SECTION 8

Leveraging Success: Spreading and Sustaining

Introduction

Including considerations for sustainability and spread in the initial planning of the oral health integration program will support long-term success. In this section, strategies to support sustainability are described, including considerations related to:

- The use of data to promote spread.
- Staff turnover, training, and workflows.
- Finances.

Methods of spread (e.g., by population, by clinician) are described, as well as strategies to ensure successful spread.

"The challenge is to not underestimate the work of actually doing it. Challenges will come up, with referrals, with the EHR [electronic health record]. The best way to approach them is to break them down into their basic components and identify what is working and what isn't, and then identify a person to own the pieces that aren't working. It's going to seem that it goes a lot slower than you anticipated, but it's important to take small pieces and keep moving forward." —Michael Purdy, MD, Hilltown Community Health Center

An oral health integration program can be considered sustainable when it becomes an integral part of the primary care practice's processes and mindset. When the cultural norm is that diseases of the mouth are equivalent to those in other body systems, and neither patients nor clinicians can imagine not addressing oral health during the course of a primary care visit, sustainability will be achieved. This section discusses some strategies for a practice to consider when planning for the long-term sustainability of oral health integration, as well as important considerations for the program leadership team when planning the spread of the pilot test of change.

Strategies for Sustainability: Clinical, Operational, and Financial Factors*

How to best ensure an organization's integrated oral health program continues into the future? When people think of sustainability, they often confuse it with financing. While financing is critical, it is only one component of what makes integrated care stick. A solid sustainability plan includes both administrative and clinical components. Designing reports to tell a story is the key to successful implementation, sustainability, and spread. Set up reporting at the outset of the program, preferably before making changes to the workflow. Clearly define the target population and create reports showing the target population for each clinician and care team. Define the standard of care for management of the target population, focusing on:

- How the target population will be assessed and how findings will be documented as structured data, in this case, use of the Oral Health Delivery Framework (the Framework).
- How frequently the target population will be assessed, for example, yearly for patients with diabetes, or at the first prenatal visit for pregnancy.
- What the standard set of responses for specific issues found on assessment will be, e.g., high risk of caries will be addressed with fluoride varnish and oral hygiene/diet coaching; caries or periodontal disease will be addressed with referral to dentistry.
- How the responses will be documented.

Create reports that focus on the following care gaps:

- Patients in the target population who have not been assessed.
- Patients in the target population who were assessed and found to have oral health problems but who did not receive the standard intervention.

The Oral Health Data Reporting Template and Run Chart tool can be used with the data reports a practice generates to create run charts in order to visually monitor progress over time.

Set aside designated time on at least a monthly basis to review progress on goals and make any workflow changes as necessary. Staff should protect the time needed to review quality measure reports and take steps necessary to improve.

Once the care gaps are defined, the pilot team will make workflow and health information technology (HIT) changes intended to close the care gaps. Reporting at one-month intervals with a rolling look-back will determine the impact of the workflow/HIT changes.

Take time for a team tune-up

An essential component of sustainability is regular time for the care team to gather together and assess their function, discuss disruptions to the planned workflow, orient new team members, and develop team communication and trust. Gathering as a team to review data reports and discuss the workflow process allows team members to examine and problem solve as challenges arise. Common challenges might be that a change to the workflow is not working for a member of the care team, or that an intervention rate has plateaued because of an unanticipated obstacle. This can be done in different ways, such as meeting over coffee once a month, or blocking a regular team lunch session. The goal of this time is to allow the team to analyze their current state, review data, and discuss progress, obstacles, and solutions to implement in order to ensure that the team is continuing to develop the communication skills and processes needed to ensure successful oral health integration.

* This section draws on the learnings from the Safety Net Medical Home Initiative. Ratzliff A. Organized, Evidence-Based Care Supplement: Behavioral Health Integration. Phillips KE, Holt BS, eds. Seattle, WA: Qualis Health, MacColl Center for Health Care Innovation at the Group Health Research Institute, and the University of Washington's AIMS Center; 2014.

Maintain leadership support

Leaders are essential for the development of a sustainable oral health integration program. While the bulk of the initial pilot work is carried out by the pilot team, it is important for program leadership to maintain a connection to the work, and to make time to assess the progress of the pilot, support the development of the program, and celebrate and share the success of the pilot team with the broader practice and stakeholders. Leadership develops the vision for the long-term oral health integration program and will need to continue to refine that vision over time, as well as planning and supporting the necessary spread efforts. To learn more about how leaders can support transformation efforts, review the Engaged Leadership Implementation Guide.

Leaders can also reach out to community stakeholders, elected officials, hospitals, and foundations to let them know that their practice is improving care and how those efforts might affect issues important to them. Remember that audiences may remember some data, but they'll always remember a powerful story.

"We have experienced project leadership turnover. Without a lead, the work got a little lost. We were able to get back on track with a new lead—you should document all processes and make sure they are kept somewhere clearly marked. You should also always have a second hand person, someone you can bounce ideas off of and who is involved in everything, so that ownership of the work doesn't live with just one person."

— Practice Manager in an urban federally qualified health center

"Early in the pilot, we had two instances of staff turnover that impacted the progress we were making. The key to overcoming that turnover was having the remaining clinicians own the idea of oral health integration and decide what they could do, while shifting as much work as we could to the support staff."

—Heather Hicks, RN, Heart of Kansas Clinic

Prepare for turnover

Staff turnover can undermine the intervention. Turnover happens within all teams, and at all levels of the team. This was a common challenge experienced in the field-testing sites, and in all cases, it forced teams to develop creative ways to keep the oral health integration pilot on track. The practice's emphasis on integrated care should be a part of orientation for all new employees. Planning ahead for this reality includes developing tools and processes to support team members who are tasked with training new members of the team on the existing protocols and workflow. Such tools might include documented oral health workflows; job descriptions that clearly state the role responsibilities for oral health; clinical content training, and training for fluoride varnish application; and orientation checklists including oral health skills, for example, patient education, fluoride varnish administration, referral management, and tracking. The key is to focus on processes, not on people, and for new staff to be brought up to speed on oral health integration work and processes during their orientation, so they are ready to participate as soon as they join the care team.

Prepare for skills maintenance

Embedding oral health services into an organization's culture of integrated care means that every employee understands the importance of these services and operates with the expectation that all patients receive this care. Administrative policies, job descriptions, performance reviews, confidentiality agreements, and care coordination practices all support an integrated practice. Supervisory discussion during team meetings includes a review of physical health and oral health goals.

Ongoing staff and clinician skill brush-ups will be needed. Continue to build all employees' whole-health literacy. Consider routine review of the Smiles for Life curriculum for clinical staff, inclusion of fluoride varnish administration in clinical staff members' annual skills competency checklists, and routine review of patient teaching materials and methodology.

> "As new staff have come on board, we have just presented it as one of the components of their quality plan."
>
> —Heather Hicks, RN, Heart of Kansas Clinic

Monitor and communicate metrics

Clinicians looking to sustain their current array of integrated services must be able to make data-driven decisions to determine which integrated care components actually improve care. Regularly reviewing the clinic-wide metrics and clinician-level metrics will allow the team to assess which workflow changes they have made are working, and where they can most effectively focus their quality improvement efforts. Consider including a set of key metrics, such as those outlined in the Recommended Oral Health Integration Metrics tool, in the practice's quality improvement dashboard, sharing these metrics on a monthly basis with clinicians and staff members and posting metrics in public areas within the practice for greater accountability. If resources are not available for robust reporting, consider performing periodic small-scale chart reviews to audit oral health integration processes. Continuous quality improvement is a valuable way to make sure that an organization is meeting its goal of improving the oral health status of its clients.

Continue to improve workflows

Clinical and operational workflows need to be reviewed regularly. Consider using clinician meeting time to walk through a typical episode of care. This can help the team identify internal care transitions, external referrals, or other "pain points" that could become the focus of a quality improvement effort.

Consider financial impacts

Financing options for oral health integration vary, depending on the state, clinician type, and/or population of focus.

Pediatrics

Reimbursement for selected oral health interventions for medical clinicians is largely in place for pediatric populations. All but one state Medicaid program reimburses medical clinicians for administering fluoride varnish, and most states provide additional reimbursement for caries risk assessment and family oral health education. Moreover, nearly all states allow medical clinicians to delegate care to clinical staff. Refer to the American Academy of Pediatrics (AAP) Oral Health Reimbursement Chart for state-specific delegation and reimbursement information. Fluoride varnish and fluoride supplementation were given B ratings by the United States Preventive Services Task Force (USPSTF) in 2014, and are now required benefits for all qualified commercial health plans, meaning there is no charge to patients for the intervention.[26] Age ranges vary by payer. Many Medicaid programs provide reimbursement for preventive oral health services for children birth through age 21; some states and some commercial payers limit reimbursement to children six and under, consistent with the USPSTF guidelines.

Adults

Adult dental services are optional in Medicaid plans, and many states do not include an adult dental benefit. A recent report from the Medicaid and CHIP Payment and Access Commission (MACPAC) summarizes the coverage of Medicaid dental benefits for adults in each state. Federal statute specifically excludes payment for the treatment of teeth and supporting structures under Medicare. Advocates are working to improve dental coverage for adults.

It is possible to fit some of the Framework actions into existing preventive and chronic care visits for both children and adults, with minimal impacts on workflow and finance. For more information on designing efficient workflows, refer to Section 5: Staffing Options and Workflow. Practices have successfully integrated oral health preventive care into primary care under a wide array of payment models, indicating that integration is possible even in restrictive payment environments.

"Basically, we're just paying for it and see it as part of the service we offer…In the scheme of things, if you realize that you're doing this a couple of times a year for patients, and if you're reducing the caries rate by 1–3 caries per child, that's ultimately a big cost savings for the system."—Steve Wrightson, MD, Bluegrass Community Health Center

Some states will allow reimbursement for oral health preventive activities for adults under expanded Medicaid guidelines, and it is important to know what documentation is required. Practices can check with their local state Medicaid office to learn the guidelines in their state.

With the release of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and alternative payment models (APMs), the outline of the emerging reimbursement structure is becoming clearer. Practices need to be poised to develop serious strategies to address clinical quality and manage cost. Oral health is part of that strategy.

"Two ingredients that will move the needle in a significant way are if oral health was a part of required quality improvement benchmarks, and if there is reimbursement for it. Healthcare is moving in the direction of value-based reimbursement. When you're being paid for patient outcomes, and oral health is part of that outcome, then it will be worth people's while to take that extra minute."

—Judith Haber, PhD, APRN, BC, FAAN, Ursula Springer Leadership Professor in Nursing, New York University

Spreading Improvements

Spread is based on generalized acceptance of a compelling story that the pilot care team can tell using their data and should be considered from the beginning. To spread a successful pilot effectively, the care team needs to be able to show who their target population is, what care gaps they found when they assessed the target population systematically, what they did to close the care gaps, and the impact their efforts had on the target population. Opportunities to implement oral health integration more widely may include intensifying the intervention, including:

1. Spreading from a single target population to other target populations.
2. Spreading from a single care team to other clinicians within the same practice site.
3. Spreading from care teams at one practice site to multiple other sites in the system.
4. Spreading from a single component of the Framework to multiple components.

"We started with one clinician, and we have now spread to two others. We waited until we had the SmartPhrases set up in the EHR and had the workflow figured out, including how information would be documented, before rolling it out. While we were still making adjustments we didn't want other people doing it their own way. It took a few months to have a process that was stable enough to spread, where I was comfortable in my workflow and documentation, and my clinician was regularly documenting."

—Justina Johnson, MA, Community Health Center of Cape Cod

When spreading oral health integration, keep in mind the following strategies for securing buy-in and engagement for maximum effectiveness:

- During the pilot, involve representatives from care teams or sites who will be engaged in spread efforts, which may increase their level of buy-in.
- Use the pilot team to coach others. Identify training and mentorship opportunities for members of the pilot team.
- Involve key administrative and clinical leaders to develop and support the spread plan.
- Facilitate clinician-to-clinician discussion and planning; this increases the likelihood that clinicians will recognize value in oral health integration and may allay anxiety about the amount of work involved.
- Use data from the care gap reports collected by the pilot team, patient success stories, and staff and clinician satisfaction testimonies to inspire new care teams.

Case Vignette: Using Data to Support Spread at Sound Family Medicine

Sound Family Medicine, a four-site private primary care clinic system in Puyallup, WA (population 38,000), a suburb south of Seattle, started its oral health integration pilot with a single clinician team and spread to other clinicians within the original clinic location. Marc Aversa, MD, medical director, explains, "The main thing we've done with the data is to look at it in terms of spread. When we first looked at the overall clinic data, we thought our pilot clinic was doing well and we were ready to spread to our other clinic locations. Then we decided to look within the pilot clinic and saw that there was a lot of variation from clinician to clinician." Aversa decided to delay spread to other clinics and focus first on getting all clinicians within the original pilot site to a more stable level of implementation. "We shared the data with our clinicians, and our floor supervisor is looking at ways to standardize and improve the workflows. Once we get that sorted out, we'll spread to our other three clinic locations and we will look at adding other target populations," shares Aversa.

Some organizations include a spread plan in their initial implementation plan. Consider using the Institute for Healthcare Improvement (IHI) Spread Planner, which is based on the Framework for Spread and uses questions to prompt the user to consider the actions needed to effectively guide the spread process. There are some common errors that practice teams often make when beginning the spread process. IHI's Seven Spreadly Sins describes these and provides alternative steps to take.

Oral health integration offers opportunities to improve workflow efficiencies, streamline processes that may not be working smoothly (e.g., structured referrals), and meet a currently unmet patient need. Ensuring sustainability and successful spread so that all care teams and all patients in a practice can benefit from these outcomes is essential to the ongoing success of oral health integration.



Case Vignette: The Spread Process at Rodgers Health

At Rodgers Health, a four-site federally qualified health center located in the urban core of Kansas City, MO (population 467,000), oral health integration began within the smallest of the four clinic locations, Lafayette Family Medicine, a rural practice located 45 miles east in Lexington, MO. First, a program leadership team was developed, which included clinic managers from all four clinic locations, the Lafayette clinic's clinician, Rodgers Health's quality improvement coordinator and HIT manager, corporate dental and medical directors, and the chief quality and clinical officer. The leadership team identified a pilot team at the Lafayette Family Medicine clinic, which included the APRN clinical leader, the clinical assistant, an LPN, and a reception staff member. They were supported closely by the quality improvement coordinator and the HIT manager, who were felt to be of crucial importance to Rodgers Health's goal of eventually spreading the oral health integration work to all sites within the system. The program leadership team met regularly to track progress, remove roadblocks, and monitor data. They have continued to meet to guide the spread process across all four clinics.

After beginning with well visits for adults and pediatrics, the pilot team spread to all obstetric patients, and then added patients with diabetes within the original site. That process took seven months, at which point the leadership team decided to spread to the other clinic sites in the Rodgers Health system.

Patricia Beatty, quality improvement coordinator, shares, "It took longer to get up and running at the new sites than it originally did at the Lafayette Family Medicine clinic. Lafayette is small, and the medical and dental practices are located on the same hallway, around the corner from each other. We thought we would start with that team and develop a process that we could roll out to everybody." Beatty explains, "When we started to spread to the Cabot Westside Medical clinic, we realized that every site was a little different, so there was going to need to be some variety in the implementation. It was a little more involved than we originally anticipated, and we had to take a step back and look at the workflow at the new site." The team decided that they did not need to start from scratch at the Cabot clinic, or at the Clay County Family Medicine clinic, which was their third site in the spread process. "We started with the Lafayette clinic's workflow and wound up taking some of it and then creating some new components based on feedback from the new teams. When we spread to the Cabot clinic and the Clay clinic, we spread to all clinicians at the site at the same time," explains Beatty. When the team prepared to spread to the largest site in downtown Kansas City with ten primary care teams, they felt the workflow process would be different enough that they started with just one department (pediatrics) before spreading to the others.

Conclusion

Oral disease has a significant negative impact on patient health, and untreated oral disease has been linked to increased medical costs and reduced quality of life. In a primary care medical home, attending to patients' oral health is thus an inextricable part of providing organized, evidence-based care. Primary care teams have the core competencies to understand and intervene in the oral disease process by identifying risk factors, initiating appropriate preventive interventions, and coordinating care for those with active disease. The Oral Health Delivery Framework presented in this guide provides a practical and flexible approach for achieving comprehensive, whole-body care. The Framework was tested and vetted by 19 diverse primary care practices in five states, demonstrating that implementation is feasible in a wide variety of practice settings and policy environments. The experience of field-testing sites, described in case examples and vignettes throughout this guide and Section 9: Field-Testing Results and Case Examples, further highlights the benefits of integrated care, including improved patient care, improved care coordination, and opportunities to improve care processes. A full and annotated toolset to help guide your own journey is provided in Appendix A.