Creating Medical Dental Integration: Helpful Hints and Promising Practices

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Strengthening the Oral Health Safety Net
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Objectives

- Assess the level of integration in a Health Center
- Describe challenges to integration
- Understand the strategies to overcome integration barriers
- Plan an interdisciplinary collaborative project
Why Integrate Healthcare Disciplines?  
Triple Aim

- Increase communication and collaboration
- Improve quality
  - Better health outcomes
  - Increased patient satisfaction
- Reduce costs
Interdisciplinary Collaboration
Not Just Increasing Access

- Recent study compared medical costs of diabetic patients who received periodontal treatment vs. no treatment over three years
- Commercial medical and dental insurance
- Periodontal treatment was associated with a significant decrease in hospital admissions, physician visits and overall cost of medical care in diabetics. Savings averaged $1,814 per patient in a single year independent of age and sex

Current HRSA Initiative: (IOHPCP)  
Integration of Oral Health and Primary Care Practice

- 2011 IOM report *Improving Access to Oral Health Care for Vulnerable and Underserved Populations*
- Improve access for early detection and preventive interventions by expanding oral health clinical competency of primary care clinicians (MD, NP, PA, CNW)
- HRSA developed core set of oral health competencies for health care professionals
- Adopt and implement core clinical competencies
Five Interprofessional Oral Health Core Clinical Domains and Competencies

1. Risk assessment
2. Oral health evaluation
3. Preventive intervention
4. Communication and education
5. Interprofessional collaborative practice
HRSA/NNOHA Integration Projects

- Oral Health Disparities Collaborative Pilot
  - 0-5 & Perinatal

- Medical-dental Integration Assessment
  - General survey & early adopter interviews
  - *Patient Centered Health Home Action Guide*

- Interprofessional Oral Health Core Clinical Competency Pilot
  - Adopt and implement OH core clinical competencies resulting in integration of oral health and primary care through inter-professional collaborative practice
What Does Integration Look Like at the Health Center Level?
### Table 1. Six Levels of Collaboration/Integration (Core Descriptions)

<table>
<thead>
<tr>
<th>COORDINATED</th>
<th>CO-LOCATED</th>
<th>INTEGRATED</th>
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</thead>
<tbody>
<tr>
<td>KEY ELEMENT: COMMUNICATION</td>
<td>KEY ELEMENT: PHYSICAL PROXIMITY</td>
<td>KEY ELEMENT: PRACTICE CHANGE</td>
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<tr>
<td>LEVEL 1</td>
<td>LEVEL 2</td>
<td>LEVEL 3</td>
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<tr>
<td>Minimal Collaboration</td>
<td>Basic Collaboration at a Distance</td>
<td>Basic Collaboration Onsite</td>
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**Behavioral health, primary care and other healthcare providers work:**

- **In separate facilities, where they:**
  - Have separate systems
  - Communicate about cases only rarely and under compelling circumstances
  - Communicate, driven by provider need
  - May never meet in person
  - Have limited understanding of each other’s roles

- **In separate facilities, where they:**
  - Have separate systems
  - Communicate periodically about shared patients
  - Communicate, driven by specific patient issues
  - May meet as part of larger community
  - Appreciate each other’s roles as resources

- **In same facility not necessarily same offices, where they:**
  - Have separate systems
  - Communicate regularly about shared patients, by phone or e-mail
  - Collaborate, driven by need for each other’s services and more reliable referral
  - Meet occasionally to discuss cases due to close proximity
  - Feel part of a larger yet ill-defined team

- **In same space within the same facility, where they:**
  - Share some systems, like scheduling or medical records
  - Communicate in person as needed
  - Collaborate, driven by need for consultation and coordinated plans for difficult patients
  - Have regular face-to-face interactions about some patients
  - Have a basic understanding of roles and culture

- **In same space within the same facility (some shared space), where they:**
  - Actively seek system solutions together or develop work-a-rounds
  - Communicate frequently in person
  - Collaborate, driven by desire to be a member of the care team
  - Have regular team meetings to discuss overall patient care and specific patient issues
  - Have an in-depth understanding of roles and culture

- **In same space within the same facility, sharing all practice space, where they:**
  - Have resolved most or all system issues, functioning as one integrated system
  - Communicate consistently at the system, team and individual levels
  - Collaborate, driven by shared concept of team care
  - Have formal and informal meetings to support integrated model of care
  - Have roles and cultures that blur or blend

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

- Medical staff provides ECC risk assessment and fluoride varnish
- Dental staff provides HIV, diabetes or depression 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
Early Adopter Characteristics
Facilitators

- Leadership Vision & Support
- Integrated HC Executive Team
- Co-location
- Organizational Culture of Quality Improvement
- Staff Buy-in: Understanding the “Why”
- Patient Enabling Services
- Champions
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”
Integrated HC Executive Team

- Part of organizational structure
- Includes all operations team meetings, committees and communications
- Present when planning and clinical policy and protocol decisions made to advocate and give input and perspective
Co-location

- Staff from any Health Center department could bring a client to dental
- Bi-directional
- “warm hand-off”
- Positive attributes of having multiple services (e.g. nutrition, behavioral, social workers etc.) in one location.
Organizational Culture of Quality Improvement

- In-depth knowledge of QI terminology and methodology
- Culture permeated all levels of the Health Center-part of how departments conduct daily functions
- Focus on outcomes – using measures to drive change, improving from baseline, using these concepts for all aspects of clinic operations
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, instead explaining the "why"
  - Changes achieve better patient outcomes, best care
  - Generate revenues and maintain financial sustainability
Patient Enabling Services

- Patient navigators, family support workers, health coaches available to other departments
- Assist in making appointments, engaging patients, motivational interviewing, goal setting
Champions

- Confident, proactive, sure of the importance of oral health in improving health status of the patients they serve
- 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.”
Challenges
Barriers to Integration

- Capacity
- Health Information Technology
- Training
- Systems
- Competing needs/issues
- Reimbursement
Capacity & Co-location

- Norm is to not have dental co-located with medical at the same site
- 2012 UDS data
  - 4.3 million dental users
  - 18 million medical users
- Dental capacity for 24% of medical users
Strategies

- Pilot integration at one co-located site
- Develop systems
- Expand to non-dental sites
- Consider mobile diagnostic & preventive services, telehealth, integrated practice, workforce innovation
Lack of System Integration Between EMR & EDR

- All Paper Medical Record Only
- Electronic Dental Record Only
- Separate Electronic Medical and Dental Records
- Electronic Medical Records with Dental Templates
- Home Grown Electronic Medical & Dental Records
- Interfaced Electronic Medical & Dental Record
- Fully Integrated Electronic Medical & Dental Record
- Fully Integrated Electronic Medical & Dental Record + Electronic Health Record

No integration

Full integration

1 2 3 4 5 6 7 8 9
## Separate EMR and EDR

<table>
<thead>
<tr>
<th>Pros</th>
<th>Cons</th>
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<tbody>
<tr>
<td>• Dental can usually see primary care</td>
<td>• Primary care can’t see dental</td>
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<tr>
<td>• Sets the stage for tighter integration between the two systems</td>
<td>• Requires license for both programs</td>
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<td></td>
<td>• Must toggle between and log in/out of 2 distinct systems</td>
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<td></td>
<td>• No single sign on</td>
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<td>• Dual data entry</td>
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Strategies

- Generating population lists from other database
- Convert & track through Excel or Access
- Fax alternative to eReferral
- In general true that resources must be allocated to develop work-arounds
Interfaced Electronic Medical and Dental Records (i.e. HCCN)

**Pros**
- HL7 messaging is an accepted interoperability standard
- Keep existing systems
- Opportunity to obtain Meaningful Use certification

**Cons**
- Limited information sharing
- Duplicate information between two systems
- Generally there is an extra cost for HL7 interface set up and any future upgrades
## Fully Integrated Electronic Medical & Dental Records

<table>
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<tr>
<td>• EDR dental specific</td>
<td>• Generally the combined cost can be more. Internal IT and clinical</td>
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<tr>
<td>• Streamlined and tightly integrated</td>
<td>staff need to maintain and service both applications</td>
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<tr>
<td>patient record and functions</td>
<td></td>
</tr>
<tr>
<td>• Single sign in</td>
<td></td>
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<tr>
<td>• Increased patient safety</td>
<td></td>
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<tr>
<td>• Medication reconciliation</td>
<td></td>
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<tr>
<td>• Single clinical view of patient record</td>
<td></td>
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<tr>
<td>• Immediate access to patient records</td>
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<tr>
<td>within the Health Center</td>
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Training

- Primary care staff needs
  - Importance oral health to systemic health
  - Clinical competencies
  - Referral protocols

- Dental staff needs training in clinical skills & latest guidelines
  - Children 0-5
  - Perinatal
Primary Care Training

- [http://www.smilesforlifeoralhealth.org/](http://www.smilesforlifeoralhealth.org/)
- [https://www2.aap.org/ORALHEALTH/pact/index.cfm](https://www2.aap.org/ORALHEALTH/pact/index.cfm)

Dental Training

- CE- Dental school, local, state and national meetings
- Guidelines
Systems

- **Policies** – Proposed or adopted course or principle of action
- **Protocols** – Established code of procedure in group, organization or situation
- **Forms**
- **HIT infrastructure**
- **Clinic flow**
- **Training**
Developing Policy/Protocol

- Share with all staff
- Feedback
- Pilot Test
- Final version
- Reminders as needed until institutionalized
- Continuous monitoring
Competing Needs

- Competing needs/issues - existing practice management issues
- Magnified or worsen with implementation of medical-dental integration?
Reimbursement Issues

- Unable to bill same day medical & dental FQHC visit—varies by state
- Most states do not cover non-emergency dental treatment, especially periodontal treatment for adults
- Not able to capture FFS enhancements for PCP delivering OH procedures
Common Practice Management Issues

...and how integration can help...
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 procedures & time frame
  - Low variability
  - Team members perform many aspects
  - Does not need a dental chair

- Increase encounters by scheduling between restorative visits
Where are the Infants?

- 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
- Refer from primary care to dental
Low Revenues

- Add new patients that have payer sources
- Does not replace current groups, add new populations
- Young children and perinatal patients may be in category
- Refer from primary care to dental
No Shows

- Can fill dental N/S appointments with pre-determined open access clients
  - Infants?
  - Children?
  - Perinatal?
- Refer from primary care to dental
Medical-Dental Integration is Key!!!!!

Primary care identifies & refers

Dentists willing to treat
Capacity to treat
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 primary care

- **What are the first planning steps?**
  - Assess leadership support
  - Assess primary care interest
  - Brainstorm a quick plan w/ dental staff
  - Consult with primary care for feedback
On Demand Access

- *Strategies for on demand/open access for children 0-5?*
  - Primary care staff calls dental
  - Primary care 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?*
  - Executive team meetings, general staff 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 primary care staff
- Improvement in tracking measures
Conclusion
Interdisciplinary Collaboration...

- Is the future
- Improves health status
- Helps create more efficient dental programs
- Contributes to Triple Aim
- The right thing to do
NNOHA Resources

- PCHH Action Guide
  http://www.nnoha.org/generalpage.html
- Oral Health Collaborative
  http://www.nnoha.org/oralhealthcollab.html
The National Primary Oral Health Conference is largest gathering of safety-net oral health professionals. Conference sessions cover important clinical, policy, and program management topics with the objective of strengthening both individual oral health programs and the safety-net as a whole. Conference attendees include:

- Safety-net dental directors and dental program managers,
- Dentists,
- Dental hygienists,
- Safety net clinic administration and leadership,
- State level oral health leaders,
- Government and private sector partners, and
- Oral health advocates.
Contact Us!

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