

Oral Health Disparities Collaborative Pilot



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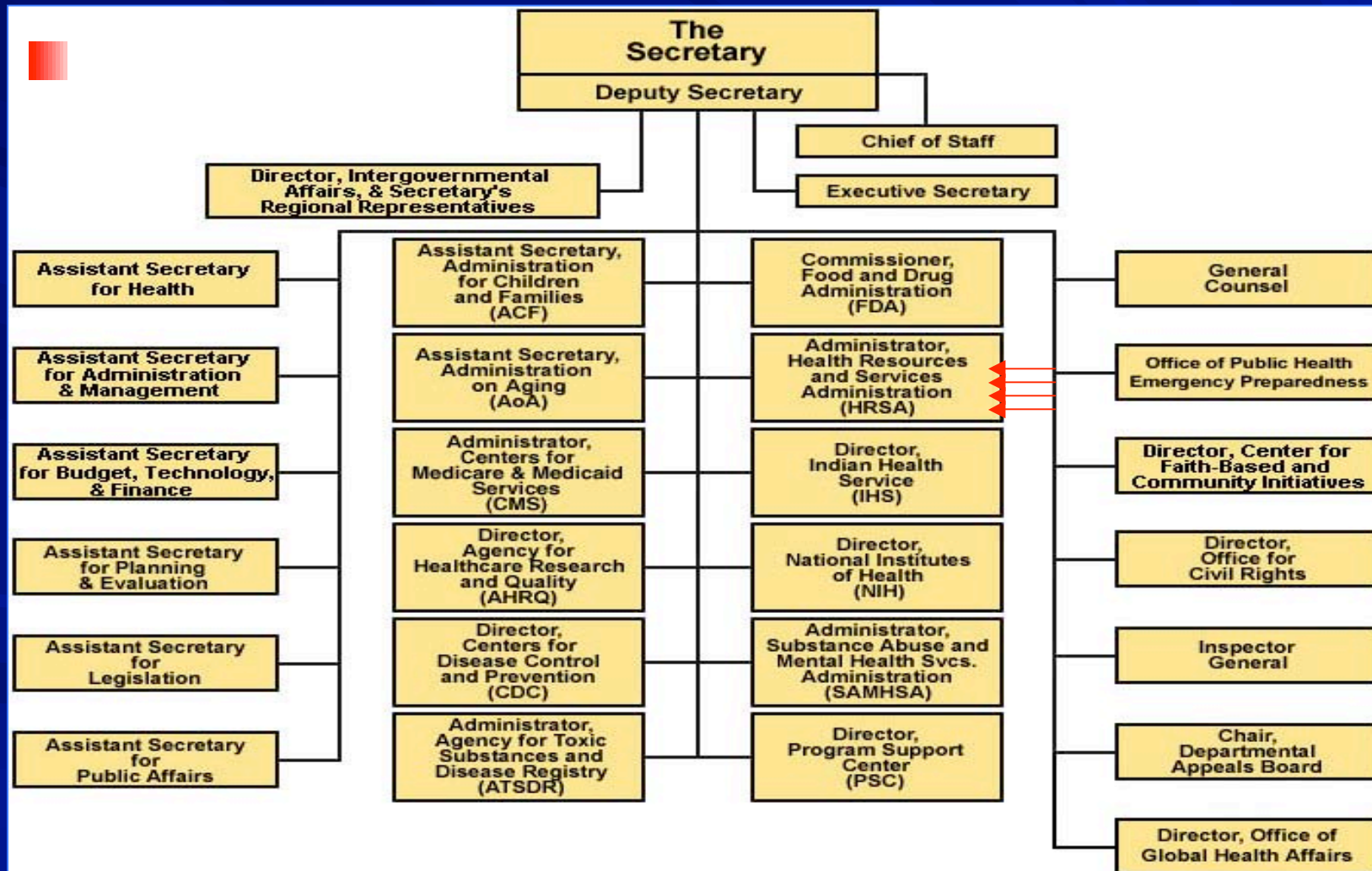
Goals for the Conference

- Provide background and history of collaboratives in Community Health Centers (CHCs)- **today**
- Describe attributes of collaboratives and the models collaboratives are based on- **today**
- Explain the planning and development of the Oral Health Collaborative- **today**

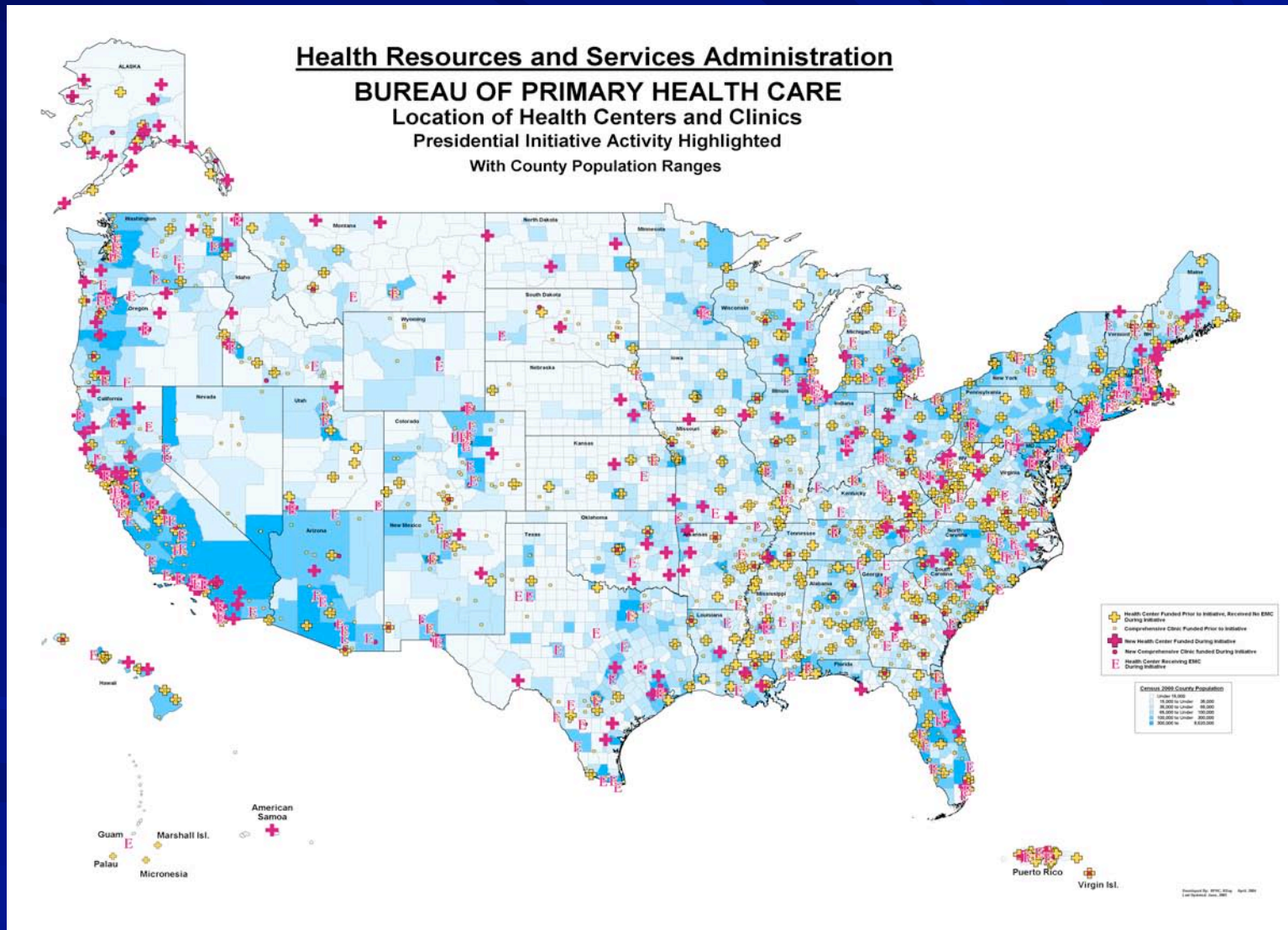
Goals for the Conference

- Learn the clinical Best Practices the Oral Health Collaborative are using - **today, Tuesday and Wednesday**
- Share the experiences of the four participating Pilot Teams- **today**

United States Department of Health & Human Services



Community Health Centers



Source: Uniform Data System, 2004

Questions

- What is a collaborative?
- Do I want to join a collaborative?
- Should I be afraid?

Super-Brief History of Collaboratives in CHC's

- Prior to 1998- HRSA/BPHC looks at the most common ICD-9 diagnosis in the CHC medical population
- 9 million users then - 16 million users now
- Diabetes

- Can we do something better? Manage care better? Improve outcomes? Improve quality?

Super-Brief History of Collaboratives in CHC's

- The **Planned Care Model**- basic elements for improving care in health systems at the community, organization, practice and patient levels was developed by Improving Chronic Illness Care (ICIC), a national program of The Robert Wood Johnson Foundation
- The **Institute for Healthcare Improvement (IHI)** is a collaborator of ICIC and the HRSA contractor to train CHC's in the Planned Care Model
- The **Diabetes Collaborative** was born

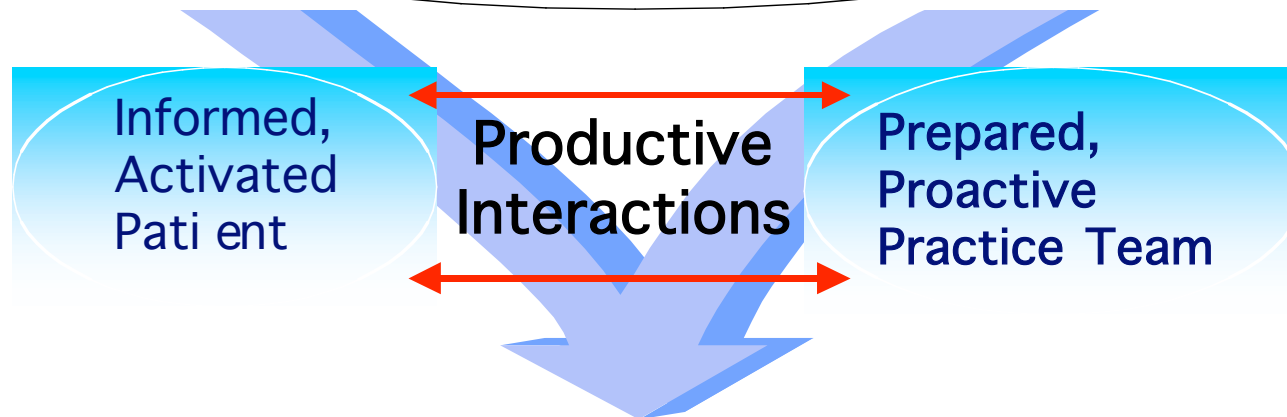
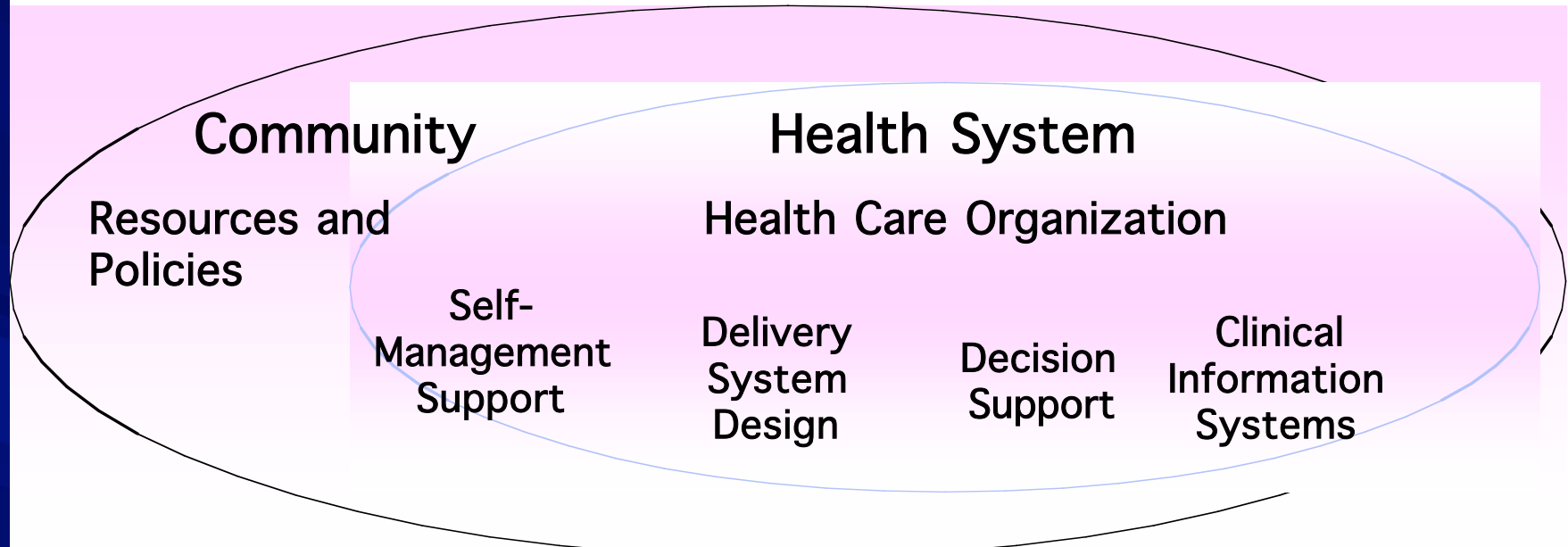
Original Diabetes Collaborative

- 1998 – 5/10 pilot teams
- 1999 – Spread to 88 teams
- 2000- Additional 120 teams
- Today hundreds of CHCs have diabetes collaboratives
- Today over 800 CHC's are involved in at least 1 collaborative

HRSA's Health Disparities Collaboratives

- Asthma
- Cardiovascular disease
- Cancer Screening
- Depression
- Prevention
- Diabetes

Care Model



Functional and Clinical Outcomes

(Planned) Care Model

1. The health care organization
2. Community resources and policies
3. Self-management support
4. Decision support
5. Delivery system design
6. Clinical information systems

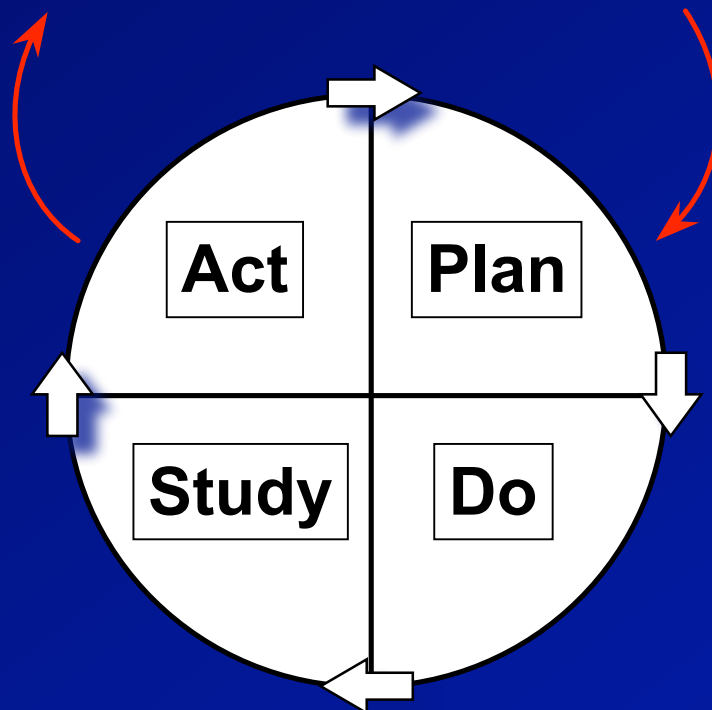
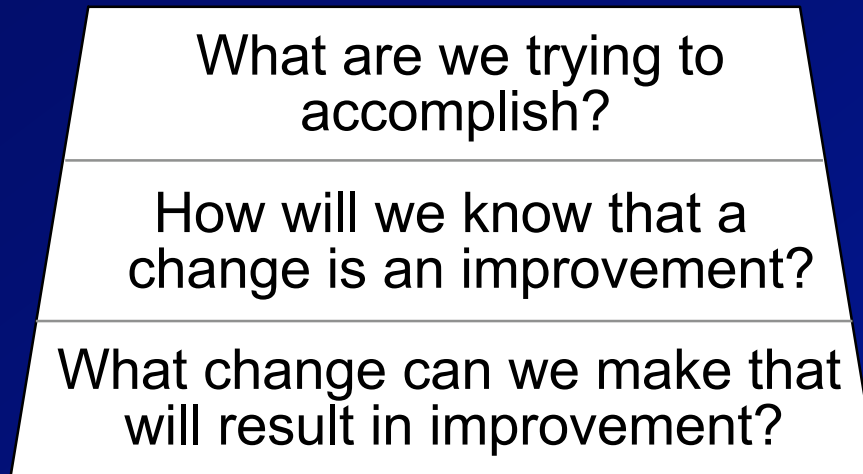
(Planned) Care Model

- Based on the concept that there are **Best Practices** to manage chronic health conditions
- The Best Practices are not being used in a given population because of:
 - Lack of knowledge
 - Non-supportive systems
 - Resistance to change

Concurrently: Delivery System Redesign

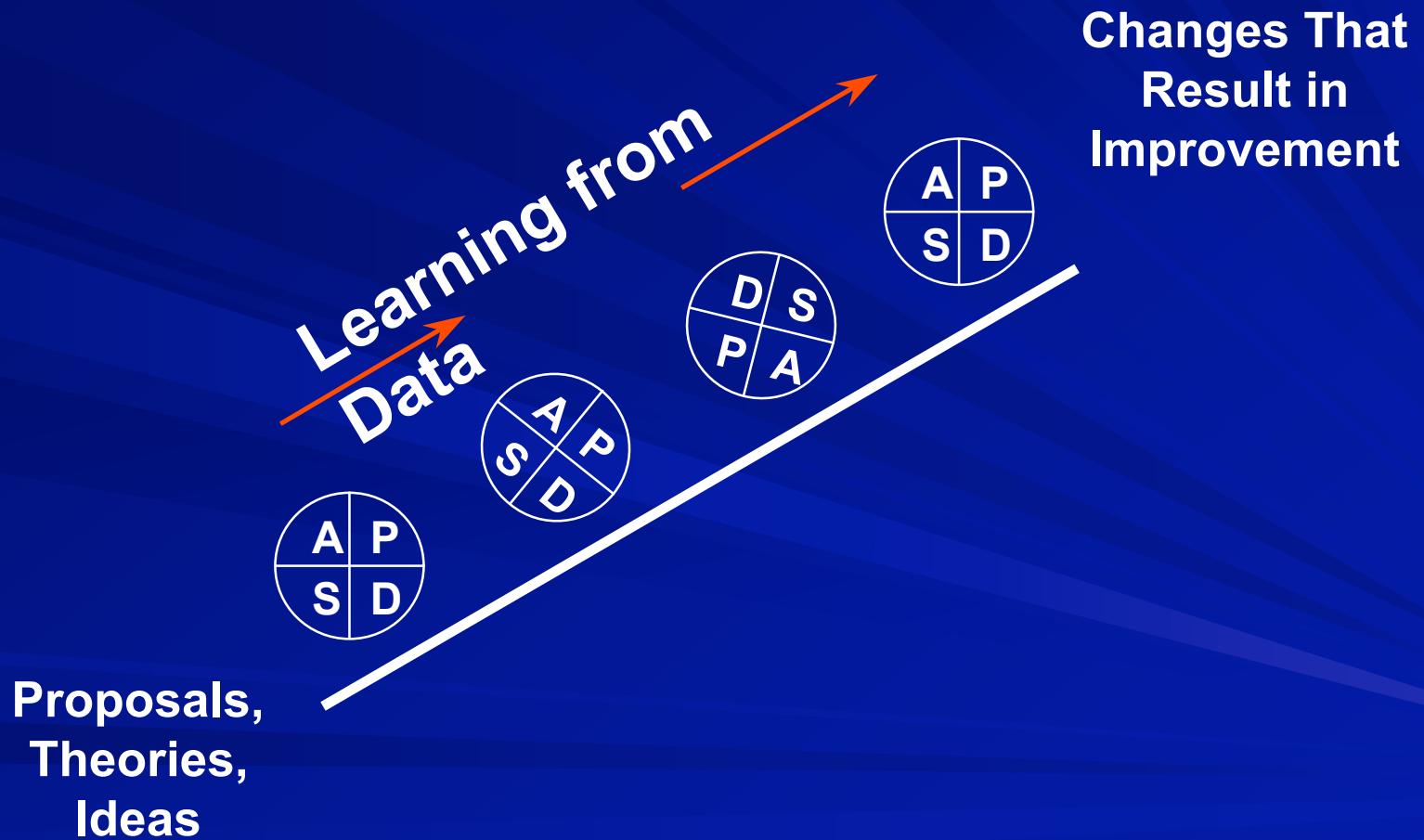
- Helpful to implement Best Practices in a Health Center
- Allows full development of all 6 aspects of the Planned Care Model
- Goes hand-in-hand with Collaborative activities

Model for Improvement- PDSA Cycle



The Model allows us to test and implement changes in care in a fast and efficient way

Repeated Use of the PDSA cycle



The Questions?

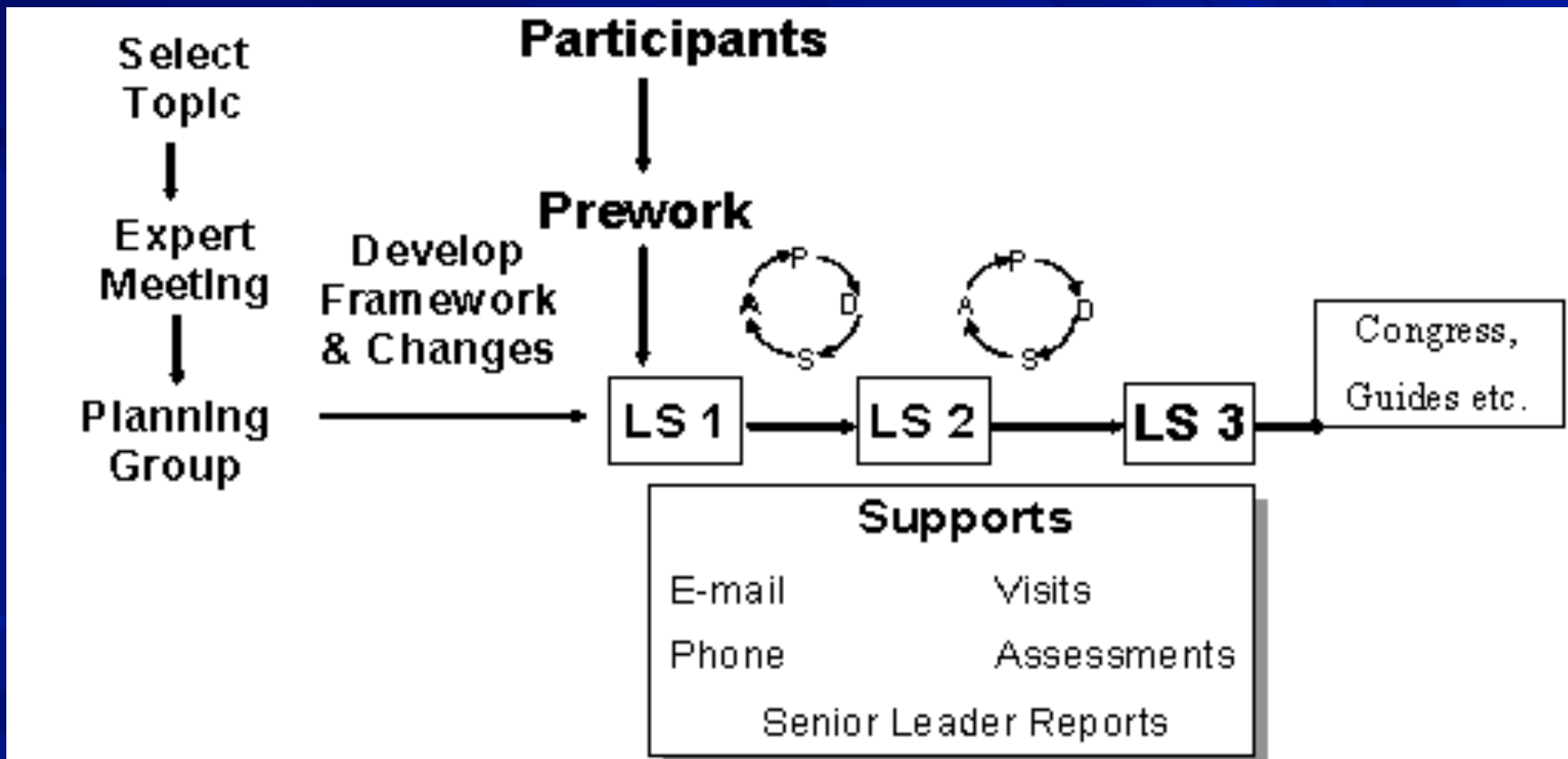
- Could the Planned Care Model of health delivery and management be applied to oral health care?
- Could the Model be used to develop comprehensive system change interventions that would generate major improvements in process and outcomes for patients?

The Path to the Answers

- HRSA/BPHC
 - Dr. Jay Anderson
 - Dr. Ahmed Calvo
- Funding for a Pilot
- And off we went into the unknown!



Collaborative Learning Model



Vanguard Meeting

August 2005

- After our Atlanta Meeting
- Presentations by experts on oral health current research
- Introduction to Planned Care Model
- Potential areas for collaborative
 - Diabetes
 - Early Childhood Caries (ECC)
 - Oral Cancer
 - Perinatal

Populations of Focus

- Children 0-5: Early Childhood Caries prevention and treatment
- Pregnant Women: Improving perinatal oral health in caries and periodontal disease
- *Concurrent emphasis on practice redesign and office efficiencies that support improvements in the targeted areas*

Oral Health in America:
A Report of the
Surgeon General



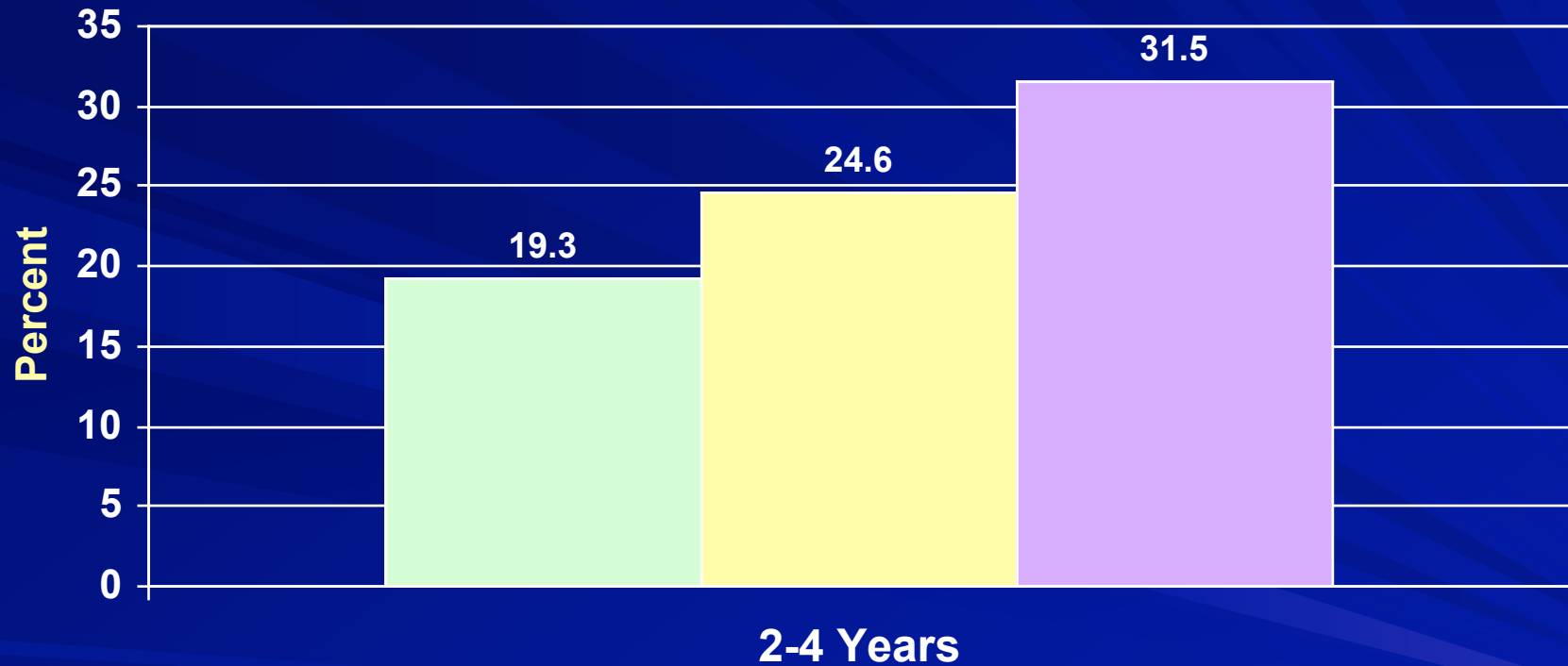
Department of Health and Human Services

Why those groups?

“There are profound and consequential oral health disparities within the U.S. population.”

Early Childhood Caries Disparities

% 2-4 y/o Untreated Decay



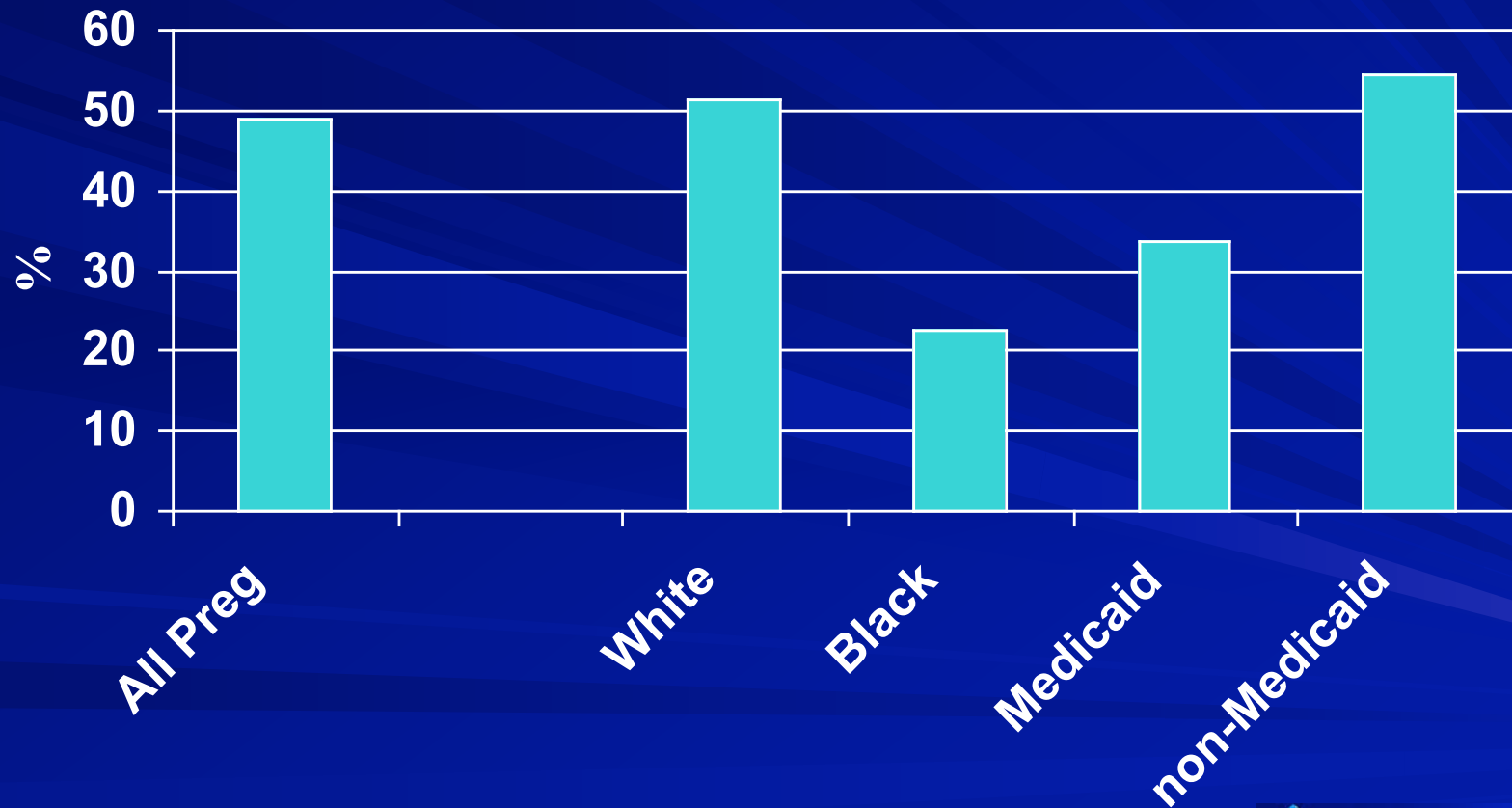
NHANES 1999-2000

■ Non-Hispanic White ■ Non-Hispanic Black ■ Mexican American



Dental Visits: 2002 PRAMS

(Pregnancy Risk Assessment Monitoring System)



Planning Group

September 2005

- Jay Anderson DMD, MPA- HRSA
- Colleen Lampron MPH- Co-chair
- Irene Hilton DDS, MPH- Co-chair
- Francisco Ramos Gomez DDS, MPH- ECC Faculty
- Mary Foley RDH, MPH- Perinatal Faculty
- Marty Lieberman DDS- Redesign Faculty
- Tracy Jacobs RN- IHI Program Officer
- Kevin Little- IHI IT Consultant
- Jim Sutherland DDS, MPH (ex-officio)

Dentistry ISN'T
like medicine



Kevin

Selection of Participating Teams

- Community Health Partners, Livingston MT
- High Plains Community Health Center
Lamar, CO
- Salud Family Health Centers
Fort Lupton, CO
- Sunrise Community Health Center
Greeley, CO

Develop Measures

- Measures are needed to drive change, for example implement a best practice
- Allow you to see if a desired change is occurring
- Can help answer the question – *How will we know that a change is an improvement?*

Core Measures - Perinatal

 % Pregnant women with comprehensive dental exam completed while pregnant

 % Pregnant women with completed **Phase I dental treatment** plan within 6 months of exam

 % Pregnant women with **Self Management Goal (SMG)** set while pregnant

Core Measures-ECC

 % Children with dental evaluation by age 12 months

 % Children 12 -60 months with dental evaluation in last 12 months

 % Children 12-60 months with completed Phase 1 dental treatment plan within 12 months of exam

 % Children 12-60 months with documented Self Management Goal set

Learning Sessions

- November 2005
- January 2006
- March 2006
- June 2006
- Learn planned care model, PDSA's,
- Training in the clinical Best Practices, redesign concepts
- MIS/IT
- Share experiences, achievements, hints
- Bond

Action Periods

- Time in between Learning Sessions
- 2 month intervals
- Weekly calls with Planning Group
- Planning Group had separate weekly calls
- Teams implement best practices and data collections systems
- Integrate Collaborative Planned Care model into dental clinics

Harvesting- November 2006

- Teams gathered to have key elements of successes documented in a mass “brain dump” of change concepts
- Data will be collected and organized into the Oral Health Collaborative **Change Package** that will be used as the manual or template for the expansion of the collaborative to other health centers

Conclusion

Our Successes

- Greater collaboration between medicine and dentistry
- Standardized implementation of best practices previously not universally being performed
- Focusing on the preventive approach rather than surgical or end-stage treatment of dental disease

Collaborative Aim

- Apply the health services delivery Care Model, currently utilized extensively by Community Health Center collaboratives to manage chronic conditions such as diabetes, asthma and cardio-vascular disease, to the delivery of oral health care

The Need

- HCs currently employ 1,586 dentists at 930 Health Centers – many of these are one provider operations*
- Current dental capacity: 2.1 million users vs. 11 million medical users
- Estimated unmet dental need nationally (to close the access disparity gap): 33 million persons

*HRSA 2005 UDS

The need continued...

- Oral medicine is changing rapidly
- Growing recognition of oral systemic connection
- Widening gap between oral health of rich and poor
- Prevention strategies exist that benefit the most vulnerable populations – the oral health collaborative implements these

Collaboration in Primary Care Between Medicine and Dentistry

- The cooperation of dental, medical, and other health professionals to provide comprehensive health care could enhance patients' access to care and their overall health, well-being, and quality of life.
- Although the specialized restorative care of a dentist cannot be replaced, it is extremely important to establish collaborations among dentistry, medicine, and other health-related professions to increase oral health awareness, prevention, and coordinate care of interrelated health.

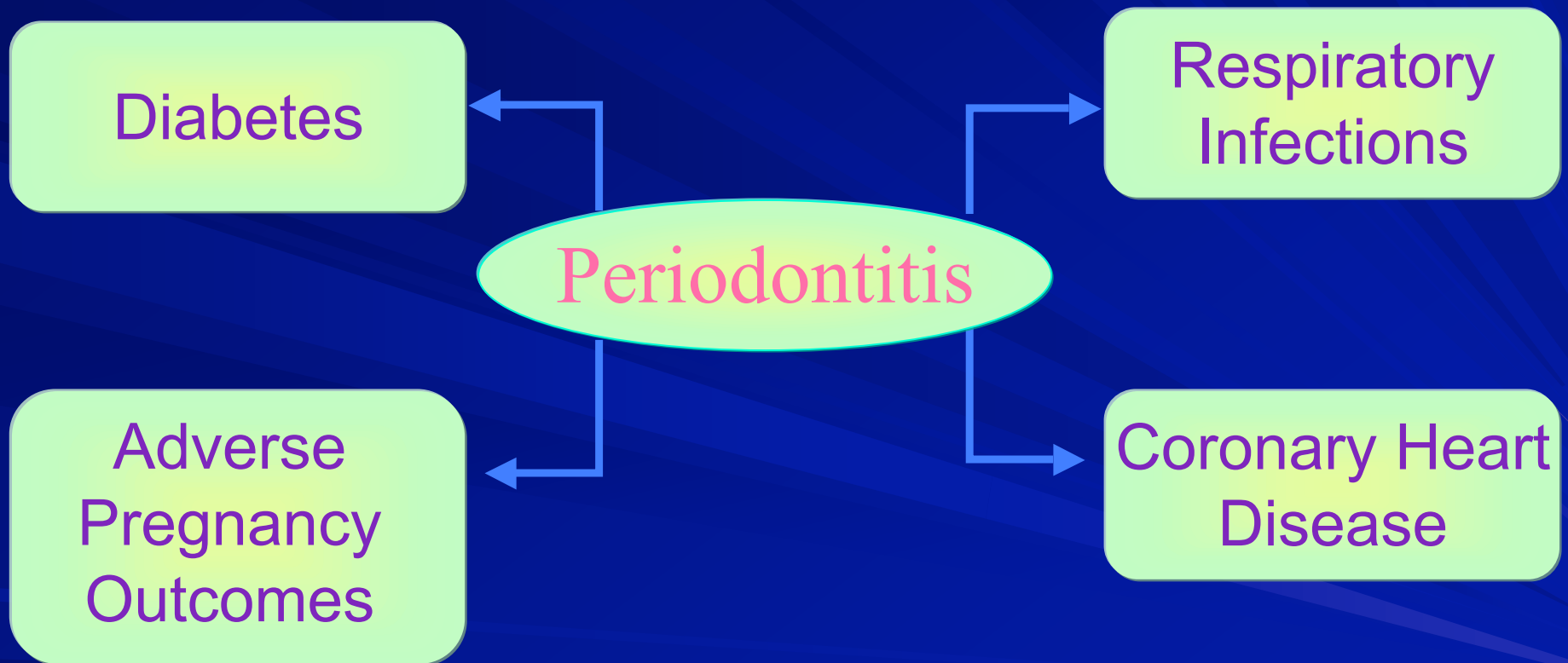
Collaboration in Primary Care Between Medicine and Dentistry

- It is a reassuring fact that the majority of pediatricians and general care providers already agree they have an important role to play in the prevention of dental diseases and the promotion of oral health.
- It would seem that integrating oral health into primary medical care for children and adults could be a strategy to consider in any community where access to dental care is a problem.

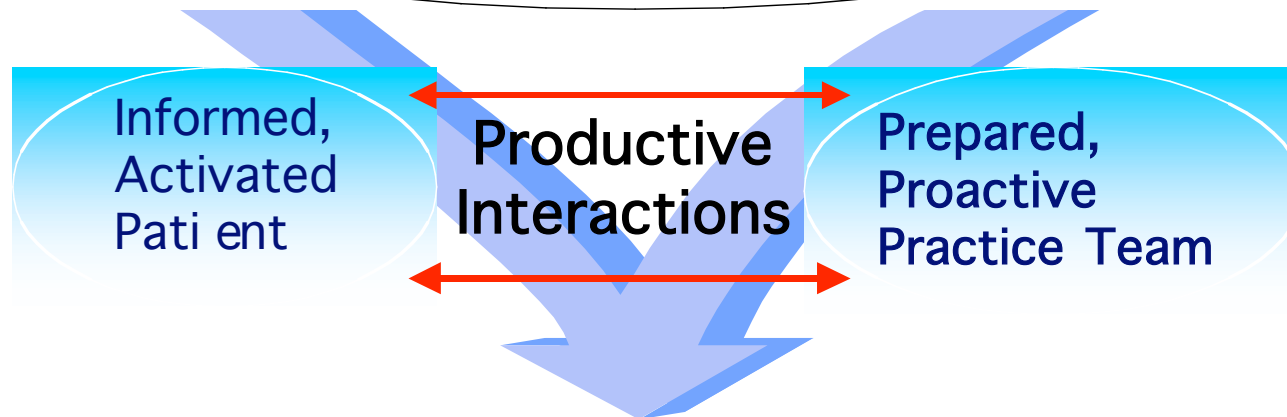
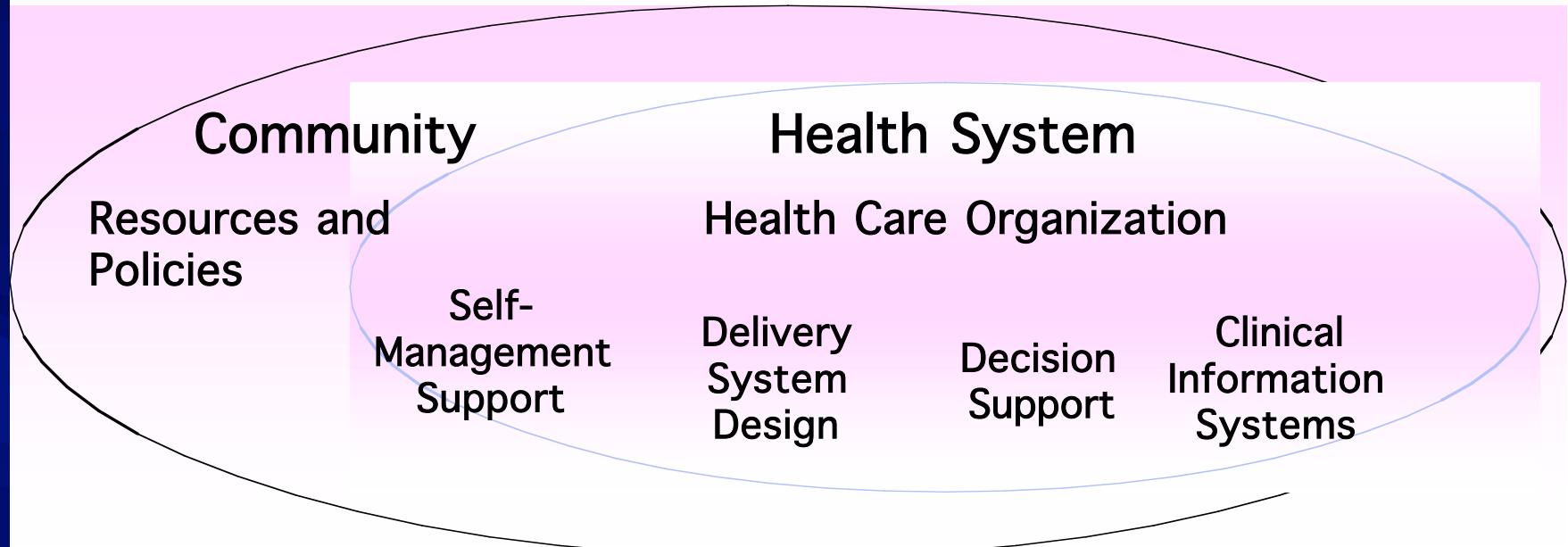
Medical Dental Collaborations

- Pediatricians and Primary Care Physicians are being trained to provide an oral assessment, basic oral health education and application of a fluoride varnish to qualifying children.
- As a result, these medical providers can play an integral role in improving the oral health of their young patients.

Periodontal Disease Associations



Care Model



Functional and Clinical Outcomes

Oral Health Care Model

**National,
State and
Community
Resources and Policies**
**HP2010, State Wide
Oral Health Plans,
Data, Oral Public
Health Infrastructure ,
Organized Dentistry,
Dental Education**

Health System –Oral Health System

Health Care Organization

Private Practice, Public and Community Coordination

**Patient Self-
Management
Support**

**Delivery
System
Design
Workforce
Models**

**Decision
Support**

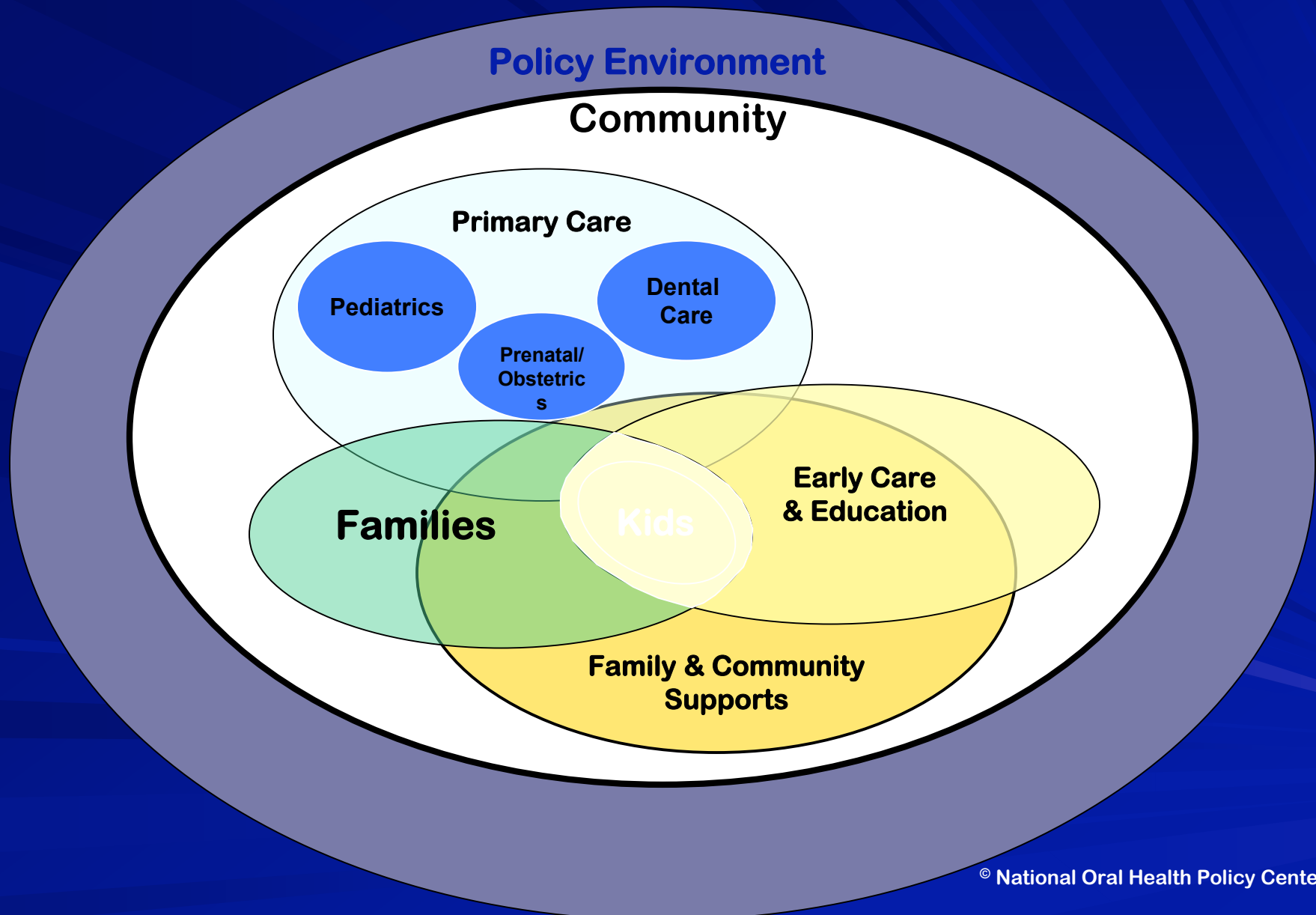
**Clinical
Information
Systems**



**Improved Oral Health Status, Functional and
Clinical Outcomes**



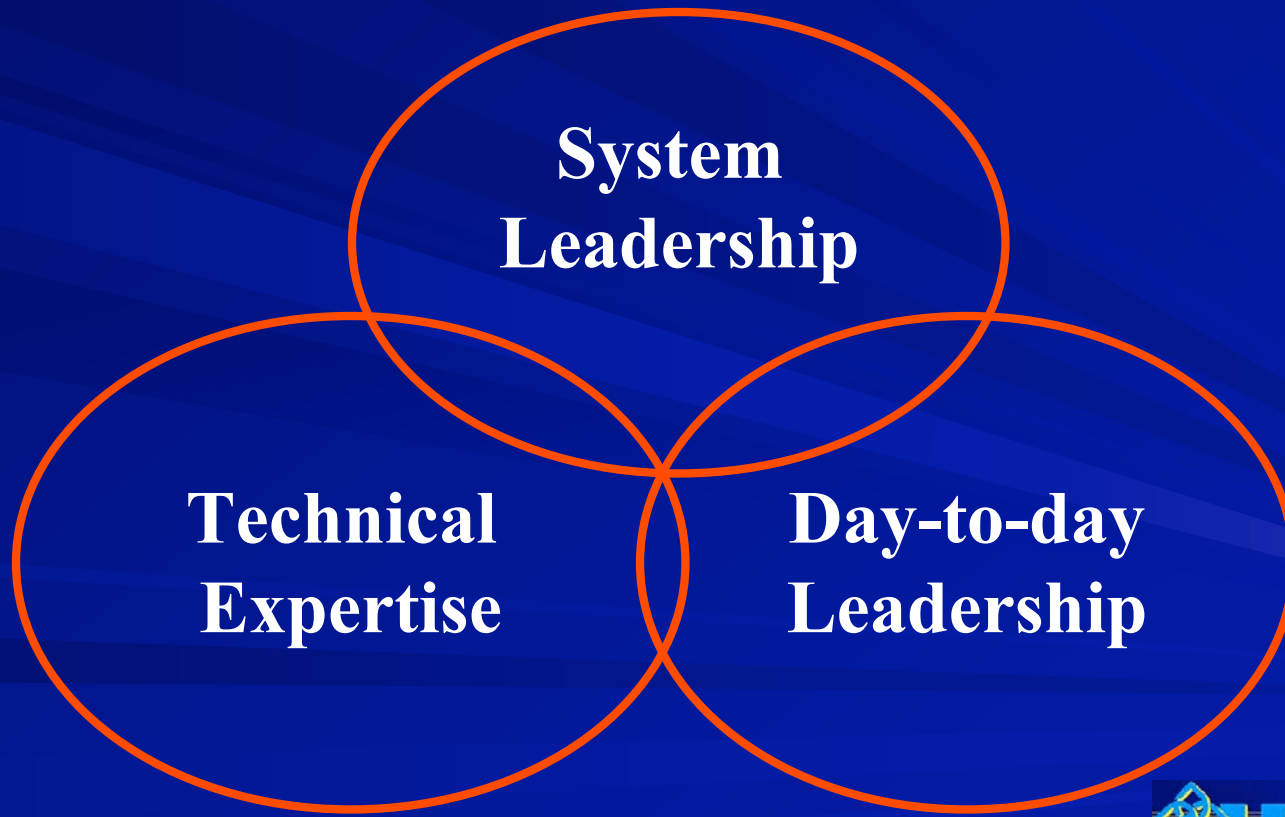
Conceptual Diagram of Community and Policy Environment Interactions



How do we organize for improvement?

- Understand where we are headed
- Consider how to efficiently reorganize care so we more consistently do what matters
- Understand who we serve
 - What is our denominator of care?
- Share tools and knowledge (the learning community)
 - It doesn't take any time to make dumb decisions ...
- Install credible measures to monitor progress
 - What measures will indicate progress?
 - Who is our denominator of care?

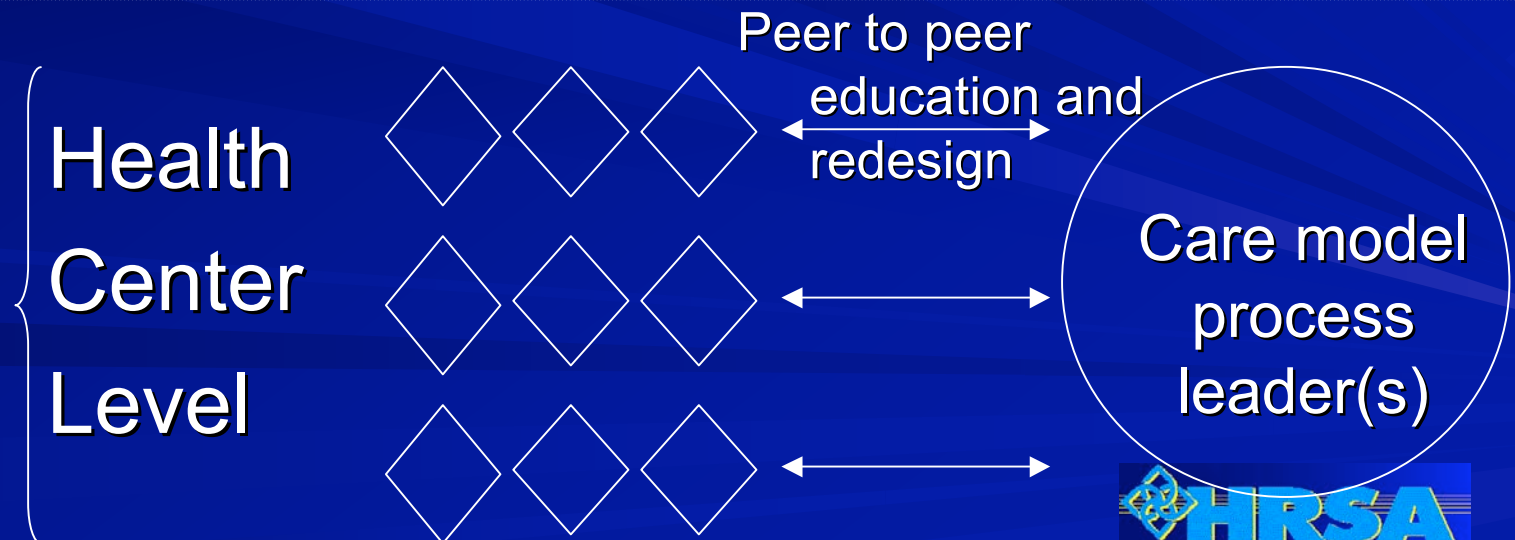
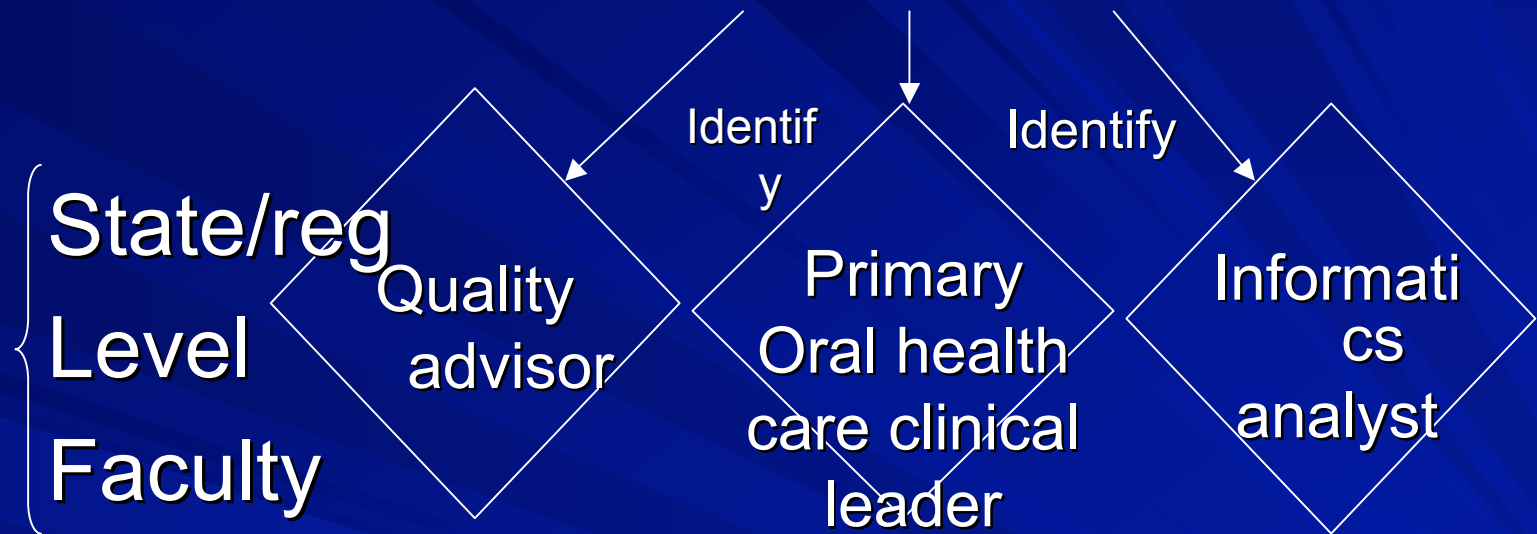
Three ingredients of an effective team



That's what this meeting is about.....

- Learning how to work as a community to organize for continual learning and improvement in order to achieve
 - “optimal oral health for all, supported by a health care system that assures access to comprehensive, culturally competent, quality care”

National Faculty (HRSA, IHI, NNOHA)



Care is affected by multiple levels of influence

A. HRSA/BPHC Leadership, Public Policy/Regulations, Purchaser Requirements.
Market Pressures Professional Group Standards/Accreditation, Reimbursement

B. COMMUNITY Leadership, Covered Benefits Financial Features Risk
Distribution/Resources, Contractual Relationships Structure & Culture; Care
delivery/management policies

C. GRANTEE Leadership, Resources, Structure, Procedures,
Systems, Culture

CLINICIAN/TEAM
CHARACTERISTICS

ENCOUNTERS
INTERACTIONS
CONTACT

PATIENT (and family)
CHARACTERISTICS

PATIENT
ADHERENCE

Information Systems

OUTCOME

Patient:
Health Status
Satisfaction
Quality of

Efficiency
Equity
Effectiveness

Facility: Leadership, Systems, Organization



Communities are Needed to Improve Oral Health Care in Health Centers

- Identify Sponsorship/Champion/Leader
 - Who convenes and validates the community?
- Clarify Domain
 - What is the focus of work?
- Begin Practice
 - Convening calls and/or meetings
 - Solving problems
- Measure, Measure, Measure

Information Systems and Measurement as a Tool for Care

- We need measurement and care systems that can manage the denominator
- Three key elements
 - Patient level data on oral health care and follow-up
 - Population measures
 - Population reports with information to facilitate care
 - Who is due for Exam/screening?
 - Who has been referred but has not been treatment planned?
 - Who has not completed phase I oral health care?
 - Who has not been seen for follow-up?
- We'll learn about how some centers have handled this
- But now we'll learn about how understanding denominators is relevant to care in general

Access and Redesign

Supports Denominator-Based Care in Five Ways

- Organizes the population to support provider accountability and patient continuity
- Manages provider demand and supply
- Assures that the patients are seen when they ask to be seen (advanced access)
- Establishes skilled, efficient provider-led teams
- Removes waste from the system and improves capacity

Access and Redesign

Organizes the population to support provider accountability and patient continuity

- Identification of the CHC Panel of patients (the CHC “Patient Denominator”)
- Assignment of Provider Panels
 - “Denominator” for which the provider is accountable
 - Population managed by the Provider
 - Basis for provider report card, incentives, and pay for performance
- Continuity of care for patients

Access and Redesign

Manages provider demand and supply

- Demand for and supply of providers is monitored -3rd appt available
- Demand and supply of provider appointments is managed
 - Alternate care delivery mechanisms are utilized (EDDAs)
 - Team members manage appropriate patient needs
 - Provider/operatories/assistants -1fte dentist, 2-3 chairs, 2-3 assistants
 - Patient continuity of care with provider or provider team is maintained (increases efficiency, decreases rework, & increases patient safety)
 - Visits are “maxpacked” at point of service (Quadrant Dentistry)
- Contingency planning by providers and administration
 - Proactively monitor the supply of providers
 - Plan for attrition, vacations, and medical leave
 - It is a Partnership aimed at meeting patient demand

Access and Redesign

Assures that the patients are seen when they ask to be seen (advanced access)

- The backlog of future appointments is reduced
- Necessary follow-up appointments are scheduled
- Patients get appointments when they request it
 - Patient illness/concern managed promptly
 - Decrease in Walkin/Emergency
 - No need to book unnecessary future appointments
 - No need for resource intensive telephone triage
- Clinical Outcomes and Satisfaction improve
- “No Show” rate decreases
 - Wasted appointments minimized (capacity increases)
 - Decreased waste of resources (rooms, staff, provider)
 - Productivity and cost per case improve 2700+ \$130

Access and Redesign

Removes waste, and improves capacity

- Processes and procedures are redesigned for efficiency
- Wasted appointments (no shows) are reduced
- Provider does only provider-work
- Provider and team manage patient demand appropriately and efficiently
- Clinic rooms are maximally used -- room capacity increases

Access and Redesign

Establishes skilled, efficient provider-led teams

- Consistent Provider-led teams
 - Promote trust and teamwork
 - Promote training and delegation of tasks
 - Promote continuity of care by the team
 - Promote efficiency (patient knows team, team knows patient)
- Maximization of team member roles so that the Provider does only “provider-work”
- Rooms are similarly designed, and stocked

Major Task

- Entering all Dental patients into a registry
- Be prepared for delays in the process.
- Provide IT support to assist in working through any problems.
- New thinking

A New Era of Clinical Practice

- Greater collaboration between medicine and dentistry
- Implementation of best practices
- Focusing on the preventive approach rather than surgical or end-stage treatment

A New Era of Clinical Practice

- Providing ECC risk assessment and disease management to very young children in the medical and dental settings
- Providing comprehensive dental services to perinatal patients
- Developing, implementing and evaluating practice efficiencies

Early Successes

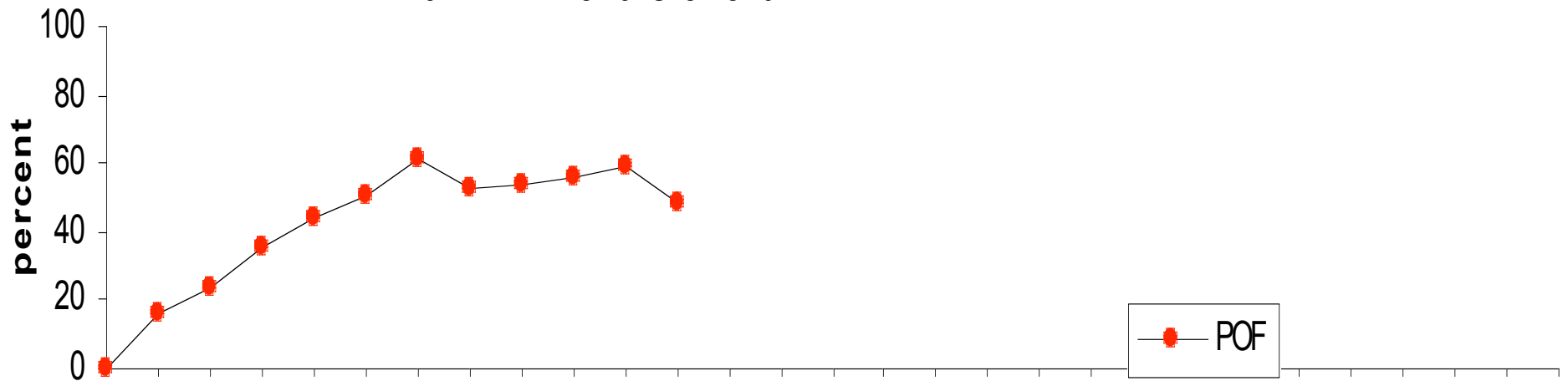
- Implementation and standardization of referral mechanisms from medical to dental.
- Greater collaboration and communication between medical and dental
- Increased oral health knowledge of medical staff

Early Successes

- Improving access to oral health care for young children and pregnant women
- Paradigm shift to approach clinical dentistry from a prevention standpoint
- Initial development of oral health specific clinical information systems and efforts to integrate oral health into PECS 3

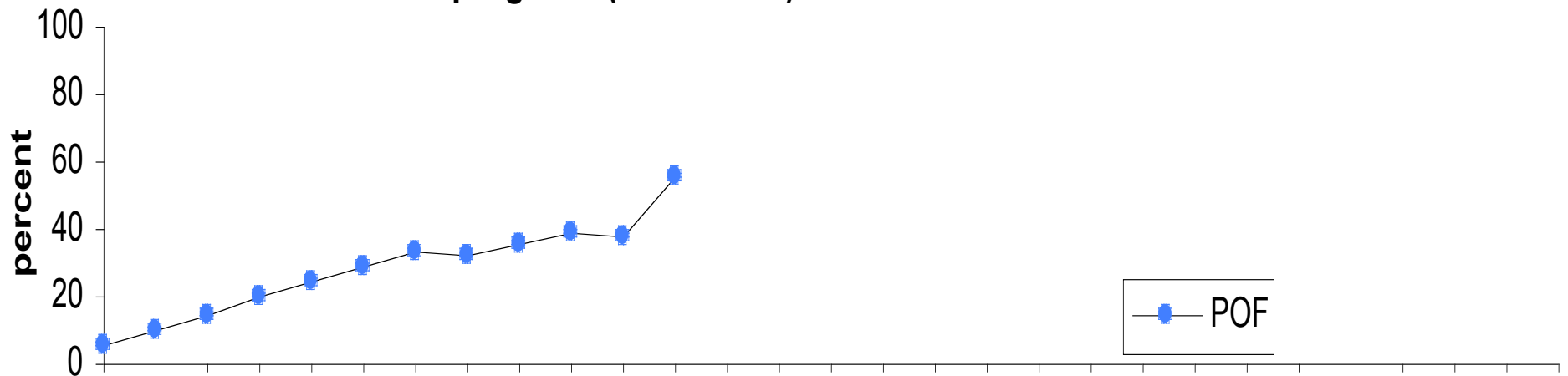
Treatment Completed - Children

Patients ≥ 12 months and ≤ 60 months completed Phase 1 treatment within 12 months of exam



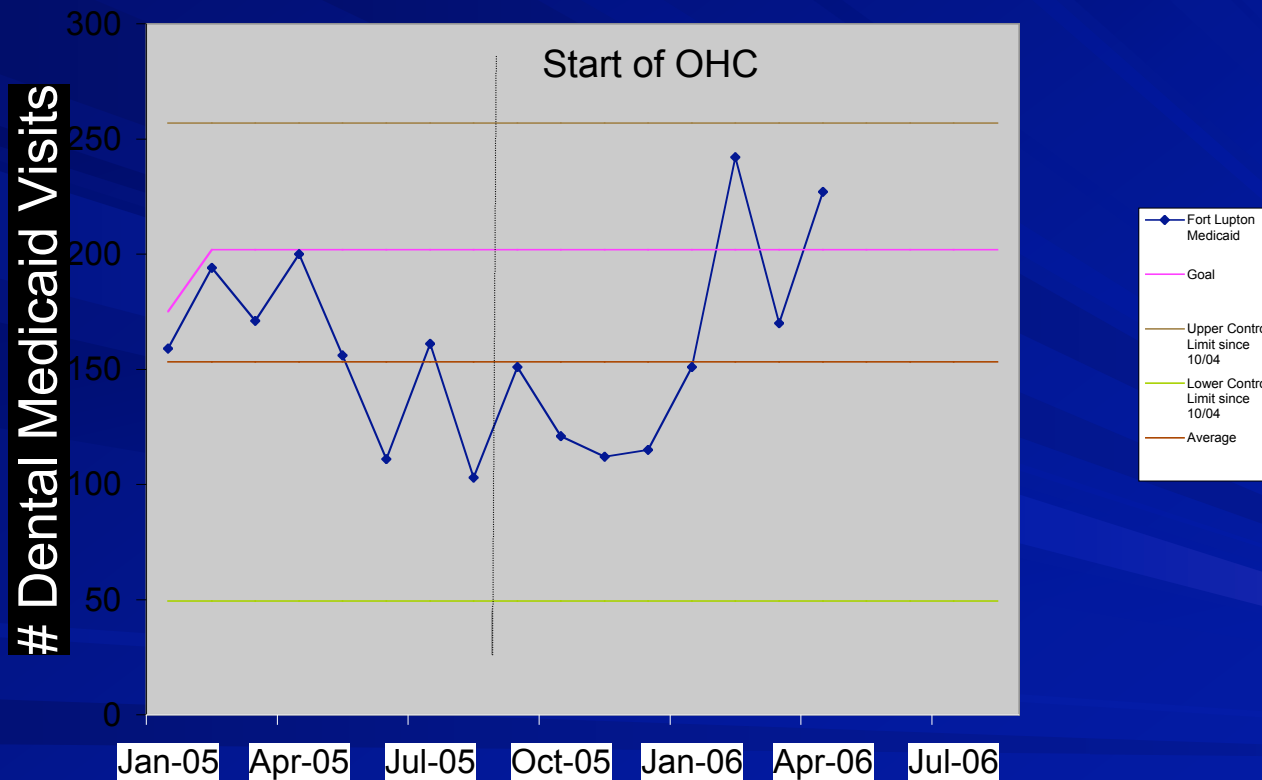
Perinatal Access to Dental

Pregnant women with comprehensive dental exam completed while pregnant (12 months)



The Business Case: Dental Medicaid Visits

Salud Case Study



Lessons Learned so far...

- Each collaborative team member brings important skills to the effort
- After gaining best practices education, dental providers are able to overcome their reluctance to provide treatment to pregnant women and very young children
- Referrals by medical providers are key. Without reinforcement and support from medical staff, patients in the Populations of Focus have a variety of personal and systemic reasons to not access dental services

Challenges

- Extensive training needed for dental staff
- Competing organizational priorities may limit commitment
- MIS/IT/data challenges
- Capacity issues in dental
- Prioritization of certain populations an issue

The Future

- Beyond...

- Development of Oral Health Collaborative Manual
- Expansion of oral health collaborative to other Community Health Centers!

Thank You!

■ More information:

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