

Oral Health Disparities Collaborative Pilot



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Acknowledgment

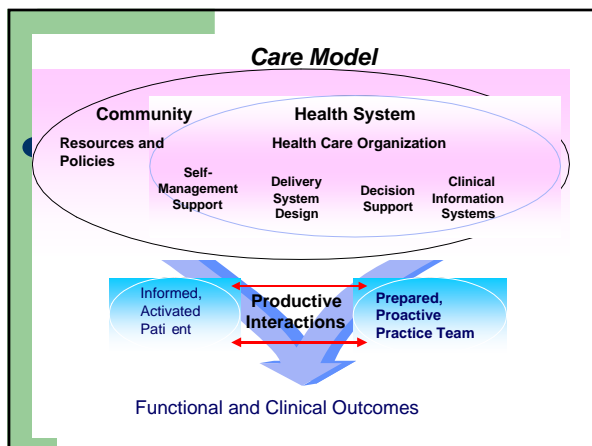
- Irene Hilton, DDS, MPH Oral Health Collaborative Pilot Co-Chair
- Colleen Lampron, MPH Oral Health Collaborative Pilot Co-Chair
- Jay Anderson, DDS, MS – Faculty and Visionary
- Marty Lieberman, DDS – Faculty
- Francisco Ramos-Gomez, DDS, MPH – Faculty
- Mary Foley, RDH, MPH – Faculty
- Jim Sutherland, DDS, MPH
- Pioneering 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
 - Tracy Jacobs, BSN IHI Collaborative Director
 - Kevin Little, PHD, Data Guru
 - Richard Scoville, PhD, Data Guru

Questions

- How many of you have participated in a Health Disparities Collaborative?
- How many of your Health Centers have participated in a Collaborative?
- How many of you were at the sessions on the Oral Health Collaborative last year?

Collaborative Aims

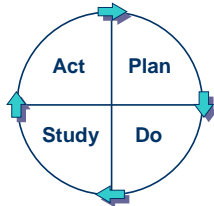
- **Develop comprehensive primary oral health care system change interventions that generate major improvements in process and outcome measures for:**
 - Early childhood caries prevention and treatment
 - Perinatal oral health
 - *Concurrent emphasis on practice redesign and office efficiencies that support improvements in the targeted areas*



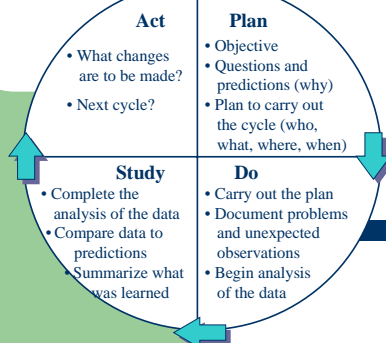
Model for Improvement

- 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 an improvement?

Model for Improvement: PDSA

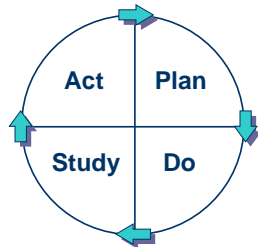


What is the PDSA Cycle?



The PDSA Cycle

Why Test?



Why Test?

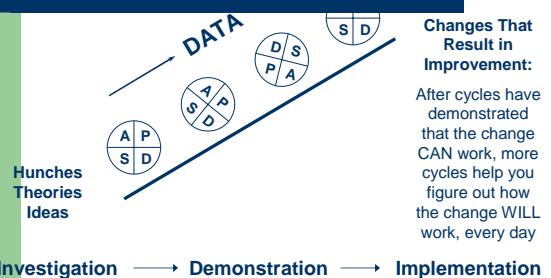
- Increase the belief that the change will result in improvement in your environment
- Predict how much improvement can be expected from the change
- Learn how to adapt the change to conditions in the local environment
- Evaluate costs and side-effects of the change
- Minimize resistance upon implementation

When tests fail to deliver predicted results...

- Grasp the opportunity to learn about your system
- Recognize different reasons for failed tests
 1. Change not executed well
 2. Support processes inadequate
 3. Hypothesis/hunch wrong:
 - Change made but it does not cause improvement of test measures
 - Improvement of test measures does not help the health center achieve its aim

You need to collect **data** during the **Do** phase of the Cycle to help identify which reason applies in your situation.

Repeated Use of the Cycle



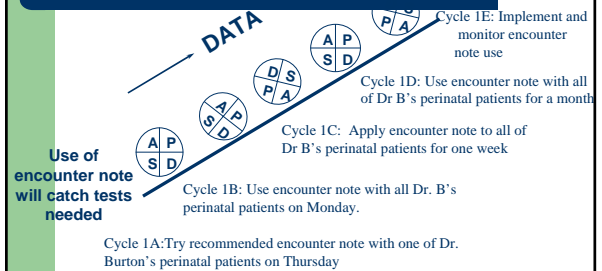
What we mean by implementation

You know a change has been **implemented** when you can have 100% staff turnover in your center and the change will remain in place.

Implementation requires that staff and leaders have built the change into formal plans, job definitions, training, and explicit reviews.

Aim: Use **evidence-based guidelines** in patient visits by incorporating a standard encounter form

Improved care



Dental Caries-Silent Epidemic

- Most common chronic childhood disease
- 5 times more common than asthma
- 80% of the disease is in 20% of the population – the people Health Centers serve
- Affect our ability to attend school, go to work, learn, and get a job

Perinatal Oral Health

- Less than 50% of pregnant women had a dental visit in 2002 (PRAMS)
- Disparities in access between black/white populations and Medicaid/non-Medicaid populations
- Lack of knowledge about importance of perinatal oral health

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

The Question...

- Could the Collaborative 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 improvements in process and outcomes for select patients?
 - Children 0-5
 - Pregnant women

Planning and Process

- Stakeholder Advisory
- Faculty Selection and Training
- Learning Sessions
- Training Materials
 - Management Tools/Operational and Pt Centered
 - Evidenced based literature and resources
- Conference Calls
- Virtual Office
- Data Collection
- Harvesting Sessions
- DATA Monitoring and Change Assessment

Results

- Paradigm shift focusing on the preventive approach rather than surgical or end-stage treatment
- Integration of oral health in PECS 3
- 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

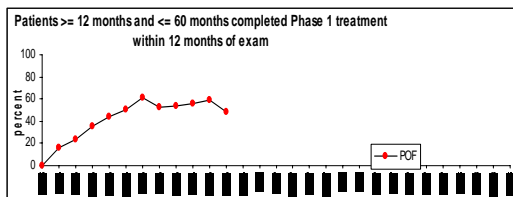
A New Era of Best Practices

- Providing value-added preventive dental visits
- Providing ECC risk assessment and disease management to very young children in the medical and dental settings
- Providing comprehensive dental services to perinatal patients
- With a concurrent emphasis on redesign

Selected Measures: ECC Prevention

- Oral health counseling by PCP
- Dental exam by age 12 mos
- Dental exam within last 12 mos
- At least one fluoride varnish in last 12 mos
- Completed phase 1 treatment in last 12 mos
- Caregiver with self- management goal documented
- Maintenance phase- recall within last 12 mos

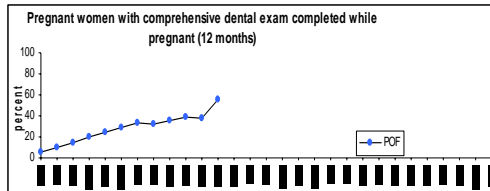
Selected Measures: Treatment Completed- Children



Selected Measures: Perinatal Oral Health Care

- Comprehensive oral exam while pregnant
- Completed phase 1 treatment within 6 mos of exam
- Perio Treatment completed during pregnancy
- Documented self-management goal setting

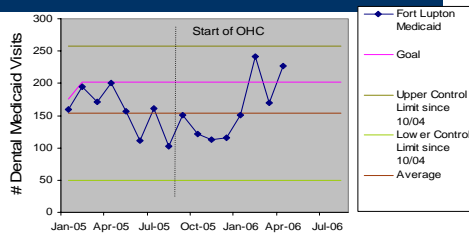
Selected Measures: Perinatal Access to Dental Care



Other Baseline Measures

- Number of patients in registry , 12 mos age
- Number patients >12 mos, < 60 mos age
- Number patients > 24 mos, < 60 mos age
- Total number of patients < 60 mos age
- Number of pregnant women in registry
- Number of pregnant women in registry with periodontitis

The Business Case: Dental Medicaid Visits Salud Case Study



In their own words:

- Scheduling **8 days out** vs. 4 months out
- **5% "no-show"** vs. 12% "no-show"
- **40% Medicaid** vs. 20% Medicaid
- **18.3pts/day** vs. 12pts/day (based on 8 hour day)
- Dentist billed **\$51,281 Aug 2006** vs. \$16,205 Aug 2005
- The OHDPC made dentistry relevant to the delivery of health care within a Community Health Center. The dental department is at the table and no longer a sideshow.
- At Sunrise, we are a completely different department than we were 18 months ago and it shows in how we now practice dentistry.

Challenges

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

Pioneering National Leadership

- 1st organized oral health initiative in the county that has a protocol for treating pregnant women
- 1st national entity that has a protocol for treating kids at age 1
- 1st national oral health quality improvement effort for Health Center dental programs
- We have the technology, change package, and desire to do this
- How do we get there?

The Need for Expansion

- CHCs currently employ 1,868 dentists and 709 dental hygienists at 694 Health Centers – many of these are one provider operations
- Current dental capacity: 2.6 million users vs. 13 million medical users
- Estimated unmet dental need nationally (to close the access disparity gap): 33 million persons

Thank You & for more information...

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