FEATURE

Oral Health Integration—
The Next Frontier for Health Centers

Adapted from: Hummel J, Phillips KE, Holt B, Hayes C. *Oral Health: An Essential Component of Primary Care.* Seattle, WA: Qualis Health; June 2015.

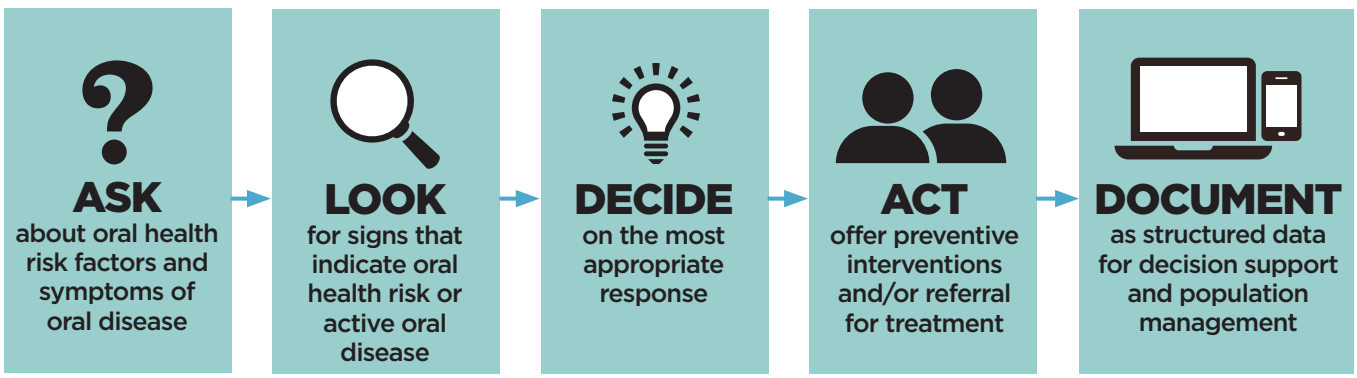
"Whole-person orientation" was a founding principle of the Patient-Centered Medical Home (PCMH) Model of Care; yet for many health centers, holistic care has remained an elusive goal. The ability to deliver and/or organize behavioral health services is now recognized to be a core component of comprehensive primary care. What's the next step in advancing whole-person care? Incorporating oral health in routine medical care.

Oral health is essential for healthy development (IOM 2011) and healthy aging (Griffin et al., 2012); yet nationwide, among all age groups, there is an unacceptably high burden of preventable oral disease (Dye et al., 2012) (Beltran-Aguilar et al., 2005). The costs and consequences are significant, particularly for low-income and other vulnerable populations. Due to insurance and workforce distribution challenges, access to dental care remains inadequate, and in most communities, dental care is among the most commonly cited unmet healthcare needs. Enhancing access to affordable dental care is an important goal; however, this alone is unlikely to be sufficient for reducing the burden of oral disease — the need is simply too great. To improve population-level oral health, we need to expand the oral disease prevention workforce and develop a new model of partnership between primary care and dentistry in which both professions work together to address oral disease.

The Oral Health Delivery Framework

The Oral Health Delivery Framework (Figure 1) delineates the activities for which a primary care team can take accountability with the goal of protecting and promoting patients' oral health. These activities directly align with how primary care teams manage preventive, acute, and chronic care needs for a wide range of clinical conditions across the lifespan. The recommended oral health activities are within the scope of practice for primary care; and if organized efficiently, can be integrated into the office workflow of diverse practice settings. The Framework was developed in partnership with a panel of experts that included primary care and dental care providers; leaders from medical, dental, and nursing associations; payers and policymakers; a patient and family partnership expert; and oral health and public health advocates. It has been supported by 20 leading organizations, including primary care provider organziations and the National Association of Community Health Centers.

Figure 1: The Oral Health Delivery Framework



Many patients screened during the course of a primary care visit will need dental care, including definitive diagnosis and treatment that only a dentist-led team can provide. The basic premise of the Oral Health Delivery Framework is that referrals to dentistry ought to be as smooth as referrals to any other medical or surgical specialist—the burden should not be on the patient to coordinate the transition of care. The goals of a "structured referral" to dentistry include:

1. The patient should leave the primary care office with a referral to a specific dentist or dental office, understanding what to do, what to expect, and whom to contact if problems arise;
2. An agreed upon set of information is sent from the primary care office to the dentist, so the dentist understands the reason for the referral and has sufficient information about the patient's health context to be able to safely provide appropriate treatment;
3. The dentist sends the primary care provider a consultation note documenting when the patient was seen, what was done, and any future treatment plans; and,
4. All referrals are documented in the Electronic Health Record (EHR) as structured data so they can be tracked by the primary care team, and the referral process can be monitored to ensure patients found to have active disease are, in fact, referred.

These goals exist irrespective of the patient's insurance status or whether or not the patient has a preexisting relationship with a dentist. Modeled on the best-practice for any other specialist referral, the authors recommend that primary care and dental practices establish referral agreements to clarify expectations and confirm guidelines, protocols, and standards of communication and information sharing.

Testing a Conceptual Model

The Oral Health Delivery Framework is a conceptual model for reducing the burden of oral disease. To establish its viability in diverse practice settings, Qualis Health and initiative sponsors are actively '"field-testing" the Framework in partnership with 19 primary care organizations in five states (Kansas, Massachusetts, Missouri, Oregon, Washington). Participants include 15 Federally Qualified Health Centers (FQHCs) and four private practices. They reflect urban, suburban, and rural locations; serve diverse patient populations; and use five different electronic health record (EHR) systems. Participating organizations receive technical assistance from Qualis Health, and in Kansas, Massachusetts, and Oregon, from their state's Primary Care Association. All have agreed to collect and share data to identify the impact of integrated care on patients, families, and practice operations. Detailed case examples will be published this year.

Early experience demonstrates that implementation is possible in diverse practice settings, including health centers without co-located dental resources, and that referral rates are manageable. Anecdotal evidence also suggests that patients appreciate their healthcare provider paying attention to their oral health. There are, however, challenges, as would be expected with any care delivery redesign effort. Challenges identified to date include: Competing priorities and change fatigue in the primary care setting; limited reimbursement for adult preventive care and care coordination; challenges associated with sharing information between primary care and dental practices, particularly with the return of dental consultation notes; and rigid health information technology, which limits a primary care practice's ability to collect and report oral health information.

The operational experience of field-testing sites, including workflow issues, the use of health information technology, and the referral process, will be published in the fall of 2016 in an Oral Health Integration Implementation Guide. Additionally, this resource will include tools and resources intended to accelerate adoption among primary care practices nationwide. ◆

Acknowledgement:
Oral Health: An Essential Component of Primary Care was sponsored by the National Interprofessional Initiative on Oral Health with support from the DentaQuest Foundation, the REACH Healthcare Foundation, and the Washington Dental Service Foundation. All materials are free and publically available at: www.QualisHealth.org/white-paper.

A new white paper, **Oral Health: An Essential Component of Primary Care,** provides clear guidance and practical strategies for delivering oral health preventive care in the primary care setting and enhancing partnerships between primary care and dentistry. Health centers are leading the way in testing this new model of patient-centered care. To learn more, visit: www.QualisHealth.org/white-paper