Oral Health and the Patient Centered Health Home

Irene V Hilton, DDS, MPH
Dental Consultant
National Network Oral Health Access

Idaho Oral Health Alliance
October 14, 2011

Objectives

- Share results of NNOHA's PCHH needs assessment
- Describe the barriers to integrating dental into the PCHH
- Understand the characteristics of Health Centers that have achieved high levels of medical-dental integration
- Learn best practices

NNOHA- Who we Are

- National organization representing oral health providers and supporters working in HC's/safety-net. 1,700+ members
- HRSA cooperative agreement
- Conduct a needs assessment to identify barriers that prevent Health Centers from developing patient-centered health homes that meet oral health needs

HRSA PCM/HH Initiatives

- Encourages Health Centers to undertake the practice changes that will enable them to gain NCQA Patient-Centered Medical Home (PCMH) recognition
- Support, training, TA to apply

Methodology

- Online assessment of 77/270 HC dental directors
  - Level of medical-dental integration
  - Perceived barriers
- Follow-up guided interviews with 9 high performing dental programs
  - Program characteristics
- Best practices

Practices Indicative of Medical-Dental Integration

- Dental providers have immediate access to patient's current medication and problem list
- Health Center clinical staff is able to access the scheduling system to coordinate dental appointments with other care
- An oral health measure has been incorporated into the Health Center Diabetes, HIV or Prevention collaborative
- The percent of perinatal patients that receive a dental exam while pregnant is reported on a monthly basis
- Dental leadership participates in strategic planning for the organization

Clinical Practices

- Specific policies and procedures exist for referral, tracking and follow-up of diabetic patients into dental care
- Specific policies and procedures exist for referral, tracking and follow-up of dental patients into behavioral health care
- Specific policies and procedures exist for follow-up and tracking of dental patients with abnormal BP readings
- Early Childhood Caries risk assessment is incorporated into well-child visits for ages 0-5 years

Results Routinely-Sometimes-Never

- Occurring "routinely"
  - Dental providers have immediate access patient's current medication and problem list (55.8%)
  - Dental leadership participated in strategic planning for the organization (51.9%)
  - Health Center clinical staff able to access the scheduling system to coordinate dental appointments with other care (48.7%)

Routine Clinical Practices

- An oral health measure incorporated into the Health Center's Diabetes, HIV, or Prevention collaborative (44.0%)
- Early Childhood Caries (ECC) risk assessment incorporated into well-child visits for ages 0-5 years (41.6%)
- Specific policies and procedures for follow-up and tracking of dental patients with abnormal blood pressure readings (38.2%)

High Performers

- Of the 77 responding Health Centers, thirteen (17%) stated that they "routinely" performed at least 6 out of the 9 practices indicative of medical-dental integration and the PCHH

Barriers to Integration

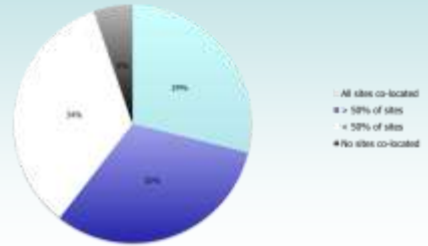
- Definite Barrier (46.8%)
  - Lack of necessary infrastructure, especially IT systems, to facilitate integration of oral health with other health center services

Possible Barriers

- Patient reluctance- lack of understanding of value of integration and coordination of patient care (56.6%)
- Lack of knowledge of resources to support integration of oral health into other Health Center services (e.g. best practices, etc.) (55.8%)
- Lack of training for Health Center clinical staff (medical and dental) or guidelines for care (52.6%)
- Lack of clear incentives to integrate/coordinate oral health into other Health Center services (50.0%)

Facilities Infrastructure

Co-located Medical & Dental Services



IT Infrastructure

- EMR- 75%
- EDR- 54%
- Systems interoperable- 23%

Associations with High Performance

- High-performing programs were much more likely to state that lack of necessary infrastructure, was not a barrier for them
- Lower performing Health Centers were much more likely to state that lack of necessary infrastructure, was a barrier to integration for them

Nine High Performer Interviews

- Six different HRSA regions
- Range of 1-20 medical sites
- Range of 1-7 dental sites
- Dual medical-dental users: 10-70%
- Tenure as Dental Directors: 2-26 years (average 11.6)

NCQA PCMH Certification

- 9 programs
- 3 achieved Level III certification
- 4 programs in progress
- 1 planning 2012

Seven Key Characteristics

1. Leadership Vision & Support
2. Dental Integrated into HC Executive Team
3. Co-location
4. Organizational Culture of Quality Improvement
5. Dental Staff Buy-in: Understanding the "Why"
6. Patient Enabling Services
7. Dental Director Leadership

Leadership Vision & Support

- Starts with ED/CEO
- Insure same message throughout organization
- *"Treating the patient as a whole is part of the mission and culture of the Health Center"*

Dental Integrated into HC Executive Team

- Not based on personal relationships- part of organizational structure
- Completely integrated into the administrative structure of the HC
- Included in all operations team meetings, committees and communications
- Present when planning and clinical policy and protocol decisions made to advocate for oral health to and give dental input and perspective

Co-location

- Staff from any Health Center department could bring a client directly to dental
- Bi-directional with dental staff able to send patients directly to medical department for same day assessment
- "warm hand-off"
- Positive attributes of having multiple services (e.g. nutrition, behavioral, social workers etc.) in one location.

Organizational Culture of Quality Improvement

- In-depth user's knowledge of the terminology and methodology of quality improvement
- Culture permeated all levels of the Health Center- part of how the dental program conducted its daily functions
- Focus on outcomes - of using outcome measures to drive change, of improving from a baseline, and using these concepts for all aspects of clinic operations

Dental Staff Buy-in: Understanding the "Why"

- Progress the result of a continuous process
- Resistance to change from staff addressed not by telling staff *what* to do, but rather explaining the "why"
  - Changes would achieve good patient outcomes, provide the best care for patients
  - Generate revenues and maintain financial sustainability

Patient Enabling Services

- Patient navigators, family support workers, health coaches
- Assist in making appointments, engaging patients, motivational interviewing, goal setting
- "Floaters" available to dental also
  - Dental appointments
  - Weight control

Dental Director Leadership

- Proactive, sure of the importance of oral health in improving the health status of the patients they serve
- Confidence to advocate for oral health
- Long-term vision, taking time to develop influence, relationships and grow credibility
- *"Remember the reason for doing this is not for a piece of paper of recognition but to better serve our patients and improve their quality of life."*

Challenges- Training

- Medical providers open to educational efforts about oral-systemic topics
  - Once the evidence base presented, happy to refer specific populations (HIV, diabetics, perinatal, young children)
- Initially, resistance from some dental providers and staff to expanding services to infant and perinatal populations
  - Comfortable once training occurred

EHR Issues

System	# using	Issue/notes
None	1	Will be getting EMR soon
EMR only	1	Interoperable after dental director created dental templates for the EMR- dental integrated into the EMR- one program
Interoperable EMR/EDR	2	Selected by HC precisely because system is interoperable- 2 separate programs
Sep EMR + Sep EDR + HL7 bridge	2	Clinics contract with a HC management network and as part of services, pay for proprietary software HL7 bridge that allows EDR to be interoperable with EMR- 2 separate programs
Sep EMR + Sep EDR	3	Non-interoperable- 2 separate programs

Clinical Issues

- Usually dental can see medical but not vice versa
- Prescription writing a tremendous issue
  - Medical providers have no way of knowing if a patient has received a prescription in dental
  - Some HC protocols have dental provider check EMR first before writing Rx and double enter prescription into EDR and the EMR

Best Practices

- Online needs assessment
- Interviews
- Categorized in six components of Chronic Care Model

Clinical Information Systems

- Generate lists of children, perinatal, diabetics, HIV that have not seen in dental for follow-up
- Track number of referrals from medical that are seen in dental
- Documentation of dental visits placed in medical chart
- Utilize IT system to identify and alert medical providers about special populations that need a dental referral) through ICD-9 code

Decision Support

- Standardized curriculums used for training of medical and dental staff (i.e. Society of Teachers for Family Medicine (*STFM) Smiles for Life*)
- Specific HC procedures and protocols support integration
- Minimum bureaucracy - ability to get a form or protocol approved and implemented in a few days - why delay an improvement?
- Grand rounds, lunch & learn

Delivery System Design

- Family Support Workers/Patient Navigators/Health Coaches make appointments for clients
- "Open access" - referring same-day pediatric patients to dental department for same day visit
- "Max-packed visits" – immunizations in medical and exam with dentist in one visit
- Call center appointment staff see both medical and dental schedules simultaneously

Self-Management Support

- Focus on patient literacy
- Dental education brochures in medical clinic waiting rooms
- Patients access health records over the internet/phone. Communicate the relationship between lifestyle and results.
- In the future phone apps could transmit finger stick, BP results or *s.mutans* testing to the Health Care Provider

Health System Organization of Health Care

- Dental staff located in WIC, pediatrics, primary care
- Hire in terms of buying into PCHH culture
- Develop quality improvement measures related to integration
- HC staff compensated based on patient outcomes

Community Resources and Policies

- Bilingual dental outreach worker- self-supporting by generating new clients and acting as an advertising arm of the clinic (Head Start, schools, homeless shelters, La Leche league, Hispanic groups)
- Board training
- Dental staff outreaches at county social services office/department of public health, local dental hygiene schools and dental society components
- Statewide PCA Learning Collaboratives

Limitations

- Conclusions about the entire health center universe should be drawn carefully
  - Selection bias
  - About 10% of total HC with dental programs

Next Steps

- PCHH/OH Action Guide under HRSA review
- Sessions on PCHH at 2011 NPOHC
- Develop Core Curriculum on the integration of oral health services and medical care services
  - Service delivery programs (HC's)
  - Workforce programs (NHSC)
- Continue to indentify best practices
- Advocate for inclusion of oral health into HRSA's HIT and *meaningful use* initiatives

Acknowledgements

- NNOHA staff
- Dental Directors/managers at the nine HC
- HRSA- Lisa Wald & Wendy Mouradian, MD
- Think2 Associates

NNOHA's mission is to improve the oral health of underserved populations and contribute to overall health through leadership, advocacy, and support to oral health providers in safety-net systems

www.nnoha.org

Thank You!