Oral Health in Primary Care: A Framework for Action

Oregon Primary Care Association
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Objectives

• Demonstrate the impact of oral disease
• Describe the benefits of integrating oral health preventive care in routine medical care
• Establish connections between oral health preventive care and PCMH principles and concepts
Why should we care about oral health?

• Nationwide we have an unacceptably high burden of oral disease
• Little improvement in oral health status
• The oral healthcare system, as currently configured, fails to reach the populations with the highest burden of disease resulting in significant and pervasive health disparities
• All for a largely preventable disease
The Burden of Oral Disease: Children

Tooth decay is the most common chronic disease of childhood

- Pain, infection
- Impacts growth and speech
- Puts children at risk for dental disease in adulthood

25% of 3rd graders have experienced tooth decay
The Burden of Oral Disease: Adults

25% have untreated caries (20-64)
19% suffer from destructive periodontal diseases (18-44)

Cumulative Result?
By age 44, 69% of Oregonians have lost at least one permanent tooth
By age 65, 25% of Americans have no natural teeth

Oral cancer kills 7,800 people each year 2.0x the number who die of cervical cancer, a major preventive care focus
Oral Disease Impacts Overall Health

“The mouth is a mirror for the body.” U.S. Surgeon General

- New evidence is demonstrating a relationship between periodontal disease:
  - Diabetes
  - Ischemic vascular disease
  - Pre-term delivery and low-birth weight
Poor oral health compromises more than health…

Oral pain can restrict activity, impair nutrition, and disturb sleep

- **Adults lose 164 million** work hours each year due to oral complications
- Indirect economic costs: Adults with missing teeth are more likely to report trouble finding employment
- Older adults with missing or no teeth report lower overall quality of life
- **Children** with poor oral health are more likely to miss school and have poor academic performance, independent of race and socioeconomic status
- Impacts self-esteem
Access and Affordability Challenge

Dental care is the most common unmet health need

40% of the population lacks dental insurance

2.5x the % who lack medical insurance

• Even with insurance, dental care is often not affordable
• 47 million people live in dental shortage areas
Results?

• Unnecessary complications
• Late-stage interventions
  – Waste valuable resources
  – Introduce significant risk for patients
  – Do not address underlying cause of disease: bacteria fueled by an unhealthy diet and ineffective hygiene

Reliance on Emergency Department
• 2.1 million visits for non-traumatic oral problems
• 28,000 in Oregon (2010); $8 million price tag
So what’s the answer?

“You can’t fix your way out of the problem with more dentists; you have to prevent tooth decay in the first place.”

R. Michael Shirtcliff, DMD, President & CEO, Advantage Dental Plan, Oregon

Another Solution

• Incorporate oral health in routine medical care
• Apply a population health management approach to oral disease
• Find new ways to engage patients and families in the prevention of oral disease
Why primary care?

Access:
- Frequent contact with patients across the lifespan, particularly high-risk groups: Children, pregnant women, adults with diabetes

Skills:
- Prevention
- Patient engagement
- Care coordination
- Population health management approach
It’s a natural extension of what primary care teams already do:

- Measure BMI and provide information about healthy diet
- Advise on sunscreen, look for suspicious moles, refer
- Screen new moms for depression

Why should the mouth be excluded?

- Common problem, serious consequences
- Patient and family behavior (self-care) is key
- Most problems can be recognized early and treated to reduce impact
Partnership for Prevention

Primary Care
- Population Management Reporting
- Quality Improvement Methodology
- Structured EHR Data Including Dx Codes
- Management of Chronic Diseases

Dental Care
- Restorative Treatment of Caries
- Endodontics
- Orthodontics
- Crowns and Implants
- Deep Scaling and Root Planning for Periodontal Disease

Prevention
- Medication List Management
- Risk Assessment
- Diet Counseling
- Oral Hygiene Training
- Smoking Cessation
- Fluoride Varnish
- Antibiotic Rinses
- Screening for Oral Diseases
- Dental X-rays
- Dental Sealants
- Periodic Cleaning
- Mouth Guards
Where does oral health fit in practice transformation?

Engagement in oral health is a strategy to achieve primary care's goal of improved care for individuals, improved health for populations, and lower overall costs.

- Component of Organized, Evidence-Based Care
- Patient-Centered/Advanced Primary Care Practices have specific capacities and resources to leverage:
  - High-functioning teams; care managers, health educators, referral coordinators
  - Quality improvement; supporting technology
- Opportunity to fulfill commitment to comprehensive, “whole-person” care
- Behavioral health integration efforts are instructive
Oral Health in Primary Care Project

Informed by a Technical Expert Panel

Primary care and dental providers; medical and dental associations; payors and policymakers; patient, family, public health advocates

Sponsor: [Logo]

Consultant: [Logo]

Funders: [Logo]

[Logo] Community Advocates for Oral Health
Solve the challenge:
How to fit oral health into an already packed workflow, in a way that:
1. Maximizes the value of the service to the patient and his/her family;
2. Minimizes disruption to all of the other priorities that a busy care team is expected to manage; and,
3. Is perceived to be feasible across diverse primary care settings.
Oral Health Delivery Framework

Symptoms & Risk Factors
- Pain, bleeding
- Burning, dry mouth
- Dietary patterns
- Adequacy of fluoride
- Oral hygiene
- Time since last dental visit

Signs of Disease
- Dry mouth
- Chalk marks
- Obvious caries
- Inflammation
- Exposed roots
- Mucosa abnormalities

On the most appropriate action using standardized criteria based on the answers to the screening and risk assessment questions and findings of the oral exam, and the values, preferences, and goals of the patient and family.
Offer Intervention to Reduce Risk and/or Refer for Treatment

1. Make changes in the medication list to protect the saliva, teeth, and gums
2. Offer fluoride therapy
3. Offer dietary counseling to protect the teeth and gums
4. Demonstrate and coach good oral hygiene, for example by using teach-back to model brushing and flossing
5. Offer therapy for tobacco, alcohol, or drug dependency
6. Refer for treatment
Oral Health Delivery Framework

Document Findings and Measure Care Processes

– Structured data
– Reporting functionality
– Measures to gauge impact on patients, families, practice as a whole
Structured Referral

- Many patients will need care that only a dentist can provide
- Referrals to dentistry ought to be as smooth as referrals to medical specialists:
  - Referral network able to serve diverse patients
  - Referral agreements to clarify expectations
  - Tracking and care coordination processes
  - Logistical support
  - Connectivity; ability and commitment to transfer information

**Goal:** To support patients and families in accessing dental care, ensure the primary care practice remains the hub for the patient’s overall healthcare
Who will do this new work? *It depends*

- FQHCs with co-located dental practices or additional resources will have additional options
Can this be done?

• A comprehensive approach
• Advanced practices have capacities and resources in place to implement now
  – High-functioning teams; care managers, health educators, referral coordinators; quality improvement methodology; supporting technology
• Others can consider an incremental approach while they continue to build their capacity
  – Process
  – Population

All primary care practices can take meaningful steps to improve patient and family oral health
Field-Testing a Conceptual Framework

Develop | Test | Improve | Disseminate

12+ diverse primary care practices

Project design underway:

- Private practices (3) adults with diabetes & pregnant women
- Safety net sites (2) w co-located dental offices peds & all well visits
- FQHCs (4) peds & adults with diabetes

Kansas Association of the Medically Underserved (FQHCs)
Oregon Primary Care Association (FQHCs)
Resources to Guide the Way

1. White paper—articulating the case for change (June 2015)
   - *The Oral Health Delivery Framework*
   - Case examples from early leaders

2. Implementation guide—toolkit for primary care practices (2016)
   - Sample workflows
   - Referral agreements
   - Risk assessment/screening questions
   - Patient education resources
   - Clinical training resources
   - Case studies and impact data

3. Recommendation to PCMH Recognition programs (2017)

Available at: [www.safetynetmedicalhome.org](http://www.safetynetmedicalhome.org)
Sources

Questions?
Reactions?
Ideas to share?
Contact Information

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Mission

• The mission of Neighborcare Health is to provide comprehensive healthcare to families and individuals who have difficulty accessing care; respond with sensitivity to the needs of our culturally diverse patients; and advocate and work with others to improve the overall health status of the communities we serve.

• Our purpose is to improve health by engaging, educating and empowering people in the communities we serve.

• Our Ultimate Goal is 100% Access, Zero Health Disparities.
### Who is Neighborcare Health?

- **50,000** Unique patients
- **~600** Staff
- **24+** Sites in the city of Seattle
- **40** Languages and dialects spoken by patients and staff

#### Programs

- Dental
- Medical
- Midwifery
- School Based Health
- Homeless
How did we begin our journey

“Mouth is connected to the body”

• Started from the top with the Board and CEO recognizing the importance of oral health

• Chief Dental Officer – Martin Lieberman (2002-2014)
  • Institute for Healthcare Improvement
  • IHI IMPACT Approach
How did we begin our journey

Vision continues with our current Chief Dental Officer - Sarah Vander Beek
What have we done:

1. IHI IMPACT Team (2004)
   a) Design PDSAs aimed at improving medical and integration.
   b) Medical Providers and knee to knee exams
   c) Community Health Worker – identify children without a medical or dental home
What have we done:

1. Patient and staff education on the importance of dental
   a) Martin Lieberman presented at site medical staff meetings and OB team meetings.
   b) Patient handouts created (diabetes and pregnancy)
What have we done:

1. Co-located medical and dental clinics with shared clinic manager
2. Referrals process improvement work
   a) Created a standard referral process for pregnant women and diabetic patients to be seen in dental.
   b) Conversation part of medical visit with provider and care team members
   c) Regular data to site leadership
OB Dental Report visit dates x 1 yr, EDD dates x 9 mos

- 45th M
- GMC
- HP
- LC
- RB
- RP
- Total Ave
- Goal (Co-located)
- Goal (Non co-located)
What have we done:

1. Mobile Dental Program
   a) Screenings in non-Neighborcare elementary, middle, and high schools
   b) School-based Health Centers

2. ARNP in school-based clinics doing dental screenings

3. Youth Dental Clinic at Neighborcare Health 45th St Clinic
What are we doing now:

1. Removing scheduling barriers to improve access
2. Chief Dental Officer to join Site Medical Director meetings to talk about dental care and their role.
3. Dental Pathways - standardizing the process for identifying patients who need dental care
   a) Direct Scheduling between all sites
4. Expanding mobile dental program to Neighborcare Health Ballard Homeless Clinic
High Point Clinic’s Journey: What have we done

• Kids Get Care – safety net in place for kids to get access to care
• Shadowing Program with Providers and Dental Residents
• Shared Meetings – all site staff and retreats
• Dental staff using the EHR
• Front Desk integration – one team
• Oral Health Collaborative in Washington State
High Point Clinic’s Journey: what are we doing now

1. Bringing IMPACT team back
   a) Medical and Dental Champions

2. Opportunities to connect patients to medical or dental:
   a) Adding information on check-out slips
   b) Referring patients with high BP to medical for teaching
   c) All dental ER patients are referred to medical if they do not have a medical home.
High Point Clinic’s Journey: what are we doing now

1. Care team model – replicating model from medical
   a) Care Team: PSR, Dental Provider, DA
   b) Meeting weekly to:
      i. Review schedules, identify scheduling errors, missing information such as specialty agreements.

2. Check HgA1c in Dental (future)
Lessons Learned

1. Starts at the top: Support from Senior Leadership and Board are critical
2. Provider champions in medical and dental
3. Protected time for outreach work
4. Having an integrated EMR and EDR
5. Continuously look for opportunities to improve processes
6. Find ways to keep people motivated
Q&A
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