Dental Public Health Project Descriptive Report Form

Name of Project

Medical-Dental Integration as an Organizational Strategy in a Safety-Net Dental Program

Executive Summary

Petaluma Health Center's medical-dental integration program has evolved over more than two decades in response to persistent oral health access barriers among underserved populations. What began in 2005 as a small dental program receiving high volumes of referrals from medical providers grew into a sustained, organization-wide effort to align oral health with primary care, prenatal care, chronic disease management, behavioral health, and school-based services.

The central problem was not only limited access to dental care but also fragmentation between systems serving the same patients. Over time, the program tested multiple integration models. Successful approaches included pediatric teledentistry supported by a dental assistant champion, direct scheduling of dental visits by medical assistants, direct scheduling of prenatal patients by an obstetrics (OB) case manager, pandemic-era teledentistry with care packages and coaching, bidirectional medical-dental workflows for patients with diabetes, and more recent pediatric same-day visits embedded within well-child visits workflows. Less effective strategies included referral-only workflows, walk-in dental visits offered after prenatal appointments, and remote call-center scheduling without strong ownership or stable staffing.

Key lessons learned were that integration must be operationalized, not merely encouraged; closed-loop scheduling outperforms passive referral; staff champions are essential; and sustainability depends on continuous quality improvement, data review, and adaptation to changing conditions. The program's long-term aim has been to make oral health a routine and visible part of whole-person care, especially for children, pregnant women, and people with chronic disease, such as diabetes. This report focuses on medical dental integration for patients 6 months to 3 years old and pregnant patients.

Name of Program or Organization Submitting Project

Petaluma Health Center

Detailed Project Description

Project Overview

The project addresses fragmentation between oral health care and primary care in a safety-net setting, where many patients face both high disease burden and major barriers to timely access to dental care. When the dental program began in 2005, referrals from medical providers were already substantial, but dental and medical services were not co-located, and the dental program consisted of a single dentist. Demand quickly outpaced capacity, with long waiting times and many patients presenting with advanced disease after years without access. This made it clear that referral alone was insufficient.

The underlying problem was not simply lack of appointments; it was the absence of reliable, patient-centered systems linking medical care and dental care early enough to support prevention, early intervention, and coordinated follow-up. The need for integration became more visible as the organization expanded. Co-location with medical in 2011 created opportunities to test new models. Subsequent work showed that patients were more likely to reach dental care when scheduling occurred in real time, when education was delivered by trusted staff, and when workflows were deliberately designed rather than left to chance. The project evolved as a response to operational bottlenecks, population health needs, and the recognition that oral health is part of overall health.

1. Target populations

The primary target populations are children seen for well-child care and pregnant women receiving prenatal service; underserved patients in a community health center environment, especially Medi-Cal beneficiaries; and uninsured patients who face structural barriers to dental access.

2. Project goals

The key project goals have been to increase the percentage of children with a dental visit before age one and to increase the percentage of pregnant patients that received dental care during pregnancy. Increased upstream access to preventive interventions has been shown to reduce disease burden in the patient population, to reduce the cost of care and to increase the quality of care. These key goals have been pursued through operational strategies, such as same-day or closely coordinated medical-dental care whenever feasible. The program has sought to build infrastructure, staff capability, and electronic health record (EHR) supported workflows that make integration more reliable over time.

3. What lessons learned would be useful for others seeking to implement a similar project, including what did not work?

Integration works best when it is treated as an operational system rather than a referral expectation. Passive referrals, fax-based communication, and manual handoffs produced limited completion and were resource-intensive. Direct scheduling into the electronic health record (EHR) by medical or case management staff, already embedded in the patient visit, was markedly more effective.

Not every seemingly convenient model succeeds. Offering prenatal women a walk-in dental visit immediately after their OB appointment had low uptake even though services were co-located. Patients were often fatigued and already juggling competing priorities. Similarly, expanding pediatric scheduling to a remote call center was not successful because turnover was high and the staff were too distant from the clinical workflow to sustain the process.

Champions matter. Some of the strongest results came from a highly engaged community dental health worker in pediatric integration and from an OB case manager who combined patient education, trust building and direct scheduling for prenatal patients. When these champions were consistently engaged with the patient at the right time and place in the visit workflow, performance improved substantially.

Quality improvement methods were essential. Small tests of change, workflow refinement, scripts, training, and regular review made it possible to adapt models over time. The program repeatedly had to pivot in response to COVID-19, workforce shortages, technology limitations, and changing reimbursement incentives. Narrowing scope to populations of focus and feasible workflows often produced more durable results than trying to integrate everything at once.

Resources, Data, Impact, and Outcomes

1. **What resources were necessary to support the project, such as staffing, volunteers, funding and collaboration with other agencies or organizations?**

   Key resources included dental and medical leadership, dentists, registered dental assistants, community dental health workers, medical assistants, front-office staff, OB case management staff, informatics support, quality improvement leadership, and executive sponsorship. Critical collaborations included the organization's quality improvement department, OB and pediatric teams, and external partners, such as the University of California at San Francisco and national and state oral health improvement collaboratives.

   Training resources included Smiles for Life and internally developed scripts, workflows, and patient education presentations. Awareness, understanding and acceptance increased with regular oral health trainings for medical staff on clinical and operational dental topics. Partial funding from the California Dental Transformation Initiative (DTI), the Perinatal and Infant Oral Health Quality Improvement (PIOHQI) project and the California Advancing and Innovating Medi-Cal (CalAIM) have been used to fund some of these initiatives. For some initiatives we received technical assistance from the National Network for Oral Health Access (NNOHA) through their Learning Collaboratives.

2. **What process measure data (counting) were collected, such as number of sealants placed or people served?**

   One process measure looked at how many children 6 months to 3 years old came in for a well child check visit and had a same day dental visit if due. Another measure looked at the monthly number of dental visits scheduled by the OB case manager for pregnant patients. We tracked the number of dental visits scheduled by medical assistants (per assistant and per team). Other data was collected via the Plan-Do-Study-Act method (PDSA), such as number of warm hand offs between OB and dental, number of OB walk ins, and the number of dental visits scheduled by call center staff, Operational metrics included referral

completion and visit completion. This process measure data was used to guide testing and implementation.

For example, we collected the percentage of patients 6 months to 3 years old that came in for a well child check visit (WCC) and had a same day dental visit, if due. We collected this data daily and shared it with internal stakeholders monthly. Here are data tables from the last 2 years and 9 months for our two main sites that serve a large patient population under 21 years old, and are co-located with medical. 934 patients ages 6 months to 3 years had same day WCC and dental visits between July 2023 and March 2026 across the two sites.

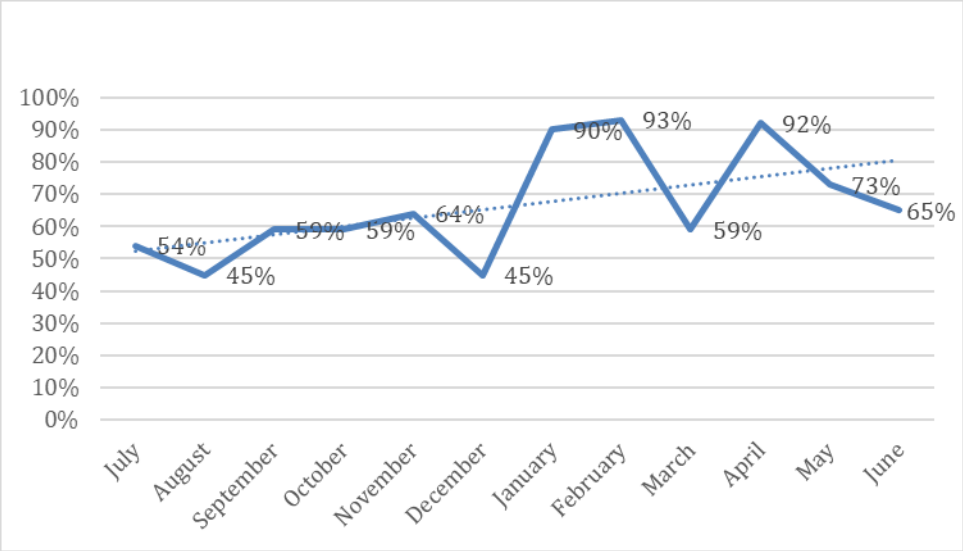


Table 1 – Site 1

This table shows the monthly increase in % of patients 6 months to 3 years old with a WCC that had a same day dental visit, if due. Data is for period July 2023 – June 2024.

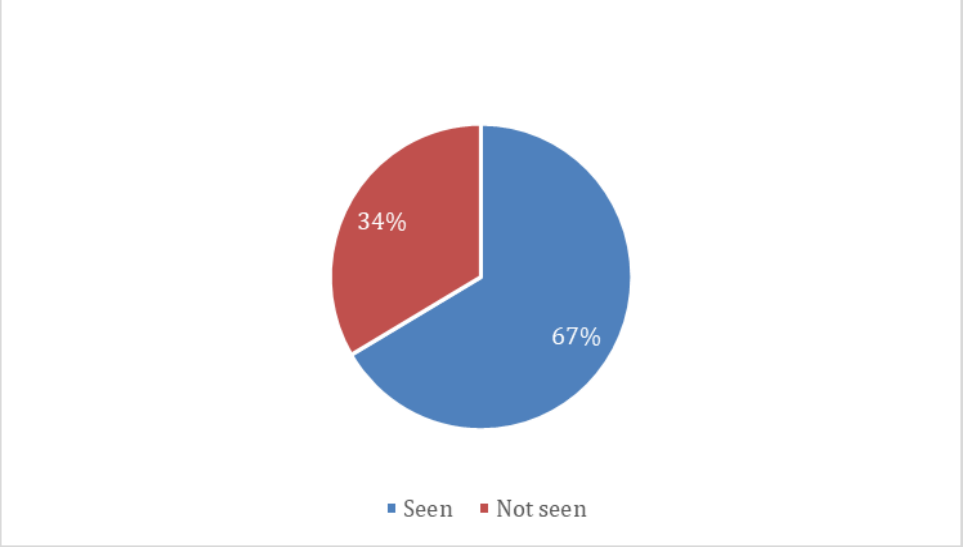


Table 2 – Site 1

This annual table shows the % of patients 6 months to 3 years old who came in for a WCC and had a same day dental visit, if due (67%) and those that did not (34% missed opportunities. Data is for period July 2023 – June 2024 with 236 patients seen.

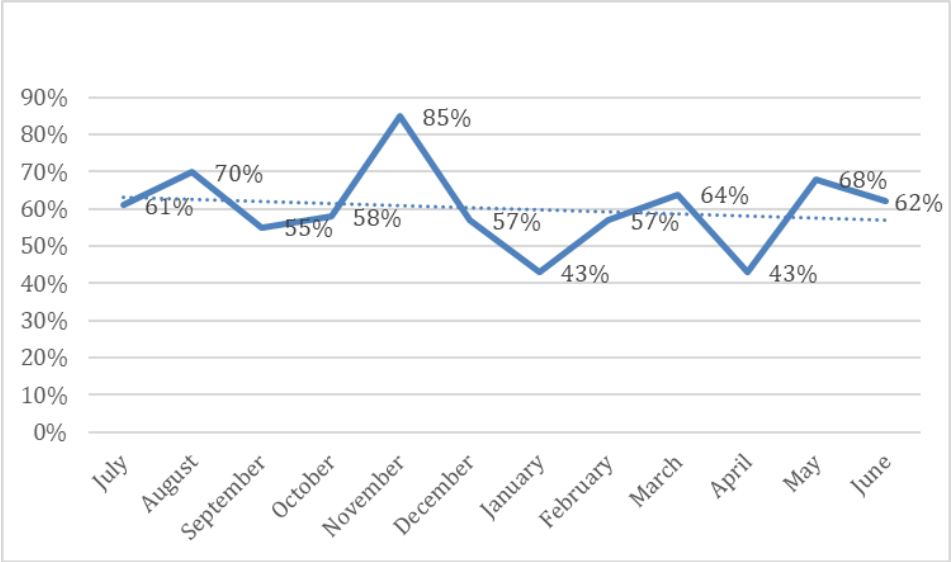


Table 3 – Site 1

This table shows the maintenance in the gains of monthly % of patients 6 months to 3 years old with a WCC that had a same day dental visit, if due. Data is for period July 2024 – June 2025.

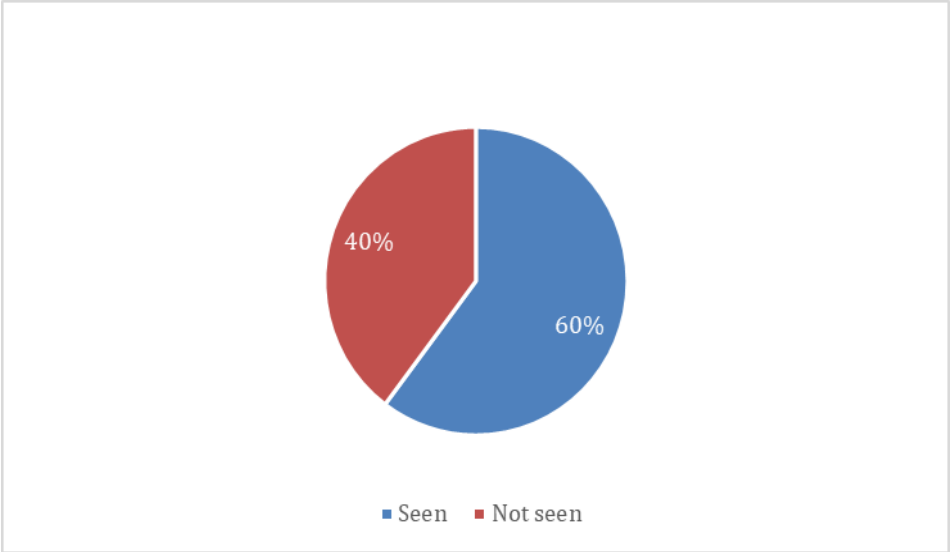


Table 4 – Site 1

This annual table shows the % of patients 6 months to 3 years old who came in for a WCC and had a same day dental visit, if due (60%) and those that did not. Data is for period July 2024 – June 2025. This data shows sustainability of improvement from previous year. 164 total patients seen.

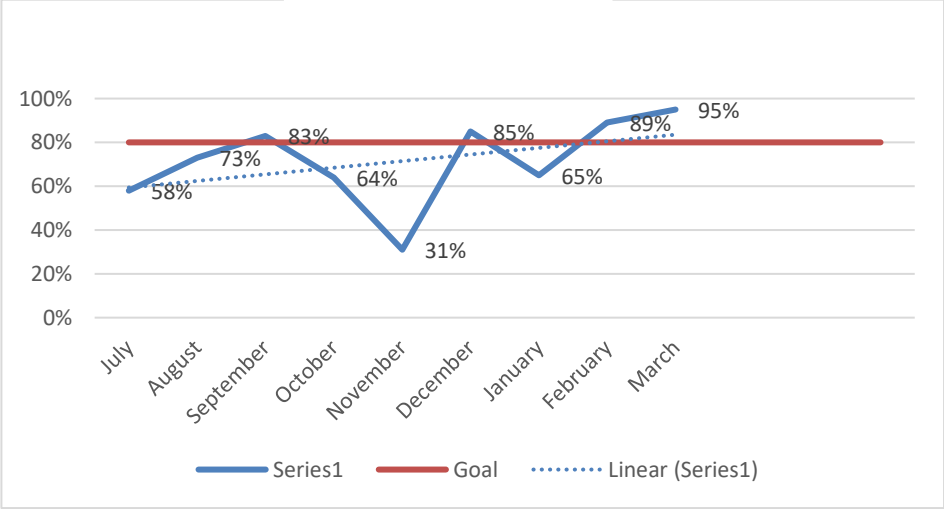


Table 5 – Site 1

This table shows continued increase in % of patients 6 months to 3 years old with a WCC that had a same day dental visit, if due. Data is for period July 2025 – March 2026.

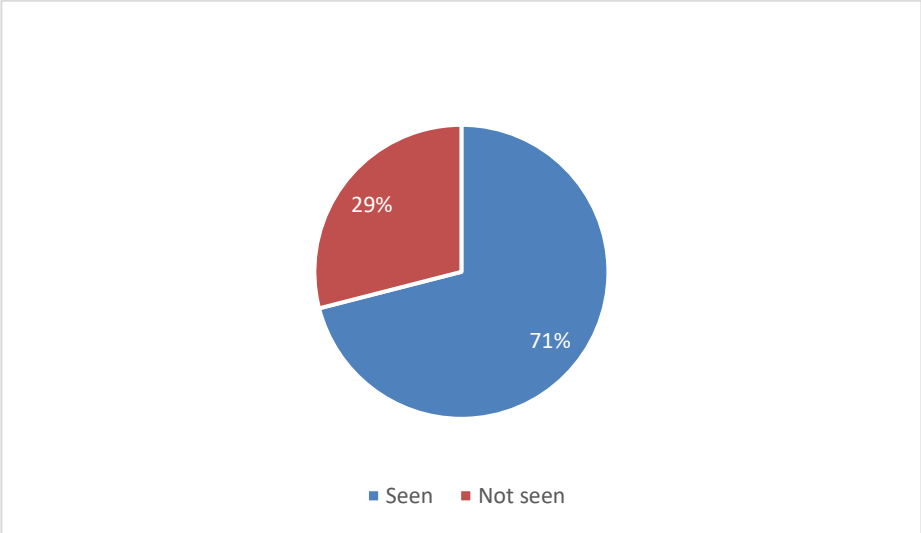


Table 6 – Site 1

This annual table shows the % of patients 6 months to 3 years old that came in for a WCC and had a same day dental visit, if due (71%) and those that did not. Data is for period July 2025 – March 2026. This data shows continued improvement. 117 total patients seen through March.

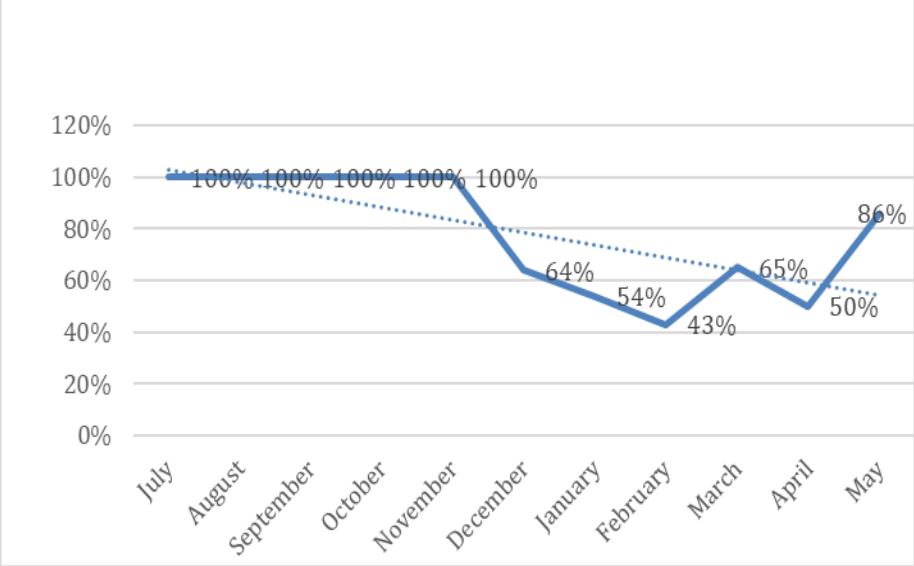


Table 7 – Site 2

This table shows a downward trend in the % of patients 6 months to 3 years with a WCC that had a same day dental visit, if due. Data is for period July 2023 – June 2024. Small denominator caused wide variation in percentages. Despite the downward trend here, you can see in table 8 that a large percentage of patients were seen in dental.

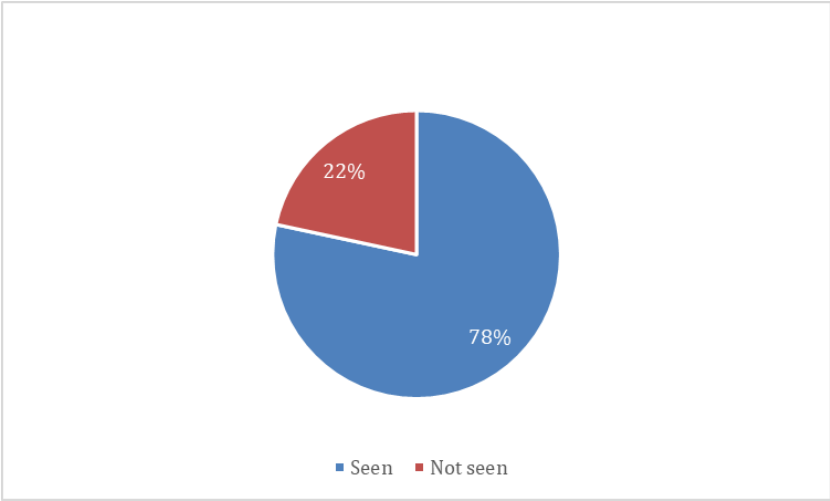


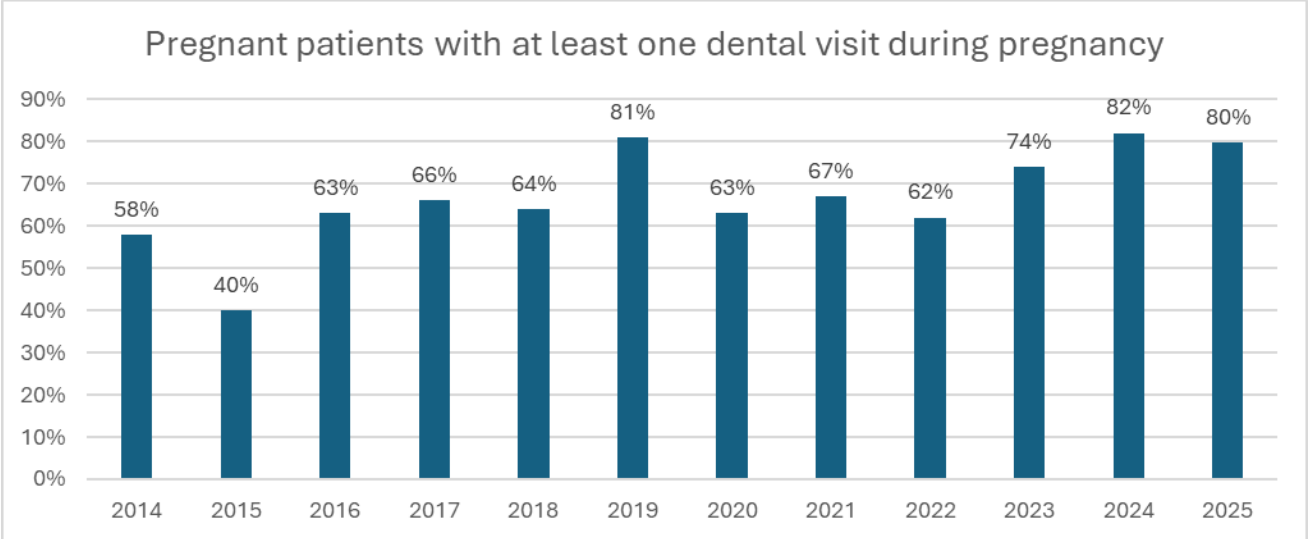
Table 8 – Site 2

This annual table shows the % of patients 6 months to 3 years that came in for a WCC and had a same day dental visit, if due (78%) and those that did not. Data is for period July 2023 – June 2024. A large percentage of patients were seen. 123 total patients seen.

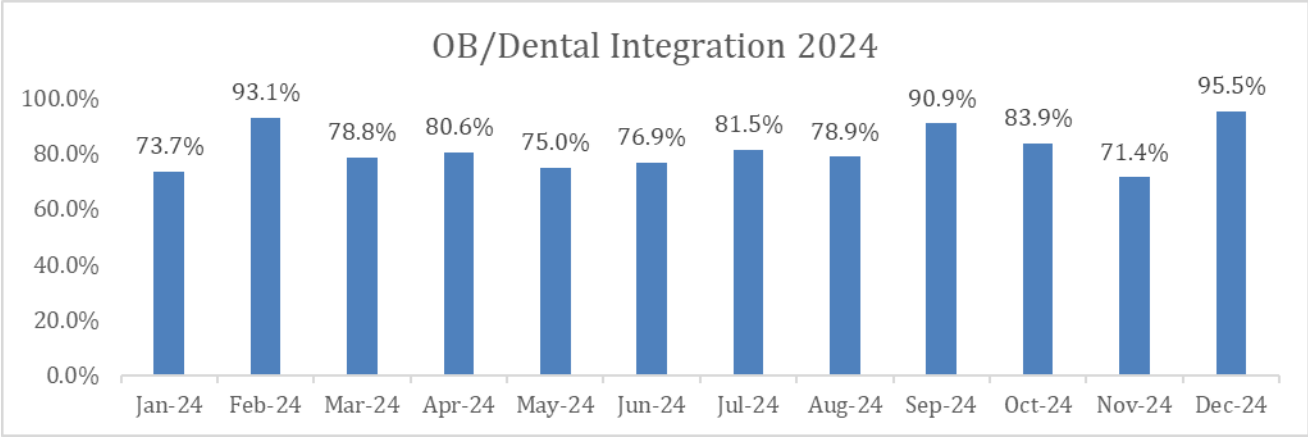
3. What outcome measure data (results) were collected, such as improvement in health?

The two outcome measures currently part of our dental dashboard are the percentage of patients with a dental visit by age 1 and the percentage of OB patients with at least one dental visit during pregnancy.

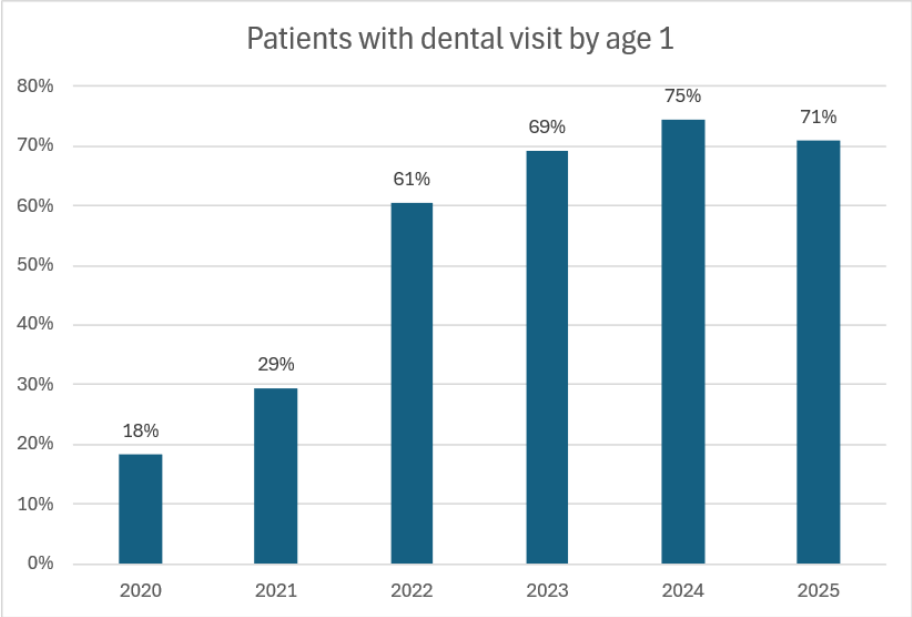
Here are the data for these two measures over time for the entire dental program.



Percentage of health center OB patients with at least one dental visit during pregnancy for period 2014 – 2025. A decrease during the pandemic and integration efforts over the past three years led to an increase of up to 20% integration.



Monthly data for health center OB patients with at least one dental visit during pregnancy (2024) when integration efforts accelerated with the aim of reaching and maintaining 80% integration.



Health center patients with a dental visit before age one. Significant improvement year over year between 2020 and 2025.

4. **How frequently was data collected?**

   The data came from the EHR and we built reports in *Relevant* software. Data were collected daily and monthly as part of ongoing QI work for internal improvement, and annually for communicating with external stakeholders.

5. **How were the results shared?**

   Results were shared internally through QI meetings, team meetings, workflow reviews, and board meetings. Findings informed iterative redesign of workflows and supported participation in learning collaboratives focused on integrated oral health care. Where applicable, results were shared with organizational leadership and external partners to support spread, sustainability, and alignment with value-based care initiatives.

Budget and Sustainability

1. **What was the budget for the project?**

   A precise project budget is not provided because the integration work developed over several years and was embedded within broader dental, medical, QI, and operational functions rather than funded as a single stand-alone grant project.

2. **What was the sustainability plan for the project?**

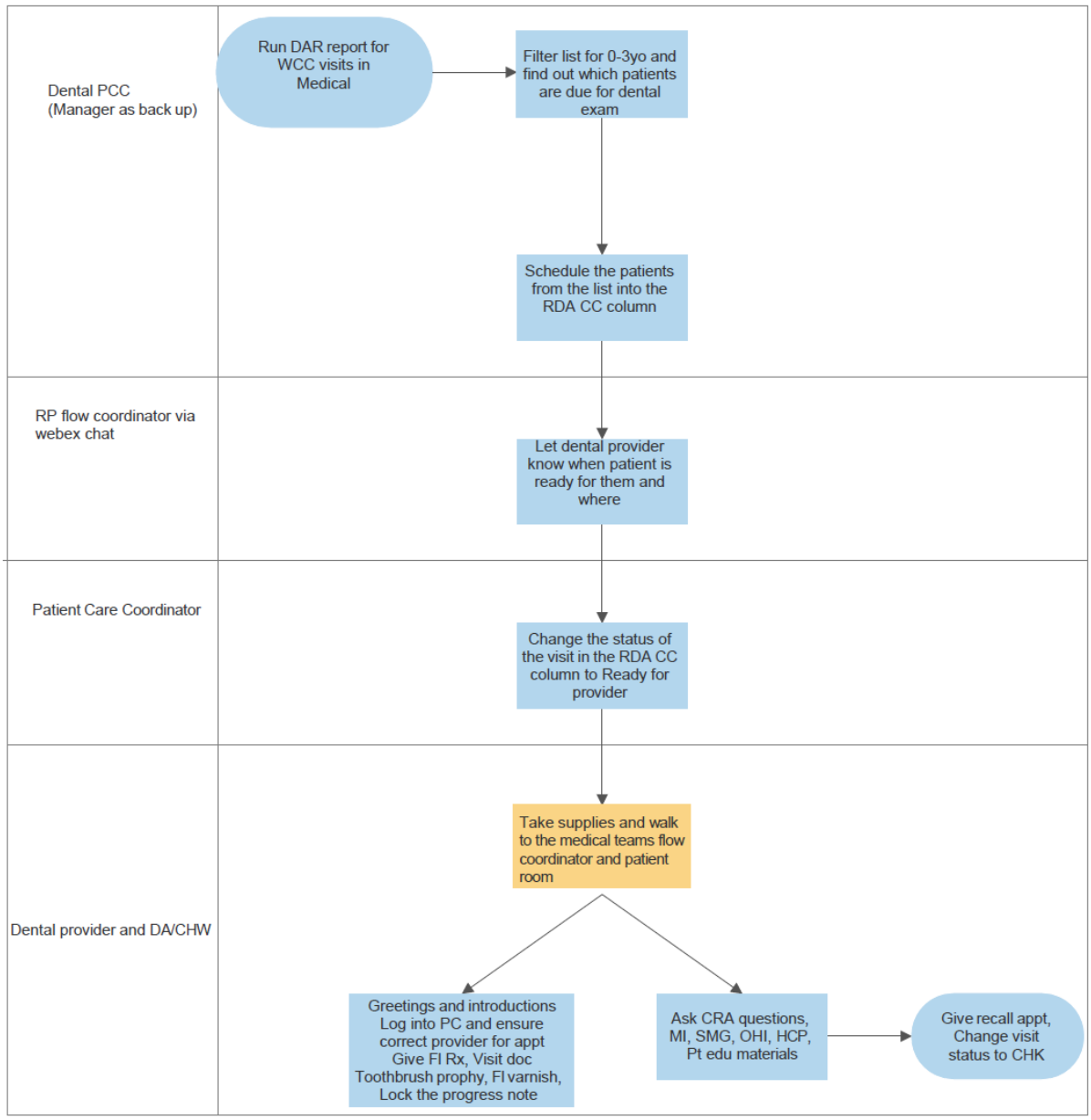
   Sustainability depended less on short-term pilot funding than on building workable models into routine operations. The most sustainable approaches were those that fit naturally into existing roles, such as direct scheduling by personnel already trusted by patients and

already present in the visit flow or adding a same day dental visit to an existing medical visit. Sustainability improved when workflows were supported by the shared medical-dental EHR, standardized documentation, training, scripts, and recurring review in internal QI processes.

Participation in communities of practice, alignment with managed care quality incentives, and preparation for value-based models, such as the Dental Transformation Initiative and California Advancing and Innovating Medi-Cal, further strengthened sustainability by creating strategic and financial reasons to maintain and refine the work.

Resources developed through this work:

- Medical-dental integration workflows for children and prenatal care
- Staff training materials such as the *Smiles for Life Oral Health Curriculum* and locally adapted oral health education materials
- Scheduling scripts for medical assistants and case managers
- Brief caries risk assessment tools and aligned patient education content for medical teams
- EHR templates and documentation workflows supporting oral health screening and education



(c) Ramona English DMD, MPH, Petaluma Health Center

Petaluma Health Center Daily MDI workflow swim lane diagram for patients 6 months to 3 years that have a WCC visit

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