

Clinical Connections Summit:

**Integrating Oral Health
&
Primary Care**

Double Tree Hotel

November 5, 2015

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The Status of Integration: Oral Health into Primary Care

Massachusetts League of Community Health Centers

November 5, 2015

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



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Oral Health Care Delivery: We Need a Different Approach

- **We know:**
 - A person's oral health impacts overall health and quality of life
 - Most oral disease is preventable
- **Despite the availability of effective prevention and treatment methods:**
 - We have seen small improvements in oral health status over the past two decades
 - Among some populations, oral health status has declined
- **Lack of access to oral health care contributes to profound and enduring oral health disparities**
- **The current model of oral health care delivery doesn't work for large segments of the population**
- **We need a new approach**

A New Approach: Integrate Oral Health Into the Primary Care Setting

- Primary care providers are the only medical specialists many patients see
- If we integrate oral health care into the primary care setting, providers can:
 - Screen for signs of early oral disease
 - Administer treatments such as fluoride varnish
 - Provide information about oral disease prevention and self care
 - Refer patients who need dental treatment to dental providers
- **The results would be:**
 - Earlier detection of oral disease
 - Improved health outcomes and reduced chronic disease burden
 - Cost-savings
 - Improved consumer/patient satisfaction

Integrating Oral Health Into Primary Care: Consistent with Comprehensive Care Practices

- Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. (IOM, 1996, 1978)
- Primary care practice, four pillars: first-contact care, continuity of care, comprehensive care, and coordination of care. (Starfield, B., 1992)
- Patient centered care: Providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions. (IOM, 2001)
- So, what took us so long to begin to integrate oral health into primary care?

Historic Barriers to the Integration of Oral Health Into Primary Care Practice

- Oral health care has been separated by tradition: training programs, payment structures, delivery systems; these created medical and dental silos
- The view that if we just trained enough dental providers, we could address the nation's unmet oral health needs
 - There would still be distribution problems
 - Many people can't pay for dental services and would still be without care
 - Some providers still would not treat uninsured, underinsured or non-paying (charity) patients
- We lacked an interprofessional approach that integrates the mouth back into the body and engages all health care providers

Why is “Now” the Time to Integrate Oral Health and Primary Care?

- Primary care and health services delivery systems are already undergoing “delivery system reform” and “transformation” – this impacts payment, delivery sites, services, and creates an openness to new models
- The ACA created accountable care organizations and other “patient-centered” approaches to care, designed to keep costs down, improve health outcomes
- There’s tremendous interest across multiple disciplines/professions and sectors in “patient-centered” care and interprofessional practice; improves quality
- Families and patients want to see changes that result in patient and family-centered care; get the patient out of the coordination role

An “Interprofessional” Approach to Integrating Oral Health Into Primary Care

- **Who is “calling” for an interprofessional approach to oral health care?**
 - Surgeon General’s Report on oral health called for all health providers to participate in oral health care (2000)
 - Echoed by the Institute of Medicine in 2010; HRSA in 2014
- **What is “interprofessional practice”?**
 - Interprofessional Practice (IPP) is a collaborative practice which occurs when healthcare providers work with people from within their own profession, with people outside their profession and with patients and their families (Canadian Interprofessional Health Collaborative, 2009; but there are more...)
- **Is it different from team-based care?**

How Do We Make Interprofessional Practice Happen in Oral Health Care?

- **Who has to be involved?**

- Dental providers – need to embrace the concept and see themselves as part of a patient-centered interprofessional team
- Primary care providers – need to see oral health as part of comprehensive health care and take responsibility for integrating oral health care in their practice setting
- Educators, accreditors, licensing boards – need to build oral health into health professions' curriculum, accreditation requirements, credentialing
- Practice and systems administrators – need to envision how this can happen and provide cross-organizational leadership
- EHR systems administrators – create IT systems that share information across and within practice settings

How Do We Make Interprofessional Practice Happen in Oral Health Care?

- **What tools and resources are we going to need?**
 - Tools to teach primary care students and providers about oral health
 - Tools that teach dental and primary care students and providers about interprofessional practice
 - Models and frameworks for successful oral health and primary care integration
 - Articles, meetings and efforts that “get the word out” and create the climate and expectations for oral health integration into primary care
 - A consumer campaign to create the expectation that oral health care will be integrated into primary care, and that dental providers will be connected to primary care providers

National Interprofessional Initiative on Oral Health



What Work Is Already Underway?

NIIOH

- **Supported by three Foundations**
- **Mission: Oral health is a component of whole person care**
- **Primary strategy: Address oral health needs of patients in routine medical visits**
 - natural extension of existing routines
 - health behavior change counseling readily adaptable to oral health
 - team approach works
 - clinical competency can be developed

What Work Is Already Underway?

NIIOH (continued)

- **Investments in Physician Assistant education, accreditation and credentialing (Anita Glicken, lead)**
 - Physician Assistant Faculty Workshops, Summit
 - Result: In 2008, 33% of PA programs provided oral health instruction; today, 78% do
- **Support for nursing education and practice (Dr. Judi Haber, NYU, lead)**
 - Oral Health In Nursing Education and Practice
 - Result: In 2011, no midwifery programs integrated oral health instruction; in 2015, 70% do
 - HEENT to HEENOT– APHA Journal
- **Annual Symposium**
 - Shared goals and values, engage new provider groups



What Work Is Already Underway? NIIOH Continued

- Smiles for Life
 - National Oral Health Curriculum – oral health care clinical competencies
 - Broadly endorsed
 - Free, on-line continuing education credit – ADA and others
 - Viewed by more than 500,000 visitors
 - There’s an app for that!

Smiles for Life
A national oral health curriculum

There Are Others Engaged in The Integration of Oral Health Into Primary Care

- **HRSA**
- **National Professional Associations – for example**
 - NACHC
 - American Academy Of Pediatrics
 - National Society for Teachers of Family Medicine
 - American Association of Family Practitioners
- **Dentaquest Foundation**

DQF - OH 2020 Goal 5: Integrate Oral Health Into Person-Centered Healthcare

Target: Oral Health is integrated into at least 50% of emerging person-centered care models

Primary/Secondary Drivers:

- Effective Care Models
 - Recognized accreditation standards and quality measures that include oral health
 - Oral health data included in electronic health records includes oral health information
- Provider Engagement
 - Development and adoption of person-centered care models that include oral health
 - Engaged and supportive care provider leadership
 - Adequate oral health workforce capacity

OH 2020 Goal 5: Integrate Oral Health Into Person-Centered Healthcare

- **Drivers (continued)**

- Family and individual engagement
 - An increase in oral health literacy
 - Optimal home care practices, including brushing, diet and nutrition
- Financing mechanisms
 - Integrated data that demonstrates cost effectiveness and optimal outcomes

What Else Will We Need to Do to Promote the Integration of Oral Health Into Primary Care?

- Develop and field test of oral health model implementation tools
 - Oral Health: An Essential Component of Primary Care, Qualis Health



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Oral Health in Primary Care: A Framework for Action

MLCHC Integration Summit

Kathryn E. Phillips, MPH

November 5, 2015



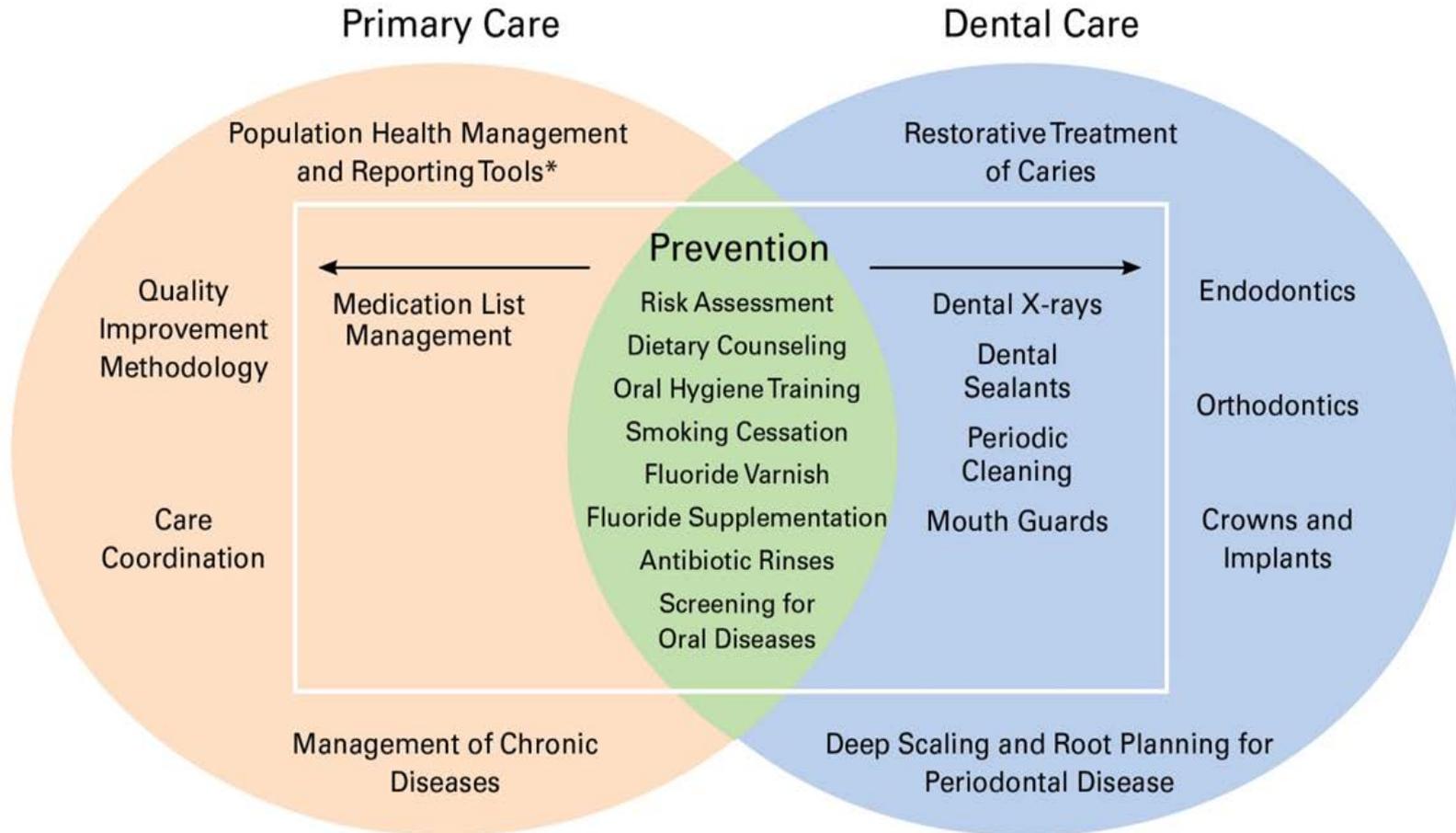
Advancing Healthcare
Improving Health

Objectives

- Present a new vision for how to improve population oral health
- Reflect on why oral health integration is perceived to be so challenging; what can be learned from the success of behavioral health integration efforts
- Present a practical framework for delivering oral health preventive care in the primary care setting & improving referrals to dentistry
- Share early efforts to “test” these ideas in practice



Partnership for Prevention



*Including structured EHR data and diagnostic codes, disease registries, and other tools

Care for Ms. G



- Ms. G is a 69 year-old woman suffering from diabetes, hypertension, and asthma.
- Her medical care is managed largely in a primary care clinic, which monitors her blood sugar and blood pressure every 3 months, and adjusts her medications accordingly.
- Her asthma severity is briefly assessed at each visit, and every autumn (before influenza season) her care team reviews her lung function, adjusts her medications if necessary, and makes sure she receives her flu shot.
- At a yearly visit, special attention is given to testing for kidney disease and loss of sensation in her feet. She is seen by an optometrist for an eye exam.



Care for Ms. G

- A year ago, her care team began screening for **oral disease** while assessing her eyes, feet, and kidney function.
- The initial oral health assessment showed moderate to severe periodontal disease and several root caries.
- The care team trained her in optimal oral hygiene and helped her identify ways she could reduce the sugar content in her diet.
- Her primary care provider also referred Ms. G to a dentist with a formal request to evaluate and manage her periodontal disease and root caries.
- The referral included a copy of Ms. G's problem list, medication list, and allergy list.
- The dentist returned a consultation note to the referring provider in which the dentist noted his impression, described the interventions taken, and outlined a care plan.



Oral Health in Primary Care

Goal: To prepare primary care teams to deliver preventive oral health care and improve referrals to dentistry.

- Reviewed literature and results of recent efforts to integrate behavioral health services, once fragmented yet now recognized to be a key component of comprehensive care
- Convened a Technical Expert Panel to guide us: Primary care and dental providers; leaders from medical, dental, and nursing associations; payors and policymakers; patient and family engagement expert; public and oral health advocates



Question: What will it take to change the standard of care?

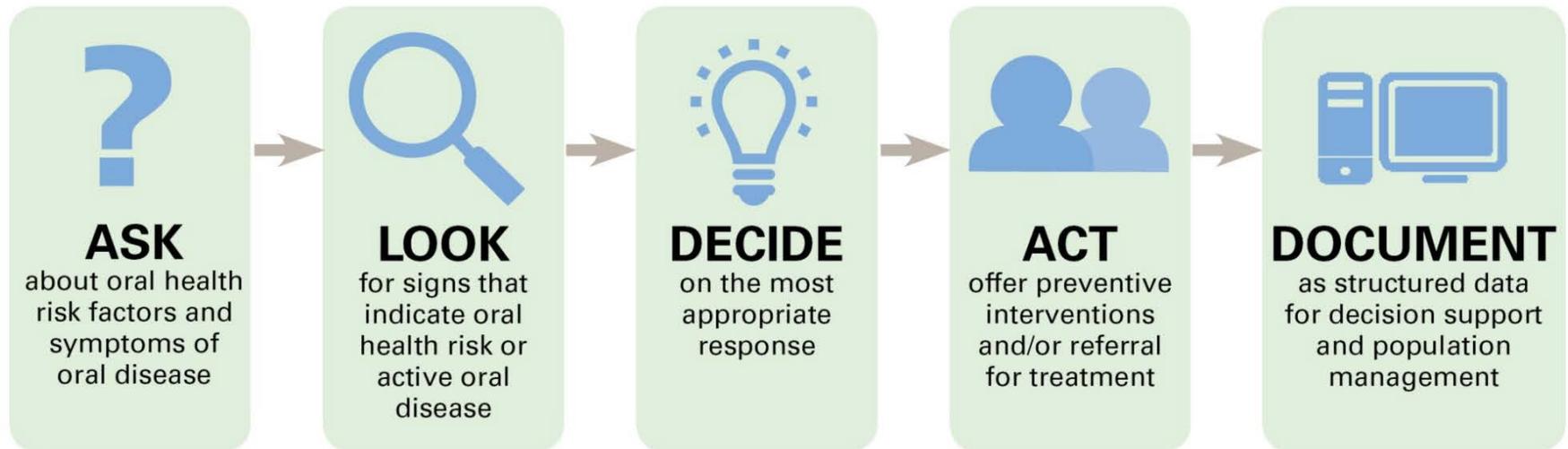


1. Clear definition of what can be done in the primary care setting to protect and promote oral health.
2. Streamlined process for fitting oral health into an already packed primary care workflow.
3. Practical model for a close collaboration between medicine and dentistry.



Oral Health Delivery Framework

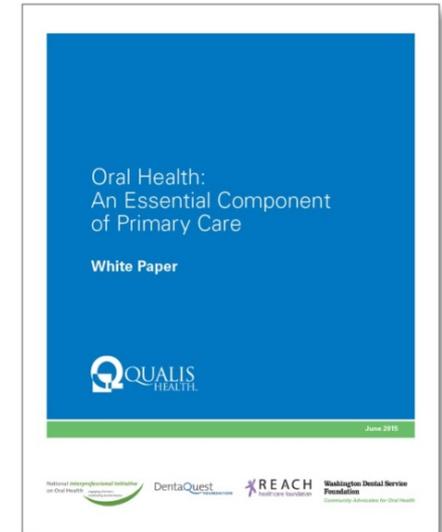
5 actions primary care teams can take to protect and promote their patients' oral health. Within the scope of practice for primary care; possible to implement in diverse practice settings.



Preventive interventions: Fluoride therapy; dietary counseling to protect teeth and gums; oral hygiene training; therapy for substance use; medication changes to address dry mouth; chlorhexidine rinse.

Oral Health: An Essential Component of Primary Care

- White paper, published June 2015
 - Case for change
 - Oral Health Delivery Framework
 - Supporting actions from stakeholders
 - Case examples from early leaders: Confluence Health, The Child and Adolescent Clinic, Marshfield Clinic
 - Endorsed by leading organizations



Available at: www.QualisHealth.org/white-paper



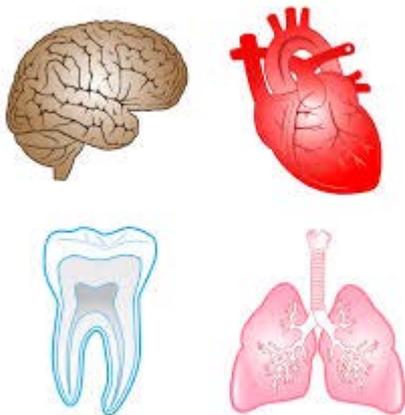
What did we learn from reviewing recent experience with behavioral health integration?

- Instructive model; both have histories of marginalization within greater healthcare system
- Success with behavioral health integration demonstrates that big change is possible; changing the status quo takes concerted effort from a broad base of stakeholders



Similarities

- Common, serious problems
- Lifelong consequences if untreated
- Early intervention can reduce impact and prevent complications
- Problems present in primary care; interfere with general health



Big difference?

- Many BH problems can be **treated** in primary care setting without specialized equipment

Result?

PCPs developed competencies & confidence in addressing BH problems:

- Screening
- Treatment (e.g., prescribing)
- Consults
- Structured referrals to mental health and substance abuse specialists



Why is oral health integration perceived to be *more* difficult?

- Education and training is still (almost) entirely separate
- Relationships between physicians and dentists are under-developed compared to physicians and psychiatrists (other professions follow suit)
- Payment systems are still (almost) entirely separate
- No history of structured referrals to dentistry



What helped behavioral health integration efforts take hold?

- Provider receptivity:
 - Primary care providers *needed* help
 - Behavioral health specialists *wanted* to provide support
- Clear demand from patients and families, broad array of stakeholders (e.g., mental health parity)
- Visible problem



Oral disease is a more hidden problem... concentrated in vulnerable populations



Brooke Shields speaks candidly to ABC News about her postpartum depression



David Beckham: Dealing with OCD



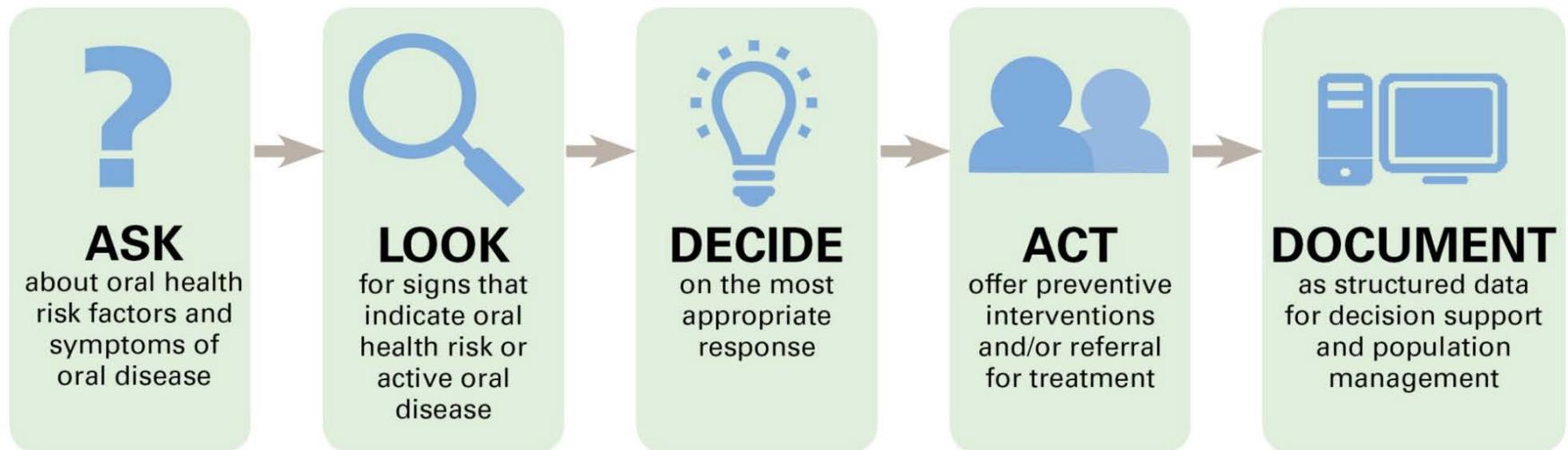
What else helped?

- Clear evidence that integrated BH care produces better outcomes at lower costs
- Payment and policy changes (slow and steady):
 - Reduction in “carve-outs”
 - Elimination of barriers (e.g., 2 visits per day)
 - Shift from FFS to value-oriented payment models
- Development of practical tools that helped PC Team identify patients at risk and determine impact of treatment (e.g., PHQ-9, GAD-2)
- Clarity on what can be addressed by PCP and what requires specialty support



Oral Health Delivery Framework

5 actions primary care teams can take to protect and promote their patients' oral health. Within the scope of practice for primary care; possible to implement in diverse practice settings.



Ask About Oral Health

Question	To identify...
How many days each week (average) do you brush daily twice for 2 minutes with fluoride toothpaste, and floss?	Inadequate oral hygiene
On average how many times daily do you have dessert, a sugary snack, or sugary drink	Excessive exposure to sugar
Do you have dry mouth, or need water to swallow dry food like crackers?	Salivary dysfunction
Do you experience pain or bleeding with brushing or eating?	Signs of caries or periodontal disease

Look in the Mouth

Examine	To identify...
Saliva	Dry mouth
Teeth	Oral hygiene, plaque, caries
Gums	Gum inflammation, recession, signs of periodontal disease



Offer Preventive Interventions

- Fluoride: Varnish, supplementation, prescription toothpaste
- Patient education/anticipatory guidance
- Dietary counseling to protect teeth and gums
- Oral hygiene training: Active demonstration
- Therapy for substance use
- Medication changes to address dry mouth
- Chlorhexidine rinse



Structured Referrals

- Many patients will need treatment that only a dentist can provide
- Referrals to dentistry ought to be as smooth as referrals to medical specialists -- *burden should not be on the patient*
- How is a structured referral different?
 - Referral issued as a clinical order
 - Referral tracking & care coordination processes
 - Logistical support
- What will this require?
 - ✓ Primary care-dentistry referral networks with adequate capacity to serve diverse patients
 - ✓ Ability and commitment to share information with one another



This is a new paradigm...

- Referral agreements help clarify expectations
- Guidelines for appropriate referrals
 - Clinical conditions
 - Insurance
 - Pre-referral work-up (if any)
- Protocol
 - Timeliness of referral
 - Efforts by consultant to contact patient
 - No show policy
- Information exchange



Info PCP to Dentist

- Service requested and reason for referral
- Additional relevant clinical data
 - Problem list (abbreviated to relevant issues)
 - Current med list
 - Allergy list
 - Relevant medical/surgical history
 - Pertinent labs and imaging

From Dentist to PCP

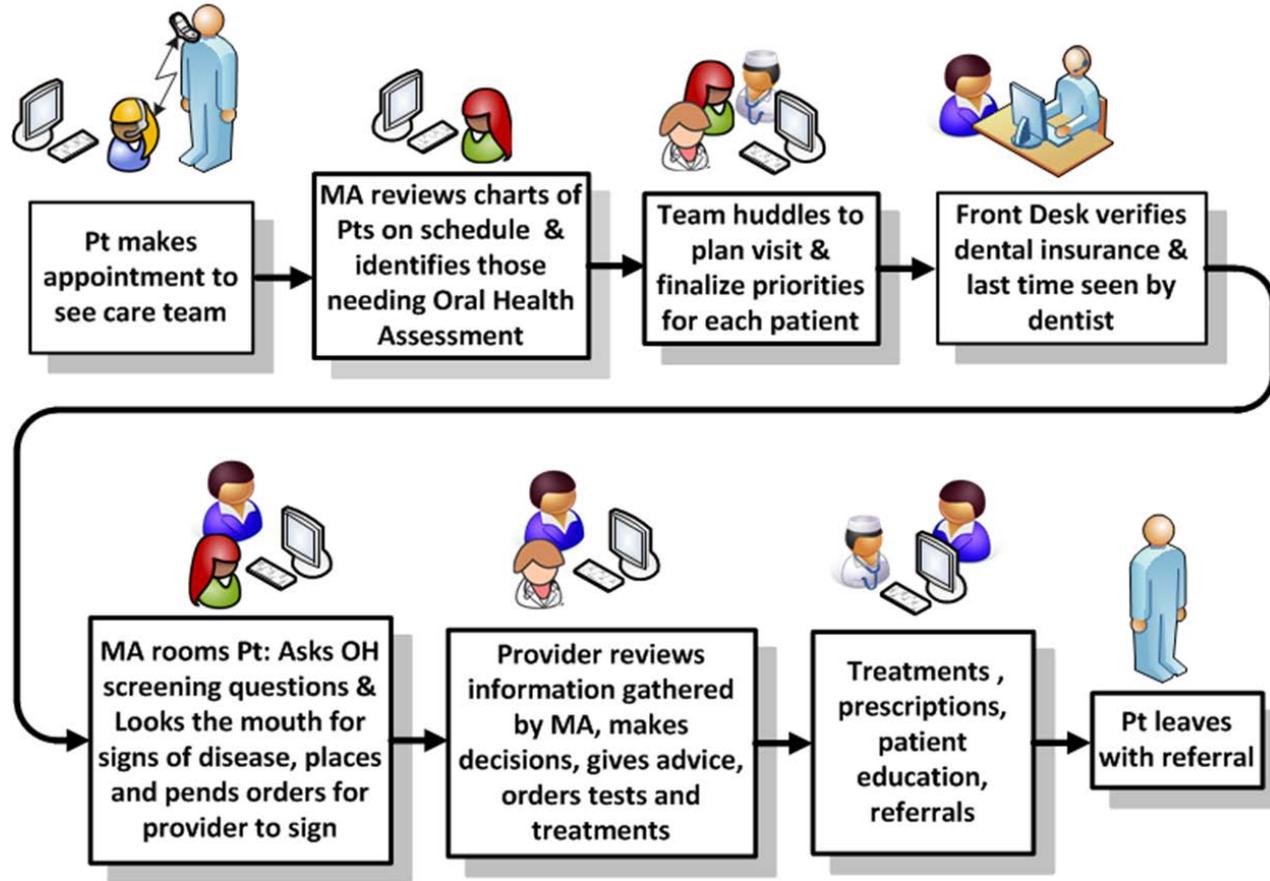
- Date patient seen
- Impression: What was found, e.g.,
 - Caries in multiple teeth
 - Periodontal dis. severity
- Disposition: What was done
 - Procedures
 - Any meds prescribed
- Brief treatment & follow-up plan



Who will do this new work? *It depends*

- Size and structure of the practice
- Provider comfort with delegation
- Needs and preferences of patient population
- Visit type

There are many options.



Common Question: *Is it feasible?*

- Possible without new members of the team and within a small practice setting
- Most activities can be performed by a trained Medical Assistant or LPN; minimal impact on provider time
- Does not require specialized equipment or space
- Advanced primary care practices have resources in place to implement now; others can take an incremental approach:
 - ✓ Begin with risk assessment and risk reduction; or,
 - ✓ Screening and structured referral
- Viability in long-run will take policy and payment changes



Field-Testing a Conceptual Framework

Develop

Test

Improve

Disseminate

19+ diverse healthcare delivery organizations: Private practices, Federally Qualified Health Centers; medical only and on-site dental

Adults with diabetes (12), pediatrics (5), pregnancy (1), adult well visits (1)
eCW (5), EPIC (8), NextGen (2), Centricity (2), Success EHS (2)



**Washington Dental Service
Foundation**

Community Advocates for Oral Health



**Oregon Primary Care Assoc.
Kansas Assoc. Medically Underserved (*)
Massachusetts League of CHCs**

*Support also provided by:
Kansas Health Foundation
United Methodist Health Ministry Fund



Technical Assistance

Qualis Health & State Primary Care Assoc.

- Assessment and goal setting
- Workflow mapping
- Clinical content training
- Development of a referral network (mix of private practice dentists and CHCs)
- HIT modification guidance
- Planning for spread: Patient populations, teams, sites



Impact Data

Goal: Gauge the impact on patients, families, practice as a whole



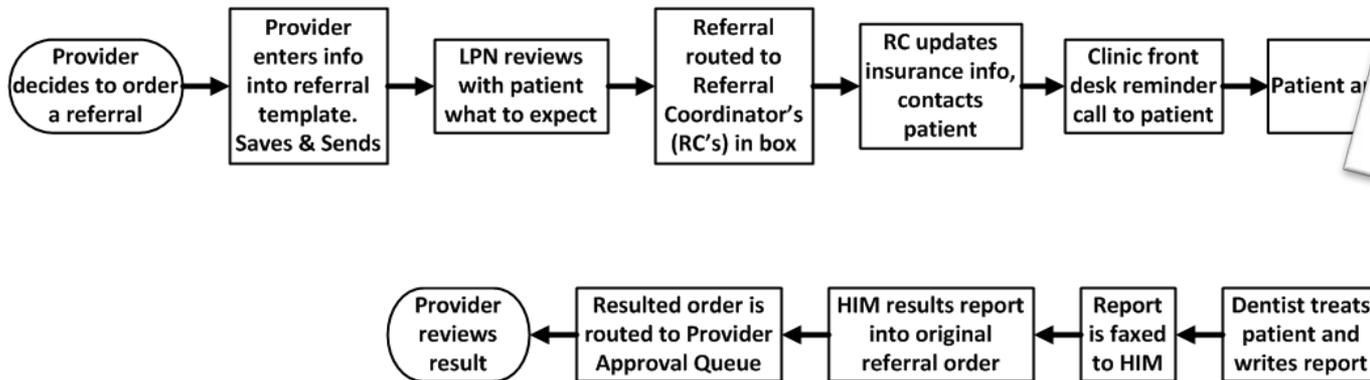
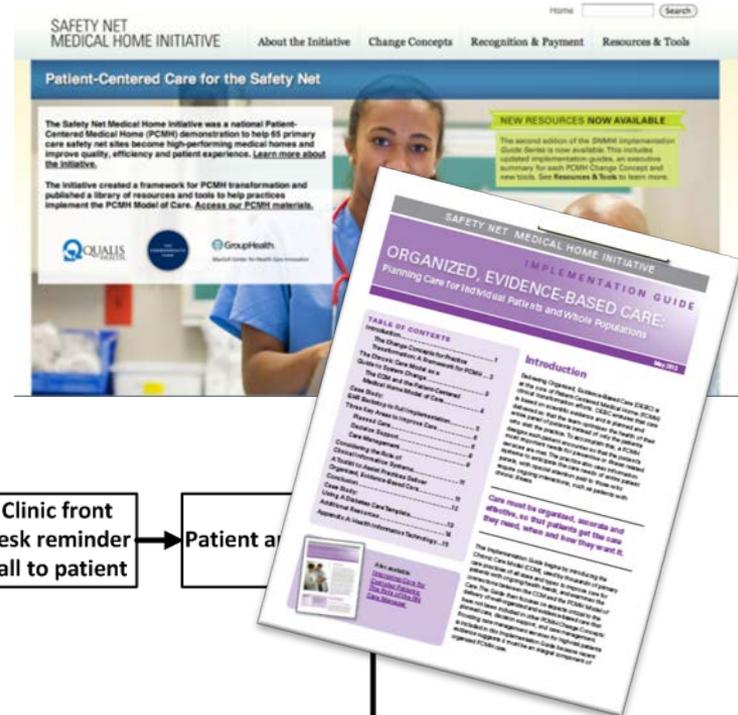
- % given screening assessment (ask and look)
- % positive for risk factor or signs of disease
- % given preventive intervention
- % referred to a dentist
- % referred with a completed referral



Resources Resulting From Field-Testing

Implementation guide—toolkit for primary care practices (Sept 2016)

- Sample workflows
- Referral agreements
- Case studies and impact data



What motivates primary care teams to engage in oral health?

- Awareness of disease burden & knowledge that intervention can make a difference
- Recognition that poor oral health compromises *overall* health: New evidence demonstrating a relationship between periodontal disease & diabetes, ischemic vascular disease, pre-term delivery and low-birth weight
- Positive feedback from patients

“This is the right thing to do for my patients.”



Primary Care 'aha' Moments

- Pathophysiology is familiar: Infection and inflammation
- It *really* does only takes a few minutes
 - HEENT to HEENOT



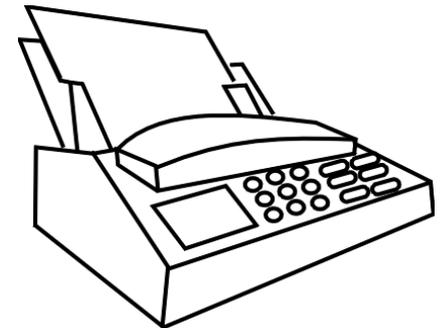
There are challenges...

- Competing priorities & change fatigue: Behavioral health integration, value-based reimbursement, ICD-10, other chronic disease care
- Behavior change is difficult; limited time for dietary counseling and oral hygiene training in a 15-min visit
 - Distill to core messages
 - Successful practices think creatively about *who* can help: MA/LPN, AmeriCorps Volunteer, WIC Specialist, Community Health Workers, waiting room video

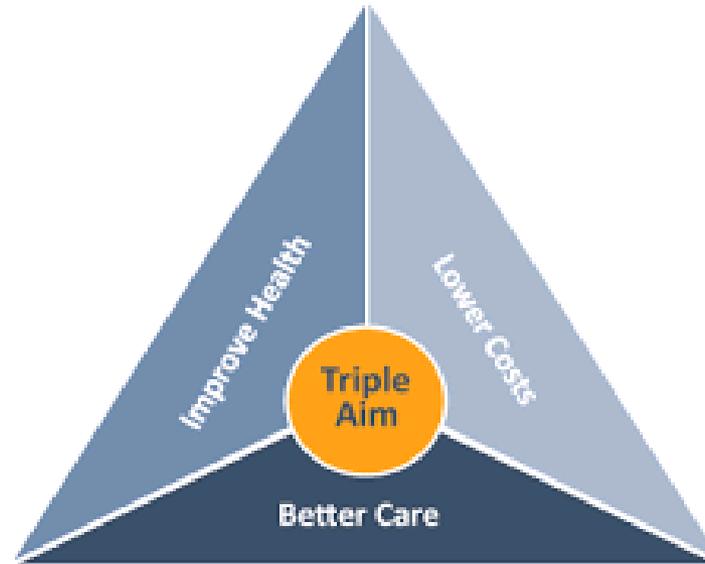


Challenges

- Referral process to dentistry is new; there are bugs to work out – **even with co-located dental practices**
- Health information technology is rigid and must be modified to support preventive oral health care & structured referrals:
 - Not all practices have the capacity to modify their systems directly
 - May lack knowledge, time, or authority
 - Vendor solutions can be expensive



Opportunity to Achieve Triple Aim



- Strong evidence that integrated behavioral health care produces better outcomes at lower costs; patients value and appreciate “whole-person” care
- Expect the same for integrated oral health care



Questions? Reactions?

Resources available at:

www.QualisHealth.org/white-paper

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