HRSA Health Disparities Collaborative Oral Health Pilot

2007 National Oral Health Conference
Advancing Access & Taking Action for the Nation's Oral Health
American Association of Community Dental Programs
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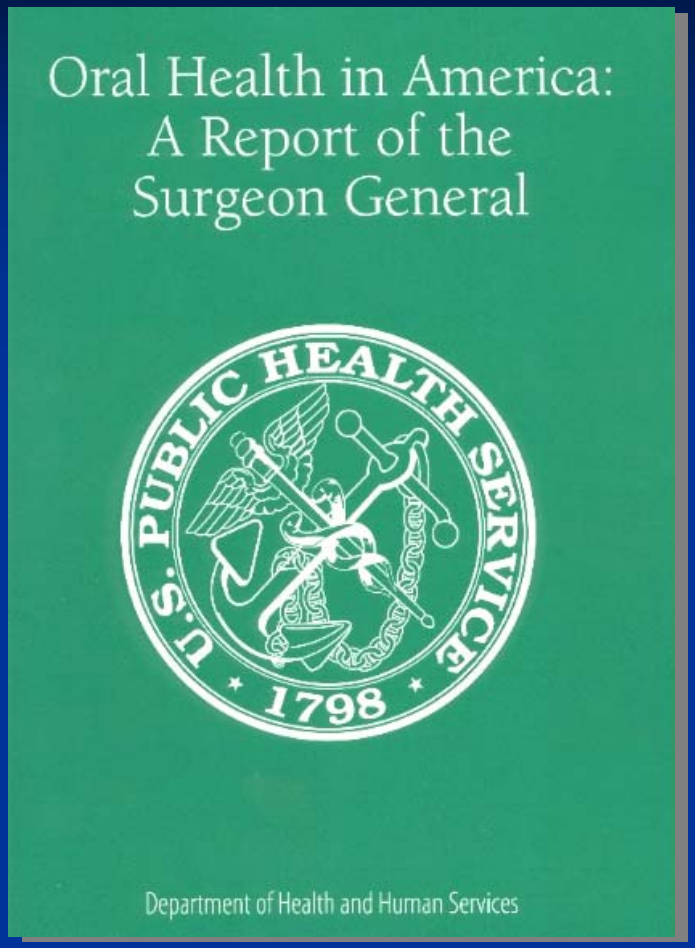
Jim Sutherland, DDS, MPH
Regional Dental Consultant, Denver Regional Division
Health Resources and Services Administration



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

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

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.

Preterm Low Birth Weight (LBW)

- In the United States, 10% of newborns are LBW
- 25% of preterm LBW cases occur without any known risk factors
- The number of low birth weight babies increased 6% between 1985 and 1993
- While efforts to rescue LBW infants are excellent, efforts to prevent LBW or preterm births have generally been unsuccessful

Periodontal Infection and Preterm Birth: Results of a Prospective Study . Obstetrical & Gynecological Survey. 57(1):5-6, January 2002.
Jeffcoat, Marjorie K.; Geurs, Nico C.; Reddy, Michael S.; Cliver, Suzanne P.; Goldenberg, Robert L.; Hauth, John C

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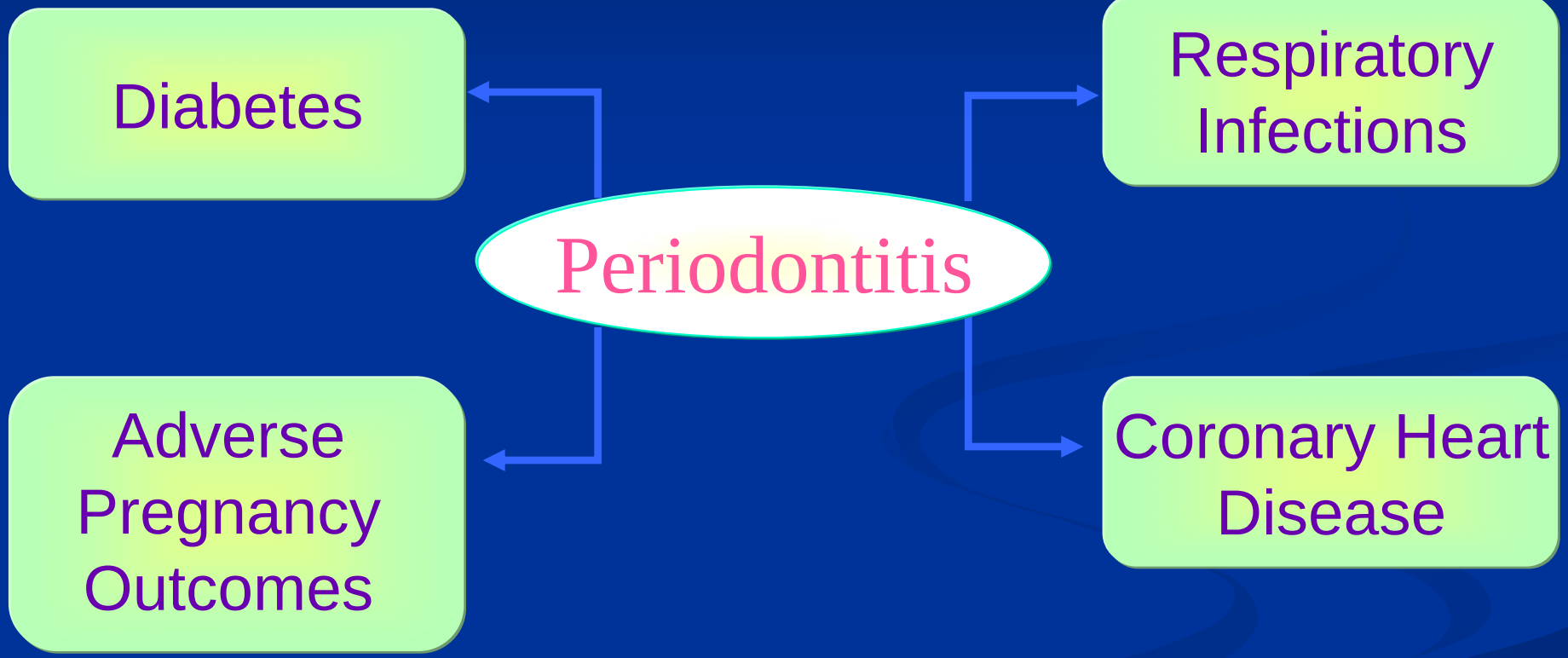
Periodontal Disease Associations



Periodontal Disease & Pregnancy

- Case control (Offenback, Beck et al 1996, 1998) and prospective (Offenback 2001, Jeffcoat 2001) studies have both shown association between LBW outcomes and periodontal disease
- Known risk factors such as smoking, race, alcohol use, age etc. were controlled
- Large scale NIH-funded clinical intervention studies underway (Jeffcoat 2003) MOTOR & OPT

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Collaborative Timeline

- Vanguard planning meeting- August 2005
- 1st Collaborative learning session- November 2005
- 4th Collaborative learning session- June 2006
- Harvesting- November 2006

Collaborative Aim

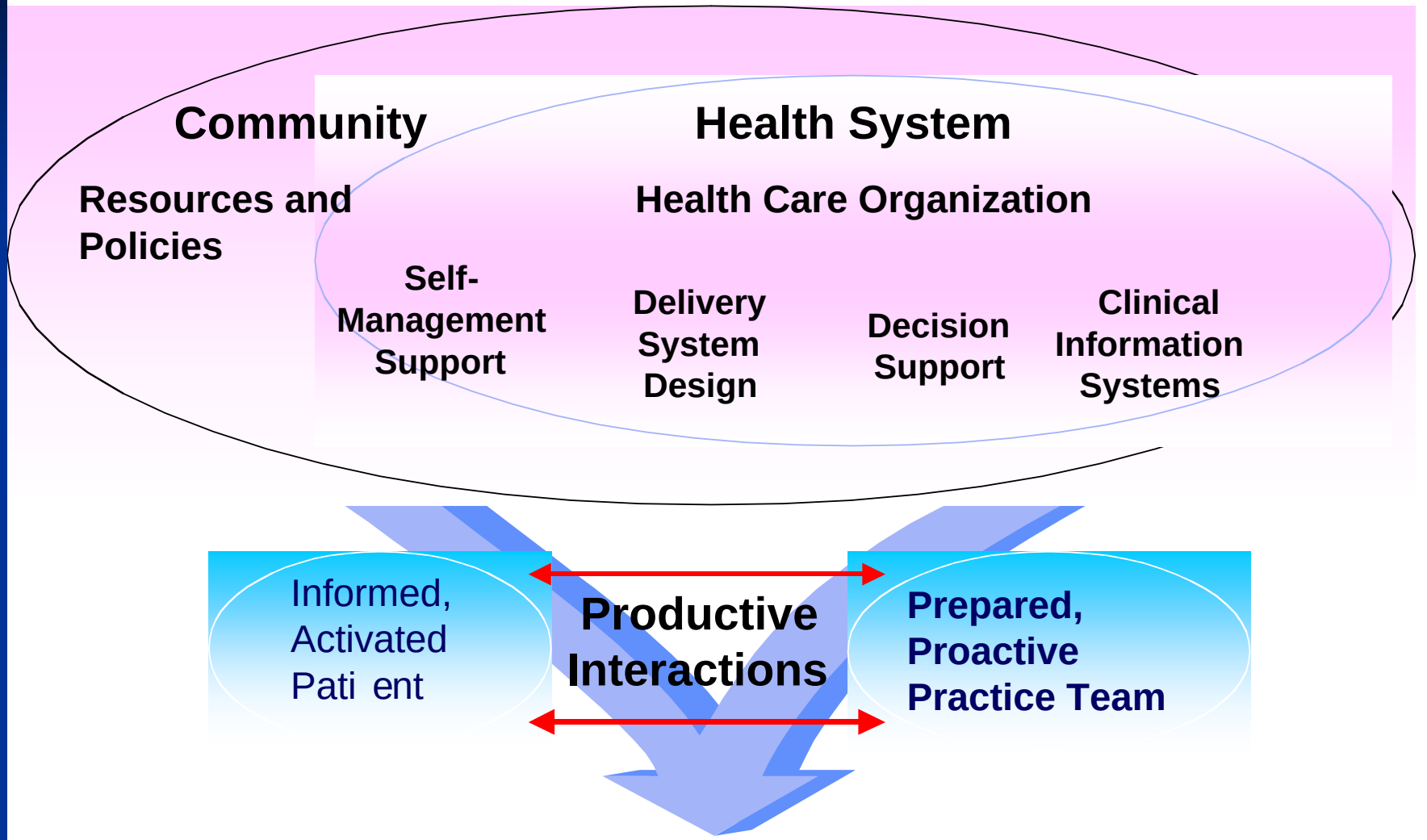
Apply the health services delivery Care Model, currently utilized extensively by Community Health Center collaboratives to manage chronic conditions such as diabetes, asthma and cardio-vascular disease, to the delivery of oral health care

Collaborative Aims

Develop comprehensive primary oral health care system change interventions that generate major improvements in process and outcome measures for:

- **Early childhood caries prevention and treatment**
- **Perinatal oral health**
  - *Concurrent emphasis on practice redesign and office efficiencies that support improvements in the targeted areas*

Care Model



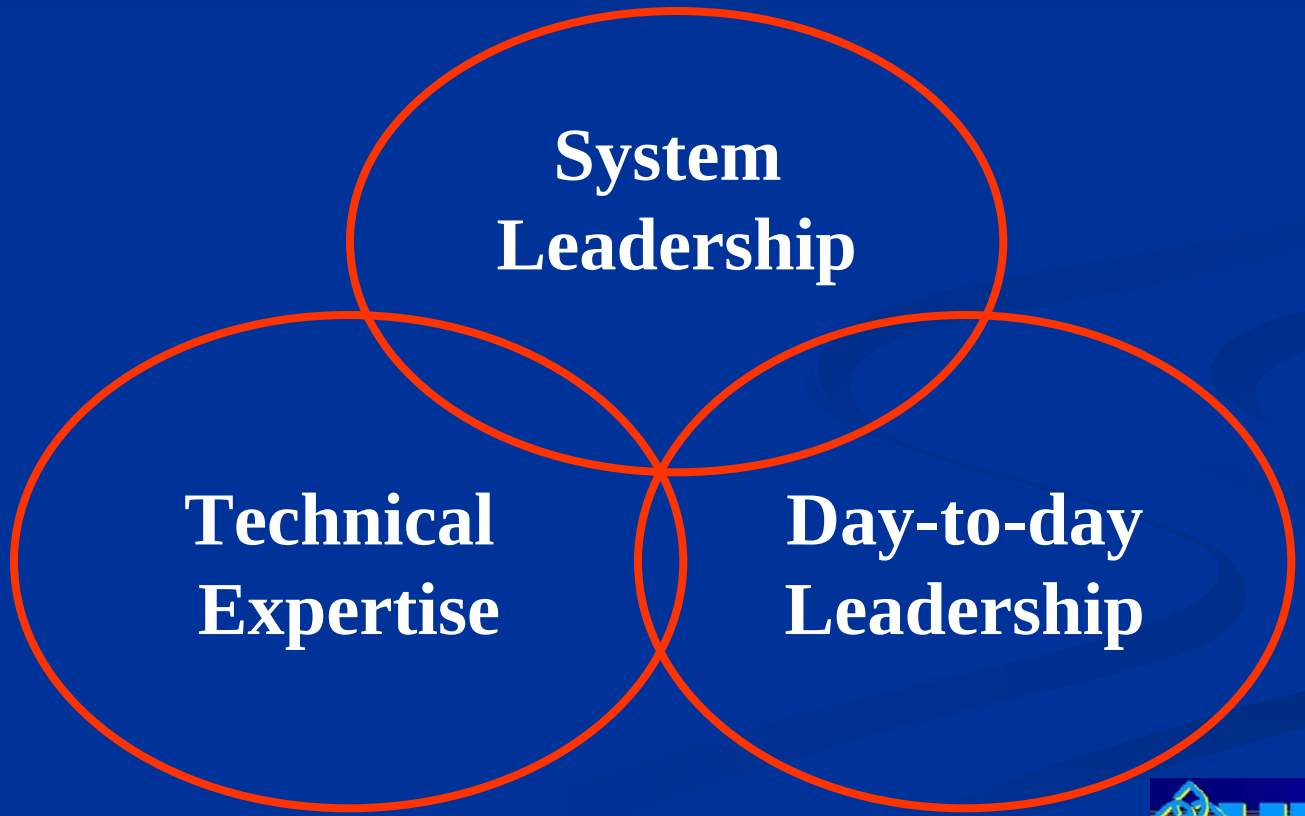
Functional and Clinical Outcomes

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?

It takes teams…..

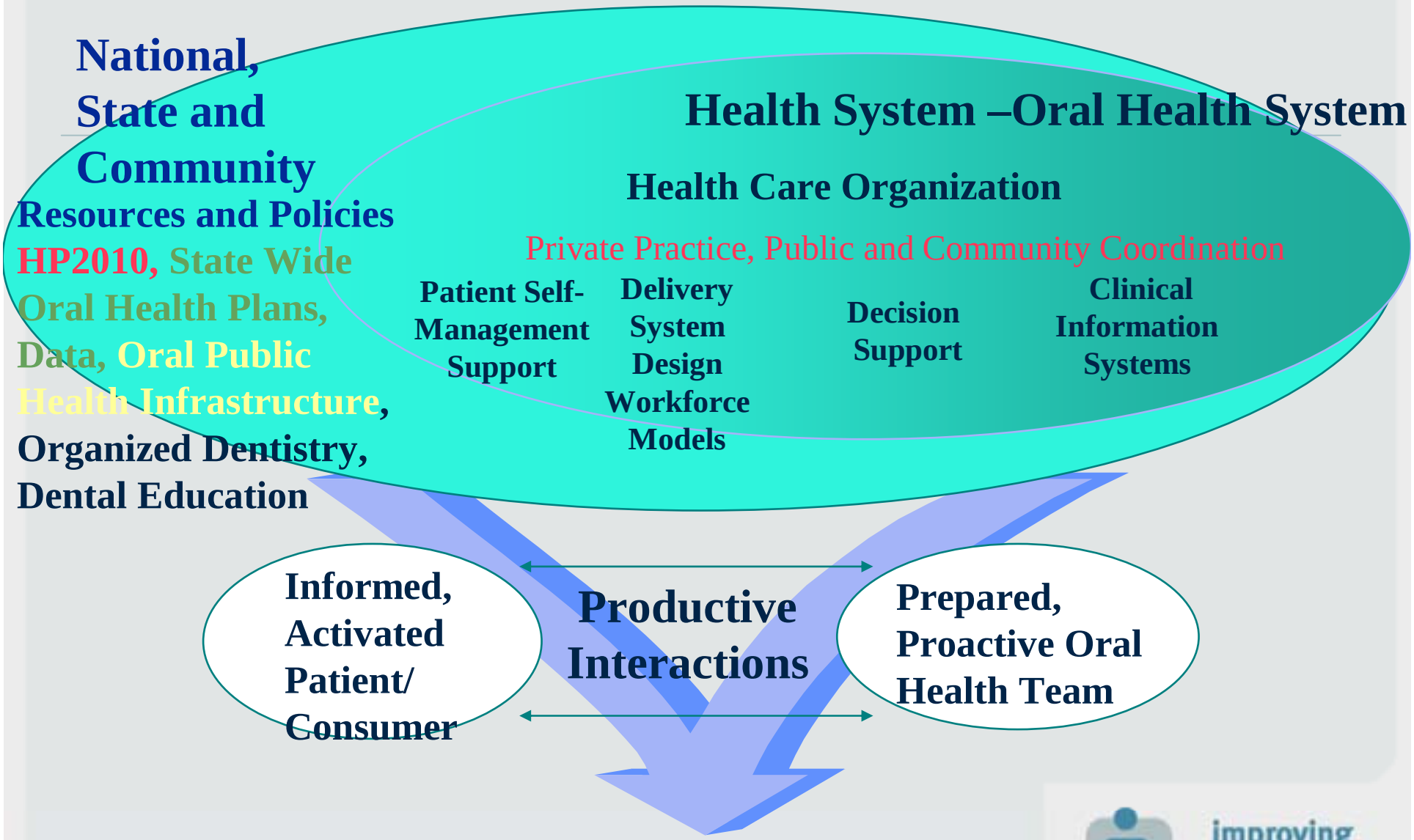
Three ingredients of an effective team



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"

Oral Health Care Model



Improved Oral Health Status, Functional and Clinical Outcomes

improving chronic illness care

National Faculty (HRSA, IHI, NNOHA)

Identify

Identify

State Level Faculty

Quality advisor

Primary Oral health care clinical leader

Informatics analyst

Peer to peer education and redesign

Health Center Level

Care model process leader(s)

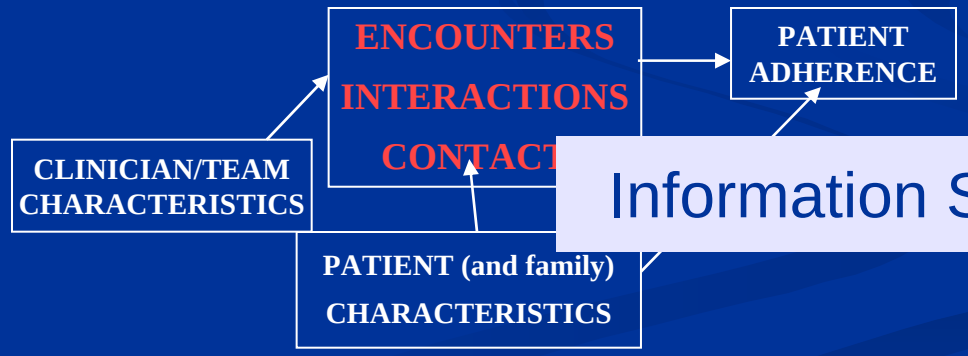
Care is affected by multiple levels of influence

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



Information Systems

Facility: Leadership, Systems, Organization

OUTCOME

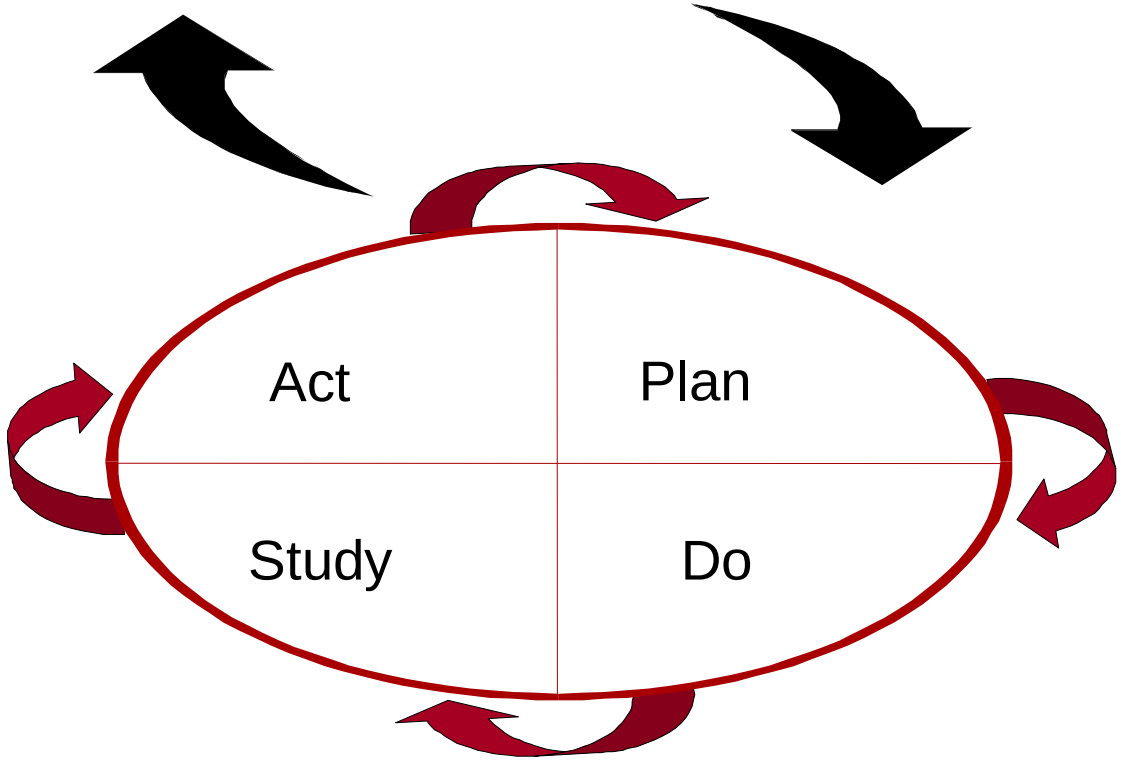
Patient:
- Health Status
- Satisfaction
- Quality of

Efficiency
Equity
Effectiveness

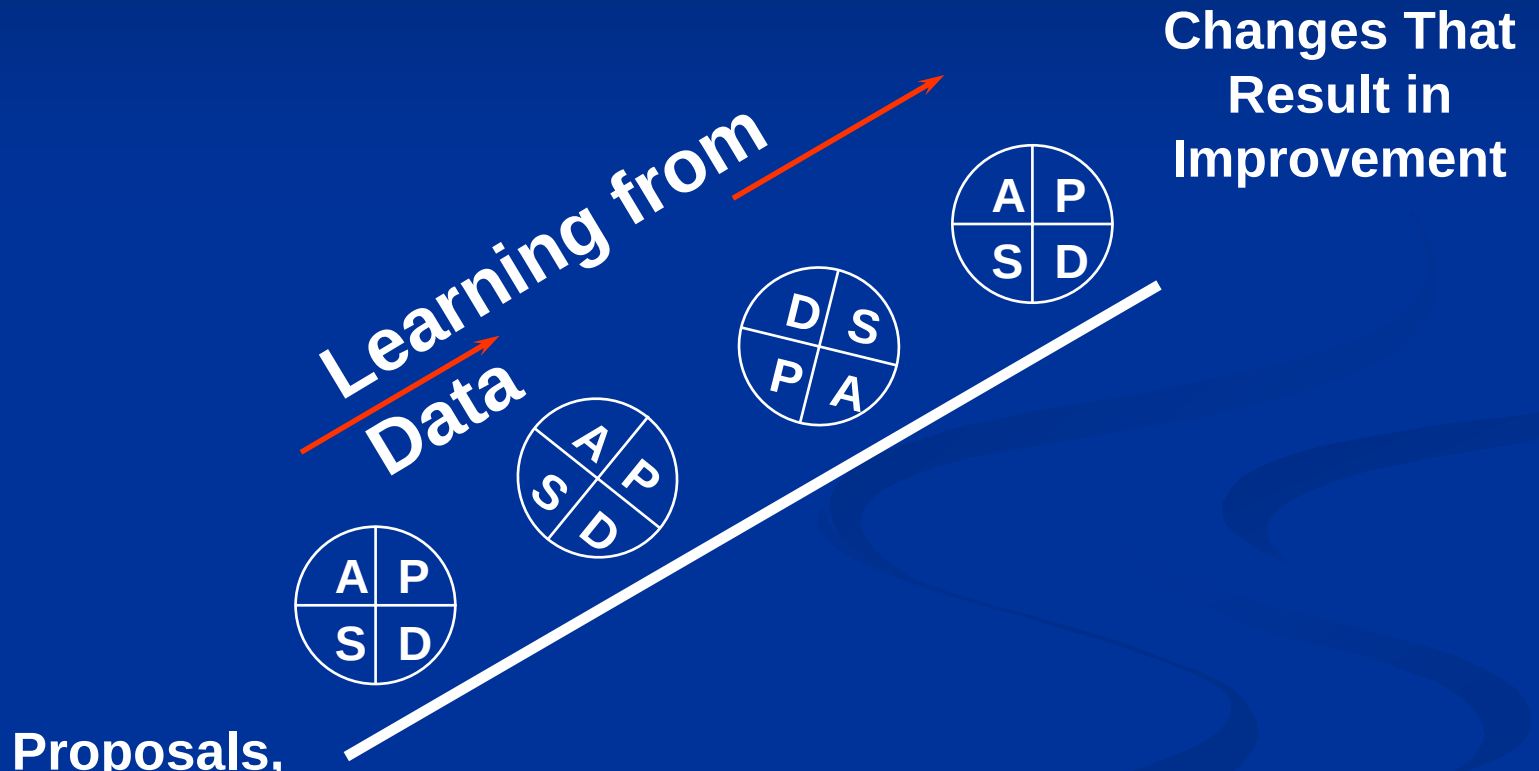
What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?



Repeated use of the PDSA cycle



Planning Group/Faculty

- Jay Anderson DMD, MHSA- HRSA Project Officer
- Colleen Lampron MPH- Co-chair
- Irene Hilton DDS, MPH- Co-chair
- Francisco Ramos Gomez DDS, MPH- ECC Faculty
- Jim Sutherland, DDS, MPH- Fluorides Faculty
- Mary Foley RDH, MPH- Perinatal Faculty
- Marty Lieberman DDS- Redesign Faculty
- Tracy Jacobs RN- IHI Collaborative Director
- Kevin Little- IHI Improvement Advisor

Communities are needed to 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
  - 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?
- How can this work in a community health center environment?
- First, lets understand how the denominator 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
  - Walkin/Emergency decreased
  - No need to book unnecessary future appointments
  - No need for resource intensive telephone triage

- Clinical Outcomes and Patient 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

Participating Teams

- Community Health Partners
  Livingston MT

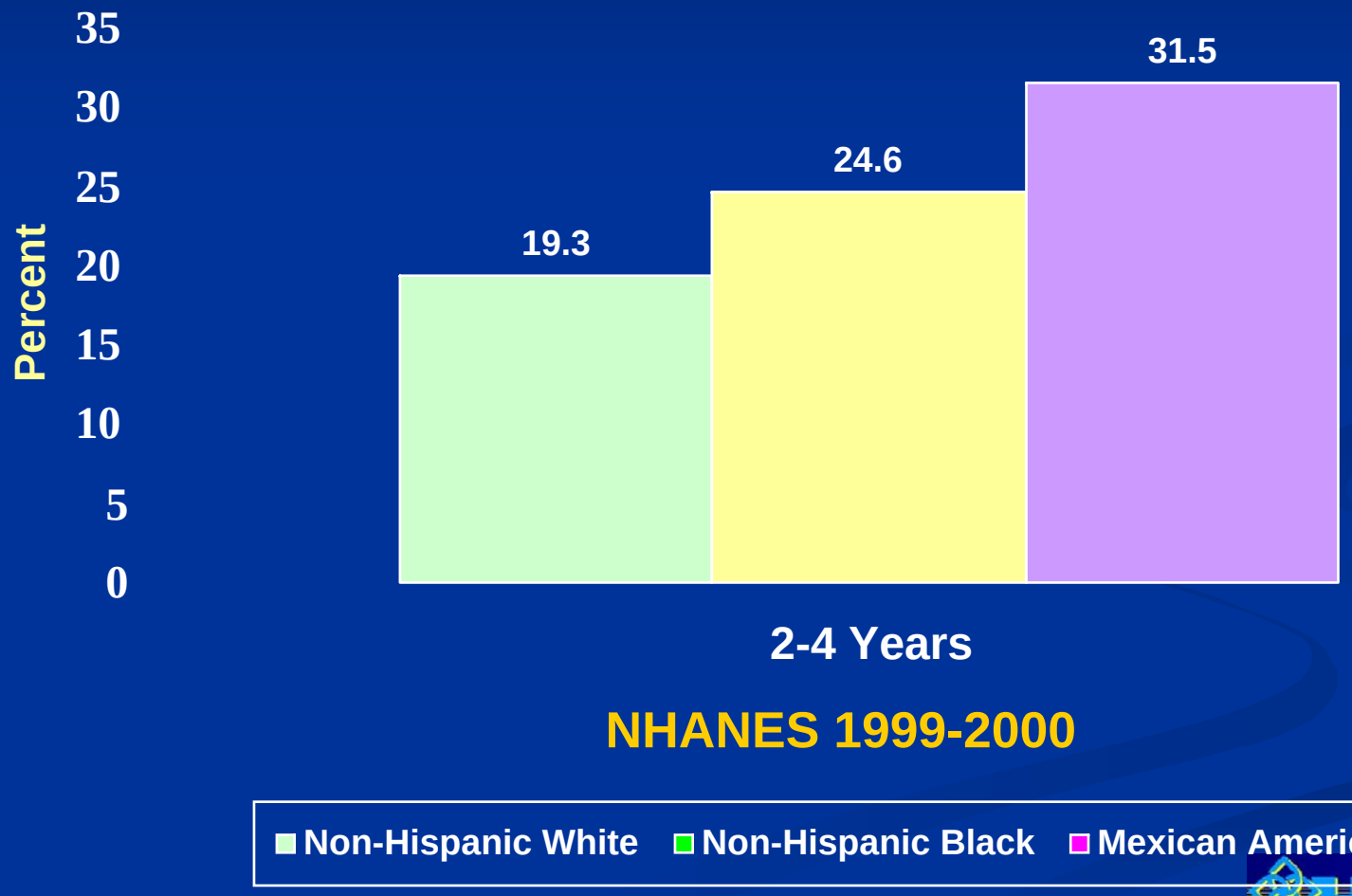
- High Plains Community Health Center
  Lamar, CO

- Salud Family Health Centers
  Fort Lupton, CO

- Sunrise Community Health Center
  Greeley, CO

Early Childhood Caries Disparities

% 2-4 y/o Untreated Decay



Data Source: **NHANES IV, 1999-2000, NCHS/CDC.**

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Measures-Early Childhood Caries

- Children <24 months of age with dental exam or evaluation by age 12 months.
- Patients >24 months and <60 months with dental exam/evaluation in last 12 months
- Patients >12 months and <60months in clinical information system with dental counseling by a primary care provider documented (last 12 months.

Measures-Early Childhood Caries

- The number of patients age >6 months and <60 months in the clinical information system with fluoride assessment documented in last year.
- Patients age > 6 months and < 60 months in the clinical information system with inadequate fluoride who have been prescribed fluoride.
- Number of patients >12 months and <36 months with 1 or more fluoride varnish applications documented in the last year.

Measures-Early Childhood Caries

- The number of patients 1-5 years in the clinical information system with documented self management goals in the last 12 months.
- Patients age >24 months and <60months with caries and with completed treatment plan for caries.
- Patients age >24months and <60 months with a dental evaluation and recall in last 12 months.

Measures - Perinatal

- Pregnant women in last 12 months referred by medical to dental for comprehensive oral health exam
- Pregnant women in last 12 months who have received patient education for oral health and anticipatory guidance while pregnant
- Pregnant women in last 12 months with comprehensive dental exam completed while pregnant
- Pregnant women with completed **Phase I dental treatment** plan within 6 months of exam (12 months)

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

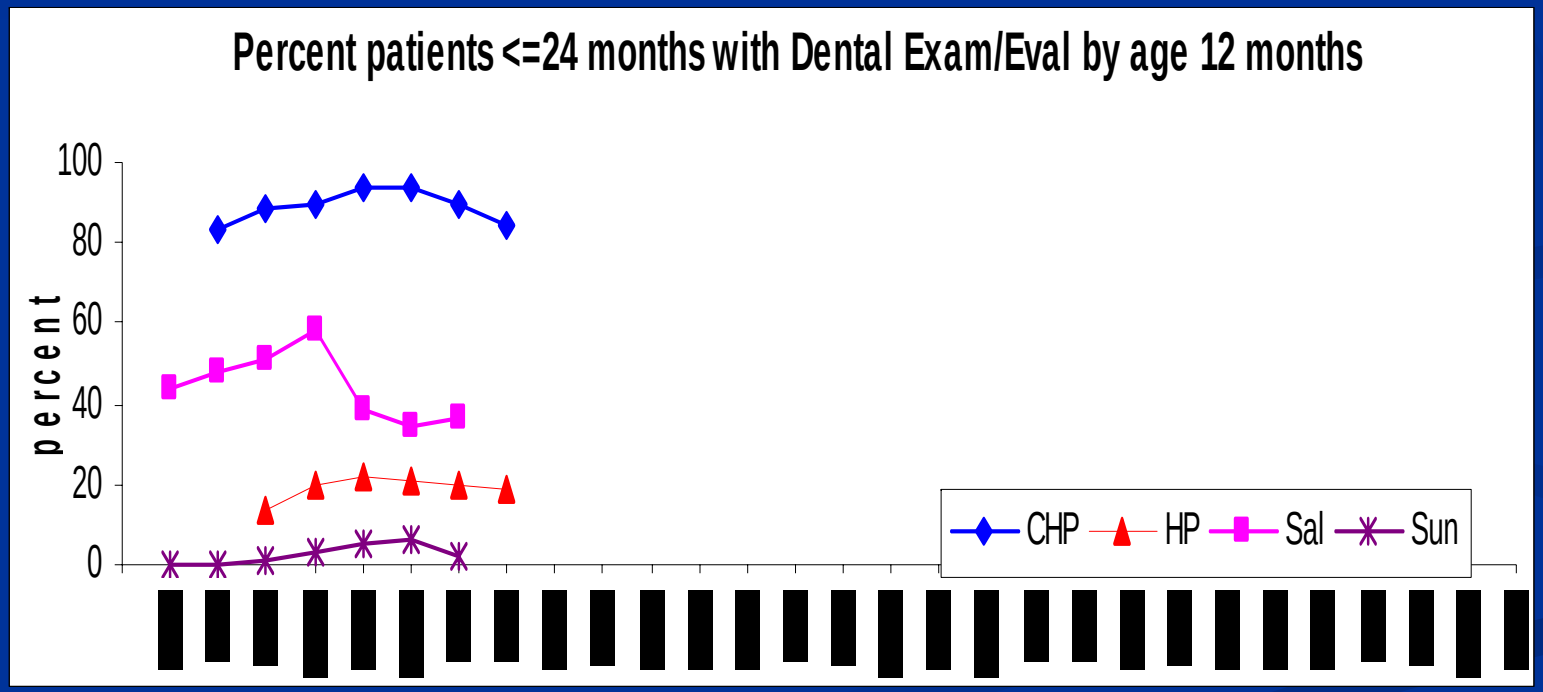
Early Successes

- 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

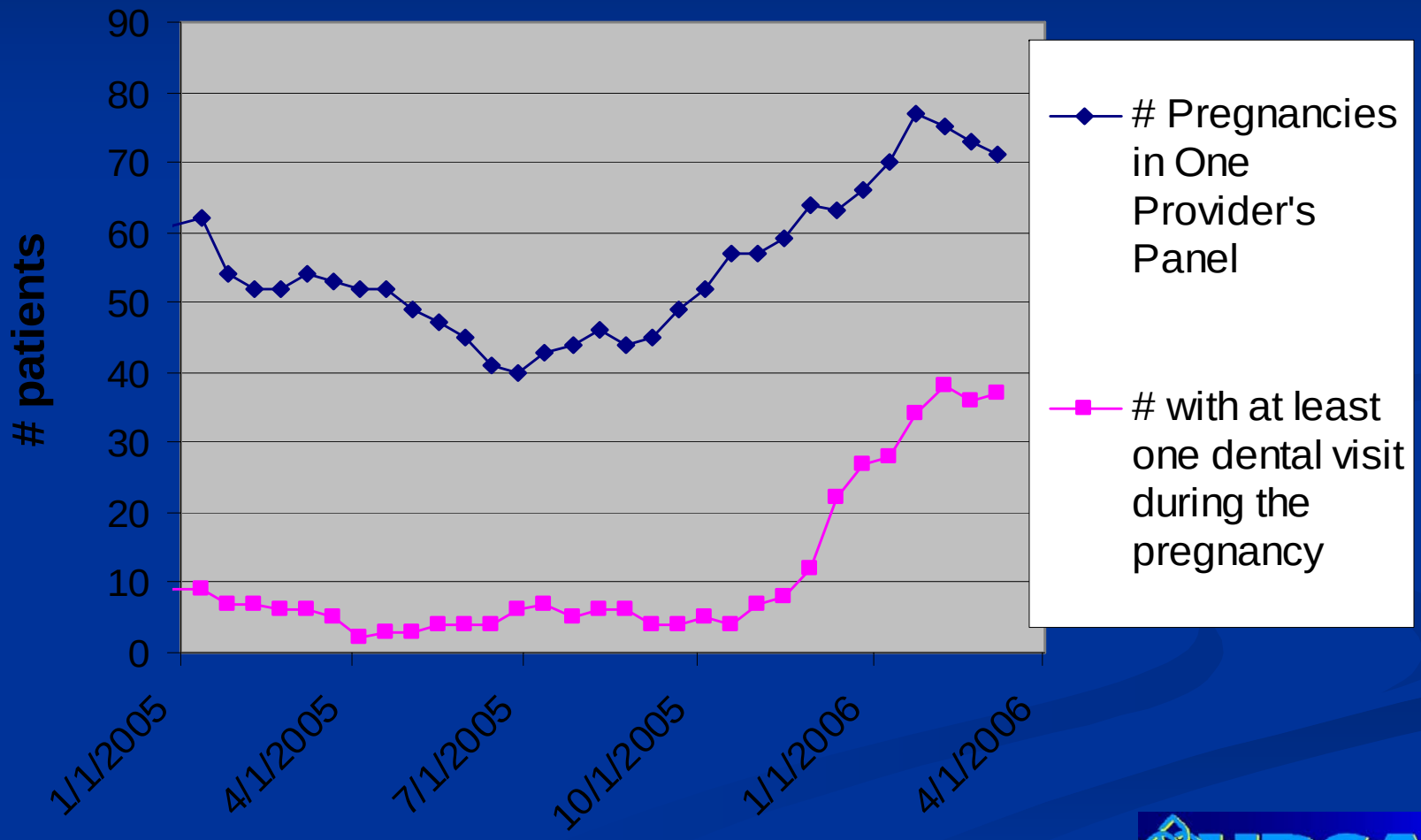
Early Successes

- 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

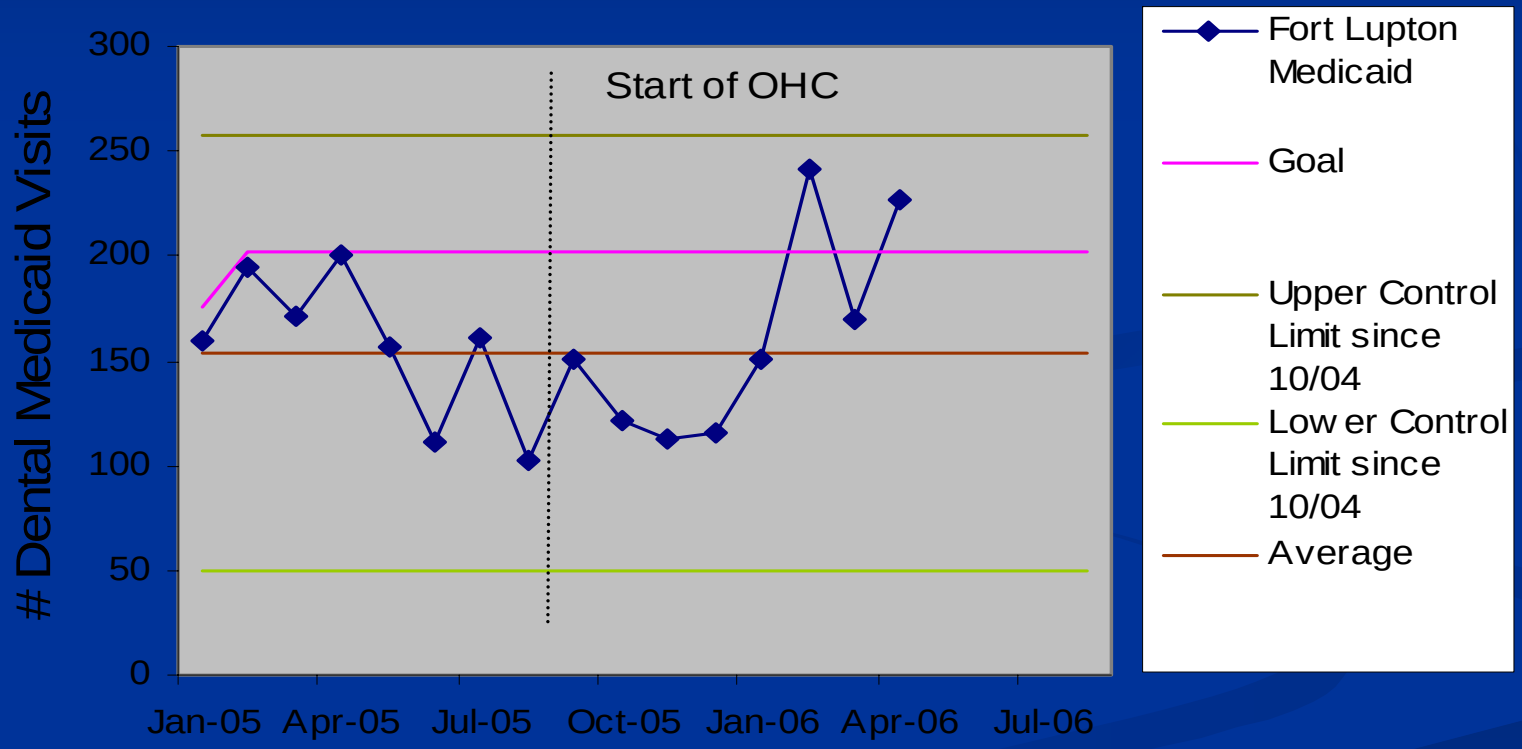
Dental Clinic Access for Children < 24 m/o



Perinatal Access to Dental Clinic



The Business Case: Dental Medicaid Visits
Salud Case Study



Concurrently: Delivery System Design

- Teams collecting data on:
  - Time to 3rd next available appointment
  - Office visit cycle time
  - Value-added time
  - No show rate
  - Patient care encounters per provider per hour
  - Phase I Treatment Plan Completion Rates for target populations
- Baseline for redesign efforts to improve efficiency and patient care quality

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

Progress

- November 2006:
  - Harvesting from pilot teams
  - Dissemination of collaborative experience and results to nationwide CHC dental audience at December, 2007 BPHC Primary Oral Health Care Conference
- Beyond…
  - Expansion of oral health collaborative to other Community Health Centers!
  - Development of Oral Health Collaborative Manual

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

Resources

- HRSA Programs http://www.hrsa.gov/
- HRSA Health Disparities Collaborative Oral Health Pilot Healthdisparities.net
- HD Collaborative OH Pilot Contacts:
  - HRSA BPHC- Dr. Jay Anderson: Jay.Anderson@hrsa.hhs.gov
  - HD Collaborative Co-Chair/Colleen Lampron: colleenlampron@gmail.com
  - HD Collaborative Co-Chair /Dr. Irene Hilton: ivhilton@ix.netcom.com

Thank you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