Debt	$11,500	
Total Support Costs	$158,004		Total Support Costs	$149,254	
Building-Related Costs			*Building-Related Costs*		
Maintenance	$6,000		Maintenance	$6,000	
Rent/Mortgage	$30,000		Rent/Mortgage	$30,000	
Utilities	$10,000		Utilities	$10,000	
Telephone/Internet	$5,000		Telephone/Internet	$5,000	
Total Building Costs	$51,000		Total Building Costs	$51,000	
Total Direct Expenses	$612,004		*ECOH Program Costs*		
Indirect Expenses			FL Varnish	$1,367	$1.32/visit
Total Support & Admin Allocation (12% of direct expenses)	$73,440		Medical Materials Costs (Anticipatory Guidance)	$4,500	$3/visit
			Medical Staff allocation to reimburse for time spent in screening, FV application and AG	$12,975	
TOTAL EXPENSES	$685,444		Total ECOH Program Costs	$18,842	
TOTAL REVENUE	$768,045		Total Direct Expenses	$687,096	
PROFIT	$82,601		Indirect Expenses		
			Total Support & Admin Allocation (12% of direct expenses)	$82,452	
			TOTAL EXPENSES	$769,548	
			TOTAL REVENUE	$905,065	
			PROFIT	$135,517	
					736 additional visits for "Baby Days"

The above financial model uses the assumptions developed by SNS on the previous page to show the value of oral health integration. OACHC is happy to provide you with a blank template to prepare your own, health center specific, ECOH Financial Model.

To be directed to the tool, please click ECOH Financial Model Template.

ECOH Initiative Measures

As with any new initiative, it is important to track where you started and where you want to go. Procedures should be established for the collection of data to assist in the processing, analysis, and review of the data to provide timely feedback of the success of the program and areas of potential improvement. These measures were established to meet the criteria of the ECOH grant requirements but can also serve as a starting point for your implementation of the program.

Dental Home

According to the American Academy of Pediatric Dentistry, a dental home is defined as "an ongoing, comprehensive relationship between a Dentist and the patient, delivered in a continuously accessible, coordinated, and family-centered way; a dental home includes referrals to dental specialists when appropriate."

Early Childhood Oral Health (ECOH) Initiative Measures

MEASURES				
Measure	**Definition**	**Data Gathering Plan**	**Goal**	**Indicators/Behaviors**
1. **Patients ages 9 to 36 months with documented oral health screening**	At least 70% of patients ages 9 to 36 months will have a documented oral health screening at well child visit	On the last workday of each month, search the clinical information system for all well-child patients 9-36 months to calculate number of patients with documented oral health screening	>70%	(Identified through visual screening by medical/dental staff)
2. **Patients ages 9 to 36 months with documented indication for dental care referred to a dentist**	At least 70% of patients ages 9 to 36 months with documented indication for dental care will have a documented referral from PCP to a dentist	On the last workday of each month, search the clinical information system for all well-child patients 9-36 months to calculate number of dental referrals made by PCP	>70%	(Indicators: moderate to high risk for Early Childhood Caries (ECC) and/or PCP determination that dental referral is medically necessary
3. **Patients ages 9 to 36 months referred for dental care and seen by a dentist**	At least 50% of patients ages 9 to 36 months with dental referral from PCP will be seen by a dentist	On the last workday of each month, search the clinical information system for all well-child patients 9-36 months to calculate number seen by a dentist	>50%	
4. **Patients ages 9 to 36 months with a documented fluoride varnish application**	At least 70% of patients ages 9 to 36 months with a documented fluoride varnish application	On the last workday of each month, search the clinical information system for all well-child patients ages 9-36 months	>70%	
5. **Parents/caregivers of children ages 9 to 36 months with documented oral health education**	At least 70% of parents/caregivers of children ages 9-36 months will receive age appropriate dental health education/guidance	On the last workday of each month, search the clinical information system for all eligible parents/caregivers with children ages 9-36 months who received oral health education	>70%	

Health Center Clinical

- Building the ECOH Team
- Referral Process

Building the ECOH Team

According to Robert N. Lussier, PhD and Christoper F. Achua, D.B.A. in their book "Leadership" a team is defined as a unit of interdependent individuals with complementary skills who are committed to a common purpose and set of performance goals and to common expectations, for which they hold themselves accountable. Lussier and Achua continue to explain that in order to have an effective team you must have 3 components:

1) **Task Performance** - The degree to which a team's output (product or service) meets the needs and expectations of those who use it.
2) **Group Process** - The degree to which members interact to relate in ways that allow the team to work increasingly well together over time
3) **Individual Satisfaction** - The degree to which the group experience, on balance, is more satisfying than frustrating to team members

The common goal to ensure access to high-quality, affordable health care for all patients regardless of a person's insurance status or ability to pay, binds the members together to form a team. When interviewing a potential health center staff member it is important to ask about their feelings toward oral health. **Every health center employee must value the importance of good oral health**, not only for the patients but also for themselves. It is important to address any dental phobias the staff may have and how their attitudes, fears, and misconceptions may be transferred, even inadvertently, to patients and their families.

When building your own ECOH team think about the people in your organization that are motivated to take on new projects and can spark some initiative in others. The team composition will be interdisciplinary and include members willing to try new ways of delivering care within and across the system. If you have on-site dental at your health center a productive working relationship between medical and dental will also be critical for success. Is there someone on staff that has a special interest in oral health care? Is there someone that enjoys pediatrics? Is there someone that is practiced at quality improvement

"I am a member of a team, and I rely on the team, I defer to it and sacrifice for it, because the team, not the individual, is the ultimate champion"

Mia Hamm,
US Soccer Player

and/or program implementation? The answers to these questions should lead you to the team members that can successfully lead the team. The ECOH team should consist of the following members:

Senior Leader
Senior leadership includes the Executive Director, Dental Director, Medical Director, Chief Operating Officer, etc. and without leadership buy-in and guidance no program can be fully integrated into the health center. The senior leader has the accountability for the outcome of the initiative and should ensure the team can meet their goals, support changes and remove obstacles.

Program Champion
This could be a Physician, Physician's Assistant (PA), Nurse Practitioner (NP), Registered Nurse (RN) or Quality Improvement Manager of the Health Center; someone who would take on the responsibility of ensuring that EVERY child has an oral examination and is provided a fluoride varnish application (if eligible) along with anticipatory guidance to the caregiver. This person should have a good rapport with other staff members and be capable of driving change.

Program Coordinator
A staff member should be designated as the coordinator for the program. This person should be responsible for working with other staff in developing and implementing the plan for integrating the program into the clinic, making parents/caregivers aware of the program, addressing both patient and staff questions and concerns, and addressing operational issues that arise. Most importantly, the program coordinator should monitor the implementation of all aspects of the program to establish quality control/improvement practices and create appropriate policies and procedures to ensure that the program becomes standard operating procedure (determine who does what during the patient visit). This person is the key contact for all other staff and be able to keep others on task.

Clinical Staff
All other health center employees, including the front desk to the medical and dental staff, should value and understand the importance of good oral health.

Referral Process

The referral section is divided into two areas for health centers; with dental or without dental on site. For health centers with on-site dental that have adopted the concept of "Patient Centered Medical Home" and/or an integrated delivery system this should be old news. All health centers should strive to provide primary care in an environment that is fully integrated, providing comprehensive medical, dental and behavioral health care that is focused on prevention and early intervention. True integration between medical and dental is the consideration of clinical issues beyond the traditional "silos" and the ability to work as part of a team. For example, the dental staff can be providing HIV and diabetes screenings just as the medical staff conducts Early Childhood Caries (ECC) screenings and the application of fluoride varnish. By having each department conduct these types of screenings it builds in an automatic referral to the other department, thereby increasing productivity and reimbursement.

In children at increased risk of poor oral health, early intervention and prompt referral to a dentist is more cost effective and can improve a child's quality of life.

There are several different types of referrals that can be employed by the health center staff, including:

- Written referral from the primary care provider, usually for services at a future date (the most common way);
- Verbal or "warm hand-off" from the primary care provider;
- Phone triage by a primary care provider or nurse.

What is a "warm hand-off"?

A warm hand-off is when the primary care provider physically introduces the patient to the dental provider at the time of the medical visit. This type of referral aims to ensure that the patient is seen that day for an acute clinical condition. Subsequently, the dental team needs to ensure the patient is promptly brought into the operatory to wait for further examination. If the patient is made to wait in the general waiting area there is potential for flight.

It is particularly difficult, but essential to have an effective referral system in place if the health center does not have a dental clinic as part of the health care team. Because oral health problems may be identified that are beyond the practitioner's scope of practice, an effective referral system must be established in order to refer patients to the dental community. The implementation of the ECOH program in the health center can be used as a tool to strengthen

support from the local dental community and encourage dental providers to accept referrals of (a) young children; (b) children on Medicaid, or; (c) uninsured children. It is useful for the health center to generate a list of dentists willing to accept these referrals. Additionally, procedures must be established to correctly identify when a referral may be necessary, assist the parents/caregivers in obtaining a referral appointment, communicate the necessary information to the referral dentist, and follow-up with the dentist and/or parents/caregivers to ensure that the child was seen by the dentist and determine the nature of any follow-up care. It is critical that appropriate staff educate parents/caregivers regarding the importance of the referral to ensure compliance and serve as a liaison if problems arise with the referring dental provider.

Over the course of the ECOH program, OACHC developed a referral list of area Children's Hospitals with dental clinics that would see children in need. In many instances these hospitals are able to provide sedation and/or general anesthesia if a dental surgery is necessary. Please use this referral list as a resource and/or template for the development of your own community-based form.

Please click the [Referral List](#) to be directed to the document.

An additional resource to locate dentists serving low-income Ohioans is the Ohio Safety Net Dental Clinics website at www.ohiodentalclinics.com.

TRACK 2
Preparation for Start-up

Health Center Operations

Health Center Clinical

Preparation for Start-up
- *0-4 weeks prior*

TRACK 2: Preparation for Start-up

In this section we get down to some of the details. Here is where we start preparing the forms, ordering the supplies, and having everything in place, ready to begin. It is hard to know exactly what needs to be done, unless you have done it before, so allow us to "conduct" you through the process and keep you on the "right track"!

Health Center Operations

It has been said that the only constant in this world is change. System-wide change is never easy. Adoption of a fluoride varnish program is a new standard of care. Implementing a fluoride varnish program into a health center is literally adding a new procedure for the medical provider. This is NOT something they have been trained to do. It is imperative to communicate this change to the entire organization.

John Kotter, a Harvard Business School professor, developed a well-known and widely adopted approach for managing organizational change. This approach, explained in Kotter's book, *Leading Change and The Heart of Change*, involves the following eight stages:

1. **Establishing a sense of urgency**
   Successful transformation efforts usually begin when leaders examine the market for changes that may lead to new competitive realities for the organization. These changes can stem from demographic shifts, social trends, new technology, market or competitor changes, or new government regulations. The leaders should explain that a potential crisis or major opportunity is imminent, and they should encourage frank discussion throughout the organization. Creating a sense of urgency that the status quo is no longer acceptable is essential to gain the workforce's energetic cooperation.

2. **Creating the guiding coalition**
   Once employees feel a sense of urgency, leaders should establish a group with enough power to lead the change. Members need substantial authority based on position, expertise, credibility and leadership, as well as effective management skills and proven leadership abilities. This coalition must learn to work together based on trust and set a common goal. Many guiding coalitions build trust through off-site meetings, joint activities and conversation.

3. **Developing a vision and strategy**
   The guiding coalition should craft a clear vision for the future, motivate people to take appropriate actions and coordinate workers' actions. An effective vision is imaginable, desirable, feasible, focused, flexible and communicable, according to Kotter. Creating an effective vision takes time and can be a challenging process, but the end product provides a clear direction for the future.

4. **Communicating the change vision**
   Once the guiding coalition has developed the vision, its members should provide extensive communications about how the change will improve the business and how those improvements will benefit employees. Key elements in effective communications include simplicity, use of examples, multiple forums, repetition, explanation of apparent inconsistencies and two-way communication. The group should model the behavior expected of employees.

5. **Empowering employees for broad-based action**
   To empower workers to support change and act on the vision, change leaders should identify and remove obstacles. Four categories of important obstacles are:
   a. Formal structures that make it difficult for employees to act.
   b. A lack of needed skills.
   c. Personnel or information systems.
   d. Supervisors who discourage actions toward implementing the new vision.

6. **Generating short-term wins**
   Successful and enduring change takes time, which can be discouraging to employees at all levels of the organization. To maintain urgency, leaders should create conditions that support early successes and visible improvements. The key is to actively search for opportunities to score early achievements and to recognize and reward those who made these accomplishments possible. Good short-term wins have unambiguous results, are visible to many people and are clearly related to the change effort.

7. **Consolidating gains and producing more change**
   Until major changes are embedded in an organization's culture (which could take up to a decade), they remain vulnerable to resistance and regression. It is important to use the early successes as a foundation for larger challenges, and change all systems, structures and policies that do not fit the change vision. HR can consolidate gains by hiring, promoting and developing employees who can implement the transformation vision. Additionally, the change process can be reinvigorated with new project themes and change agents.

8. **Anchoring new approaches to the culture**
   The final stage in Kotter's model for successful change is linking the changes to two key components of corporate culture—norms of group behavior and shared values. Methods for anchoring changes to the organizational culture include:

a. Creating better performance through customer- and productivity-oriented behavior, more and better leadership, and more effective management.
b. Articulating the connections between new behaviors and organizational success.
c. Developing means to ensure leadership development and succession.

Health Center Clinical

The clinical team will need to meet and work out the details of how this initiative will become part of the existing patient care process. Decisions must be made as to who will be screening the patient, applying the varnish, and educating the caregiver. Because these are new activities being added into an already busy practice, they must be efficiently and effectively integrated into the clinical setting with policies and procedures in place to support the work.

Clinical staff must be appropriately trained to provide the necessary anticipatory guidance to parents and caregivers regarding good oral health behaviors, conduct the oral health screening on the child with correct identification and documentation of oral health problems, correctly apply the fluoride varnish to the child's teeth, address any parent or caregiver questions or concerns, and lastly make appropriate dental referral decisions. In addition, staff should receive training on how to handle situations when the child is uncooperative or crying. Training should include both observation and practice, and should be peer-led if possible (e.g. dentist or physician training physicians). The trainer should be available for follow-up questions and technical assistance (via phone or site visit) especially in the early stages of implementation. Follow-up training sessions are important for new staff members and can be an effective way of re-energizing or engaging lagging providers.

"Parents are grateful for the fluoride varnish program and the opportunity to prevent Early Childhood Caries. It is easy and quick to apply at the end of the physical exam. Fluoride varnish application is definitely within the scope of practice for doctors and advanced practice nurses and is a preventive service like immunizations."

Dr. James Duffee
Rocking Horse Center
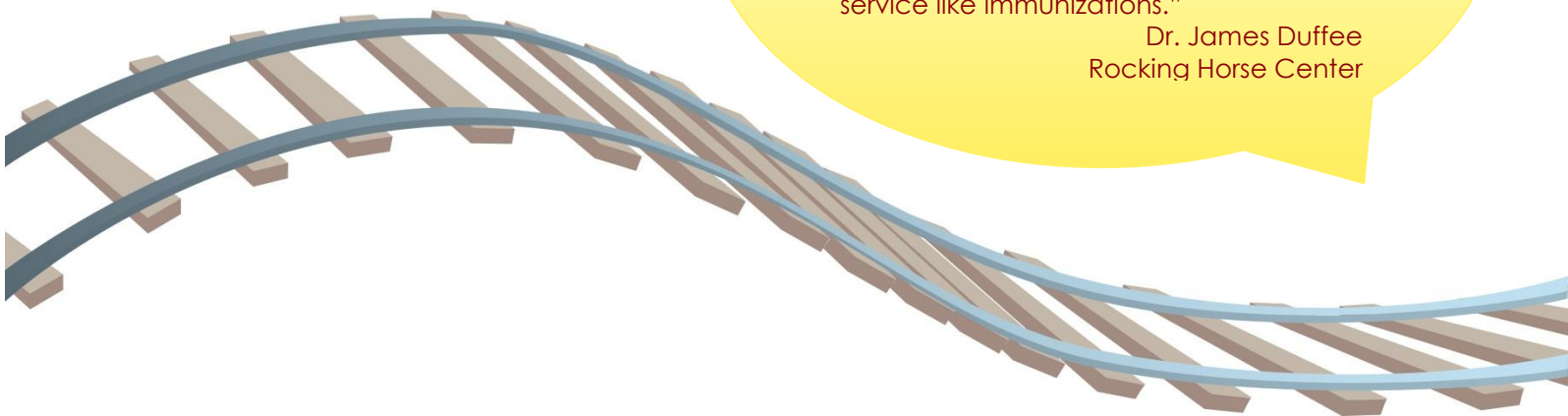
TRACK 2 - Tools and Resources

Health Center Operations

- Identify Your "Roll-out" Plan
- How Does the Electronic Health Record Fit In?
- Prepare Job Descriptions
- Develop Relevant Policies and Procedures
- Determine Documentation and Coding

The "Roll-out" Plan

Each health center should determine how they will initiate the change. There a few different approaches that we have found to be successful; termed horizontal and vertical/soft rollouts. A "horizontal" roll-out is defined as a single process being used by the entire health center at once (this can also be true for all providers in a health center). A "vertical or soft" roll-out is when a single site (or provider) tests the functionality of the plan before the entire organization begins implementation. The unanticipated or unresolved questions are dealt with and the initiative can be rolled-out to the other sites as scheduled. Keep in mind that roll-out does not need to be an all or nothing process. The program can start with one doctor/site beginning the program and go from there.

During the roll-out phase, it can be helpful to think about using the framework of **The Model for Improvement** which has been tested and used in many collaboratives. The improvement model provides a process to improve the quality of care at an accelerated pace. Using the PDSA or Plan, Do, Study, Act cycle to evaluate and correct any problems that may occur during implementation.

The Model for Improvement, developed by the Associates in Process Improvement, is a trial-and-learning tool (learn by testing) to help test the effectiveness of a current system or procedure. This model, along with The Chronic Care Model, provides a process to improve the quality of care at an accelerated pace and is a tool that can be used by staff throughout the
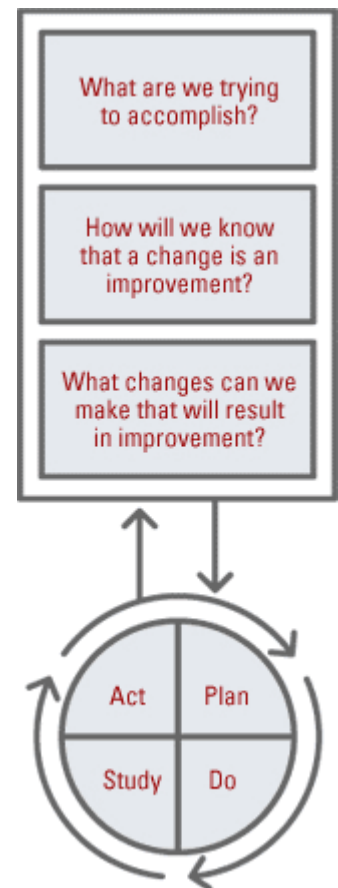
implementation process. The Model is based on three fundamental questions: 1) What are we trying to accomplish?; 2) How will we know that a change is an improvement?; and, 3) What changes can we make that will result in an improvement? The emphasis on study is the key to learning and establishes knowledge base, which will enable you to set your baseline in order to measure change. The PDSA is a quick improvement tool and can be performed by all members of team. There is also a PDSA worksheet that can assist teams as they begin the process of improvement.

Please click PDSA Worksheet to be directed to that document.

Please click PDSA Dental Navigation to see an example of how to assess the transition of a pediatric patient from medical to dental.

Electronic Health Record

Health centers need a system for recording clinical findings during the oral health examination. Depending on if your health center is meaningfully using an Electronic Health Record (EHR) there are a variety of tools that can be used for either an electronic system or a paper system. OACHC has compiled a few resources that can be used in either scenario as well as some examples from health centers that participated in the ECOH initiative. The American Academy of Pediatrics (AAP), Oral Health Risk Assessment Tool was developed to aid in the implementation of oral health risk during the well-child examinations. AAP also created a companion document to assist with the process, the Oral Health Risk Assessment Tool Guidance.

Both documents are available on line at http://www2.aap.org/oral health/RiskAssessmentTool.html or by accessing the following links: Oral Health Risk Assessment Tool and Oral Health Risk Assessment Tool Guidance.

AAP Section on Oral Health most recently developed a template for documentation of risk factors, protective factors, and clinical findings within the EHR to coincide with the use of the Oral Health Risk Assessment Tool.

Please click EHR Template-Key Elements to Incorporate Oral Health in the Pediatric Electronic Health Record to access the template click the following link http://www2.aap.org/oralhealth/RiskAssessmentTool.

As your health center is exploring ways to determine how to best document the oral health assessment please consider discussing options with your EHR vendor that will be easiest

to pull reports if you so choose (we recommend to do so for your required oral health measure for UDS). A participating ECOH Initiative health center provided screen shots from their EHR to aid in the development of electronic templates.

Please click EHR Screen Shots to the series of examples.

Job Descriptions

Job duties for Physicians, mid-levels, and other clinical support staff as it relates to oral health and the application of fluoride varnish must be included in the written job descriptions and even discussed during the interview process of potential employees. During the interview process try to screen potential team members for what we call the "unteachables". Now you are probably thinking, what exactly is an "unteachable"? The oral health assessment, caregiver education and application of the fluoride varnish are all things that can be taught. However, to

Non-dental health care clinicians may be the first or only clinicians to evaluate the oral health of some children.

see the unteachables you must look for the employee's disposition towards children and oral health in general.   Every health center employee should value the importance good oral health, not only for their patients, but also for themselves. It is important to identify any dental phobias that employees might have and how their attitude, fears and misconceptions may be transferred to patients and their families. The employee must believe that teeth and gums are just as important as every other body part and ensure that patients receive good oral health care. It also communicates to the caregivers that good oral health is a vital part to one's overall health. Staff performance regarding this initiative should also be included as part of their annual evaluation demonstrating the health centers commitment to oral health for children.

Please click the following link for examples, Medical Assistant job description and Nurse job description.

Policies and Procedures

According to Merriam-Webster a standard operating procedure (SOP) is defined as "established or prescribed methods to be followed routinely for the performance of designated operations or in designated situations." It is very important to have an SOP or policy in the health center's Procedure Manual detailing the process for the fluoride varnish application to be included during the well-child exam. By developing a policy and procedure regarding early childhood oral health it sets the expectation for all staff that it is something they are required to do and ties in with the center's value and promotion of good oral health. Often times newly implemented programs are the first to be sidelined when staff get busy and by having a SOP and policy in place the option to sideline the program would be eliminated.

Please click the following links for examples, [FV in Medical-Policy and Procedure](#) and [Fluoride Varnish Standing Medical Order](#) sample.

Documentation and Coding

Perhaps the most widely used scientific research method is quantitative research. Recording data is very important in order to notice changes or patterns in variables over a period of time. It is important to keep accurate records to compare and/or defend your procedure. Health Centers are required to track an undefined oral health measure for the annual UDS Report; this includes health centers with and without dental. The easiest and least expensive way for health centers that do NOT have dental is to measure fluoride varnish applications during the well-child exam. As a requirement of the ECOH Initiative, participating health centers had report data on five different measures. In the state of Ohio the Medicaid program reimburses for the application of fluoride varnish with documentation of the dental CDT D1208 code (three total components include oral assessment, varnish application and referral). For ECOH, the health centers used the CDT code for the actual application of the fluoride varnish and used "dummy codes" for the other four. By using a uniform method for documentation it enables the centers to pull data from the EHR or practice management systems most effectively.

- **D1208S** - Patients ages 9 to 36 months with documented oral health screening
- **D1208R** - Patients ages 9 to 36 months with documented indication for dental care referred to a dentist
- **D1208V** - Patients ages 9 to 36 months referred for dental care and seen by a dentist

- **D1208** - Patients ages 9 to 36 months with a documented fluoride varnish application
- **D1208E** - Parents/caregivers of children ages 9 to 36 months with documented oral health education

Ohio Medicaid Guidelines on FV Reimbursement

Reimbursed Provider	Services	Reimbursement Amount	Procedure Code	Delegation Allowed
MD, NP, PA	Fluoride Varnish	$15.00	CDT D1208	Y (RN, LPN)
	Oral Exam			
	Oral Health Risk Assessment			

Training Required (Y/N)	Number of Varnishes Allowed	Payors (Fee for Service MCOs, etc)	State Oral Health/Fluoride Varnish Program	
N	Once every 180 days under 3 years of age	Fee for Service and Managed Care	*Smiles for Ohio*	

Ohio Medicaid coverage of fluoride varnish by non-dental providers

The purpose of **Medical Assistance Letter MAL No. 503** is to inform providers of physician services of the coverage and limitation of OAC rule 5101:3-4-33 Coverage of fluoride varnish by non-dental providers.

This new physician services rule, effective July 1, 2006, authorizes Medicaid program coverage and separate reimbursement for eligible providers of physician services to perform fluoride treatment, within their scope of practice, through the application of fluoride varnish during the course of a well or sick child examination for children to age three when medically appropriate. Coverage of fluoride treatments by physician providers is limited to one application every one hundred eighty days.

Fluoride varnish can arrest demineralization and remineralize teeth damaged by the decay process. The application of fluoride varnish has three components each of which must be performed: oral assessment, varnish application and referral.

In addition to the oral assessment and varnish application, parents or guardians must be provided with information about the fluoride varnish procedure and proper oral health care for their child. If the child has obvious oral health problems and does not have a dental provider, he/she must be referred to a dentist or the county department of job and family services.

In order to be reimbursed for the professional services associated with the application of fluoride varnish, clinics should follow their standard billing procedures. Cost-based clinics (e.g. Federally Qualified Health Centers, Outpatient Health Facilities, Rural Health Clinics) must submit code T1015 with the appropriate two digit modifier in addition to CDT code D1203 (topical application of fluoride (prophylaxis not included) - child).

Cost-based clinics cannot bill the application of fluoride varnish as a separate encounter. Cost-based clinics that provide dental services must bill fluoride varnish as part of a dental encounter as they currently do. Cost-based clinics that do not provide dental services must bill fluoride varnish as part of a medical encounter. T1015 U1 (medical) cannot be billed twice on the same date of service related to the provision of fluoride varnish (once for the visit and a second for the application of fluoride varnish)

The appropriate modifiers for a medical or dental encounter are:
FQHC: U1 (medical encounter), U2 (dental encounter)
OHF: U1 (medical encounter), U2 (dental encounter)
RHF: U1

For dates of service on and after 01/01/2013 providers should bill CDT code D1208 "Topical application of fluoride" for the topical application of fluoride (including fluoride varnish). As of the publication of this Implementation Guide, there is no new Medical Assistance Letter (MAL) to reflect this change in coding.

Ohio Administrative Code, 5101:3-4-33 Coverage of fluoride varnish by non-dental providers.

(A) Physicians may be reimbursed for the professional services associated with the application of fluoride varnish for children from first tooth eruption to age three. This service is billable in addition to a well or sick child visit but should not be the sole reason for the visit.

(1) In order to be reimbursed for the professional services associated with the application of fluoride varnish, physicians must submit current dental terminology (CDT) code D1203 as contained in the HCPCS level II codes set as defined in 5101:3-1- 19.3 on a physician claim form.

(2) Coverage of fluoride varnish application by physicians is limited to one application every one hundred and eighty days.

(B) The application of fluoride varnish has three components each of which must be performed: oral assessment, varnish application and referral.

(1) The oral assessment is for the identification of obvious oral health problems and risk factors. When combined with an EPSDT visit, the oral assessment does not need to be repeated prior to fluoride varnish application.

(2) At the time of the fluoride varnish application, parents/guardians must be provided with information about the fluoride varnish procedure and proper oral health care for their child.

(3) If the child has obvious oral health problems and does not have a dental provider, the physician must provide referral to a dentist or the county department of job and family services

Health Center Clinical

- Training Guidelines
- Roles and Responsibilities

Training Guidelines

As you start to train your staff on ECOH it is imperative to provide consistent training methods and allow time for both self-paced learning and didactic sessions. Hosting lunch-and-learns is a great way to have a captive audience for an extended period of time and it also allows staff to interact and ask each other questions if necessary. Because programs like ECOH have seen such success there are several quality teaching tools available for clinicians to access. In order to keep staff skills fresh it is recommended that the Team Leader provide ongoing, intermittent training opportunities and conduct coaching sessions with annual assessments being done as part of annual evaluations.

A sample training curriculum could mirror the following steps:

- **Pre-test/Post-test**
  - Assess staff's current knowledge base and measure success
- **Self-paced Tutorial**
  - Begin with Ohio Department of Health's *Smiles for Ohio - Fluoride Varnish Training for Primary Medical Care Providers Serving Young Children Enrolled in Medicaid*
- **Group Instruction**
  - OACHC's Fluoride Varnish Training coupled with a hands-on demonstration
- **Coaching & Training**
  - Should be conducted by Team Leader prior to "go live" implementation date
  - Included as part of a new hire's orientation/skills demonstration
  - Annual staff assessments

ECOH Training Tools
(click on each item to be directed to the document or website)
Pre-test/Post-test
Smiles for Ohio - Fluoride Varnish Training for Primary Medical Care Providers Serving Young Children Enrolled in Medicaid
OACHC's Fluoride Varnish Training
Smiles for Life – A national oral health curriculum
Supplemental Training Materials
AAPD Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents
NASHP Engaging Primary Care Medical Providers in Children's Oral Health
Oral Health in America, A Report of the Surgeon General
JADA Professionally Applied Fluoride Varnish, Executive Summary of Evidence-Based Clinical Recommendations
AAP Dental Screening and Referral of Young Children by Pediatric Primary Care Providers
AAP Fluoride Varnish Use in Primary Care: What Do Providers Think?
AAP Association Between Parents' and Children's Use of Oral Health Services
A Healthy Mouth for Your Baby (English & Spanish) booklet – free ordering information National Oral Health Information Clearinghouse, 1 NOHIC Way, Bethesda, MD 20892, www.nidcr.nih.gov

Roles and Responsibilities

Determine Which Team Member Will Apply the Fluoride Varnish

One thing we all know is that every health center is different. Something else we all know is that every provider is different. In the ECOH Initiative there were some centers whose physicians preferred to do the screening, anticipatory guidance and the application of the varnish while other utilized SOPs and delegated to their clinical support teams. Other health centers had the physician do the screening while the LPN performed the anticipatory guidance and application of varnish. Whichever method works best for your team is how it should be done. One tip that is commonly practiced in almost all heath centers is to apply the fluoride varnish BEFORE the shots!

Identify Easily Accessible Locations for Supplies and Decide Who is Responsible for Managing Supplies

Determine within the health center where the fluoride varnish supplies will be housed. Some health centers may prefer to have a bin at the nurse's station which held individual sets (in sandwich baggies) that included the fluoride varnish kit, gauze, and gloves. They found this process to work well; the LPN would grab a baggie as she/he was heading into the exam room for a well-child exam. This may sound like an improbable feat, to have pre-made baggies; however, some health centers would use this as an opportunity for a community/volunteer project so it would not interfere with staff time. Another option would be to keep the supplies in every exam room in a cupboard. Either option works well once the team has decided their preference. The key to both is to ensure that the supplies are kept fresh and stocked for the day by the team member designated to manage supplies. This team member should also notify the team leader (if it is not the team leader's duty) as to when to re-order from suppliers.

How Will the Role of the Case Manager Work?

Earlier on the Implementation Guide we discussed the role of the referral specialist/case manager/patient navigator/care coordinator as pediatric patients transition from medical to dental during the warm hand off. The team needs to come to consensus as to how this process will work so both departments have a clear understanding and can be prepared when the appropriate team member presents with a dental referral. This should also be included in the health center's policies and procedures as well as included in the appropriate staff members' job description.

The Team Leader's Role in Data Collection and Quality Improvement

Although reporting is not a requirement of this initiative OACHC recommends collecting data on the ECOH Measures as a method to incorporate the initiative into the health center's quality improvement efforts. The health center's QI Committee should have representation from dental if applicable and have oral health as a standing agenda item so program and process improvements can be discussed and established.

ECOH Team from Family Health Care of Northwest Ohio standing in front of their ECOH banner in the patient waiting area. This is a great tool to raise patient/caregiver awareness of the new initiative.

Patient Care Kits

As part of the ECOH grant, OACHC was fortunate to have the ability to provide kits to patients who received a fluoride varnish application during their well-child exam. This was a huge success and received praise from both the clinical staff and the patients. The kits include 1 adult toothbrush, toothpaste and floss, 1 child toothbrush, toothpaste and floss, and 2 stickers.

TRACK 3
Implementation

Health Center Operations

Health Center Clinical

Implementation

- *Days 1-60*
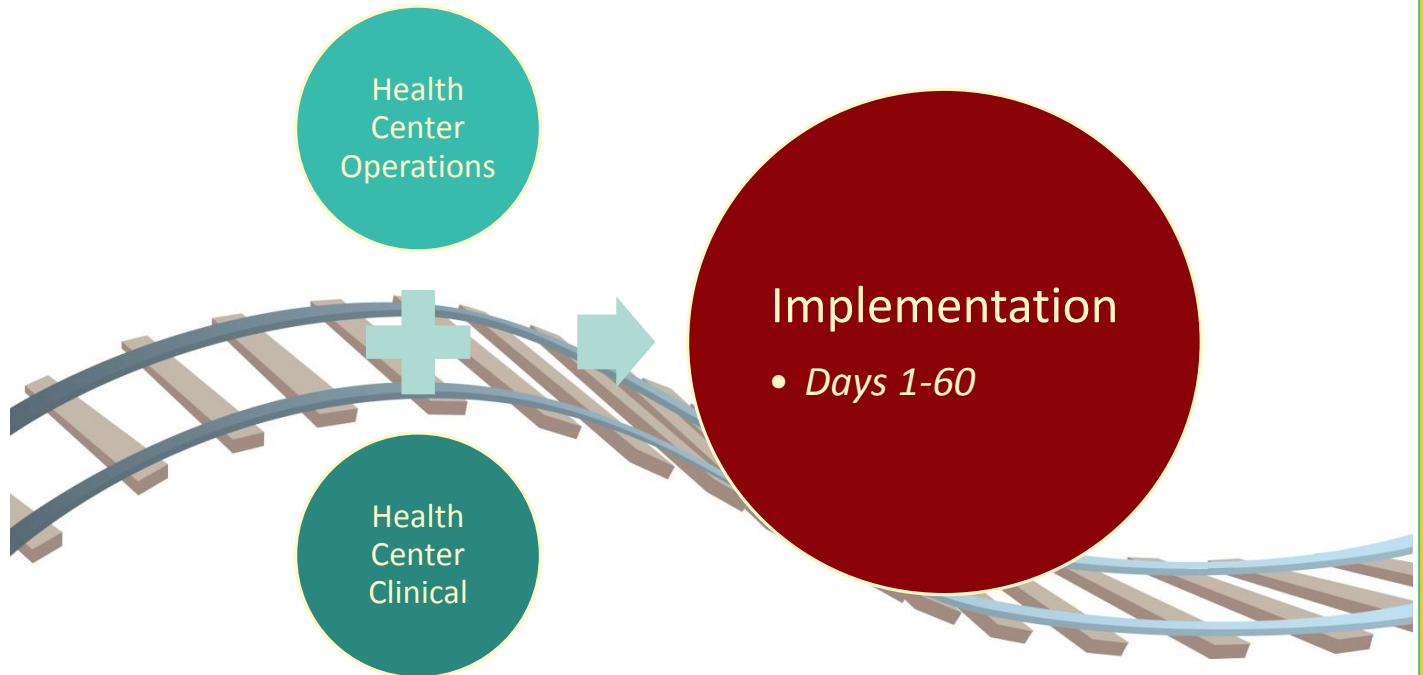
TRACK 3: Implementation

This is the fun part! After all the preparation and planning it is time to begin. It is important to be sure all the supplies are in the appropriate places, encounter forms have been updated, dummy codes have been entered into the EHR and most importantly, the team has been appropriately trained. If you have followed TRACKS 1 and 2 then you are well prepared for your go-live date. It will be important to evaluate your team on a daily, weekly and then monthly basis to ensure the process is working efficiently and effectively and that team members feel confident and are adapting to the changes in procedure.

Health Center Operations

Encouraging primary care providers to share responsibility for children's oral health is an important step in improving overall health and supports a more cohesive working relationship between medical and dental. During implementation of the fluoride varnish initiative the health center's leadership must provide oversight and encouragement to the team and validate the importance of their efforts.

Health Center Clinical

Primary care providers must take responsibility and ownership for integrating their aspect of the program into the practice. Clinical support staff will look to providers and the team leader for guidance and support and through effective monitoring and coaching; implementation will be a seamless transition. The incorporation of oral health into the QI Program is also an essential step toward sustainability. The team, center leadership and the Board must believe that that failure to integrate oral health into the medical setting is unacceptable and to not do so for every child is poor quality of care. This initiative must not be perceived as another thing to do but as a new standard of care.

TRACK 3 - Tools and Resources

Health Center Operations

- Program Oversight and Encouragement

Program Oversight and Encouragement

During the Implementation stage of the initiative, the leadership of the health center should provide program oversight and encouragement for the team. They should also expect a training curve which may temporarily affect productivity until the team becomes comfortable and has established the correct work flow; this is a fluid process and the ECOH team may need to make some extra adjustments.

Health Center Clinical

- ECOH Checklist
- Monitor Progress of ECOH Team
- Incorporate Oral Health into Quality Improvement
- Peer-to-Peer Coaching

ECOH Checklist

The ECOH Checklist is your cheat sheet for clinicians to use when implementation begins. It can be made into a pocket size cheat sheet or full size and hung at the nurses' station, in exam rooms, or even placed with the chart of the patient. The checklist can also be made into a flow chart for easier visualization.

To be directed to examples, please click ECOH Flow Chart and HPWO Flow Chart.

ECOH Fluoride Varnish Checklist	
Is this a well-child visit?	Y / N
Is the child between the ages of 9-36 months?	Y / N
Has the child received varnish in the last 3-4 months?	Y / N
Do you have the appropriate supplies? (gloves, varnish, gauze)	Y / N
Do you have the ECOH brochure?	Y / N
Complete the caries risk assessment tool.	☐
Physician completes the oral screening and anticipatory guidance.	☐
Apply varnish.	☐
Educate caregiver and provide brochure and patient care kit.	☐
Refer to dental home or for follow-up with Dentist.	☐

Monitor Progress of ECOH Team

The Team Leader should continue to monitor the implementation of all aspects of the program and establish quality control and improvement policies and procedures. The Team leader should be available to coach the clinical staff that might have questions or is not adapting to the change in a timely manner.

Days 1-5
The ECOH team should discuss how the process is working. Have a quick 5 minute huddle at the end/beginning of next day to discuss what went well and what changes need to be made to the procedure.

Days 6-15
The ECOH team should hold weekly meetings to check on things that are working and discuss changes that need to be made.

Monthly
The ECOH team should continue to hold monthly progress reporting meetings using the Improvement Cycle Tool.

Dr. Allison J. Metz, PHD from the National Implementation Research Network (NIRN) was contracted by ECOH in February, 2011 to assess current implementation structures, practices and strategies to strengthen and sustain the ECOH initiative. The mission of NIRN "is to advance the science and practice of implementation, organizational change, and system transformation to help solve social problems. Dr. Metz defines "Implementation" as the process of incorporating effective practices into typical health and human service settings to benefit children and families." According to Dr. Metz, "many initiatives fail for lack of study and reflection on what is actually done and what the results are. Observing, describing and

documenting are key aspects to a program improvement cycle, and particularly critical during the pilot phase when key functions of interventions are emerging."

To assist health centers with the process of implementation Dr. Metz created by the ECOH Improvement Cycle Tool. This tool was designed to help teams implement a sustainable improvement cycle during the ECOH Initiative. The Improvement Cycle Tool is divided into two sections. The purpose of Section 1 is to develop a program improvement plan including identifying data sources, roles and responsibilities, and communication protocols. Section 2 provides a series of questions for implementing the plan each month. It is recommended that during the first year of the ECOH Initiative that program improvement activities take place monthly.

To be directed to the document, please click ECOH Improvement Cycle Tool.

Incorporate Oral Health into Quality Improvement

The Institute of Medicine's (IOM) defines **quality in health care as a direct correlation between the level of improved health services and the desired health outcomes of individuals and populations**. According to the National Network for Oral Health Access (NNOHA) "in order to comply with HRSA regulations, Health Centers are required to establish a QA program that examines management practices and clinical care, including oral health services." Both HRSA and NNOHA provide extensive resources regarding the development of Quality Improvement program for health centers. HRSA has developed a Quality Toolkit as well as a web-based Quality Improvement Planning Learning Series to facilitate the growth of process and quality improvement programs.

Health Center Program Requirement regarding QI/QA

Quality Improvement/Assurance Plan: *Health center has an ongoing Quality Improvement/Quality Assurance (QI/QA) program that includes clinical services and management, and that maintains the confidentiality of patient records.*

The QI/QA program must include:

- a clinical director whose focus of responsibility is to support the quality improvement/assurance program and the provision of high quality patient care;*
- periodic assessment of the appropriateness of the utilization of services and the quality of services provided or proposed to be provided to individuals served by the health center; and such assessments shall:
  - be conducted by physicians or by other licensed health professionals under the supervision of physicians;*
  - be based on the systematic collection and evaluation of patient records;* and
- identify and document the necessity for change in the provision of services by the health center and result in the institution of such change, where indicated*

(Section 330(k)(3)(C) of the PHS Act, 45 CFR Part 74.25 (c)(2), (3) and 42 CFR Part 51c.303(c)(1-2))

Why Is a QI Program Essential to a Health Care Organization?
(from the HRSA Quality Toolkit)

An organization that implements a QI program experiences a range of benefits:

- Improved patient health (clinical) outcomes that involve both process outcomes (e.g., provide recommended screenings) and health outcomes (e.g., decreased morbidity and mortality).
- Improved efficiency of managerial and clinical processes. By improving processes and outcomes relevant to high-priority health needs, an organization reduces waste and costs associated with system failures and redundancy. Often QI processes are budget-neutral, where the costs to make the changes are offset by the cost savings incurred. Additional information, including tools and resources to assist an organization with improving processes and outcomes can be found in the Redesigning a System of Care to Promote QI module.
- Avoided costs associated with process failures, errors, and poor outcomes. Costs are incurred when nonstandard and inefficient systems increase errors and cause rework. Streamlined and reliable processes are less expensive to maintain.
- Proactive processes that recognize and solve problems before they occur ensure that systems of care are reliable and predictable. A culture of improvement frequently develops in an organization that is committed to quality, because errors are reported and addressed.
- "Improved communication with resources that are internal and external to an organization, such as, funders, civic and community organizations. A commitment to quality shines a positive light on an organization, which may result in an increase of partnership and funding opportunities. When successfully implemented, a QI infrastructure often enhances communication and resolves critical issues.

When an organization implements an effective QI program, the result can be a balance of quality, efficiency, and profitability in its achievement of organizational goals.

NNOHA has developed an *Operations Manual for Health Center Oral Health Programs* and dedicates Chapter 6 to Quality. They describe Quality Improvement to be "a formal approach to the analysis of performance and systematic efforts to improve it. It is aimed at improvement - measuring where you are, and figuring out specific changes to improve." This is an excellent resource that can be used to build a Quality Improvement/Quality Assurance program.

Oral Health should be represented on the Quality Committee and the Team Leader should participate on the QI committee, if not, at every meeting they should be reporting the progress and data to the committee. Remember that quality is ongoing and continuous. Monitoring, evaluation and improving the process is vital to the sustainability of the initiative. Using the ECOH Monthly Progress Report tool will make it easy to pull that data.

To be directed to the document, please click *ECOH Monthly Progress Report.*

QI Resources
(click on each item to be directed to the document or website)
HRSA Quality Improvement Planning Series
HRSA Quality Toolkit
NNOHA Operations Manual for Health Center Oral Health Programs
Ohio Association of Community Health Centers

Peer-to-Peer Coaching

The Ohio State University defines peer coaching as "a relationship where two people share insights and seek better understanding about what's going on in their lives, and practice skills that can improve their personal and professional effectiveness. No matter the job titles, it's a partnership of equals." Coaching provides guidelines, outlines appropriate timeframes and sets expectations.

Peer-to-Peer coaching is an effective way to gauge if the clinical staff is comfortable in providing anticipatory guidance to the caregivers, correctly identifying and documenting any oral health problems, and correctly applying the fluoride varnish to patients. After the initial training the team leader should make it a priority to visit each team member and document that each step of the process is being performed correctly. Coaching one-on-one allows the staff member to ask questions as they demonstrate the procedure and allows instantaneous feedback from the coach.

Tips on building a strong peer coaching relationship:

Build Openness and Trust

Set expectations, be open to sharing, and keep confidences. Clarifying the parameters and goals of your relationship up front ensures both people benefit.

Be Consistent

Meet on a regular basis, set a basic agenda for each meeting, and follow up on conversations.

Focus on Personal and Professional Development

Look at where you can increase your personal effectiveness, and how you can make your next career step.

Peer Coaching Support

Here are some tips to help you provide effective support to each other:

- It's easy to focus on the negative. Help each other look at the good news in information gained from stakeholders. Give equal airtime to the good as well as the more challenging areas.
- Remind each other it's not about the past. Reframe everything in the form or what can be done in the present and future.
- Avoid criticism, judgment, analysis, blame. Remember, this is Peer Coaching so you both are getting comments that aren't so easy to hear! It requires courage, honesty and humility to admit past mistakes. Look at them as clearly as you can without dwelling on them, make your sincere apologies and move on. Your only point of effectiveness is what you do with this information in the future.
- Help each other move past personalities. Don't try to figure out who made what comments, if you've received anonymous suggestions. Just look for the nuggets of opportunity, forgive everyone else for their side of the challenges, and look forward to how you can create a positive outcome for the future.

http://www.marshallgoldsmithlibrary.com/docs/articles/Peer-Coaching-Overview.pdf

Sample Coaching Template

		Yes	No	n/a
Name of Team Member				
Date				
1. Did the team member complete the caries risk assessment?				
2. Did the team member complete the oral health screening?				
3. Did the team member give anticipatory guidance to the caregiver?				
4. Was the fluoride varnish applied correctly?				
5. Did the team member make a dental referral?				
Areas for Improvement:				
Comments:				
Name of Coach				

ECOH Brochure Tool

The brochure was created to help with the anticipatory guidance portion of the visit. Many of our providers wanted to have a tool to teach from and then be able to give to the caregivers to take home to reinforce what they learned at the doctor's office.

Chew Chew Brochure [Printable]

Chew Chew Brochure, Spanish [Printable]

SUMMARY

Sustainability and PCMH

As we have found to be true over the past several years in order for implementation to be most effective, sustainability of the ECOH initiative must be integrated into the health center's strategic framework. Sustainability will depend on examining and modifying existing patient care practices and policies and procedures to accommodate the incorporation of the program into well-child visits. At this point, the fluoride varnish initiative should be considered a standard of care and the entire staff should be champions of oral health integration and your patients should come to expect this service at the time of their appointment.

For those health centers currently undergoing Patient Centered Medical Home (PCMH) transformation, the concepts of integration, care coordination and patient centeredness are nothing new; and although oral health is not a predefined measure for PCMH accrediting bodies, it must be included by the health center and not placed in its own silo. The Ohio Association of Community Centers is currently assisting health centers with PCMH transformation through various methods, one of which is the development of the Ohio Learning Community and can be of assistance for further technical assistance regarding PCMH transformation. Additionally, the National Network for Oral Health Access, (NNOHA) has prepared an action guide titled "Oral Health and the Patient-Centered Home" which can help to facilitate medical-dental integration. NNOHA conducted a needs assessment of health center Dental Directors and follow-up interviews with nine early adopter organizations that have made substantial progress integrating oral health into their health centers to develop the action guide.

Please click Oral Health Action Guide to be directed to the document.

As you start to take the necessary steps toward oral health integration and begin to transform your practice, remember that implementation is an ongoing, fluid process. The purpose of this guide is to "Keep You on the Right Track" and provides you with the many tools and resources available that can make implementation of the ECOH Initiative a reality for your health center. Please continue to refer back to the different Tracks within the Implementation Guide to set the foundation of the program and build from there.

The classic children's book, "The Little Engine That Could", teaches us the value of optimism and hard work. If you remember, a stranded train is unable to find an engine to take it up and over the difficult mountain to its destination. Only the brave, little, blue engine is willing to try and says over and over again "I think I can…I think I can" as he slowly accomplishes his task. Like the stranded train, we can help these vulnerable children who need our help. Here at OACHC, we know you can do it! So keep "CHUGGING" along and say…

"I THINK I CAN…I THINK I CAN"