Innovations in Integrated Service Delivery for Pre-School Age Children: Improving Performance in Safety Net Clinics

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First 5 LA

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Kansas City, MO
April 28, 2015
SESSION OVERVIEW

- **J. Crall**: Overview of UCLA-First 5 LA Oral Health Program
  - Context, Goals, Objectives, Strategic Components

- **M. Doherty**: Safety Net Solutions’ Role & Process in the UCLA-First 5 LA Oral Health Program

- **C. Lampron**: UCLA-First 5 LA Quality Improvement Learning Collaborative
  - Applications of quality improvement methods, training and skills to promote and integrate risk-based care by dental, medical and community outreach personnel

- **J. Crall**: Summary and Lessons Learned

- **All**: Exercises / Q & A

April 28, 2015
Early Childhood Caries remains a common, significant problem

- ~54% of CA children have caries experience by kindergarten
  - 28% have untreated decay / 19% have extensive decay
- >70% of CA children have caries experience by 3rd grade
- <50% of U.S. children visit a dentist annually
  - Uninsured/Medicaid utilization rates are generally < commercially insured

Persistent oral health disparities (low-income, racial/ethnic minorities)

Growing recognition of the importance of early interventions
Overview of the UCLA-First 5 LA (F5LA) Oral Health Program (OHP)

UCLA-F5LA 21st Century Dental Home Project and

UCLA-F5LA Children’s Dental Care Program

JIM CRALL, DDS, SCD
UCLA-FIRST 5 LA OHP PROGRAM DIRECTOR
The primary goal of this project is to increase access to dental and oral health care for at least 53,000 children ages 0-5 in LA County in partnership with 20-22 additional community clinic sites and other community-based partners.

The project seeks to improve the capacity of community clinics to deliver quality oral health care to young children, increase parents’ and child care providers’ awareness of the importance of oral health care for preschool children, and develop a sustainable community “dental home” model.
Program Objectives

- Address barriers that limit young children's access to oral health/dental care services and clinics’ abilities to serve as dental homes for at-risk children
- Increase providers’ awareness of the importance of oral health/dental services and dental homes for children 0-5
- Increase # of children 0-5 who receive preventive services from dental, medical and community health care providers
- Increase # of clinic dentists that treat children ages 0-5
- Increase parents’ and caretakers’ awareness of the importance of oral health for young children
- Establish sustainable systems that promote oral health education and access to risk-based care within community clinics’ primary care perinatal, pediatric and dental services
UCLA-F5LA Partnership:
Multi-faceted approach focused on young children & families

DHP: 12 clinics
CDCP: 10 clinics

~ 530,000 0-5 year olds covered by DentiCal, with no dental services
UCLA-F5LA Children’s Dental Care Program

Selected Clinics:

- East Valley CHC
- Mission City Community Network
- San Fernando Community Health center
- Venice Family Clinic
- St. John’s – Magnolia Place
- Altamed-Boyle Heights
- St. John’s – Compton
- Children’s Dental Health Center

Legend

- Other Clinics/Dental Groups:
  - D.H.P. Clinics
  - P.T.A. 2009 Clinics
  - Children’s Dental Group

- O.S.H.P.D. 2011 Nonprofit Clinics:
  - F.Q.H.C.
  - F.Q.H.C. Look-Alike
  - Neither F.Q.H.C./Look-Alike

- Eligible Non-Users of DentiCal
  - By Zip Code

- Service Planning Area

- 0 3 6 9 12 18 24 Miles
Oral Health Training for Primary Care (Pediatrics & Ob/Gyn)

Care Coordination & Disease Mgmt Program

Community Dental Home Coordinators

Child Care Providers

Resource & Referral agency

UCLA & Partners Training and TA for Dental Homes

J. Crall: 2015 NOHC
1. **Infrastructure:**
   - Support for part-time on-site pediatric dentist support
   - Support for hiring a Community Dental Home Coordinator (CDHC)
   - Provide population health data management software
   - UCLA–First 5 LA financial support to implement enhancement plans

2. **Safety Net Solutions:**
   - Clinic enhancement plans / clinic productivity technical assistance

3. **Training:**
   - Dental and medical personnel
   - On-line, in-person and on-site training for each clinic

4. **Quality Improvement Learning Collaborative:**
   - Enhance clinic personnel ability to conduct quality improvement
   - Improve system operations issues to increase evidence-based care, dental-medical integration, and improve outcomes and efficiency
     - **> 10,000 more 0-5 year-old children with medical primary care visits in 12 DHP clinics annually compared to # with dental visits**
UCLA CLINIC STAFF TRAININGS

- UCLA trainers to visit both medical and dental clinics to review progress made and help in additional training of staff.

All Staff (Medical/Dental)
- Hiring CDHC/Pediatric Dentist
- Smiles for Life – Online Training
- Baseline Training: Medical & Dental Teams
- CDHC trainings
- Pediatric Dentist Training
- Online webinar – Project Overview and Roles and Responsibilities
- PEDIATRIC CARIES MANAGEMENT
- ENT AND PULP THERAPY – Lecture and Workshop

CDHC
- Project Overview, ECC Management, Infant Oral Care, Fluorides, Nutrition, Insurance Navigation, Oral Health basics and data reporting and other modules

Pediatric Dentist
- Hiring Community Dental Home Coordinator (Full Time) and Pediatric Dentist (at least 1/2 day/week)
- Smiles for Life is a national comprehensive oral health curriculum
- Clinical Training for all providers and staff members

General DDS
- Advanced Training: General Dentists

All Staff
- On-Site Medical & Dental Training

April 28, 2015
J. Crall: 2015 NOHC
1. Child Care Provider Trainings (CCALA)

2. Collaboration with Best Start Programs, other community-based agencies (HS, WIC) and child care providers

3. Community Resource Guides

4. Outreach by Clinic Community Dental Home Coordinators and Other Community Outreach Providers
GIS Support for Outreach to Child Care Providers and other Sites Near Community Health Centers
UCLA-First 5 LA
Oral Health Program Strategy

To implement a *population health-based system* of oral health care ...... in partnership with community health centers that:

1. integrates dental, medical and community outreach services to reduce caries risk
2. ‘triages’/’channels’ children to effective and efficient care pathways based on risk level
3. improves the oral health and caries risk status of children ages 0-5 years
4. develops sustained linkages to community partners
Population-Based Approach for Dental / Oral Health Care Delivery

ASSESSMENT PARAMETERS

- **RISK LEVEL** (low, high)
- **LESION STATUS** (none, initial, advanced)
- **NEED FOR TREATMENT** (urgent, basic, advanced)

<table>
<thead>
<tr>
<th>No Lesions</th>
<th>No Lesions</th>
<th>Initial Lesions Only</th>
<th>Advanced Lesions</th>
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</thead>
<tbody>
<tr>
<td>Low Risk</td>
<td>High Risk</td>
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- Establish dental home
- Counseling to maintain low caries risk (diet, fluoride toothpaste)
- Provide primary preventive services (e.g., fluoride varnish - FV)
- Anticipatory guidance
- Data entry (CRA results, recommended follow-up)
- Schedule periodic follow-up visit per guidelines
- Care Coordination (as needed)

- Establish dental home
- Treatment plan and preventive services (FV)
- Risk reduction program (self-management goals)
- Anticipatory guidance
- Reassess progress and schedule periodic evaluation visit per program guidelines
- Data entry (at each visit)
- Care Coordination (as needed)

- Establish dental home
- Treatment plan and preventive services (FV)
- Basic disease management program to control disease and reduce risk
- Restorative services
- Anticipatory guidance
- Reassess progress and schedule periodic evaluation visit per program guidelines
- Data entry (at each visit)
- Care Coordination (as needed)

- Establish dental home
- Treatment plan and preventive services (FV)
- Advanced disease management program to control disease and reduce risk
- Restorative services
- Anticipatory guidance
- Reassess progress and schedule periodic evaluation visit per program guidelines
- Data entry
- Care Coordination (as needed)

Integrated Risk Assessment & Disease Management Care Pathways

**ORAL HEALTH WELL-CHILD CARE**
@ 6, 9, 12, 18, 24 months & yearly thereafter
- Review medical and dental history
- Perform Caries Risk Assessment (CRA)
- Perform clinical oral assessment
- Apply fluoride varnish

**Effective Engagement and Communication**
- Explain caries process and causes of ECC
- Counseling to maintain low caries risk (diet, fluoride toothpaste)
- Anticipatory guidance
- Periodic follow-up visits per guidelines

**Low Risk and < 3 y.o.**

**High Risk or ≥ 3 y.o.**

**Follow Up / Care Coordination**
- Verify establishment and maintenance of dental home
- Repeat well-child protocol at well-child visits for children with no dental home

**Dental Home Referral**

**INITIAL or PERIODIC DENTAL EVALUATION**
- Review medical history and dental history
- Perform Caries Risk Assessment (CRA)
  - risk/protective/clinical findings
- Perform clinical dental examination
  - caries charting by tooth surface and activity
- Radiographs (if indicated and possible)
- Assess cooperation
- Develop treatment plan (or refer, if indicated)
- Preventive services per guidelines

**Effective Engagement and Communication**
- Explain caries process and causes of ECC
- Define & agree on self-management goals (SMGs) if elevated risk
- Provide support for risk reduction
- Periodic follow-up visits per guidelines

**DISEASE MANAGEMENT**

**Initial or Advanced Treatment Needs**

**Low Risk** 7-12 mos
- Manage lesions and/or provide restorative treatment appropriate to cooperation level
- Referral for sedation or general anesthesia if indicated

**Moderate Risk** 4-7 mos
- Preventive services per guidelines

**High Risk** 1-3 mos
- Anticipatory guidance
- Periodic follow-up visits per guidelines

J. Crall - 2015
Table Talk

• Discussion Questions:

• Thinking of the context in which you are working, how does this approach resonate?

• How would you apply this integrated model in your work environment?
UCLA-First 5 LA 21st Century Dental Home Project

The Safety Net Solutions Team`s Role and Process

Our mission is to improve the oral health of all.
What Does Dental Home Project (DHP) Success Look Like?

To increase access to dental care for 50,000 high-risk children ages 0-5 in Los Angeles County by establishing a Dental Home model in 20-22 selected community clinic dental sites.
SNS Vision

Creation of high-quality, accessible, affordable, oral health programs that document the improvement of the oral health status of the patients we treat while being financially responsible through efficiency and effectiveness.
• Affordable Access
• Quality Managed
• Healthy Outcomes
• Financially Responsible
The Safety Net Solutions Process

1. Practice Analysis
   - Practice Management
   - Data Survey
   - Key Practice Data
   - Site Visit

2. Findings and Discussions
   - Presentation
   - Discussion
   - Strategy

3. Enhancement Plan
   - Action steps
   - Roadmap
   - Timelines

4. Supported Implementation
   - Coaching
   - Guidance
   - Motivation
   - Accountability
We objectively define who you are and ask: Who do you want to be?

Who we are

Who we want to be

The Gap

- Accurate, meaningful, timely data
- Scheduling for success
- Goals, roles, responsibilities
- Policies for everything!
- Amount and Quality of Care
- Productivity of program and people
- Health Outcomes
- Billing excellence
- Valued Patient Experience
FOCUS PDSA

- **F** Find a process to improve
- **O** Organize an effort to work on improvement
- **C** Clarify current knowledge of the process
- **U** Understand process variation and capability
- **S** Select a strategy for continued improvement
- **P** Plan the improvement action steps
- **D** Do the intervention
- **S** Study the results of what was executed
- **A** Act on these results to improve the plan
Sample Major DHP Recommendations

- Collect accurate, meaningful, and timely data
- Create sessions for 0-5
- Recruit, hire, train a CDHC
- Recruit, hire, train a pediatric dentist
- Train general dentists to treat 0-5
- Train the medical team OH integration
- Consider a place in the QI collaborative
- Institute a CRA
- Review the scheduling process for 0-5
- Create a referral process from medical to dental
- Apply all to OB-GYN
- Create standard clinical protocols
- Address ‘no-shows’
- Create a policy for each new procedure
- Review MCO billing process
- Create a strategy to mine 0-5 children inside and outside the center.
- Create a business pro-forma and goals for access and finance
Samples of what SNS measures

- Gross Charges
- Net Revenue
- Expenses
- Number of visits
- Revenue per visit
- Cost per visit
- # of Transactions/visit
- Payer Mix
- A/R out 90 days
- # of Transactions/visit
- # of Unduplicated Patients
- # of New Patients
- No-Show Rate
- Emergency Rate
- # of FTE Providers
- # of FTE Billing Staff
- # of Completed Treatments
- Number of children 0-5
- # of children receiving sealants (under 21)
- # of sealants applied
- % of Children seen receiving a preventive service
The Exercise

Given the following baseline data, select a few action steps (2-3) to get from where the data defines you are, to where you want to be in the DHP.

- Where will you start? (which areas or strategies?)
- Changes you would make (action steps?)
- How would you know if you have improved?
- What additional data might/would you collect?
Baseline Data 0-5

- Gross Charges
- Net Revenue
- Expenses
- Number of visits - 5/day
- Revenue per visit
- Cost per visit
- # of Unduplicated Patients - 1,150
- # of New Patients - 2.5/wk
- # of Transactions - 1.5/visit
- Payer Mix - 33% medicaid
- No-Show Rate - 36%

- Emergency Rate
- # FTE Providers
- # FTE Billing Staff
- # of Completed Treatments - 27%
- Number of children [0-5] - 1,150
- # of children receiving sealants (under 21)
- # of sealants applied
- % Children seen receiving a preventive service - 50%
- A/R out 90 days
UCLA-First 5 LA Oral Health Program
Quality Improvement Learning Collaborative – Supporting Teams for Improvement

COLLEEN LAMPRON, MPH, QI LEARNING COLLABORATIVE DIRECTOR

JIM CRALL, DDS, SCD, UCLA-FIRST 5 LA OHP PROGRAM DIRECTOR AND QI LEARNING COLLABORATIVE CHAIR

NATIONAL ORAL HEALTH CONFERENCE

APRIL 28, 2015
Overview

• Brief review: Breakthrough Series Collaborative
• Discuss measurement & why we measure
• Overview of Update on QILC activities to date
  – Including team progress
Institute for Healthcare Improvement (IHI) Breakthrough Series Collaborative Model (6 to 18 months time frame)

Select Topic (develop mission)

Expert Meeting

Prework

Develop Framework & Changes

Planning Group

LS – Learning Session

AP – Action Period

Supports

Email (listserv)  Phone Conferences
Visits  Assessments  Extranet
Monthly Team Reports

*AP3 – continue reporting data as needed to document success

Dissemination
Publications, Congress. etc.

Holding the Gains
Three questions and a test cycle: The Model for Improvement is a general method to help you to improve through iterative learning.

- 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?
Aim: To improve the health and well-being of LA county children, age 0-5, by improving their access to quality oral health care and reducing their caries risk. By June 2016:
- 95% of 0-5 year olds seen at participating Health Centers will have a documented caries risk assessment;
- the caries risk status of 10% of children initially at high risk will be reduced;
- X% of children will receive differentiated care based on their risk status.
Integrated Risk Assessment & Disease Management Care Pathways

**Oral Health Well-Child Care**
- @ 6, 9, 12, 18, 24 months & yearly thereafter
  1. Review medical and dental history
  2. Perform Caries Risk Assessment (CRA)
  3. Perform clinical oral assessment
  4. Apply fluoride varnish

**Effective Engagement and Communication**
  5. Explain caries process and causes of ECC
  6. Counseling to maintain low caries risk (diet, fluoride toothpaste)
  7. Anticipatory guidance
  8. Periodic follow-up visits per guidelines

**Medical**
- Low Risk and < 3 y.o.
- High Risk or ≥ 3 y.o.

**Dental Home Referral**

**Initial or Periodic Dental Evaluation**
- 1. Review medical history and dental history
- 2. Perform Caries-Risk Assessment (CRA)
- 3. Perform clinical dental examination
- 4. Radiographs (if indicated and possible)
- 5. Assess cooperation
- 6. Develop treatment plan (or refer, if indicated)
- 7. Preventive services per guidelines

**Effective Engagement and Communication**
- 7. Explain caries process and causes of ECC
- 8. Define & agree on self-management goals (SMGs) if elevated risk
- 9. Provide support for risk reduction
- 10. Periodic follow-up visits per guidelines

**Disease Management**
- Low: 7-12 mos
- Moderate: 4-7 mos
- High Risk: 1-3 mos

**Initial or Advanced Treatment Needs**

**Restorative/Surgical Treatment**
- Manage lesions and/or provide restorative treatment appropriate to cooperation level
- Referral for sedation or general anesthesia if indicated

**Effective Engagement and Communication**
- 1. Explain caries process and causes of ECC
- 2. Preventive services per guidelines
- 3. Define & agree on self-management goals
- 4. Anticipatory guidance
- 5. Periodic follow-up visits per guidelines

J. Crall - 2015
Basic Components of Each Test Step

**Act**
- What changes are to be made?
- Next cycle?

**Plan**
- Set Objective (why)
- State Questions and predictions
- Plan to carry out the cycle (who, what, where, when, how)
- Plan for data collection

**Study**
- Complete the analysis of the data
- Compare data to predictions
  - Summarize what was learned

**Do**
- Carry out the plan
- Document problems and unexpected observations
- Begin analysis of the data
Why We Measure

• In order to manage a system, we are required to make predictions about its future performance

• A predictable (and thus manageable) process operates in a more or less consistent fashion over time
## The Three Faces of Performance Measurement

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Improvement</th>
<th>Accountability</th>
<th>Research</th>
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<tbody>
<tr>
<td><strong>Aim</strong></td>
<td>Improvement of care (efficiency &amp; effectiveness)</td>
<td>Comparison, choice, performance management</td>
<td>New knowledge (efficacy)</td>
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<tr>
<td><strong>Methods:</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• Test Observability</td>
<td>Test are observable</td>
<td>No test, evaluate current performance</td>
<td>Test blinded or controlled</td>
</tr>
<tr>
<td>• Bias</td>
<td>Accept consistent bias</td>
<td>Measure and adjust to reduce bias</td>
<td>Design to eliminate bias</td>
</tr>
<tr>
<td>• Sample Size</td>
<td>“Just enough” data, small sequential samples</td>
<td>Obtain 100% of available, relevant data</td>
<td>“Just in case” data</td>
</tr>
<tr>
<td>• Flexibility of Hypothesis</td>
<td>Flexible hypotheses, changes as learning takes place</td>
<td>No hypothesis</td>
<td>Fixed hypothesis (null hypothesis)</td>
</tr>
<tr>
<td>• Testing Strategy</td>
<td>Sequential tests</td>
<td>No tests</td>
<td>One large test</td>
</tr>
<tr>
<td>• Determining if a change is an improvement</td>
<td>Run charts or Shewhart control charts (statistical process control)</td>
<td>No change focus (maybe compute a percent change or rank order)</td>
<td>Hypothesis, statistical tests (t-test, F-test, chi square, p-values)</td>
</tr>
<tr>
<td>• Confidentiality of the data</td>
<td>Data used only by those involved with improvement</td>
<td>Data available for public consumption and review</td>
<td>Research subjects’ identities protected</td>
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Measurement for Improvement
There must be a method for improvement associated with the measure(s) to be considered measurement for improvement.

Improvement requires:
• an aim that defines success,
• measures that track progress toward the aim, and
• changes to appropriate systems.

Measures help clarify the aim (the metrics for "how much, by when") but are subordinate to the aim and distinct from the changes.
To Be Considered a PDSA Cycle...

• The test or observation was **planned**
  --including a **plan for collecting data** and a **prediction** about results

• The plan was attempted (**do** the plan).

• Time was set aside to analyze the data and **study** the results.

• **Action** was rationally based on what was learned.
PDSAs

• PDSAs inform the system – think strategically about what you need to achieve and the key elements you need to get there.
Reliability Example

What proportion of parents with a young child leave a dental visit with a written idea about how they can improve their child’s oral health?

- 75% Provider assesses oral health risk
- 95% Parent counseled on self-management goal
- 60% Parent shares confidence level and perceived barriers to the behaviors
- 35% Provider & parent plan together how to address the concern
- 40% Provider checks if parent understands the plan
- 80% Plan is written down for the parent and documented in the record
- 5%
Process Out of Control
CCHC Dental Swim Lane Diagram
PDSA Exercise

• Reflection questions:
  – Considering the Aim, Care Pathway and reliability principles, what changes would you test in a safety net system to get to move towards integrated care?
  – List at least 3 changes, and design a PDSA test for one (using worksheet)
Learning Sessions

Learning Session 1

- Overview of Program and QI LC
- StoryBoards
- **Science of Improvement** – identify clear aim for action period, develop PDSA testing plan and how to integrate changes into daily flow
  - Model for Improvement
  - Assessing Readiness for Improvement
  - Developing of a Good Aim Statement
  - Measurement and data collection
  - PDSAs & Small Scale Testing
  - Planning PDSAs & Improvements at Clinic
  - Basecamp – furthering & sharing learning
- **Strategies for improving pediatric oral health** – identify ways dental and medical services can collaborate to deliver risk based disease management /oral /dental care within a clinic.
  - Population-Based Approach for Dental / Oral Health Care Delivery (4 column model)
  - 6 Steps for Infant Oral Health; Risk & Disease Management
  - Population Health and Disease Management, Role of Primary Care in Managing Caries Disease

Learning Session 2

- Overview of Program and QI LC Progress to Date
- StoryBoards and Care Process
- **Science of Improvement** – continue to work with aim and longer term plan for improvement and testing to establish reliable systems, and leading & accelerating change
  - Accelerating Change: Establishing Reliable Systems & Group Planning
  - Revisiting Aim Statement & Planning to scale up improvements
  - Leading & Accelerating Change & establishing reliable systems – Moving from Testing to Implementation
  - Team Time – Leaving in Action - Planning Improvements/PDSAs at Clinic
- **Strategies for improving pediatric oral health – Medical/Dental integration of services** - identify ways dental and medical services can collaborative to deliver risk based disease management /oral /dental care within a clinic.
  - Patient-Centered Evidence-Based Standards of Care
  - Care Process Mapping – understanding handoffs and opportunities for integration of services across medical and dental
  - Learning from each other - cross clinic discussions of improvement efforts
  - Leadership for integrated Medical and Dental care
  - Discussion on roles of various team members in implementing disease prevention and management (dental, medical, and community dental home coordinators)
  - Process Map/ Swim Lane of Medical/dental clinic process
Learning Session 1 - Storyboards
Learning Session 1
Altamed Bell Storyboard

1/30/2015:
3.5 Significant improvement: Evidence of moderate improvement in multiple drivers or processes; evidence of improvement is at least 1 outcome measure; implementation underway.

Our clinic is making changes in small steps. We have the pieces necessary to test and implement changes, but are still far off our goal, where the process is hardwired into day-to-day.

Baseline Data

PDSA Testing
Action Period 1 PDSAs Focused on...

- Reducing No-Show Rates and increasing # of children served
- Implementation of CRA in dental and medical
- Medical referrals to Dental clinic
- Documentation issues:
  - Caries Risk Assessment and Risk Level
  - Discussion of Self Management Goals
  - Electronic data capture
UCLA First 5 LA Oral Health Program
QI Learning Collaborative Dashboard
ALL CLINICS – February 2015

OM1. % age 0-5 that presented cavity free at non treatment visits
   Goal = 20% increase over baseline

OM2. 0-5 yrs newly receiving dental
   Goal = 13,000 over baseline (all clinics)

OM3. Parent Reported Behaviors
   - Good toothbrushing behaviors
   - Good food related behaviors

ALL CLINICS – February 2015

PM1a. % age 0-5 with documented CRA by Dental
   Goal = 80%

PM2. % elevated risk age 0-5 with at least 2 topical fluoride applications in 12 mos
   Goal = 65%

PM3. % elevated risk age 0-5 with SMGs reviewed
   Goal >= 80%

PM4. % age 0-2 maintained at Low Risk
   Goal = 25% increase over baseline

PM5a/b. % Risk Status Reduced
   Goal = 15% increase

PM6. % age 0-5 with On Time Visits
   Goal >= 80%
Medical Swim Lane Diagram
Arroyo Vista Highland Park

Community Dental Home Coordinator:
- Start
  - Review previous risk assessment for all patients with appointments tomorrow
  - Check medical eligibility - including varnish

Arroyo Vista Medical Flow:
- Aid in Dental Referral
  - Provide anticipatory guidance and OPC
  - FL Varnish applied in residual

If yes, Make follow-up appointment with dentist
If no, Apply FL, varnish
Send back appointment

Front Desk:
- Front Desk conducts eligibility assessments
- Checks in at front desk

Eligibility:
- Eligibility staff clarifies eligibility

Medical Assistant:
- MA takes patient to Virtual Station
- Vitals include when was last dental visit
- Patient taken to exam room
- MA begins KCRMA (Exam)
  - Places info on MD order

Pediatrician:
- Apply Fluoride Varnish
- CUSIDC to medical
- IZ dimensions after FDB patient discontinued to front desk

Determine Cansus risk
- Paper - coded later by CSHQ

Orange County
first 5 la
Giving kids the best start
Action Period 2 PDSAs Focus on...

• Systematic Documentation of Caries Risk Level
• Medical/Dental integration and Passport to Dental – various ways of improving dental visit completion following medical visit and/or referral
• Workflow issues and reliability of processes
Lessons Learned

• Use high functioning teams to test drivers, measures and change package
• Leadership is critical for success
• Need to develop baseline QI skills in dental
• Basic QI skills need constant reinforcement
• There are different levels of readiness
• Staying engaged and supporting QI will be beneficial in the long run
• This method is producing systems changes
QI Learning Collaborative Timeline

**Action Period 1**
**AP Calls/BaseCamp**
Focus areas:
- Measures Testing/data
- PDSA's & Testing Changes:
  - Increasing # 0-5 patients
  - Implementing CRAs
  - Medical/Dental Referrals
- Process Mapping/ Swim Lanes

**Action Period 2**
**AP Calls/BaseCamp**
Focus areas:
- Measure Refinement
- Sharing PDSA's Tests/Successes
  - Reliability of process
  - Medical/Dental Integration
- Using Process Map & Reliability Principles to ID areas for improvement

**Action Period 3**
**AP Calls/BaseCamp**
Focus areas:
- Applying Reliability principles
- Medical Dental Integration & standardizing care process
- Policy, billing & coding
- Strengthening and reinforcing
Summary / Lessons Learned / Keys to Success

- Comprehensive vision and multi-faceted strategy
  - Enhanced infrastructure (personnel, IT)
  - Training (dental, medical, community outreach)
  - Improve clinic operation ‘fundamentals’
  - Train and support staff to implement quality improvement to achieve sustainable systems change

- Data to monitor progress and guide strategies

- Leadership buy-in (implementation, sustainability)

- Communications, coordination, collaboration
Thank You! / Questions?

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