Oral Health and the Patient Centered Health Home

Needs Assessment Results

National Network Oral Health Access
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 are early adopters
- Learn best practices
HRSA PCM/ HH Initiatives

- HRSA encouraging 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
NNOHA’s PCHH Needs Assessment - Methodology

• Online assessment of 77/270 self identified HC dental directors
  ▪ Level of medical-dental integration
  ▪ Perceived barriers to that integration

• Follow-up guided interviews with 9 early adopter dental programs
  ▪ Came up with program characteristics and Best practices
Practices Indicative of Medical-Dental Integration

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

6. Specific policies and procedures exist for referral, tracking and follow-up of diabetic patients into dental care

7. Specific policies and procedures exist for referral, tracking and follow-up of dental patients into behavioral health care

8. Specific policies and procedures exist for follow-up and tracking of dental patients with abnormal BP readings

9. Early Childhood Caries risk assessment is incorporated into well-child visits for ages 0-5 years
Early Adopters

• 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
Facilities Infrastructure

Co-located Medical & Dental Services

- All sites co-located: 34%
- > 50% of sites: 29%
- < 50% of sites: 5%
- No sites co-located: 32%
IT Infrastructure

- EMR - 75%
- EDR - 54%
- Systems interoperable - 23%
Nine Early Adopter Interviews

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

• Of the 9 early adopter programs interviewed
  • 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
1. 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”
2. 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
3. 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.
4. 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
5. 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
6. 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
7. 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.”
Early Adopter Challenges - Training

- Medical providers needed educational efforts about oral-systemic topics and dental referrals
- Dental providers and staff needed training to expanding services to infant and perinatal populations
## EHR Issues

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<tr>
<th>System</th>
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<th>Issue/notes</th>
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<tbody>
<tr>
<td>None</td>
<td>1</td>
<td>Will be getting EMR soon</td>
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<td>EMR only</td>
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<td>Interoperable after dental director created dental templates for the EMR- dental integrated into the EMR- one program</td>
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<td>Interoperable EMR/EDR</td>
<td>2</td>
<td>Selected by HC precisely because system is interoperable- 2 separate programs</td>
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<tr>
<td>Sep EMR + Sep EDR + HL7 bridge</td>
<td>2</td>
<td>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</td>
</tr>
<tr>
<td>Sep EMR + Sep EDR</td>
<td>3</td>
<td>Non-interoperable- 2 separate programs</td>
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EHR Clinical Issues

• Usually dental can see medical but not vice versa

• Prescription writing
  ▪ Medical providers have no way of knowing if a patient has received a prescription in dental – i.e. drug seekers
  ▪ Some HC protocols have dental provider check EMR first before writing Rx and/or double enter prescription into EDR and the EMR – onus is on dentist to check.
Best Practices

• Determined by:
  ▪ 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 instead of the client going to a receptionist
• "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
Patient 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 smart phone apps could transmit finger stick, BP results or \textit{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
  - Initial survey selection bias towards centers that were familiar with PCHH or already implementing it.
  - Got responses from about 10% of total Health Centers with dental programs
Next Steps


• Develop Core Curriculum on the integration of oral health services and medical care services
  ▪ Service delivery programs (HC’s)
  ▪ Workforce programs (NHSC)

• Continue to identify best practices

• Advocate for inclusion of oral health into HRSA’s HIT and *meaningful use* initiatives