Dental Public Health Project Descriptive Report Form

Please provide a description of your organization's successful dental public health project by completing this form. Add extra lines to the form as needed but stay within **word limits**.

Please return the completed form to Lori Cofano: lcofano@astdd.org

Name of Project

Geriatric Oral Health for Elderly Asian Patients

Executive Summary (250-word limit))

Asian Health Services (AHS), a Federally Qualified Health Center located in Oakland, CA, was founded in 1974 by a group of University of California, Berkeley students. These students saw an influx of Asian immigrants to the Bay Area who were struggling to obtain health care due to their limited English proficiency. Since then, the health center has grown to provide primary medical, dental, behavioral health and specialty mental health to over 50,000 patients. A dental program, however, was not available until 2003. AHS leadership team was aware that the dental needs were significant and a small dental clinic would not be able to accommodate the entire community. The health center Board of Directors (BOD) made a policy that only medical patients could access dental services, which perfectly fit into HRSA initiative on Patient-Center Health Home (PCHH) that began a few years later. Due to this policy, AHS has been able to establish a robust medical-dental-behavioral health integration that has been identified by Operational Site Visit review teams several times as a best practice.

Name of Program or Organization Submitting Project

Asian Health Services

Essential Public Health Services to Promote Health and Oral Health in the United States

Place an "X" in the box next to the Core Public Health Function(s) that apply to the project.

	Assessment
	Policy development
X	Assurance

http://www.astdd.org/state-guidelines/

Project submissions will be categorized by the Core Public Health Functions on the ASTDD website.

Healthy People 2030 Objectives

List Healthy People 2030 objectives related to the project.

- **Reduce the proportion of adults with diabetes who have an A1c value above 9 percent — D-03**
- **Reduce the proportion of adults with high blood pressure — HDS-04**

This information will be used as a data resource for ASTDD purposes.

Keywords for sorting the project by topic.

Provide **three to five** keywords (e.g., access to care, children, coalitions, dental sealants, fluoride, policy, Medicaid, older adults, pregnant women, etc.) that describe the project. Keywords are used to categorize submissions.

Access to Care: Adults and Older Adults Services; Access to Care: Communities; Access to Care: Workforce; Prevention: Adults and Older Adults Oral Health; Oral Health and Overall Health; Health Equity; Behavioral Health

Detailed Project Description

Project Overview

(750-word limit)

The integrated geriatric care project started in 2015 when the Chief Dental Officer participated in the health center's geriatric care initiative. The champion team included the Chief Medical Officer (CMO), Chief Dental Officer (CDO) and Behavioral Health Manager (BHM). The team recognized that about 30% of Asian Health Services (AHS) patients were 65 or older, which is significantly higher than health centers' national average of 9 to11%. When the dental clinic opened in 2003, AHS Board of Directors made a policy that only medical patients could access dental services. This decision was to insure that existing medical patients at the time could receive dental care since the dental clinic had only 7 dental rooms, compared to 35 medical rooms in 2003. Patient data showed in 2015 that although the patients were mutual, many patients accessed dental services much more often than medical services.

Depression was recognized as a common condition presented by seniors; but because they didn't come into medical as often, it was easy to miss these patients. Simultaneously, dental staff shared that patients, especially the new immigrants, confided in them how depressed they were because of different cultures and language barriers. Some wanted to go back to their own country because they became very isolated and lonely. From the meetings and conversations, the AHS team decided to pilot an integrated project that would include two parts: depression screening of dental patients in dental clinic and dental screening in behavioral health setting. A referral process was created for patients who were identified as needing counseling or dental care. This was done manually because the medical department was not using an electronic health record (EHR) and only dental had an electronic dental record (EDR) in 2015. Dental used Patient Health Questionnaire-9 Form, known as PHQ-9, for depression screening of all seniors. A dental screening form was

created for Licensed Clinical Social Workers (LCSW) to use for their dental screening. Referrals were made thru email or fax. Now that the health center has EHR in all departments, all the work is done electronically thru a patient portal.

In 2018, the AHS dental program began an outreach program that provides dental screening and patient education at four senior centers in Oakland. More than 150 patients were screened and received education on various topics: brushing, flossing, oral cancer-self checks. Staff at these senior centers participated in the training. The residents who were identified with urgent care needs were brought into the clinic for care. AHS staff do this type of training twice a year.

In 2019, the dental department received a grant from the City of Oakland to begin a new integrated care model, diabetes screening and HbA1C testing in dental. The grant paid for test machines for three clinics and enough test kits for over a year. Although the focus initially was for elderly patients who are not identified as diabetic in medical charts to be screened and tested for HbA1C if indicated, the project has not applied to all patients. The goal is to identify those patients who may be at risk of having diabetes to be screened, tested, and referred for further evaluation as needed.

Diabetes has many oral health complications such as periodontal disease, dry mouth, high caries prevalence, oral infections, and slow healing. Uncontrolled diabetics are at risk for medical emergencies during dental treatment. Besides using a diabetes screening survey from the American Diabetes Association, dental staff also weigh patients, measure height and calculate BMI. Blood pressure is taken on all patients starting at the age of 12 at every visit. Although these protocols started out with geriatric, it must be noted here that the same protocols apply to all patients now.

Resources, Data, Impact, and Outcomes
(750-word limit)

An in-service training program was implemented. The Behavioral Health Manager provided training to all dental staff, providers, dental assistants and front office staff on how to use and interpret the PHQ-9 form. Additionally, BHM trained staff on how to interview patients if there is a positive PHQ-9 survey and how to invite patients to elaborate more about their own conditions. This invitation was made even if there is a negative survey, as many times patients may not truthfully put down in writing their true feelings, but providers may be able to pick up signs that patients may suffer from a mental health condition. This in-service training takes place annually for all dental staff. The CDO has regular meetings with the BHM and Specialty Mental Health (SMH) Director about the integrated care model and how to improve the process.

In pre-EHR date, the PHQ9 form was faxed to medical record staff, who then forwarded it to the BHM. The form was scanned into the patient's EDR. A special code was created in EDR to record if a PQH-9 screening was conducted and if the patient was referred. If the patient had a positive survey, a referral would be made to the medical department via fax or email. Appointments would be made and dental staff would follow up with medical to make sure patients were seen. If the survey was negative, it would be recorded in the EDR and medical would record the information in the patient's medical chart.

With an EHR, all the records, forms, referrals and follow-ups are done electronically. Data on the number of screenings, positive surveys and referrals are reported quarterly to the Continuous Quality Improvement (CQI) Committee, Executive Leadership (EL) team, Quality Assurance (QA) Committee of the Board of Directors, and the Board of Directors (BOD).

Since 2015, the dental department screens an average of 900 patients. Before COVID (March 2020), between two and eight percent of patients are identified as having depression and are referred to BH department. It is considered a big success as 100% of dental patients with positive surveys “accept” to enter counseling. The counseling program usually lasts for about six months, with either monthly or bi-weekly visits with the counselors. This hiring of an LCSW to work in the dental clinic in 2017 has greatly contributed to the success of the program. Prior to this, patients had to go to medical for their appointments although they were screened in dental clinic. With an LCSW housed in dental, dental patients did not have to wait. They could be seen on the same day as their dental visit. This makes it very convenient for the patients. Dental patients provided feedback that being able to receive counseling in the dental clinic removed the stigma, because no one knows they come to dental clinic for counseling!!! During the pandemic, mental health crisis became the most prevalent. The dental clinic, however, saw a reduction in positive rate in our depression screenings. We have attempted to figure out the cause(s) of reduction in the depression findings in our screenings but have not been able to determine. Our thoughts are that patients who have depression or mental health issues are not coming for dental treatment due to their mental health status. Another possibility is that patients who are coming in dental services have recovered from their behavioral health issues after having gone through their counseling successfully. We are planning to screen depression twice a year instead of once a year and follow up the patients who went through counseling to check on remission this coming year.

	2022-#screenings
Depression Screening (PHQ-9)	812
• Positive Screens	10 (1.2%)
• Referrals	10 (100%)
• Referral accepted	10 (100%)
HbA1C Testing	98
• Positive tests (6.5 or higher)	26 (26%)
• Referrals to PCP	26 (100%)

Diabetic screening and HbA1C testing project have had great outcomes. Patients that are considered as borderline for diabetes, HbA1C in the range of 5.4-6.4, are referred to nutritionists for nutritional counseling. Those with HbA1C at 6.5 or higher and who do not have a diabetes diagnosis in their medical charts are referred to their primary care for further evaluation. The diabetic patients who have not had a HbA1C test for four to six months are offered to be tested in dental. So far, ALL patients consent to test without any opposition! They are happy that they don’t have to wait to be tested. All test results are recorded in EHR. These data are also shared with CQI and the board.

Budget and Sustainability
(500-word limit))

The main budget impact was the hiring of the LCSW to work in dental. The clinic was able to obtain a grant of $100,000 to hire a counselor in the first year. Since the clinic was able to bill for two visits on the same day, dental and behavioral health, the financial impact became neutral after funding ended. The LCSW was also seeing patients referred from medical to keep her schedule full.

The diabetes project was initially funded by a grant from the City of Oakland. That grant has been continued. Even without the grant funding, the project will continue because it is a great service to the patients. The most expensive item for the diabetes project was the machines that were paid for by the grant.

The blood pressure and BMI protocols are routine vital sign intakes, part of clinical protocols, on every patient that has no costs.

Lessons Learned
(750-word limit))

The depression screening and diabetes screening for elderly are must-do components of the dental operation. It is easy to do and costs nothing. The form is incorporated into the new patient packet, along with other forms, such as medical history, dental history, Notice of Privacy and other consents. Dental providers are members of the patient health care team. Dental should not operate in a silo. Dentistry is no longer drill and fill. We need to see our patients as whole people, with complex needs, that we, as health care providers, are here to help patients to achieve good health outcomes, for the body, teeth and mind. When the depression screening project started in 2015, there was no resistance from dental providers and staff. It was because we had a clear plan of communication and training with our staff. As we are changing to screening patients for depression twice a year now, instead of just once a year, so that we can identify any remission cases. Staff are all ready for it. The workflow is working well, so again, no resistance from our staff. Behavioral staff, under supervision of Chief Medical Officer, who strongly supports our depression screenings, has adopted the project well. We also train behavioral health staff on dental surveys. When the diabetes project began, our staff was very excited. Training was done for all staff on the HbA1C testing and they started testing on the first day with no issues. Our staff even trains our students who rotate at our health center. Staff follow protocols strictly. Diabetic HBA1C testing is done only if patients have not been tested in medical in the last three to four months. We have identified many patients who were unaware of their diabetic conditions.

Because of the medical-dental-behavioral integration, our dental department was able to work together with our LCSW to assist an elderly female patient get into care when she experienced a mental health crisis on a Sunday in April 2020, right when the pandemic began. We were able to get a male patient into the care of an endocrinologist after our HbA1C test result showed his diabetic condition was uncontrolled at 12.3. He was on the verge of having a diabetic crisis. Another female patient presented with a blood pressure reading that indicated she was at risk for stroke. She was not taking her hypertensive medications as prescribed. Our dental providers were able to educate her on medication compliance and got her into urgent care before she experienced a cardiovascular crisis. It is clear that the integrated care model brings the best health outcomes and is the best approach to caring for our patients.

Resources

List resources developed by this project that may be useful to others (e.g., guidelines, infographics, policies, educational materials). Include links if available.

https://www.nhlbi.nih.gov/files/docs/bp_child_pocket.pdf

https://www.ncbi.nlm.nih.gov/books/NBK549816/#:~:text=For%20an%20HbA1c%20test%20to,HbA1c%20of%206.5%25%20or%20higher.

https://www.cdc.gov/diabetes/managing/managing-blood-sugar/a1c.html

https://www.hiv.uw.edu/page/mental-health-screening/phq-9

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