Creating Medical Dental Integration
Helpful Hints & Best Practices
Irene V. Hilton, DDS, MPH
NNOHA Dental Consultant

Objectives
• Describe examples of medical-dental integration at the clinical level
• Understand why medical-dental integration is a positive attribute
• List some of the administrative and clinical barriers to implementing integration across disciplines
• Develop strategies for addressing integration issues

NNOHA- Who we Are
• National organization representing oral health providers and supporters working in Health Centers/safety-net
• HRSA cooperative agreement
• Provide Health Centers with support & assistance to develop patient-centered health homes that meet oral health needs
HRSA PCM/HH Initiatives

• 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

Patient Centered Health Home (PCHH): One Definition

• Patient Centered: Care that is respectful of and responsive to individual patient preferences, needs and values
• Health Home: An approach to providing primary care where individuals receive integrated, comprehensive medical, dental and mental health care that is focused on prevention and early intervention

Health Home & Real Home

• Want to know what is happening in every room
• Condition of one may affect the other
• More efficient use of resources
• Maintains in optimal condition
**Why Integrate Healthcare Disciplines?**

- Increase communication and collaboration
- Improve quality
  - Better health outcomes
  - Increased patient satisfaction
- Reduce costs

**PCHH Concepts**

- Deals with Populations of Focus (POF)
  - Children
    - 0-5
    - Adolescents
  - Perinatal
  - Geriatric
  - Diabetes, hypertension, asthma, HIV

**What Does Integration Look Like at the HC Level?**
### Administrative Integration
- Providers & staff communicate both formally and informally across disciplines
  - Meetings, inservices
- HC administrative structure and decision making incorporates all disciplines
- Participation in HC committees
- Mutual Respect

### Clinical Infrastructure Integration
- Sharing and access to patient information across disciplines
  - Appointments
  - Medication
  - EHR
- Bilateral referrals
  - Standardized process, forms
- Standardized follow-up, tracking

### Clinical Integration
- Consideration of clinical issues beyond traditional “silos”
  - Medical staff provides ECC risk assessment and fluoride varnish
  - Dental staff provides HIV or diabetes screenings
Quality Improvement

• Use of measures to monitor and drive change related to level of integration
  ▪ % perinatal patients that receive a dental exam while pregnant
  ▪ % patients identified with HBP at dental visit that attend a medical visit within two weeks

Seven Key HC 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

Challenges
Barriers to Integration

- Physical Infrastructure - no co-location
- HIT - lack of or not integrated
- Training - lack of training on new clinical skills
- Systems - lack of policies, protocols, forms
- Competing needs/issues - existing practice management issues

Co-location

- Norm is to not have dental co-located with medical at the same site
- 2010 UDS data
  - 3.5 million dental users
  - 16 million medical users

Facilities Infrastructure
**Strategies**

- Pilot integration at one co-located site
- Develop systems
- Expand to non-dental sites
- Consider mobile diagnostic & preventive services

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**Health Information Technology**

- Lack of EMR and/or EDR
- Lack of system integration

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**EMR-EDR Options**

<table>
<thead>
<tr>
<th>System</th>
</tr>
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<tbody>
<tr>
<td>No EMR or EDR (paper)</td>
</tr>
<tr>
<td>EMR + dental paper</td>
</tr>
<tr>
<td>EMR (dental utilizes)</td>
</tr>
<tr>
<td>Integrated EMR/EDR</td>
</tr>
<tr>
<td>Sep EMR + Sep EDR + HL7 bridge</td>
</tr>
<tr>
<td>Sep EMR + Sep EDR</td>
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</tbody>
</table>
Strategies

- Generating population lists
- Convert & track through Excel or Access
- Fax friend

- In general true that resources must be allocated to facilitate
  - ARRA/ACA
  - Meaningful use

Training

- Medical staff need training on importance of oral health
  - POF
  - Clinical assessment (ECC, oral cancer)
  - Referral protocols
- Dental staff may need training in clinical skills & lasted guidelines for treatment of POF
  - Children 0-5
  - Perinatal

Training Strategies

- Dental schools
- Local, state and national meetings (NNOHA, ADA, AGD, AAPD, HDA, NDA)
- Online curricula for dental providers
  - http://www.first5oralhealth.org/
  - http://www.aapd.org/dentalhome/infantoralealth.ppt
Medical Staff Training

- http://www.smilesforlifeoralhealth.org/
- http://www.first5oralhealth.org/
- www.kidsoralhealth.org/?page=pcp-home

Systems

- Policies – Proposed or adopted course or principle of action
- Protocols – Established code of procedure in group, organization or situation
- Forms
- Tracking infrastructure

Developing a Referral System

- Engage both sides, all staff involved
- Pilot & trial
- Feedback
Steps to Consider

- Who to refer
  - Specific populations
  - Certain clinical conditions- bi-directional
    - HBP, uncontrolled diabetics, behavioral
- Define process
  - Who makes appointment
  - Patient information

More Steps

- Referral form/e-referral
  - What information
  - Pilot drafts
- Documenting & Tracking
  - Outgoing & incoming
- Closing the loop

Draft Policy/Protocol

- Share with both staff
- Feedback
- Pilot Test
- Final Version
- Reminders as needed until institutionalized
- Continuous monitoring
Referral System Case Study

- HHH FQHC
  - 8 medical/perinatal sites
  - 4 dental sites
- Dental clinics had not been targeting perinatal, nor had they been referred by medical
  - Focus on children, adult urgent & routine care
- Dental perinatal clients random

Rationale for Change

- Research on association between periodontal disease and adverse birth outcomes
  - Perinatal oral health became a priority of the community perinatal consortium of which HHH HC was a member
- State Medi-caid began reimbursing some dental care for pregnant women

Goal

- Implement dental services for all perinatal patients in the 8 medical sites
- 4 medical sites will refer to co-located dental clinics & 4 will refer to the other 4 sites
- Start from scratch
Planning

• Surveyed dentists at the four clinics to assess attitudes towards treating pregnant women
• Majority very reluctant, concerned, expressed fear of liability
  • What would you do?
• Had to inservice multiple times on perinatal guidelines, New York-then California
• Dental director clearly stated no evidence to contraindicate, employment expectation

Start Manageable

• Decided to pilot with one co-located site where dentists were more amiable to treating perinatal clients
• Work out the kinks
• Expand to the other sites

The Referral Form

• First draft taken from an external resource
• Rejected by the medical providers
• Too much fill-in, writing
  • "We want something we can just check off"
• What would you do?
Documentation

• Medical providers decided to order in carbon (2 pages)
  ▪ Perinatal staff walk patient over dental with one form & one in chart
  ▪ Fax to dental clinic then one in chart & one with patient

• Dental keeps referral forms in accordion file

At the Dental Visit

• Referral form completed by provider whether attended or N/S
  ▪ Perinatal exam appts noted in schedule notes of IT system
• Faxed back to medical by staff
  ▪ Closes loop
Ready for Expansion

• After 6 months
• Referral form had to be revised to include all 4 dental clinic sites
• Protocols and forms disseminated
  ▪ Dental staff at the 4 sites during quarterly meetings, pilot site discussed experiences
  ▪ Perinatal providers via perinatal consortium
• Referral form available online download

Tracking/ Measuring

• HHH FQHC only EMR, no EDR
• How would you track if pregnant women from medical had a dental visit?
• Appts & billing computerized
• Monthly, quarterly, yearly
• # perinatal clients in HC
• # that had dental visit
Lessons Learned/Best Practices

• Group plan rough draft
• Immediately involve the collaborators
• Small scale pilot trials/PDSA
• Discard stuff that doesn’t work, review, try something else
• Expand
• Continuous monitoring

Common Practice Management Issues

...and how integration can help...

Competing Needs

• Competing needs/issues- existing practice management issues
• Magnified or worsen with implementation of medical-dental integration?
The Why of Integration

- Providing the best, highest quality, evidence-based care to the populations we serve
- May improve fiscal sustainability
- Can contribute to improving practice management issues

Low Encounters

- 6-step Infant Oral health Care visit
  - Defined set of procedures
  - Defined time frame
  - Little variability
  - Team members can perform many aspects
  - Does not need a dental chair so can be performed outside the operatory
- Increase encounters by scheduling these exam visits between restorative visits
- Exam only blocks

Where are the Infants (POF)?

- Children 0-5 have the lowest rates of dental utilization compared to other child age groups
- Decreases with age
- Sequence of 10 well child visits between age 0-3
Medical- Dental Integration is Key!!!!

Medical identifies & refers

Dentists willing to treat

Capacity to treat

Low Revenues

- Add new patients that have payer sources
- Young children and perinatal patients may be in category
- Does not replace current groups, add new populations

No Shows

- Can fill N/S appointments with
  - On call clients
  - Drop in emergencies
  - Drop in defined-time visits
    - Infant oral care visit
Drop In Case Study

• ZZZ HC with 6 chair dental clinic, 2 FTE DDS
  ▪ N/S rate of 25% for DDS
  ▪ Appt 16/provider x 2 = 32 appts w/ 24 attended
• 15 medical exam rooms, 5 FTE MD/NP
• Primary care sees average of 10 children/day ages 0-5

Planning

• What is the goal?
  ▪ Fill in N/S appointments with infant oral health exams patients referred the same day from medical
• What are the first planning steps?
  ▪ Brainstorm a quick plan w/ dental staff
  ▪ Consult with medical for feedback

On Demand Access

• Strategies for on demand/open access for children 0-5?
  ▪ Medical staff calls dental
  ▪ Medical staff walks patient over to dental
  ▪ Coupons/vouchers
    ▪ On-demand exam that day
    ▪ Another day if convenient or traditional appointment
Advertise
• How are you going to inform medical, dental staff, patients?
  ▪ Exec team meetings, general meetings, HC communications channels, e-mail
  ▪ Posters, flyers, enabling services, WIC

Start Small Implementation
• How do you pilot test implementation?
  ▪ One morning/day
  ▪ One medical provider
  ▪ Immediate feedback

Evaluate
• How would you know if this plan is working?
  ▪ N/S rate same but encounters up
  ▪ Pleased dental staff
  ▪ Satisfied parents
  ▪ Impressed medical staff
Conclusion

Medical-Dental Integration

- Interdisciplinary collaboration is the future
- Improves health status for POFs
- Help create more efficient dental programs
- The right thing to do

NNOHA Resources

- PCHH Action Guide
  [http://www.nnoha.org/generalpage.html](http://www.nnoha.org/generalpage.html)
- Oral Health Collaborative
  [http://www.nnoha.org/oralhealthcollab.html](http://www.nnoha.org/oralhealthcollab.html)
Next Webinar June 25

EMR-EDR Configurations: How to use what you’ve got to advance PCHH efforts

Questions?