Health Centers at 50

leading the next evolution

Massachusetts League of Community Health Centers A Community Health Institute May 6-8, 2015

Integrating Primary and Oral Health Care at Health Centers: Models that Work

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CHI, May 6, 2015
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Massachusetts League
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Today's Objectives:

- **Make the Case for Change**: Demonstrate the impact of oral disease and the benefits of integrating oral health preventive care in routine medical care
- **Describe** the MLCHC's Clinical Connections Grant and implementation of the Qualis oral health delivery framework for integrating oral health into primary care at 5 CHCS.
- **Hear** from your Peers on their successes and challenges on this new initiative.

THE CASE FOR CHANGE

WHY SHOULD WE CARE ABOUT ORAL HEALTH?

How many of you know who this is?

Deamonte Driver was a 12 year old boy in Maryland who had bacteria from a dental abscess spread to his brain.

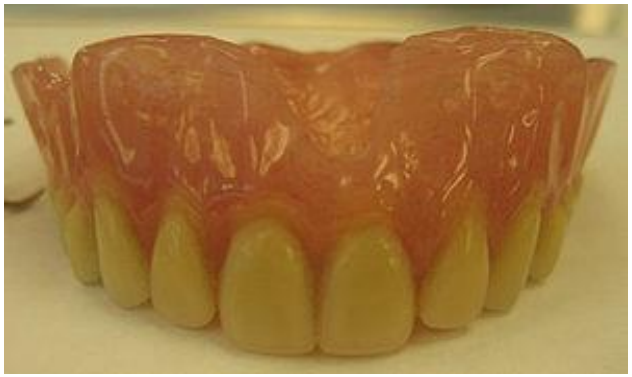
If it had been caught early, extracting Deamonte's damaged tooth would have cost $80

He endured two surgeries and weeks of hospital care totaling about $250,000 in medical bills

He died February 2007.

The Burden of Oral Disease

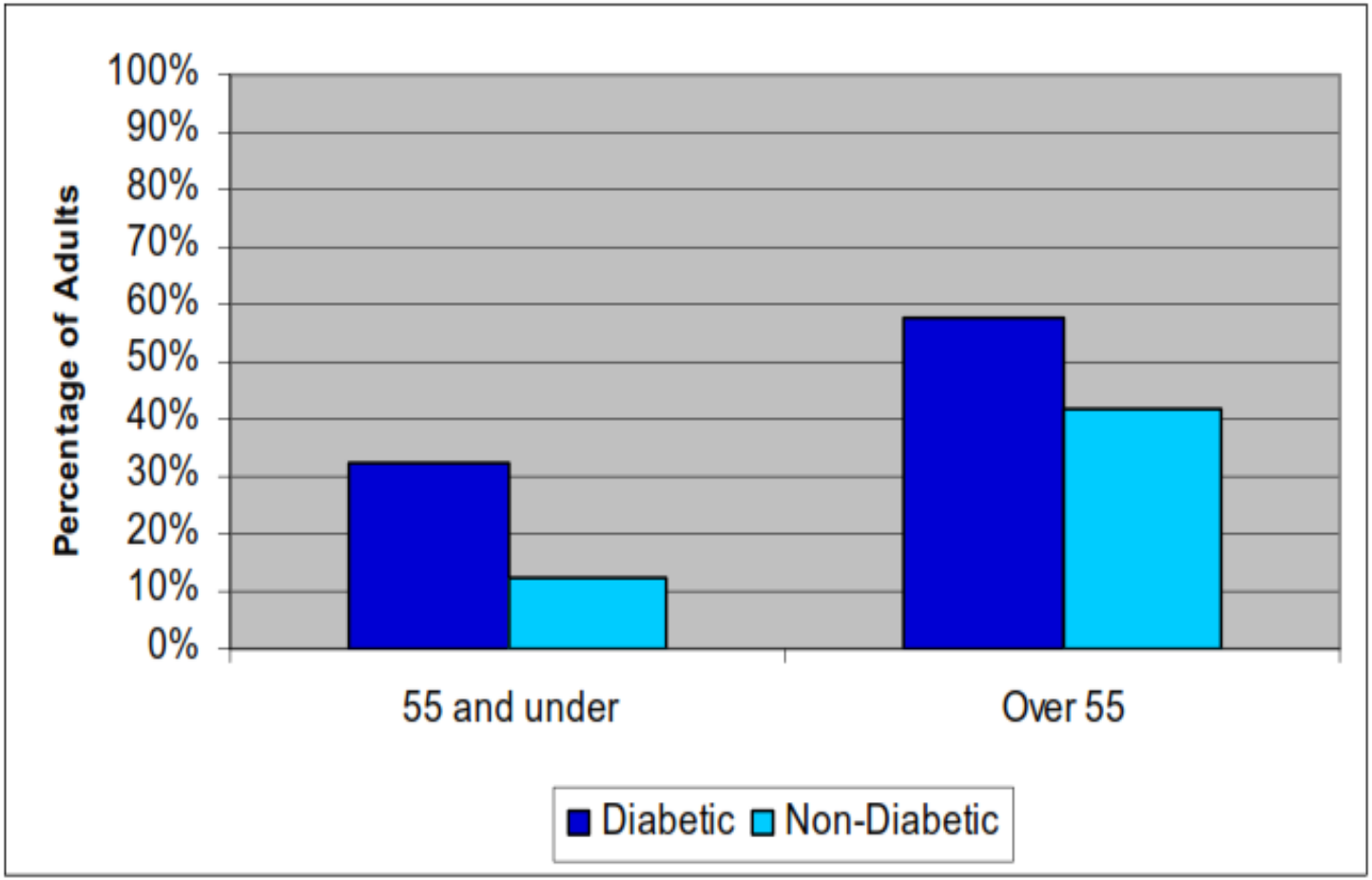
Periodontal disease: 47% of adults have some form of periodontal disease, 19% aged 25–44 have severe disease



Cumulative result?
25% of adults 65 and older have no teeth

Oral cancer kills 7,800 people each year **2.0x** number who die of cervical cancer, a major preventive care focus

Figure 13: Proportion of Massachusetts Adults With and Without Diabetes Who Are Missing Six or More Teeth, 2006



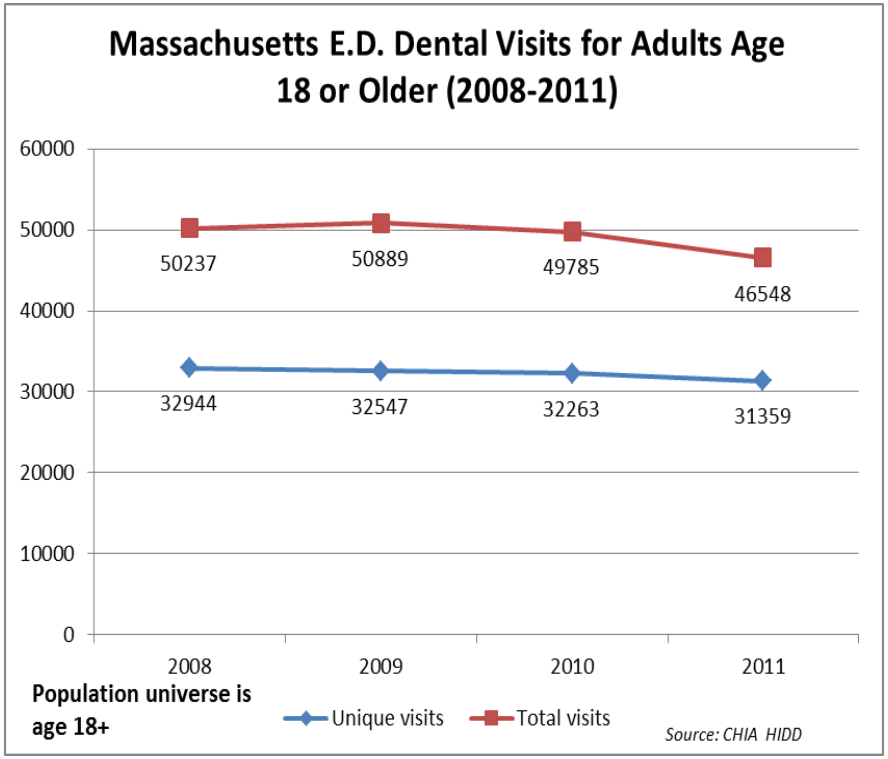
BRFSS 2006, National Oral Health Surveillance System

Costs of Oral Disease

- $111 billion spent on dental care in 2012; primarily for restoration
- Most hospital emergency departments are not equipped to treat dental emergencies
- 2.1 million ED visits
  - Oral pain
  - Infection and abscessed teeth

What About Massachusetts? (2011 data)

- 31,000 unique adult patients; half age 22-34
- 29.2% had 3 or more ED visits
- ED utilization highest among non-Hispanic blacks



Cost to MassHealth: $2.6 million

Source: Massachusetts Division of Health Care Finance and Policy. December 2012.

An imperfect solution to a big problem

- There are over 700,000 Medicaid Eligible adults in MA
- Only 54 CHC dental sites that can provide restorative care

Access and Affordability Challenges

40% of the population lacks dental insurance

2.5x the % who lack medical insurance

- Even with insurance, dental care is often not affordable
- 47 million live in dental professional shortage areas- In MA, Hilltown and Mashpee are just two.

Dental care is the most common unmet health need

Findings From Lowell:

Comparisons for key indicators of oral health and access to care

Indicator	United States	Massachusetts	LCHC
Dental decay experience (ages 2-4)	22%	28%	38%
Dental decay experience (ages 6-8)	51%	58%	82%
Untreated decay (ages 2-4)	17%	15%	28%
Untreated decay (ages 6-8)	28%	17%	64%
Adults with no tooth loss (ages 31-44)	38%	67%	39%
Dental visits in Past 12 months (children & adults)	44%	76%	55%
Dental Sealants (age 8)	35%	46%	NED*
Dental Sealants (age 14)	19%	52%	NED*

U.S. and Mass data taken from BOHMC "Oral Health Plan for Massachusetts 2010-2015

Citation: Oral Health Plan for Massachusetts: 2010-2015. Better Oral Health for Massachusetts Coalition, 2010.

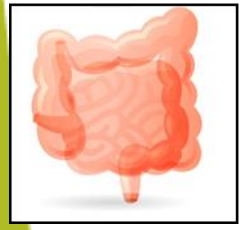
* Not Enough Data

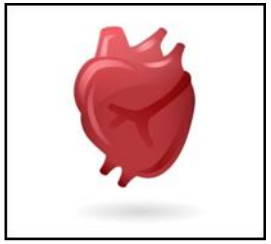
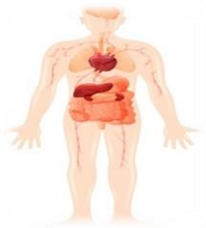
Why Primary Care? Haven't we done enough?

- The oral health care delivery system, as currently configured, fails to reach the populations with the highest burden of disease
- Expanding affordable dental care is important, but unlikely to improve population health alone–the need is too great
- Solution?
  - Incorporate oral health preventive care in routine medical care
  - Develop a new type of partnership between primary care and dentistry

Why Primary Care…

- Primary care providers *are already* supporting prevention and chronic disease management for the rest of body
- Provide information about diet
- Monitor blood pressure
- Screen new moms for depression
- Ask questions and offer risk reduction guidance about tobacco use, car seat use, sunscreen, etc.

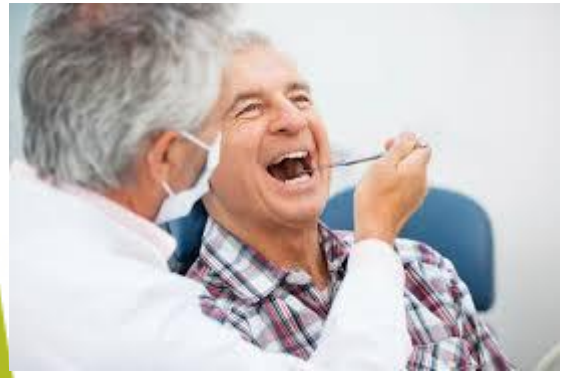



Why should oral health be excluded?

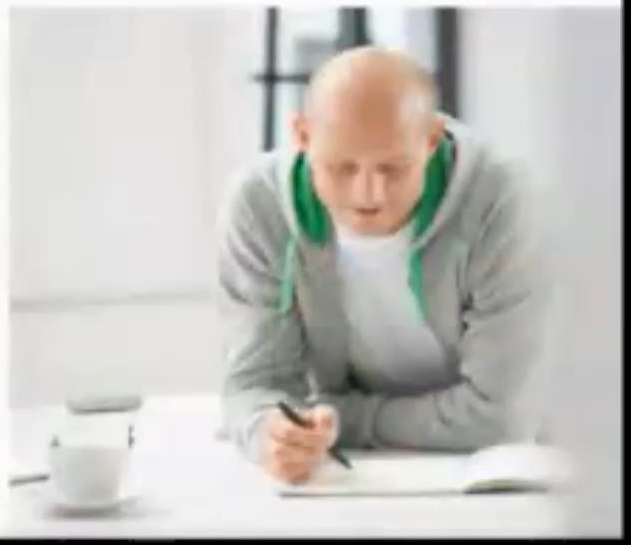
Why Primary Care?

- Studies are starting to show the connections between oral health and chronic disease and the impact/cost savings associated with getting at risk medical patients dental treatment. Example from Aetna and Columbia University.



Integrating dental and health data can lead to real cost savings

Our retrospective study of claims indicated:



Oral Health: The Next Frontier

- Where does it fit in the PCMH Model
- Right next to behavioral health!
- Both important components of:
  Organized, Evidence-based Care

- Oral health not addressed explicitly, but it "fits" in several areas, e.g.,

PCMH Element 3D: Use Data for Population Management:
At least annually the practice proactively identifies populations of patients and reminds them, or their families/caregivers, of needed care based on patient information, clinical data, health assessments and evidence-based guidelines, incl at least two preventive care services.

PCMH Element 4E: Support Self-Care and Shared Decision Making:
The practice has, and demonstrates use of, materials to support patients and families/caregivers in se lf-management and shared decision making.

Clinical Connections: Quality Improvement Leading to Clinical Integration

Goals: In summary, this project will result in

- Improved access to primary care oral health services in at least 5 CHCs;
- Increased access to dental care through improved collaboration and communication with community-based dentists;
- Increased awareness among primary care teams and leaders of the importance of oral health care;
- Enhanced PCMH implementation, resulting in improved quality, efficiency, and patient experience.

Partners

DentaQuest FOUNDATION

National Interprofessional Initiative on Oral Health
engaging clinicians eradicating dental disease

Massachusetts League of Community Health Centers

QUALIS HEALTH

CHC Community Health Center of Cape Cod

Brockton Neighborhood Health Center

THE DIMOCK CENTER
Healing and caring for the community for over 150 years.

Lowell Community Health Center

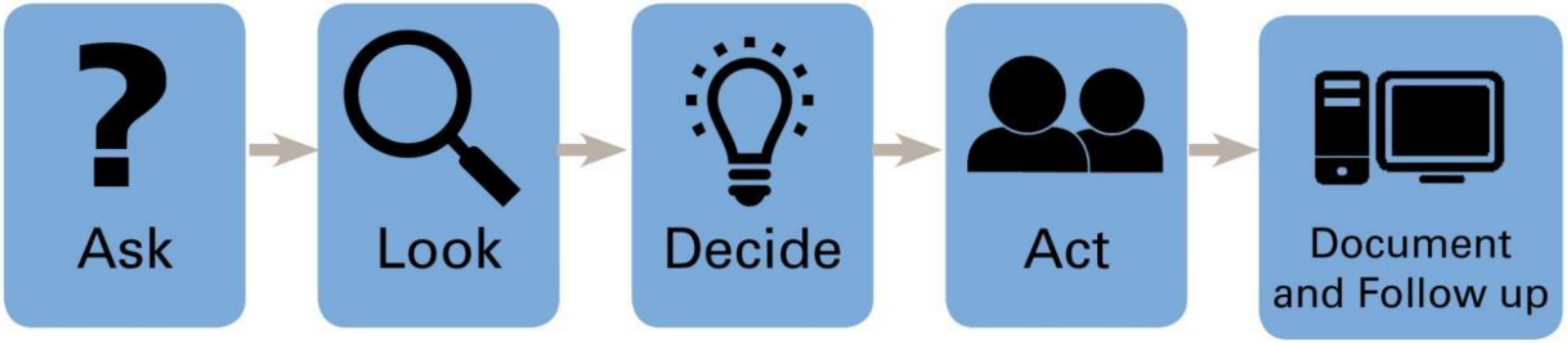
Hilltown Community Health Centers
Building a better bridge to Healthcare.

Pilots on a National Level

So How Do We Get There?

Step One: Utilize Qualis's Oral Health Delivery Framework

The Oral Health Delivery Framework



Oral Health Delivery Framework

Ask: Symptoms & risk factors

- Pain, bleeding, burning, dry mouth
- Dietary patterns
- Adequacy of fluoride
- Oral Hygiene
- Time since last dental visit

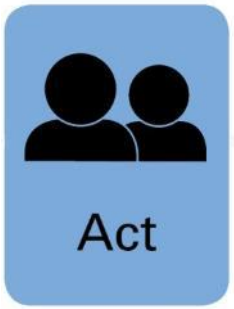
Look: Signs of disease

- Oral hygiene
- Dry mouth
- Obvious caries
- Inflammation
- Exposed roots
- Mucosa abnormalities

Oral Health Delivery Framework

Discernable Risk Factors: Present or not
Detectable signs of disease: Present or not

Oral Health Delivery Framework



Act: Clinical intervention

- Medication changes
- Oral hygiene training
- Dietary counseling
- Fluoride
- Referral

Document and Follow-up

- Structured data in EHR
- Information exchange
- Referral management
- Quality Improvement
- Population Management

Ask

- Ask about last visit to a dentist. DOCUMENT
- Ask whether patient has experienced pain or bleeding with eating or brushing or whether patient has experienced symptoms of dry mouth. DOCUMENT.
- Ask whether patient brushes teeth with fluoride toothpaste at least twice daily for 2 minutes AND flosses at least once nightly
- Ask whether the patient is experiencing dryness of the mouth.

Look:

- Look in the mouth for evidence of caries or periodontal disease. DOCUMENT

Decide:

- Are there any risk factors that can be reduced?
- Is the patient taking medications that may be causing salivary dysfunction?
- Is there a sign of disease?

Act:

ALWAYS:

- **Advise:** "Brush teeth with a fluoride toothpaste twice daily for at least two minutes concentrating on gum lines. Floss before bed each night."
- Provide patient education materials as appropriate. DOCUMENT
- Emphasize the importance of oral health in diabetes management

AS APPROPRIATE CONSIDER:

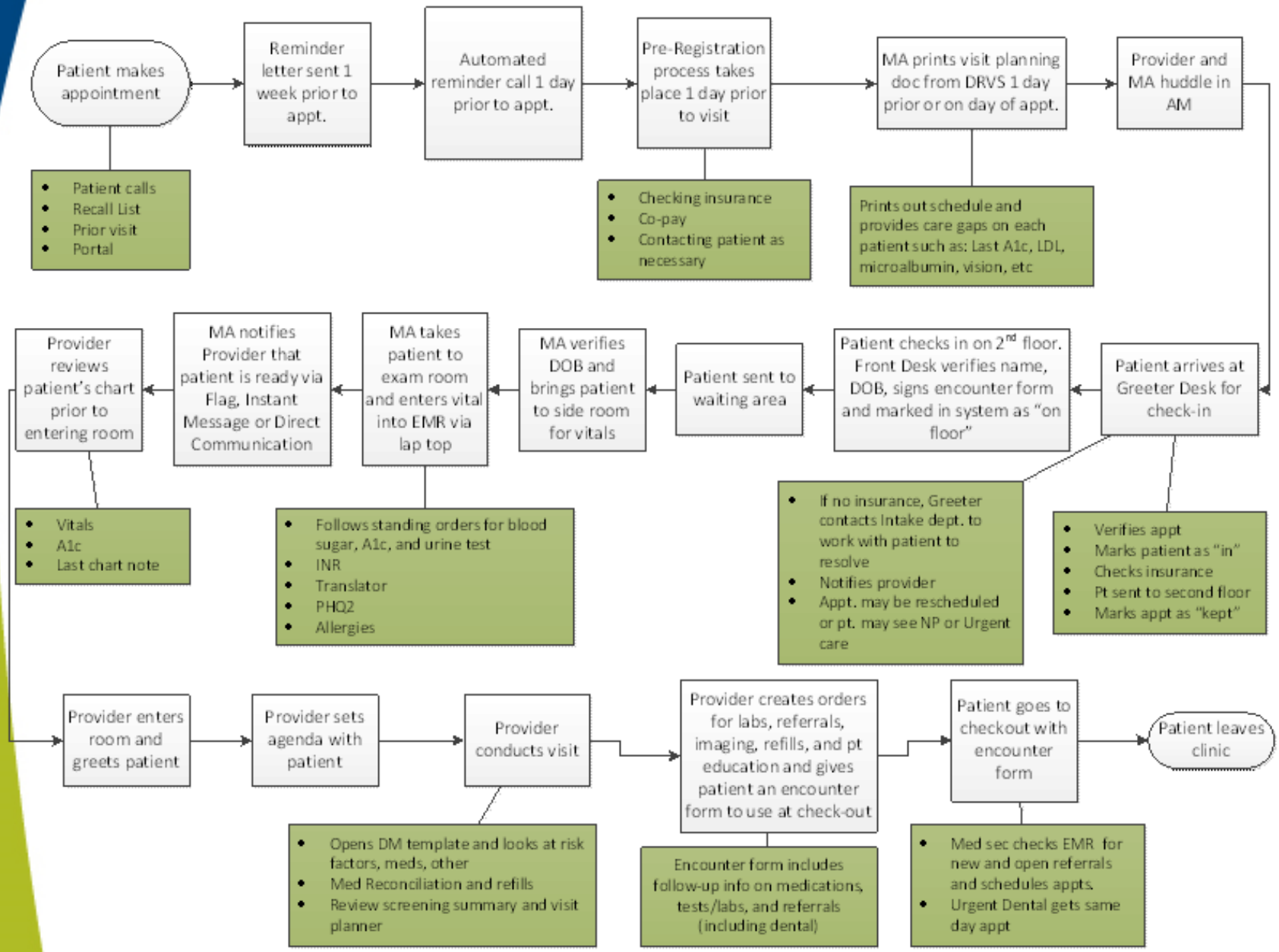
- Set up a schedule for administering high concentration fluoride . DOCUMENT
- Begin weekly antibiotic oral rinses with chlorhexidine. DOCUMENT
- Referral to a dentistry. DOCUMENT

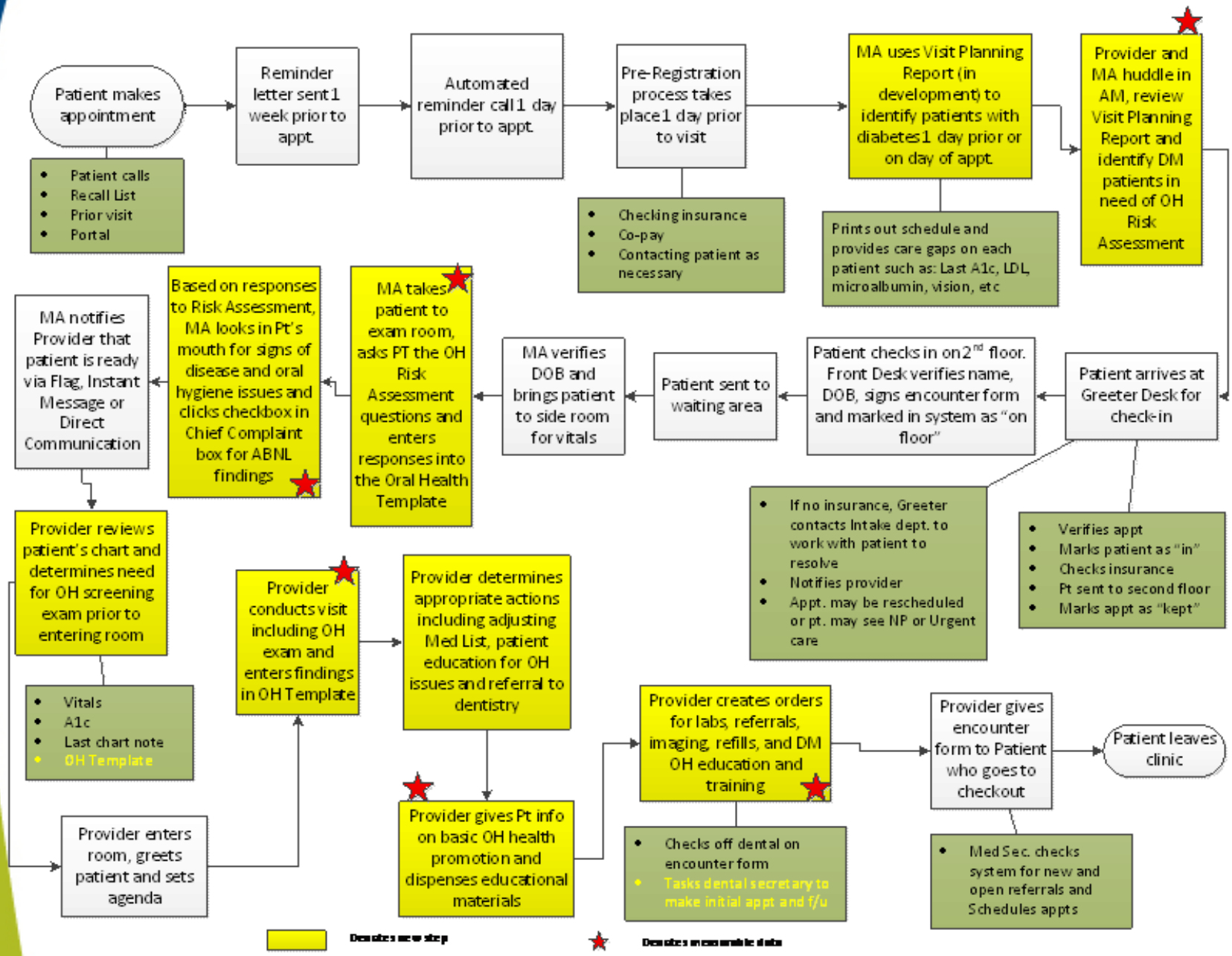
How Does a CHC Incorporate the Framework Into Primary Care?

Outline of Steps at each CHC:

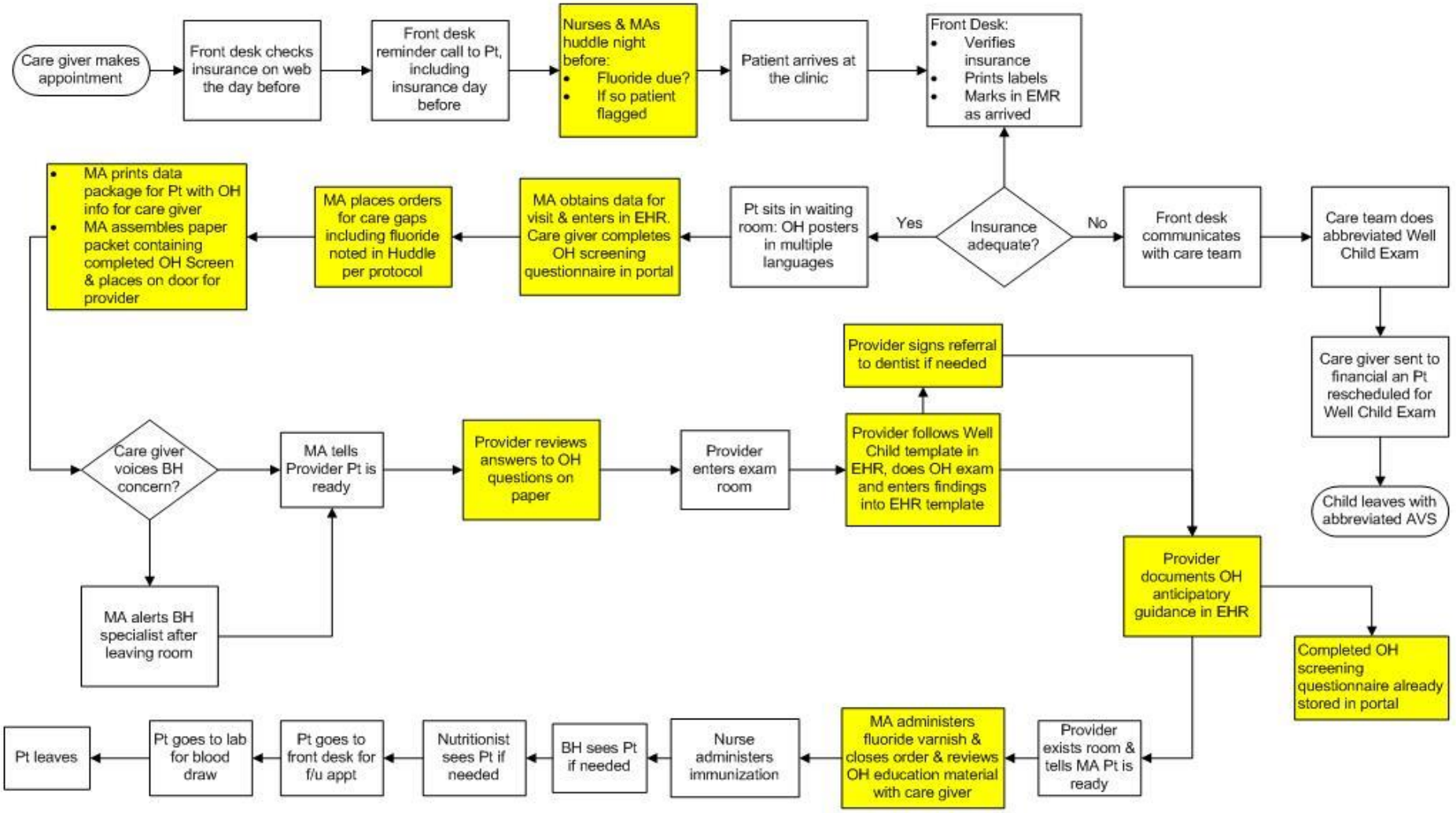
1. Leadership Meeting
2. Selection of Practice Improvement Team
3. Kick Off Meeting
4. Sites Select Population of Focus
   - Adults with diabetes
   - Pediatrics
5. Conduct Workflow Mapping
   - Current State- map out from the time a patient enters the clinic to the time they leave.
   - Future State-where the OH framework is incorporated into the workflow and Health IT is modified to support it.

Examples of Workflow Mapping


Patient makes appointment
Reminder letter sent 1 week prior to appt.
Automated reminder call 1 day prior to appt.
Pre-Registration process takes place 1 day prior to visit
MA prints visit planning doc from DRVS 1 day prior or on day of appt.
Provider and MA huddle in AM
Patient calls
Recall List
Prior visit
Portal
Checking insurance
Co-pay
Contacting patient as necessary
Prints out schedule and provides care gaps on each patient such as: Last A1c, LDL, microalbumin, vision, etc
Provider reviews patient's chart prior to entering room
MA notifies Provider that patient is ready via Flag, Instant Message or Direct Communication
MA takes patient to exam room and enters vital into EMR via lap top
MA verifies DOB and brings patient to side room for vitals
Patient sent to waiting area
Patient checks in on 2nd floor. Front Desk verifies name, DOB, signs encounter form and marked in system as "on floor"
Patient arrives at Greeter Desk for check-in
Vitals
A1c
Last chart note
Follows standing orders for blood sugar, A1c, and urine test
INR
Translator
PHQ2
Allergies
If no insurance, Greeter contacts Intake dept. to work with patient to resolve
Notifies provider
Appt. may be rescheduled or pt. may see NP or Urgent care
Verifies appt
Marks patient as "in"
Checks insurance
Pt sent to second floor
Marks appt as "kept"
Provider enters room and greets patient
Provider sets agenda with patient
Provider conducts visit
Provider creates orders for labs, referrals, imaging, refills, and pt education and gives patient an encounter form to use at check-out
Patient goes to checkout with encounter form
Patient leaves clinic
Opens DM template and looks at risk factors, meds, other
Med Reconciliation and refills
Review screening summary and visit planner
Encounter form includes follow-up info on medications, tests/labs, and referrals (including dental)
Med sec checks EMR for new and open referrals and schedules appts.
Urgent Dental gets same day appt


Patient makes appointment
Patient calls
Recall List
Prior visit
Portal
Reminder letter sent 1 week prior to appt
Automated reminder call 1 day prior to appt
Pre-Registration process takes place 1 day prior to visit
Checking insurance
Co-pay
Contacting patient as necessary
MA uses Visit Planning Report (in development) to identify patients with diabetes 1 day prior or on day of appt
Prints out schedule and provides care gaps on each patient such as: Last A1c, LDL, microalbumin, vision, etc
Provider and MA huddle in AM, review Visit Planning Report and identify DM patients in need of OH Risk Assessment
Patient arrives at Greeter Desk for check-in
Verifies appt
Marks patient as "in"
Checks insurance
Pt sent to second floor
Marks appt as "kept"
If no insurance, Greeter contacts Intake dept. to work with patient to resolve
Notifies provider
Appt. may be rescheduled or pt. may see NP or Urgent care
Patient checks in on 2nd floor. Front Desk verifies name, DOB, signs encounter form and marked in system as "on floor"
Patient sent to waiting area
MA verifies DOB and brings patient to side room for vitals
MA takes patient to exam room, asks PT the OH Risk Assessment questions and enters responses into the Oral Health Template
Based on responses to Risk Assessment, MA looks in Pt's mouth for signs of disease and oral hygiene issues and clicks checkbox in Chief Complaint box for ABNL findings
MA notifies Provider that patient is ready via Flag, Instant Message or Direct Communication
Provider reviews patient's chart and determines need for OH screening exam prior to entering room
Vitals
A1c
Last chart note
OH Template
Provider enters room, greets patient and sets agenda
Provider conducts visit including OH exam and enters findings in OH Template
Provider determines appropriate actions including adjusting Med List, patient education for OH issues and referral to dentistry
Provider gives Pt info on basic OH health promotion and dispenses educational materials
Provider creates orders for labs, referrals, imaging, refills, and DM OH education and training
Checks off dental on encounter form
Tasks dental secretary to make initial appt and f/u
Provider gives encounter form to Patient who goes to checkout
Med Sec. checks system for new and open referrals and Schedules appts
Patient leaves clinic
Denotes new step
Denotes measurable data

Future State Workflow:



After Workflow Mapping Comes:

Plan → Do → Study → Act → Plan → Do → Study → Act

'What's next?'

'What will happen if we try something different?'

'Did it work?'

'Let's try it!'

Reporting: Sample Measures to Understand Impact

Clinical Process Measures **Required*	Percentage of patients given: • A written or verbal risk assessment or screening questions • An oral exam • A referral to a dentist, if indicated based on findings
Intervention Measures ** Required*	Percentage of patients in need given: • Dietary counseling • Oral hygiene training • Risk behavior education • Fluoride varnish, or other fluoride therapy • Medication adjustment to address dry mouth
Care Coordination and Referral Process Measures	• Number of referral agreements in place with local dental partners • Percentage of referred patients with a completed dental referral-**required*
Patient Experience Measures	• Percentage of patients satisfied with the oral health preventive care offered, or coordinated by primary care • Percentage of patients who received useful oral health information, dietary counseling, or oral hygiene training
Practice Experience Measures	• Percentage of staff trained to deliver oral health preventive services • Percentage of staff with demonstrated knowledge of oral health clinical content • Percentage of staff satisfied with dental referral process

Key Points: Teamwork is Essential

- Use Health IT to identify chronic care gaps
- Involve the whole team in clinical care
  - Everyone working at top of licensure
  - Identify potential care gaps before the visit
  - Verify the care gaps while rooming the patient
  - Set up orders for the provider to sign
  - Arrange for activities at the end of the visit
- Allow the provider focus on acute episodic care needs

In a PCMH All the Pieces are There

- PCMH Primary Care has:
  - Care teams with defined populations
  - EHR capturing clinical info as structured data
  - Population reporting capability
  - Workflows designed for population health
  - Experience with behavior change
- Dentistry has:
  - In-depth knowledge of oral pathology
  - Specialty skill for procedural intervention

Goal: Matching task to skill—making the best use of dental care resources

Hearing From Your Peers

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