# Strategies for Integrating Oral and Mental Health

## January 21, 2026

**Webinar support:** Welcome to the Mental Health/Substance Use Disorder Integration Technical Assistance webinar, Strategies for Integrating Oral and Mental Health. Please note our disclosure. This event was produced for the Health Resources and Services Administration, Bureau of Primary Health Care. Participants have entered in a listen-only mode. Submit questions by using the questions and answer feature. To open the Q&A, click the Q&A icon at the bottom of your Zoom window.

Questions will be submitted to the presenter and technical assistance support staff. You are welcome to submit questions at any time. We offer mental health and substance use disorder continuing education credits for participation in technical assistance events. If you experience any technical issues during the event, please message us through the Q&A feature. This event is being recorded. The slides, recording, and transcript will be available on the TA portal following this webinar. Now we'll turn it over to Amber Murray, Deputy Project Director, to kick things off. Amber, please go ahead.

**Amber Murray:** Thank you, Kayla, and hello, good morning, good afternoon. Welcome, everybody, for today's webinar. We've got three primary objectives today during the time that we'll spend together. One, to describe key strategies for implementing mental health screenings in a dental clinic. Two, identifying several best practices of oral and mental health integration, such as universal screening, EHR (electronic health record) integration, staff training, et cetera, to effectively implement and sustain oral and mental health or substance use disorder integration. Lastly, to listen to and learn from our panelists some key strategies and integration approaches used by health centers to effectively implement and sustain oral and mental health integration.

Before we get to our presenters and our panelists, we're going to kick things off with some polls. Our first polling question, how would you rate your organization's current level of integration between dental, primary care, and mental health or substance use disorder services? Again, we've got a range from “not at all” to “fully integrated”, even a “not sure” option for anyone. Take your best guess based on what you know about your department, your organization, et cetera. It looks like we've got a little over a quarter of our participants responded here. I think we can go ahead and end that poll.

Great. It looks like we've got a nice little bell curve here with the majority saying that moderately integrated, followed by minimally integrated, and then an even split between not integrated at all and fully integrated. Most of our participants today, most webinar attendees, are somewhere on the minimally integrated to moderately integrated range. Then we've got one more quick polling question for you.

Which of the following is the biggest challenge your organization faces in integrating oral and mental health services? The options we have available here are “lack of funding”, “workforce or training limitations”, “operational workflow or workflow barriers”, “limited leadership or organizational support”, or just an uncertainty about effective models or strategies. We also have another option. If you've got something else that comes to mind, please go ahead and enter that into the Q&A if you've got something top of mind there. I think the big challenge here might be selecting just one. Which one of these would be the primary, the biggest challenge?

It looks like we've got a little over 50% of our respondents, our attendees, who've provided responses. We're getting closer to about three-quarters. I think we'll keep the polling open just a little bit longer. Responses are starting to taper off now. I think we're good to close the poll. Here, it looks like the clear winner, with just over half of you all mentioned that operational or workflow barriers are the biggest challenge in integrating oral and mental health services, followed pretty closely by an even split between uncertainty about effective models or strategies.

Hopefully, our panel can help with some of that today, as well as some of the operational or workflow barriers. Then, coming in third is workforce or training limitations. I hope that today's presentation and the panel helps address some of those barriers that you may be facing. All right. I think we can go ahead to the next slide. Now, we'll launch on into our presentation portion of today's webinar. I am pleased to introduce to you today, Candace Owen. She is a registered dental hygienist and the senior

director of education and strategic partnerships for the National Network for Oral Health Access, or NNOHA.

Her areas of expertise include workforce optimization, care access, and oral health integration. Before joining NNOHA, Candace served as a faculty member for the University of New Mexico Department of Dental Medicine. Following Candace's presentation, we will engage in a panel discussion with representatives from three health centers and the Puerto Rico Primary Care Association. We're excited for you to hear insights from these panelists that these panelists will share. If you've got any questions, please go ahead and enter those into the Q&A. We'll address those, time permitting. It's now my pleasure to turn the webinar over to Candace. Candace, the floor is yours.

**Candace Owen:** Thanks so much, Amber. Hello, everyone. Thanks for being with us today. I'm excited to be presenting on integration and mental health strategies, some work that we've done at our organization. Next slide. Actually, you can go to the next one. I'll start a little bit to tell you about the National Network for Oral Health Access, in case you're unfamiliar. We call ourselves NNOHA. We are a national nonprofit organization that was founded in 1991. What happened at the time is that there was a decline in health centers, or federally qualified health centers with oral health programs.

There were nine individuals, dental directors who worked in health centers who came together wanting to have collaboration, partnership, and support. They founded NNOHA with the principle of increasing access to oral health care for all. Our membership now includes over 5,400 dental professionals. That includes dentists, dental hygienists, dental assistants, supporters, and partners. Next slide.

NNOHA has been doing a lot of work around mental health and oral health integration. This really stems from 2020, when there was increased demand for mental health services. We decided to determine ways that dental could support that work. Health centers are really a natural point for integration to happen, just because of the way that health centers deliver care. This image here shows that how is the health center model unique in that we have patients in the middle and then around them are all of the different services that can be offered by a health center, and many of them delivered in the same roof, if not within the same system. Next slide.

A little bit of background on integration and where we got to where we are. There is a national health center program, and every health center has to submit data through something that they call the UDS or the Uniform Data System. There is this metric that was released in about the 2000s. It is the percentage of patients 12 years of age and older who were screened for depression with a standardized tool. If the screening was positive, they had a follow-up plan documented. This could be something written in the chart that they were referred, or maybe it was a warm handoff, or they had an appointment scheduled, something like that. Next slide.

This slide shows the UDS data for this depression screening measure, the trend since 2019. You can see that in 2020 there is a decline, and this is likely due to the pandemic. Then a nice bounce-back and some rebound happening with 2023. Getting back to where we were in 2019. What really started to happen for us on the next slide shows some of the thought around what would happen if dental started screening for depression, too, or even other type of mental health screenings like anxiety or other mental health screening tools that are available.

One of the key areas was obvious that if dental is able to screen for depression, it would help this UDS measure, therefore helping the health center as a whole. That also would allow for more patient-directed care and create a bilateral integration impact between oral health and mental health. We know there's a lot of evidence that talks about the relationship between oral health and mental health. Knowing that and ways that dental can support that, as well as mental health professionals supporting oral health conditions, we decided to work with some health centers to pilot integration of oral health and mental health.

The next slide shows a framework that we have. This is NNOHA's framework. We call it a systems-level framework for integrating oral health and primary care practice. A little bit of background for NNOHA. We did a lot of work in 2014 with HRSA to pilot integration of medical and dental services. In that is how we developed this systems-level approach. We call it our Steps to Success. We have been using this framework for years to help health centers integrate medical and dental services. We wondered if this framework could be applied for mental health and oral health integration.

We piloted this in 2020 with a group of health centers, one of which you'll hear from today. Then from there, we started to build on that. We did, in fact, find that the systems-level approach is successful for all types of integration, not just medical and dental, but mental health and oral health. With these Steps to Success, there are five steps with four systems embedded. The first is Planning. Then we move into a Training System, which is training your providers. You have Health IT (information technology), Clinical Care System, and then the Evaluation System. I'll dive into each of those steps now.

The next slide shows a little bit of planning. We have these different buckets within one of our User's Guide for Mental Health and Oral Health Integration, which I can send the link later. There is a readiness assessment that you can fill out to determine your level of readiness for mental health and oral health integration. These are the different buckets. We found that if folks have these buckets filled, then it allows for the most success and readiness for integrating oral health and mental health. We know it's unrealistic to have every single one of these buckets full.

The intention is that you can identify where some of your gaps are, areas that you might need to better support and provide more attention to as you start your implementation. Then you can also know where your strengths are and leverage those for your implementation of the work. First, we have leadership buy-in. This is having leadership like CEOs (chief executive officers), COOs (chief operating officers), CFOs (chief financial officers), and your board of directors buy into and support integration. That integration and that culture is embedded into the organization's environment.

Then we have staff buy-in. This one's really critical because ultimately, the staff are the ones that are going to be doing the work. Making sure that your department staff understand or are willing to engage in integration. Culture of quality improvement. Having your organization understand that quality improvement methodology is important to test and implement new ideas. That's our framework for a lot of our small group trainings, just to ensure that health centers are utilizing methods like the model for improvement to allow for small-scale changes to drive change within the organization.

The executive team being integrated. Meaning that you have a dental director, a chief dental officer, that is part of the health center's management team. That oral health is valued and seen as an equal to the medical team and others in the health center. Ideally, we'd like to see a chief dental officer that reports directly to the CEO or the same individual that the chief medical officer reports to. Clinical champions is very similar to staff buy-ins. Making sure that there are champions from each of the disciplines, whether that's the mental health team and the dental team, or primary care and dental. That you have folks on each side that are championing the work from within.

We also have co-location. Co-location means that you have mental health and dental within the same building. This is obvious as far as why this would make integration easier, because you could walk down the hall and talk to each other and collaborate in that way. You could get patients directly over to care in a more seamless transition. We know that not every health center has this ability. We see a lot of times that dental is in a different building. If you're not working in a health center, then you may not have mental health and dental within the same building. Those are just ways, things that you might have to work through, helping patients navigate care and being able to collaborate and have conversations across disciplines.

Then the final thing is an Integrated Electronic Health Record or EHR. Again, if you have a medical and dental record that speak to each other and that are interoperable, so you could see each other's schedules, see previous notes, it just allows for the integration to be a bit more seamless. Again, not a reality for a lot of health centers or a lot of clinic settings. Just finding ways to make sure that you can refer to each other and be able to communicate findings from each other's appointments.

Next slide dives into the training system. Really, the idea here is having mental health professionals train dental professionals on the depression screening tools, the relationship between oral health and mental health. Also, having dental train mental health to understand what are some of the impacts that could happen to the mouth and the teeth when there are mental health conditions. Then also having trainings on the workflows. When you have these things integrated, you want to understand how that fits into your appointment, what does a referral look like, and what happens if there is an emergency, that someone needs to have immediate care, and what is the process for that.

Those are some of the things that we see within the training system. Next slide. Again, thinking about training for bilateral integration, we have different ways that you can do this. There's obviously a standardized mental health screening tool for depression. We often see it being the PHQ-2 (Patient Health Questionnaire-2) or the PHQ-9 (Patient Health Questionnaire-9). The PHQ-2 is shorter. It's only two questions long, so that tends to take less time from the dental appointment. Having some trainings with your oral health professionals to understand what's in the screening tool, how do they ask those questions, and what to respond to if a patient needs mental health support.

Then, on the other side, having dental professionals provide training to mental health professionals about screening for oral health diseases and conditions. What's on the slide is a sample questionnaire for patients. It's just five questions talking about their oral health. In a lot of situations, it's, do you have an existing dentist? Is that part of the health center? When was your last dental visit? Do you have any pain or discomfort? Do you want to be referred to the dental department? Pretty short and sweet, but ways that dental and mental health can collaborate. Next slide.

The second system is Health IT. It's our third step. This is leveraging technology, primarily your electronic health record, for increased integration and collaboration. Utilizing your electronic dental record, having the depression screening tool embedded within that, having bilateral referrals between the medical and dental department. In most cases, the mental health team utilizes the electronic medical record. Being able to make sure that there's ways where they can communicate, see referrals that are being sent over, and whatnot. Then also the ability to track completed referrals. That way, the dental professional knows that the patient, in fact, did go and complete a mental health visit and vice versa.

Next slide just shows a scale of different levels of integration. You can start with something like no integration. This is having separate medical and dental records. This is often like paper, for example. If you're still using paper records in the dental clinic, there's no way that that's going to integrate with an electronic medical record system. Minimal integration would be when you have two separate electronic medical and dental records, that maybe you do have a bit of access. Maybe you have a login, and you can log into the electronic medical record, and you can look at it that way. They don't communicate with each other, but you are able to look at each other's records, or some way to do that, a workaround.

Then you have moderate integration. This is like an interface, like an HL7 (Health Level 7) interface, for example, where you have electronic medical and dental records that have some interface that was manually created, and it allows them to have access to some aspects of the health record. Full integration would be having a fully integrated and interoperable medical and dental system. Medical and dental departments are on the same record, and you're able to see scheduling, shared access, pharmacy, all of that in one place.

These are what we would consider the ideal situation is having full integration. You can see where maybe you are on the scale and what are some of the things that you may need to do to help navigate integration, depending on your health IT situation. The next slide just shows some workarounds. We've worked with a lot of health centers that are unable to have an integrated system or maybe not even able to modify their system. They can't embed a depression screening into their dental record. Instead, they're using things like paper. These are just two examples.

When a patient comes in, they are completing their depression screening upon intake, and then it's getting scanned into the chart. Later, the dental assistant will automatically type in the findings into the patients' dental chart. There are ways to work around and still integrate, even if your health IT system doesn't allow for it. The next slide is showing the Clinical Care System. This is essentially workflows. What are the clinical workflows and process maps for implementing mental health and oral health integration? Really, the key piece of this system is creating clear policies and procedures to allow for increased confidence of your team, but also to enable them to engage in the work.

Next slide. We have a couple of examples of workflows, and these are coming from health centers. These are just some examples from health centers that worked with us in their small group trainings, and they developed these workflows. Just some examples. Hopefully, you'll get copies of these slides so you can look at them in more depth. In many situations, we see folks starting with a PHQ-2, and then if needed, they'll move on to the PHQ-9 if they need some additional support, if they're scoring high in the PHQ-9. You can see that it is guiding them on what is the next step, a referral, sending a message, something like that.

Next slide is another example. You can see just what is happening based on score. We see two different workflows really being created. In most cases, it's a workflow of what happens during the actual appointment. Then, secondary is a decision tree to help dental professionals understand what to do if a patient scored a certain way. What we heard from most health centers is that was the biggest barrier, that dental professionals were feeling uncomfortable. What happens if a patient does have suicidal ideations or a crisis? What happens if a patient scores a certain way? I don't know what I'm supposed to do. Having these decision trees to help with that decision-making process.

The last system is the Evaluation System. That's on the next slide. What we did during our small group training is that we had these health centers that work with us report on monthly data. What we did is we really just broke down the UDS measure. We found that if you're able to measure the three measures that are listed on this slide, then you can absolutely report the UDS measure. A reminder of what the UDS measure, that's in the dark blue. Then the measures that our health centers submit are these three that are listed. First, the percentage of patients who were screened for depression.

Second, the percentage of patients who had been screened for depression with a positive screening result. Then, finally, the percentage of patients at a positive screen and had a follow-up plan documented. Next slide. A few lessons learned from our work in helping health centers. We've had about over 50 health centers work with us to integrate mental health and oral health. These are the key pieces that we found, those recurring themes. Executive leadership support, making sure that your executive leadership is on board to help advance for their patients, making sure there's integrated care.

Then, health IT challenges or things that happen often when it comes to integration, and in fact, what we see with any type of integration, mental health, primary care. Health IT challenges are the greatest challenges that the health centers experience because every single health center has a different version of their IT system, different combinations across medical and dental. It's really difficult to collaborate even with your health center peers. Identify these challenges early and work with your IT team to help work that through. Leverage your mental health team. They are great resources to provide trainings and understanding on mental health, the screening tools, and helping to guide your patients.

Also, training for dental team members is critical. As I mentioned, making sure that your dental team really understands what is expected of them and what needs to happen based on a patient's result of their depression screening. Then, finally, evaluation is critical for continual improvement. While the UDS measures are only measured annually, those are the only times that you submit them is once a year. It's important to look at your measures more often than that because if you're checking something at the end of the year when it's reporting time, you can't really make improvements if you're finding that the measure is low or maybe that your reporting was inaccurate.

Checking your data monthly is something that we advise and recommend. You can use other metrics besides the UDS measures as well, if that's helpful to you, just to make sure that change is happening, and if there needs to be changes to policies, protocols, and workflows that you have time to make those adjustments. With that, that's my presentation. As mentioned earlier, please use the Q&A box for any questions. I'm happy to respond to those as we have time. I will pass it back over to Kayla for our panel.

**Webinar support:** Candace, thank you so much for sharing those insights on mental and oral health integration. The examples you shared are a great segue into our panel discussion to talk more about how different health centers are working to integrate mental and oral health. As a reminder to our listeners, you can add your questions for Candace and our panelists at any time in the Q&A panel. It is now my pleasure to introduce our panelists for today.

Selynn Edwards is the dental director for Clackamas County Health Center in Oregon. Dr. Edwards has worked in Federally Qualified Health Centers (FQHCs) for 15 years and takes pride in making a positive impact on patients' whole-body health.

Marielys Santiago Matos serves as access to care lead at the Puerto Rico Primary Care Association. There, she oversees initiatives to expand access to mental health and substance use disorder services across the island's FQHCs.

Migdalia Perez Rivera is a mental health coordinator at Health ProMed (HPM). A clinical psychologist, Dr. Perez Rivera has developed treatment protocols for incarcerated people with mental health and

substance use disorders. She has also supervised mental health staff within multiple correctional institutions in Puerto Rico.

Laury Rios is the director of dental services at HPM. Dr. Rios manages integrated oral and mental health services at the San Juan Clinic. She has been a champion at HPM for integrating mental health services within oral care.

Rebecca Cornille is the chief dental officer of Vista Community Clinic (VCC) in California. Through integrated care, Dr. Cornille provides mental health screenings. within the dental department while increasing dental care access for older adults and people with diabetes. Thank you so much for joining us today. Amber Murray will serve as moderator. Amber, please go ahead.

**Amber Murray:** Great. Thank you, Kayla. At this point, I think we will probably take down slides, and our panelists will come off mute and onto camera. The way we'll structure this is-- apologies, I didn't come on camera myself. I've got a question, and then we'll take turns amongst our panelists answering those questions. We'll do approximately two rounds of that. Then, if you have questions along the way, please don't hesitate to enter those into the Q&A. Our first question for our panelists are, please tell us about how your health center or organization integrates dental and mental health or SUD services? What are you doing in your health centers? I'll start. We'll kick things off in the panel with Rebecca from Vista Community Clinic.

**Rebecca Cornille:** Hello, everybody. I'm happy to join you all today. This is a great segue from Candace's presentation because we very much followed the NNOHA model that she outlined. In 2020, we recognized the impact the pandemic had on mental health with our patients. Therefore, we decided to initiate administering the PHQ, or the patient health questionnaire, in all of our dental clinics. We were fortunate to participate in the collaborative with NNOHA in the fall of 2020, and that helped guide our steps.

The demand for mental health care during that period of time exceeded the capacity that our organization had to serve. We were very careful not to administer PHQs without the ability to see those who requested services. Therefore, we started with a very small pilot team and gradually moved to select teams and locations that were co-located with our mental health department. We decided to administer the PHQ-2 and/or 9 for all new patients and recalls age 12 and over. We utilized Eye2Eye, which is a health tool that helps alert us to those patients within our organization that had not been screened using the PHQ-2 or 9 in the current calendar year.

Then we decided what to do based on the score. Much like Candace outlined, if we administered the PHQ-2 and the patient scored one or higher, we administered the PHQ-9, and we entered that into NextGen, which is our electronic health record. If we administered the PHQ-9 and they scored 1 to 9, we provide mental health department information, and we do this either in the form of a paper handout or utilizing our portal. If they scored a 10 or higher, we provide mental health department information and we input a formal referral so that the patients can be contacted by our mental health staff. If they're positive for suicidal ideation or they score 1 or higher on question 9, which is related to suicide, we contact the mental health department for immediate consult and urgent referral. Since we implemented this in 2021, we have screened hundreds of patients in the dental department.

This has not only helped with our UDS measure, but it's also connected patients to services in a well-thought-out process and workflow. We have also screened several individuals who were positive for suicidal ideation, and we were able to gain valuable assistance from our colleagues within the mental health department. It's helped us work and form relationships across our departments to provide valuable services to patients in need and promote integration.

**Amber Murray:** Great. Thank you, Rebecca. That sounds like really data-informed, evidence-based approach to implementation using NNOHA's model. Thank you. All right, from here, I'll hand things over to Marielys Santiago-Matos to describe how the Puerto Rico Primary Care Association has supported oral and mental health and substance use disorder integration. Marielys?

**Marielys Santiago Matos:** Hi. Hello, everyone. Thank you, Amber. Our experience at the PRPCA (Puerto Rico Primary Care Association) prior launching this project, the PRPCA conducted a post-COVID need assessment to better understand how community needs has shift as the result of the

pandemic. As the public health emergency reshaped the care landscape in Puerto Rico, we focused on identifying emerging patients' needs in order to better support our health centers and finally adapting to the priorities of the communities.

One of the key findings from this assessment was that oral health programs experienced the most significant decline in patient volume, while mental health and substance use disorder services program remained relatively stable. Providers also reported that many patients received mental health and substance use services had a significant amount of necessities in oral health. This was happening because of the extended period of time that they used the mask, such as the widespread use of virtual care that we were inclining to use to face the distance on services and the widespread of the pandemic. This contributed to the gap on oral health services on these patients specifically.

These findings clearly highlighted the need to develop intentional strategies for the PCAs (Primary Care Associations) to better link mental health and substance use with oral health services, ensuring more comprehensive and integrated care with the communities that we were serving. In response, the PRPCA established a collaboration with GPS International, and at that moment, whose teams traveled to Puerto Rico to deliver a two-day intensive training. This training prepared two professionals from each of the 17 health centers with mental health and oral health program to become changing agents in their communities and their organizations. They basically implemented the program in the health centers.

We were very intentional in ensuring that the practice that we were giving them was a practice that was evidence-based, innovative, feasible, requiring minimal structural change, and no significant financial investment, while remaining financially more stable and patient-directed. The goal for us was to foster a trusting and healthy relationship between the patients and the providers, allowing the health centers to retain the patients that they already had but also see the return in patients in oral health that we missed during the pandemic. It was a very good and strategic project that we were meant in the PCA to do here in Puerto Rico.

As part of the process, we placed a strong emphasis on providing the education in the PCA, and many professionals for us reported that this practice increased the job satisfactions for them because it is a model that encouraged them to step outside of the traditional professional comfort zone and engage them in more integrated holistic care. In addition, the PRPCA had an important responsibility that this training were environmentally appropriate for us. Specifically in language, most of the materials are in English. We were presenting a real lifetime opportunity so we can give them a linguistic implementation approach for them.

In our case, it required investing in professional translation was necessary and making the practice easier to implement more relevant information for the providers to better align with the realities of our communities as they serve. Following the training, HealthproMed stood out for its strong implementation of the practice, successfully applying many of the strategies learned during the training. Laury will share more details later and Dr. Migdalia about the experience, outcomes, and lessons they learned from the implementation.

**Amber Murray:** Great. Thank you, Marielys, which is a great segue into Laury and Migdalia to explain and describe how HealthproMed, what HealthproMed is doing to integrate oral and mental health and substance use services. I'll turn it over to Migdalia and Laury.

**Laury Rios:** Hi, everyone. This experience was very positive with my patient. Currently, the center was integrating mental health and oral health service. We took the initiative to include a specific question in the electronic health record based on the patient response. His stress ball is provided. We also acquired and implemented aromatherapy. An additional, last year in month December, we purchased television and installed vision programming, specifically designed to promotive and relation. Once a patient is identified, the case is referred to Dr. Migdalia Pérez of case of manager.

**Amber Murray:** Thank you.

**Migdalia Perez Rivera:** Well, integration of dental and mental health was very important to me because we work with the patient-centered care model. That recognized the strong bidirectional relationship between oral health and mental health. Integration occurs both at clinical and operational side.

Clinically, dental and behavioral health providers collaborate through routine screening PHQ-9, PHQ-2, GAD (Generalized Anxiety Disorder screening), for anxiety. Once they recognize and they have anxiety, they're referred to mental health. When they make an appointment, they try to make an appointment the same day so it could be easier for the patient to assist the appointment. That is very difficult.

That's one of the challenges we have because when they have that kind of appointment, they don't go. They'll say, "Yes, I'm going," but they don't go. They are very irregular with their appointment. We are trying to work it out in our department when Laury refers or some of the others refers to try to make a different approach to the patient so we can let him know that we are trying to work with the anxiety or depression or whatever, two of them, because they are very connected, depression and anxiety. When they have one of those, depression or anxiety, they try to delay the visit to any appointment.

Of all appointments, dental is the one that they are scary sometimes to be there because the sounds and the tools, they think they're going to hurt them. They told me sometimes, "No, this is a big whatever there. I think it's going to make me more pain." We sometimes explain to the patients the benefits of the oral health, that it increases the mental health benefits too, because they are connected a big time, more than they think about it. We are holistic.

We have to try the physical and the mental, both of them, so we can have a better life, so we can live with more enthusiasm, motivating. We used to the motivational interview, so we know where they are. If they are motivated to the change, they are motivated to assist, they motivate to use the tools that we offer them to try to work with the anxiety and the depression. We have some tools that you make, detention, so you can work with that, not think about it. Just work with it.

**Amber Murray:** Thank you.

**Migdalia Perez Rivera:** Yes, I like that very much.

**Amber Murray:** Thank you, Migdalia, and Laury. Some great examples you gave of the way HealthproMed is integrating oral and mental health from screening to the referral and the communication between your oral health team and your mental health providers, as well as educating patients and using motivational interviewing. I'll hand things over now to Selynn with Clackamas Health Center to talk about how she and her team have worked to integrate oral and mental health services. Thank you.

**Selynn Edwards:** Thank you, Amber. Here over at Clackamas Health Centers, I feel we can identify either as an oral health professional or a dental patient, and having those feelings of dread or anxiety associated with those visits. When the opportunity came up for funding for an oral health integration project, for us, it felt like a no-brainer. We recognized that patients who have had adverse experiences in life, anxiety was often a barrier to their dental care, so we focused on helping our patients manage this. Our main goal was to improve our no-show rates and support more consistent engagement in their oral health, making our patients a partner in their own care, making them a partner in the decision-making.

We first started with an environmental assessment with patients and staff. What didn't they like about the dental clinic? What did they like? We talked about what kind of comfort items would they find helpful? Just simple things like ChapStick, obviously they're opening and closing a lot, music, having a comforting picture on the second screen at their foot, putting a cartoon on for the kids. The technical piece was integrating a dental anxiety scale at every new patient and recall appointment. We do this. We built it into our rooming tab since we have an integrated electronic health record. Our questions in this questionnaire evolved over time. It started out pretty clunky with four questions.

Currently, we just have two. The first one is, do you have any concerns that you'd like to discuss with the dentist? The second one is if they've ever missed an appointment because of these concerns. This really simple screening process allows us to engage the patients and really open up that conversation about fear and anxiety and normalizing those feelings. Then we have a workflow. When patients are identified as having moderate or severe anxiety, we can activate this workflow and connect them with our mental health team. Because we have this integrated electronic health record, we have tons of options in how we get our patients what they need.

We can schedule directly with our mental health consultants. We can provide in-basket messaging if they would prefer a callback. Basically, our mental health team can help provide coping strategies, relaxation techniques, and they're tailored to every patient's needs. It's so flexible. The visits can occur at the same time as a dental appointment. The mental health consultant can come with them to their dental appointment.

It can happen immediately before the dental appointment, or it can happen as a totally separate visit depending on patient preference and clinical need. Really, by embedding this process into our routine dental appointment, I feel it helps to reduce the barriers. It normalizes that conversation. It really has improved appointment adherence. It helps to ensure our patients receive the coordinated support for both their oral health and their mental health well-being.

**Amber Murray:** Excellent. Thank you, Selynn. Just a great example of how providing that integrated care framework really supports patients in addressing various health care needs that they have. Perfect. Really quickly, in the time that we have remaining, we've got about 15 minutes left, we'll do one more round of questions with the panel and then open it up. We'll do this one quickly. What one piece of advice or guidance would you offer to a health center that is considering, hasn't started, but is considering integrating dental and mental health or substance use services? I'll start off with HealthproMed. What one piece of advice would you give to a health center who's just starting integration? That can be for Laury or Migdalia.

**Laury Rios:** Hi. For the other center wishing to implement integration, my best advice is identify any barriers and prepare staff to support patients.

**Amber Murray:** Okay, great. Thank you. Moving on to Rebecca with Vista Community Clinic.

**Rebecca Cornille:** Yes. For us, NNOHA was an incredible resource for getting started. The collaborative really kick-started our journey on this integration project. It's also important to start with a really small group of members who champion the cause, who believe in what you're doing. That has to be composed of members of both your dental department and your mental health department. Those who work in the mental health department and who are trained on those tools and resources are really valuable for all the various questions that come up because there is some trepidation by dental staff when you step outside of normal dental department operations and you want to have resources for those questions.

Candace had talked about a decision tree. If this, then what? It's really helpful to have someone who's well-trained on that to walk you through those steps. Also, pilot testing with one patient. You start with one patient. That gives you a lot of insight into your timing. At what point in the dental department appointment does it make the most sense to do this? It helps with the workflow. We really don't want to slow down the dental visit by adding another component. Then you'll quickly learn that there are times where it makes sense because there's lulls in the appointment. You might be waiting for the clinician to come in. It's a great time to do this screening. It aids in the integration. Then expanding slowly.

You're starting with your small team and just start almost the train the trainer type process because you don't want to overpromise and underdeliver. As I mentioned, our access in the mental health department exceeded or our capacity, exceeded our demand for access. It was a little bit tricky to not screen too many patients and then not have available appointments for them. Staying in close contact with our colleagues and our staff in the mental health department just to make sure there was access for the demand that we were building.

Then PDSA, so the Plan, Do, Study, Act, we've all probably done. You work with one patient and then you go back to the drawing board. Whether you use a float lane diagram, you're just moving the parts and pieces around to figure out what works the best. Then sharing best practices as you encompass more teams and more sites as we go.

**Amber Murray:** Great. Thank you. Selynn?

**Selynn Edwards:** Yes. Oh, gosh. Probably the one thing I would say is just to have a workgroup, a multidisciplinary workgroup. Representatives from every role group that may be affected by the change

and continuing to add role groups ad hoc as you discover new areas of impact. There's so many ripple effects that can happen as you change one thing, add another workflow.

We had folks from our QI (quality improvement) department, our ESAs (electronic signature agreement) for our Epic Electronic Health Record. We had somebody from our mental health department, somebody from dental. Even in dental, we had all role groups, the dentist, the assistant, the hygienist, who's going to be the champion. This workgroup, it helps align your mission. Those champions in the workgroup can help push that out to the individual clinics. I would strongly suggest that.

**Amber Murray:** Great. Thank you. Then, Candace, based on all the work you've done with NNOHA, any piece of advice or guidance you'd offer with the multiple health centers you've worked with on implementation and integration efforts?

**Candace Owen:** I echo a lot of what was said. Starting small, I think, is something for really any integration work that you do. Just start with one provider or dental and mental health professional, test it out with them, work out the kinks, and then start scaling up after that. I think one challenge is in many situations we see clinics who want to just go out and implement a project. They put it site-wide, but then there's lots of input, lots of feedback. It makes it really difficult. It makes tweaks and to communicate those changes. Starting small is really critical.

**Amber Murray:** Great. Thank you. With that, we've got about eight minutes left. We did have a few questions come into the Q&A. I think we've got time for [clears throat], pardon me, a couple of them. I'll put the questions out there and then anybody who feels equipped or ready, who has got a response from the panel, can go ahead and join in or answer. The first question comes in from Analia Brown, who's asking, what got you started on your integration journey? Was there a grant or how did you do it?

**Rebecca Cornille:** I'd love to chime in on this one because that's a great question. I don't believe there always needs to be a grant. I think there needs to be passion and the will to do. In FQHCs, we're in a perfect position to integrate because oftentimes we do have so many resources and so many disciplines under one roof. It's a great opportunity to collaborate. After that, sometimes the grants come. You get a good idea. You start small. You do those things. Then people start hearing about it or you present about it.

Then a grant application becomes available, and you want to go bigger. Then you apply for the grant and then it just grows organically but not without a lot of hard work. I always call all of our integration projects my passion projects. I've got the operations. I'm a dentist. I do all those other things. You've got to really believe in and where there's a will there's a way to get it done.

**Amber Murray :** Great. Thank you. Any other responses there?

**Marielys Santiago Matos:** Yes, me. Marielys from the Puerto Rico PCA. I just wanted to add a little bit about that. We were very intentional in ensuring that the practice that we were trying to promote here in Puerto Rico was an evidence-based practice in Nueva Rives and feasible that required a minimal structural and financial investment. I think this is, like Rebecca said, a practice and an evidence-based practice that you can start small with minimal funding required.

I think that HealthproMed is a good example of this. They started with minimal changes that they could do with the things that they already had. Like Rebecca also said, you can start small and then get the funding to go bigger. It is a really good activity for the health centers to start with minimal investment.

**Amber Murray:** Great. Thank you, Marielys. Let's move on to another question, one that I think almost every panelist could answer quickly. Which screening tool do you recommend for dental mental health integration services?

**Candace Owen:** I think I mentioned a few during our presentation. We see the GAD-7 if you're looking for something with anxiety. For depression, most commonly it's the PHQ-2 and then leads into the PHQ-9.

**Amber Murray:** Great. Any different screeners?

**Selynn Edwards:** Over here at Clackamas, we made our own. We weren't really focusing on a UDS measure. We were mostly focusing on how can we engage our patients and how do we lessen our no-show rate? How do we help them value the dental care that is available to them? Why are they not coming? We made up our own. Just to normalize that conversation around, I think let's be honest, dentists, we're very problem-focused or there's usually an answer to the problem. Even asking the question of what makes you anxious about this appointment causes us great anxiety. We wanted to start small. I think our next natural step would be to incorporate a PHQ-2 or 9.

**Amber Murray:** Got you. Great. Pretty consistent across the board, I think, across health centers with the use of the GAD-7, the PHQ, some of those standardized tools. We've got time for one more. Selynn, I'm thinking this is a good question for you. I'm going to paraphrase the question that Molly Day came in with, which is wondering about whether or not dental staff get trained on safety plans and how to comfortably support patients who may have some higher-level mental health needs or concerns.

**Selynn Edwards:** Yes, that is a tough one. That caused our staff probably the most anxiety. What do we do? This is totally outside our realm. We are not mental health professionals. A lot of scripting. A lot of scripting that they could have at their fingertips or just one phrase saying, "I hear your frustration," or "I can see that you're upset." When somebody starts to break down, we immediately want to shut down. Just saying, "I can see you're upset," and acknowledging that. Also, the fact that our mental health team is there at the ready. They're geared to be able to respond in the moment.

They have a certain amount of open time to where if we have somebody in crisis, we can go get them and they will come over. A lot of scripting and a lot of training. We had our mental health staff come do trainings. One phase of our project was training for all of our staff, mental health training for all of our staff, including front desk, assistants, dentists, hygienists. Then we had a secondary one that incorporated- it was like a mental health training 201 for our dental staff. That incorporated also motivational interviewing, which was great for us. It's not something that we're taught in our professional school.

**Amber Murray:** Yes, perfect. Thank you. Unfortunately, I think that's all we've got for time. I'm going to have to hand things back over to Kayla to close us out. Thank you, all. Thank you, participants. Thank you, attendees. Thank you, panelists, for this wonderful discussion and presentation.

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