Organized, Evidence-Based Care: Oral Health Integration

Executive Summary



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National *Interprofessional Initiative* on Oral Health
engaging clinicians eradicating dental disease

DentaQuest FOUNDATION

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Community Advocates for Oral Health

EXECUTIVE SUMMARY

ORGANIZED, EVIDENCE-BASED CARE: ORAL HEALTH INTEGRATION

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For more information, see the Organized, Evidence-Based Care Supplement: Oral Health Integration implementation guide.

Whether a primary care practice is just beginning the patient-centered medical home (PCMH) journey or is an established medical home, integrating oral healthcare into primary care is an essential effort, necessary for true transformation. The goal of integrating oral healthcare into primary care is to fully incorporate care of the mouth into care for the rest of the body, thus integrating a previously isolated clinical domain into medicine.

What

Oral health is an essential component of comprehensive primary care. The delivery of preventive oral healthcare is consistent with the principles of whole-person care and should be standard practice within a patient-centered medical home or advanced primary care practice. The integration of oral healthcare into primary care is not intended to displace dental care, but rather to expand the workforce addressing preventive oral health and improve patient health outcomes.

The historical divide between medicine and dentistry cannot withstand the growing body of evidence detailing the significant negative impact oral disease has on the quality of patient care experience, health of populations, and global cost of healthcare. Primary care is the natural home for oral health integration because it has the core competencies to screen for oral health risk factors and active disease, initiate appropriate preventive interventions, and coordinate care for those with active disease. Primary care is also the natural partner for dentistry for this interprofessional collaboration because primary care is leading the way in transforming healthcare delivery.

Why

Tooth decay is a transmissible, chronic, infectious disease that is surprisingly common. Fifty percent of adolescents suffer from tooth decay, and 25 percent of seniors have lost all of their natural teeth. What's more, oral disease doesn't just affect the mouth. Periodontal disease complicates and exacerbates other chronic conditions, such as diabetes and cardiovascular disease. Disparities in oral disease are significant, with the greatest impact on the most vulnerable populations.[1,2] While oral complications are often discounted or minimized, research and experience demonstrate that a person's oral health impacts their overall health and quality of life.

Oral disease is also a growing cost concern. The total cost of dental care in the U.S. exceeded $111 billion in 2013, with much of this expense for restorative interventions that could have been avoided with adequate prevention and/or early detection and intervention.[3] In 2013, $2.1 billion was spent on emergency department services for oral complaints—further highlighting the opportunities for prevention, early detection, and coordinated care.[4,5] Although the generalizability has yet to be determined, analyses of large insurance data sets suggest potential for significant savings in total healthcare costs resulting from treatment of periodontal disease in patients with chronic conditions such as diabetes and heart disease.[6]

Implementation Overview

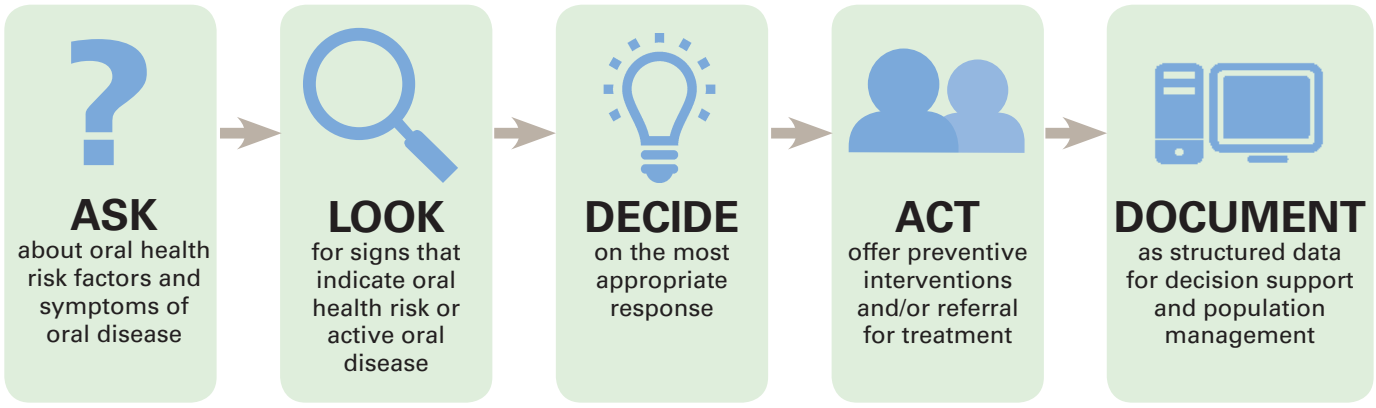
Create a vision for an oral healthcare integration program

Establish a leadership team to lead the oral healthcare integration process, identify a clinical champion and their care team to serve as pilot team members to test the new process, and develop and maintain a plan to support the goals, strategy, and timeline of the program, including a target population and standard of care for the pilot. The leadership team is also responsible for developing a strategy to spread the pilot to the rest of the organization once the pilot is stable.

Develop a pilot to test oral healthcare integration

Once the leadership team has created a goal for oral healthcare integration, it then needs to develop its approach to achieve integrated care. The Safety Net Medical Home Initiative (SNMHI) recommends the Oral Health Delivery Framework (the Framework) shown in Figure 1 as a model:

Figure 1. The Oral Health Delivery Framework



- **ASK** about oral health risk factors and symptoms of oral disease. The small set of recommended questions focus on gathering information to identify risk factors for clinical conditions (tooth decay or gum inflammation).
- **LOOK** for signs that indicate oral health risk or active oral health disease. The second part of the information-gathering portion of the Framework requires looking in the patient's mouth. The primary care team is not expected to make a diagnosis of caries or periodontal disease; however, team members can recognize signs of oral dryness, tooth decay, and gum inflammation, each of which has a corresponding set of recommended interventions.
- **DECIDE** on the most appropriate response. Clinical decisions on the part of clinicians and their care teams involve determining whether the patient's teeth and gums are normal or abnormal, and should drive a shared decision-making process about the appropriate actions to take.
- **ACT** to offer preventive interventions and/or referral for treatment. There are four basic actions the primary care team can take: individualized medical therapy; coaching and education regarding oral health hygiene, nutrition, and other oral health topics; application of fluoride varnish; and referral to dentistry.

- **DOCUMENT** findings and actions taken as structured data so the information can be used for decision support and population management. The role of health information technology (HIT) is to serve as an interactive checklist to remind care teams: Which patients need to have their oral health assessed using the Framework? The questions to ask (ASK). What to look for (LOOK). Whether or not there is an abnormality that requires action (DECIDE). The orders to consider (ACT).

Moving from the model of the Framework to implementation in a primary care setting involves thoughtful preparation, including building a case for oral health integration for staff and clinicians, clinical content training for the clinical champion and clinical members of the pilot team, and workflow optimization to determine where the steps of the Framework best fit within the primary care workflow. Once these steps have been taken, the pilot team can begin to test changes in their workflow to incorporate oral healthcare.

"What is really exciting about this work is that you can actually look and see the good that you're doing. You have concrete data to show that patients are getting good care, and that's what we're here for. We're here to take care of the patients' needs, and to not take on the integration of medical and oral health is just unimaginable." **—Michael Purdy, DO, Hilltown Community Health Center**

Monitoring Progress

Oral healthcare integration relies upon quality improvement methodology and information technology to:

- Define what the practice is trying to accomplish, including defining target populations and setting quality goals.
- Develop measures so the care team can tell that a change is an improvement by showing that workflow and decision support modifications are having the intended effect.
- Support workflow changes by organizing information and placing it at the fingertips of the people whose job it is to use the information to make decisions that drive improvement.

Practices working toward integrated care should regularly monitor their progress and the impact changes are having on patients and families, staff, and practice operations.

Leveraging Success: Spreading and Sustaining

Including considerations for sustainability and spread in the initial planning of the oral health integration program will support long-term success. A solid sustainability plan includes both administrative and clinical components.

Designing reports to tell a story at the outset of the program, preferably before making changes to the workflow, is the key to successful implementation, sustainability, and spread. Create reports that focus on the following care gaps: patients in the target population who have not been assessed, and patients in the target population who were assessed and found to have issues but who did not receive the standard intervention. Routine review of progress toward goals and the care gaps identified through reporting will enable the team to make improvements and determine the impact of changes made.

Practices should adopt strategies for sustaining the integration efforts, including:

- Maintain ongoing leadership support.
- Prepare for staff turnover and ongoing skills maintenance.
- Monitor and communicate metrics.
- Continue to improve workflows.
- Consider financial impacts and payment models.

Field-Testing Results and Lessons Learned

The Framework was field-tested in 19 diverse primary care practices in five states. These efforts demonstrated that the Framework is a practical model, and implementation is feasible in diverse practice settings. Degree of implementation, populations of focus, interventions offered, and data reporting capacity all varied among the sites, yet all were able to offer some oral health preventive care services to their patients, and all continue to look for ways to expand and spread their initial testing efforts.

- Among the 19 field-testing sites, over the course of 20 months, 13,771 patients were screened for oral health issues.
- 4,518 patients had fluoride varnish applied to their teeth.
- 1,255 patients without a regular dentist were referred to dental care.
- Through field-testing, 80 provider care teams were reached, and began addressing oral health in their primary care practice.
- Spread has been effective at sites that have engaged in it—spreading from 27 clinicians to 80 clinicians over 20 months.

What Progress Looks Like: PCMH-A Level A

The PCMH-A is a self-assessment tool to help practices understand their current level of "medical homeness," identify opportunities for improvement, and track their progress toward practice transformation. It is also a learning tool that can help start conversations within a practice about patient-centered care. The PCMH-A is scored on a 1–12 scale, which is divided into four levels (D, C, B, and A). A "Level A" item score indicates that most or all of the critical aspects of the key change addressed by the item are well established in the practice. An overall Level A score indicates that the practice has achieved considerable success in implementing the key design features of the PCMH.

Level A PCMH-A Items

For more information, see the Patient-Centered Medical Home Assessment (PCMH-A).

14. Non-physician practice team members…perform key clinical service roles that match their abilities and credentials.

16. Comprehensive, guideline-based information on prevention or chronic illness treatment…guides the creation of tailored, individual-level data that are available at the time of the visit.

17. Visits…are organized to address both acute and planned care needs. Tailored guideline-based information is used in team huddles to ensure all outstanding patient needs are met at each encounter.

31. Medical and surgical specialty services…are readily available from specialists who are members of the care team or who work in an organization with which the practice has a referral protocol or agreement.

35. Linking patients to supportive community-based resources…is accomplished through active coordination between the health system, community service agencies, and patients and accomplished by a designated staff person.

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About the Oral Health Integration in Primary Care Project

Organized, Evidence-Based Care Supplement: Oral Health Integration joins the Safety Net Medical Home Initiative Implementation Guide Series.

The goal of the Oral Health Integration in Primary Care Project was to prepare primary care teams to address oral health and to improve referrals to dentistry through the development and testing of a framework and toolset. The project was administered by Qualis Health and built upon the learnings from 19 field-testing sites in Washington, Oregon, Kansas, Missouri, and Massachusetts, who received implementation support from their primary care association. Organized, Evidence-Based Care Supplement: Oral Health Integration built upon the Oral Health Delivery Framework published in *Oral Health: An Essential Component of Primary Care*, and was informed by the field-testing sites' work, experiences, and feedback. Field-testing sites in Kansas, Massachusetts, and Oregon also received technical assistance from their state's primary care association.

The Oral Health Integration in Primary Care Project was sponsored by the National Interprofessional Initiative on Oral Health, a consortium of funders and health professionals who share a vision that dental disease can be eradicated, and funded by the DentaQuest Foundation, the REACH Healthcare Foundation, and the Washington Dental Service Foundation.

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