



ORAL HEALTH Issue Brief

Medical – Dental Integration in Minnesota Would Benefit from Changes in Law and Policy

Introduction


Integration of dental care with medical care is widely supported in concept. Experts in both medical and dental care suggest that increased collaboration could better serve the Triple Aim of better care and a more satisfactory patient experience at a lower cost. Yet, dental care in the United States has been described as a “[c]ottage industry of small private practices,” while health care and health insurance systems make up some of the largest, most complex organizations in the country.¹ As a result, efforts to build collaborative care partnerships or inter-professional teams between these small private practices and large health care systems present inherent challenges.

A history of separate development of our medical and dental systems presents challenges in many spheres. When entities such as the Minnesota Department of Health (MDH) Oral Health Program (OHP) seek to support an integrated approach, even on a pilot basis, they may encounter substantial barriers. To begin with, it can be difficult to identify a dentist or dental clinic and a primary care provider where interest, capacity, and policy are all in alignment. Further, it is important to widen the lens beyond challenges in securing participation at the level of an individual dentist or dental clinic or primary care clinic to understand the challenges to medical-dental integration at the level of systems and social norms. This issue brief summarizes the emergence of new conceptual frameworks for medical-dental integration, and briefly describes the need to address persistent practical and legal barriers to integration in order to promote emerging strategies to encourage deeper collaboration among dental providers and primary care providers.

Medical-Dental Integration

Medical-dental integration may take place in at least 4 ways:

- (1) preventive oral health services (POHS) provided by medical care providers in their medical clinics;
- (2) POHS provided by dental providers in medical primary care clinics or nontraditional settings;

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- (3) preventive (nondental) health services provided by a dental provider in a dental clinic setting;
 - (4) care coordination and case management and referral that can be provided in multiple medical, dental, or community settings.²

Moreover, the integration may take place along a continuum from full medical-dental integration, to co-location without integrated care, to shared financing and risk (as with an accountable care organization), to virtual integration through a shared Electronic Health Record system, to facilitated referrals.³


National Context

The United States Department of Health and Human Services launched an oral health initiative in 2010 that sought to elevate oral health as a priority throughout the department, and the nation as a whole. The Institute of Medicine issued two reports in 2011 that emphasized the need to train medical professionals in oral health care, maximize the contribution of current and emerging dental professions, and increase the diversity and cultural competence of both groups.⁴ Soon thereafter, the Health Resources and Services Administration (HRSA) launched an initiative aimed at Integration of Oral Health and Primary Care Practice. Specifically, the HRSA initiative sought to increase the clinical competence of primary care providers in safety net clinics with respect to oral health.⁵ A safety net clinic is a clinic (including a rural clinic), public hospital, or community health center whose mission is to provide health care regardless of ability to pay. Safety net practitioners are generally more likely than other health care providers to serve vulnerable populations, including those without any other access to dental services.⁶ Increasing the number of Federally Qualified Health Centers (FQHCs) and local health departments that provide oral health services was also expressed in Healthy People 2020 objectives.⁷ Researchers have begun to identify strategies to enhance integration of oral health care in well child visits at FQHCs.⁸ Even where FQHCs offer medical, dental, and behavioral health services, they may face challenges, such as the lack of adequate software to support shared Electronic Health Records across these previously-siloed service areas.⁹

In addition to governmental efforts, professional associations, academic experts, and private foundations have all devoted substantial time and effort to advancing understanding of and frameworks for medical-dental integration. A National Interprofessional Initiative on Oral Health resulted in a proposed Oral Health Delivery Framework which has been endorsed by numerous dental and medical professional associations.¹⁰ The 2011 Institute of Medicine reports mentioned above were forerunners to current discussions of medical-dental integration, and were updated in a 2018 report affiliated with the National Academies of Science Engineering and Medicine (NASEM).¹¹ The 2018 NASEM report was accompanied by discussion papers and published proceedings of a 2019 workshop.¹² Private foundations dedicated to supporting improved health have also identified medical-dental integration as a priority in recent years.¹³

Minnesota Context

In the past three years, the Minnesota Department of Health Oral Health Program (MDH OHP) has supported two pilot projects related to integration of oral health with primary care. In one pilot with funding from the Health Resources and Services Administration (HRSA) intended to support workforce innovation in designated Dental Professional Shortage Areas (DPSA), MDH OHP sought to facilitate information exchanges related to primary care and oral health care of diabetic patients with elevated A1C and suspected periodontal disease.. The A1C test is a blood test that shows a person's average blood sugar levels over two to three months, and thus can be used to monitor the success of diabetes management, as well as indicate diabetes and prediabetes.



Utilizing professionals from both medical and dental disciplines proved to be a crucial pillar in the execution of the project. The clinic staff members received calibration and training by the OHP staff. Examples of clinical staff involved include at least one diabetes educator, community health worker, medical assistant, licensed practical nurse, medical scheduler, collaborative practice dental hygienist, and collaborating dentist. Other professionals within each discipline could also be involved.


The other pilot, supported with funding from the Centers for Disease Control and Prevention (CDC) and intended to integrate oral health promotion with chronic disease prevention, focused on control of periodontal and cardiovascular diseases within each individual patient. MDH sought to foster collaboration between the Oral Health program and the Cardiovascular Health program within the Department, as well as test a bidirectional referral system between dental and medical clinics. The participating dental clinics obtained blood pressure readings for adult patients and made medical referrals as needed. The participating medical clinics encouraged patients with hypertension to complete a periodontal self-assessment, and referred them to a dentist if the assessment revealed concerns. The HRSA grant and CDC cooperative agreement programs in Minnesota are examples of federal interest in, and support for, medical-dental integration in many states throughout the country.

Models of Integrated Care

The past decade has been a time of ferment as it relates to integrated care, including, but not limited to, integrated dental care. Numerous states have been engaging in integrated care activities, including pilot projects, prior to and concurrent with the Minnesota Department of Health Oral Health Program's efforts. At the same time, the Excellence in Mental Health Act supported the rise of certified community behavioral health clinics to increase integration of behavioral health and primary care.¹⁴ The concurrent trajectory of integration of behavioral health and primary care may provide instructive differences as well as parallels.

A number of insights may be gleaned from this ferment and from recent academic research and conceptualization. Among the most powerful framing insights is Valentijn's Rainbow Model of Integrated Care.¹⁵ Valentijn found that integration may be advanced in 6 domains: clinical, professional, organizational, system, functional, and normative. The model is intended to contribute to an international consensus on how to describe integrated service in a primary care setting. The model may be helpful in illuminating the need for integration in all 6 domains, and in shedding light on challenges to integration activities that may have focused primarily on the clinical level, without attending equally to administrative, financial, and structural concerns, and to the concerns of all stakeholders. The 2018 National Academies report described above relies to a large extent on Valentijn's work, adapted to a health literacy lens.¹⁶ Health literacy is the capacity of individuals to obtain, process, and understand basic health information and services needed to make appropriate health decisions.¹⁷ In order to succeed, medical-dental integration must result in patients receiving information, advice, and care from all members of their care team that they can understand and act upon.

This theorization may pose challenges in practice, because pilot projects are necessarily limited in scope and scale and duration, and it may be difficult to fully address all 6 domains in a pilot project. Yet, even pilot integration projects could be positively informed by this conceptual framework. For example, while advocating for a comprehensive approach, the Oral Health Delivery Framework acknowledges that such an approach may not always be possible, and identifies examples of more incremental approaches.¹⁸ The 2019 report of the NASEM proceedings on medical-dental integration and health literacy recommends that interested parties "Call



on CMS and other funders of integration activities to provide adequate infrastructure and financial support for implementation and sustainability.”¹⁹

Barriers and Strategies in Law and Policy

The NASEM workshop proceedings offer a recommendation to “Commission a review to compare state practice acts, laws, regulations and policies to identify provisions that might hinder the integration of oral health and primary care, and propose and encourage model legislation and CMS requirements that could be used to remove workforce barriers.”²⁰ A comprehensive legal assessment could make an invaluable contribution to the movement toward medical-dental integration.²¹

Allied Dental Providers


It is telling that the NASEM integration workshop recommendation to address legal barriers begins with a reference to state scope of practice acts, because as with many other promising practices related to oral health innovation (see issue briefs describing school-based dental sealant programs and Minnesota collaborative practice dental hygiene law), changes to the laws governing the oral health workforce will be essential.²² The MDH OHP pilot described above was one component of a HRSA grant focused on oral health workforce innovations in dental provider shortage areas. One of the insights to be gained from that context is that dentists may not be the only dental providers who can advance medical-dental integration. For example, laws in states such as Minnesota may position dental providers such as dental therapists and dental hygienists to operate at the nexus of medical and dental care. And exciting progress on medical dental integration involves primary care providers including physicians, nurse midwives, physician’s assistants, and nurse practitioners, as well as those who can bridge dental and medical care, such as community health workers and dental hygienists.²³

Yet, outmoded state laws may impede such integration. For example, Minnesota has a regulation that requires that a clinic which provides dental services (including a number of preventive dental services) must have 2 dentists on staff in order for the clinic to qualify for medical assistance payments.²⁴ The regulation includes a helpful exception for rural health clinics, community health clinics, and public health clinics, but in light of the emergence of mid-level providers such as dental therapists, and new supervision models for collaborative practice dental hygienists in the state, the regulation may not support medical-dental integration and serve public health as much as it could. States may want to assess whether their own laws restrict oral health activities to dentists, and whether such a restriction is supported by the evidence. Removing such restrictions, especially as they relate to preventive care, may be an additional way to advance the Triple Aim.

Medicaid

As has been discussed in previous oral health issue briefs, changes to federal Medicaid regulations and state implementation of enrollment processes and reimbursement rates could greatly facilitate oral health workforce innovations, including those related to medical-dental integration.²⁵ Medicaid reimbursement rates for oral health services are frequently substantially lower than commercial rates for oral health services, creating a significant barrier to Medicaid participation by private dentists and dental practices. In Minnesota, treatment of periodontal disease in adults is not covered by the Minnesota Health Care Program benefit, which presented an impediment in the pilot projects supported by HRSA and the CDC.²⁶

Data Sharing and Electronic Health Records



Data sharing has been identified as a potential driver of increased medical-dental integration.²⁷ Whole books have been written about the challenges and opportunities of enhancing interoperability between medical and dental records.²⁸ While some of these challenges to meaningful use of electronic health information are practical or technical, legal and policy strategies, when paired with explicit referral protocols, may facilitate lawful exchange of relevant health information across integrated medical and dental teams.²⁹ For example, health information exchanges supported by laws and contracts between the participating parties are one means to ease the lawful flow of information. States which are not in a position to support improved data sharing may nonetheless increase efforts to collect and use oral health data for assessments, which may prompt action by policymakers.³⁰

Examples of Medical-Dental Integration

It is worth noting that Minnesota is home to Health Partners, an accountable care organization frequently pointed to nationally as a model of integrated care.³¹ However, one lesson learned from the MDH OHP pilots is that successful integration within one organization (that is, Health Partners) may not translate to integration throughout a system (that is, coordinated care with other medical and dental providers in the community or state), if business considerations are not addressed. The Hennepin County Medical Center in Minnesota operates an emergency department diversion program which utilizes community health workers at the facility and in the community to support appropriate care, including preventive care.³² The Marshfield Clinic in neighboring Wisconsin has been highlighted as a successful example of medical-dental integration in rural communities.³³

Examples of medical-dental integration with support at the state level include Washington, California, and Oregon. In Washington, the state government and private foundations have partnered on an Oral Health Connections Pilot project to provide enhanced, and more integrated, oral health services in participating counties to adults with diabetes and pregnant women.³⁴ In California, the state Department of Health Care Services is authorized to accept applications from certain local and tribal governments and academic institutions for Local Dental Pilot Programs to increase dental prevention, caries risk assessment and disease management and continuity of care among children receiving Medicaid. The Oregon Health Authority provided funding for an environmental scan to collect information and make recommendations related to strategies to incorporate medical-dental integration into the state's coordinated care organizations.³⁵ In what appears to be a private sector effort, rather than a governmental one, the Delta Dental Foundation of Colorado has created a Medical-Dental Integration Toolkit.³⁶

Conclusion

Medical-dental integration is an evidence-based strategy to improve population health and achieve lower costs. Because of the historically separate development of medical and dental care in the United States, reuniting the two types of care is no simple matter. While pilot projects face limitations in scope, scale, and nature, they can provide initial successes and build momentum for change across all of the domains needed. In order to make change at the systems level, changes in law and policy will be necessary. A comprehensive assessment of needed changes in law and policy at both the federal and state levels could substantially advance medical-dental integration.



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