ORAL HEALTH INTEGRATION FRAMEWORK

To achieve integrated care for patients, health care **teams** work **collaboratively** with one another and patients to set **shared goals, provide care, and offer education** within and **across settings** that achieve **coordinated, high-quality care**.

COMPONENTS OF INTEGRATION

COMMUNICATION

Dentists and physicians interact and share information about specific patients occasionally or on an as-needed basis.

Clinicians convene to discuss patient's health information and notes regarding health conditions, referrals, etc.; however, the practice is inconsistent.

All staff and leadership create, enact, and adhere to a protocol for discussing a patient's health information in both clinical settings before patient visits.

REFERRALS

Health history and intake forms include questions about a patient's last medical and dental visit and information is included with patient record.

All staff provide a list of recommended providers to patients if a referral is warranted; there is no appointment follow up.

The clinic has a closed-loop referral process, either through warm hand-offs or an identified team member who assists with care coordination.

PATIENT ENGAGEMENT

Information about the relationship between oral and overall health is present in exam rooms and patient waiting areas.

All staff share oral-systemic health information during visits and encourage positive behavior related to managing oral and overall health. Patient education materials are appropriate literacy level, language, and reflect community norms and patients have an opportunity to ask questions.

All staff use motivational interviewing or other patient-centered techniques to discuss oral-systemic health with patients, education materials are distributed to support self-care, and patient education groups and programs include oral health and oral health care providers.

SERVICES

Teams offer information and education that include medical and dental care (e.g. waiting room video on the importance of dental cleanings for pregnant women), but do not offer integrated services (e.g. fluoride varnish during well child visits).

Clinicians perform basic services (e.g. visual mouth exam in primary care, overall health screen in dental).

Clinical staff routinely offer interprofessional services and exams (e.g. varnish, blood pressure, A1C testing) coupled with appropriate education and referrals.

Virginia Health Catalyst
The Intersection of Overall Health and Oral Health

DATA

Staff do not share patient data. There is minimal to no collection or analysis of overlapping patient risk factors. Patient records exist in separate systems that do not interact. Staff do not collaborate on quality improvement.

Patient data is shared as needed. Appropriate staff have access to patient records; however, systems are not integrated and information is difficult to obtain. Analysis of overlapping patient needs is episodic. Staff rarely collaborate on quality improvement.

Patient data is proactively, and continuously shared and analyzed. Electronic patient records are outfitted with clinical workflows. All staff collect and analyze relevant patient data for collaborative quality improvement.

WORKFLOW

There are no formal protocols or shared workflows that reflect integrated care teams.

Staff-developed protocols and workflows exist to promote integration (e.g., oral health education included in all well-visits, all patients are asked about oral health history), but staff does not consistently implement them.

Staff-developed protocols and shared workflows (e.g., medical assistants apply fluoride varnish, dental assistants conduct mental health screening, and if identified as high risk, the patient receives a warm handoff for immediate behavioral health intervention) are embraced and consistently implemented.

WORKFORCE

All staff have a basic understanding of the association between poor oral health and chronic disease; however, training and education are episodic and provider-driven.

Clinics provide education and training for clinicians to increase interprofessional understanding of associations between oral health and overall health and promote integration activities.

Clinics provide education and training to the entire staff about the ties between oral health and overall health and staff incorporate this knowledge in patient and clinical interactions.

CULTURE

Staff understand the concepts of the whole person model of care and total health outcomes but take responsibility primarily for their aspect of a patient's care, with limited interaction.

All staff embrace the goal of the whole person care model and understand that it is their responsibility for the total health outcomes of their patients. Systems are in place to monitor and report treatment plans and total health outcomes to providers and staff.

All staff understand and embrace the whole person care model, take responsibility for the total health outcomes, and carry out and adjust care for their entire patient population. This model has expanded connections within the community.