Oral Health Practice Readiness Assessment

Goal: To assist practices and practice coaches in identifying strengths and weaknesses in preparation for oral health integration

Practice Component	Required for Success	Helpful asset(s) that may be predictive of full implementation	Troubleshooting conditions or situations for which additional technical assistance (TA) will be required
Engaged Leadership: Administrative and Clinical Active support and sponsorship from: • Executive-level senior leader. • At least one provider champion. • Dental director (if present). Content of support and sponsorship: • Articulation of the importance of the topic. • Prioritization of oral health reporting. • Removal of barriers and allocation of resources for successful implementation and spread.	X	Clear organizational strategic priorities with: • Population-based quality objectives. • Quality dashboards. • Incentives for teams. Enthusiastic and engaged frontline staff: • Clinical assistants who welcome the role of leading a preventive oral health initiative. • Dental hygienists who are content experts and can serve as internal content coaches if they understand the model and are an available resource.	Local efforts in oral health integration in settings where leadership is missing or divided may offer opportunities to practice oral health integration processes but are unlikely to be effective or sustainable.
Team-Based Care Multi-disciplinary care teams: • Clinical services shared with non-clinician team members in roles that match credentials and abilities. Regular team meetings: • Daily team huddles to plan office visits. • Meetings to develop protocols and assess progress in meeting quality goals.		Organizational culture that includes: • Delegating of preventive and chronic illness clinical tasks to non-clinician team members (clinical assistants, Women, Infants, and Children [WIC] specialists, community health workers [CHWs]). • Clinicians sharing responsibility for teaching and coaching non-clinician team members.	Challenging team environments need to be addressed prior to engaging in oral health integration: • Interpersonal conflict within a team. • Inefficient workflows. • Inadequate team resources to meet demand. • Clinicians without the skills to work in multidisciplinary teams.

Practice Component	Required for Success	Helpful asset(s) that may be predictive of full implementation	Troubleshooting conditions or situations for which additional technical assistance (TA) will be required
Referral Capacity Tools and protocols for structured referrals to dentistry: • Established relationships and protocols for medical-surgical referrals. • Ability to communicate key information. • Processes to support referral tracking. • Patient logistical support.		Standard process for exchanging administrative and clinical data with medical/surgical consultants.	
Health Information Technology Ability to modify existing HIT systems to accommodate information for oral health: • Structured data entry field. • Clinical decisions support: date of last oral health screening and order sets. • Clinical reporting: reporting database and reporting software, database analyst able to write reports, quality improvement leader to design and validate reports.	X	• Experience with clinical process and outcomes reporting in other population management programs. • Health IT department that reports to the leadership that sets clinical quality improvement strategic priorities. • Adequate resources to devote to HIT modifications required for oral health.	If capacity is limited, expect high TA needs in this area. Refer to the Oral Health Technology Assessment tool for more information.
Quality Improvement (QI) Infrastructure Individuals with ability, experience, and skills to collect, report, and interpret basic data.		• Internal resources and capacity for collecting and reporting data that can support oral health integration efforts. • Prior experience using the IHI model for improvement or similar framework.	If capacity is limited, expect high TA needs. Refer to run chart tool for additional information.

Practice Component	Required for Success	Helpful asset(s) that may be predictive of full implementation	Troubleshooting conditions or situations for which additional technical assistance (TA) will be required
Adequate Staffing Levels • Care teams with sufficient non-clinician staffing to add tasks related to patient education and structured referrals including logistical support for patients. Staffing resources may include any complement of team members, including CHWs, AmeriCorps volunteers, WIC specialists, etc., so long as they are permanent/sustainable resources. • Staff resources adequate to provide quality improvement and HIT support to the care team.		Reimbursement systems that support staffing for care outside of a strict fee-for-service model pay for care delivered outside of office visits and generally support richer support staff ratios, in turn increasing capacity for patient education and coaching.	When clinical support staffing is lean, patient coaching is very challenging.

Community/Geographic Components	Required for Success of Initiative	Helpful asset(s) that might reduce frustration for participants and/or accelerate progress	Troubleshooting conditions or situations for which additional technical assistance (TA) will be required
Capacity for Dental Referrals Capacity within the dental community to accept referrals for patients of mixed insurance status: • Community health center dental practices with capacity to accept more Medicaid patients. • Private dentists willing to see new patients with mixed insurance and sliding scale.	X	Existing relationships with dentists: • In the same community. • In the same organization.	If dental resources are (or are perceived to be) limited: • Recruit supportive dental practices in advance of pilot kickoff. • Develop or leverage informal relationships with dentists in their communities.
Support for the Concept of Oral Health in Primary Care Openness within the dental community for: • Preventive oral healthcare being delivered in the primary care setting by members of the primary care team. • Receiving structured referrals from primary care providers.		Medical and dental clinicians that share a vision and a sense of responsibility for improving the health of the community.	If supportive dental resources are limited, consider creative ways to engage the dental community, such as partnering with the state dental society to offer a lunch and learn event to bring dentists and medical providers together.

Community/Geographic Components	Required for Success of Initiative	Helpful asset(s) that might reduce frustration for participants and/or accelerate progress	Troubleshooting conditions or situations for which additional technical assistance (TA) will be required
Existing Relationships Among Selected Sites Prior experience within a learning collaborative or like arrangement or existing relationships among leaders or staff.		Medical communities with a history of working together collaboratively on other clinical topics (such as diabetes) that can use this experience to share resources and experience on oral health.	If supportive dental resources are limited, consider creative ways to engage the dental community, such as partnering with the state dental society to offer a lunch and learn event to bring dentists and medical providers together.
Shared Systems Among Selected Sites Independent clinics that use the same EHR hosted by the same service provider, allowing opportunity to share oral health information tools with minimal modification.			

Source: Developed by Qualis Health for the Oregon Primary Care Association

"Body-Mouth-Spirit: Oral Health Integration Project". Supported by the DentaQuest Foundation. 1st ed. Seattle, WA, August 2015.

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.

For more information about the project sponsors and funders, refer to:

- National Interprofessional Initiative on Oral Health: niioh.org.
- DentaQuest Foundation (now CareQuest Institute for Oral Health): carequest.org.
- REACH Healthcare Foundation: reachhealth.org.
- Washington Dental Service Foundation (now Arcora Foundation): arcorafoundation.org.

The guide has been added to a series published by the Safety Net Medical Home Initiative, which was sponsored by The Commonwealth Fund, supported by local and regional foundations, and administered by Qualis Health in partnership with the MacColl Center for Health Care Innovation.