Integrating Oral Health into the Patient Centered Health Home: More Success Stories

William Donigan DDS, MPH
Brett L. Pack, DMD

November 17, 2015
Objectives

- Explain how integrating oral into primary care increases access to dental care in Health Centers
- Illustrate the role of the pediatric dental liaison in integrating oral health into primary care
- Use quality improvement methods to drive increased integration of oral health and primary care
- Identify “take home” examples on how you can incorporate oral health into your Health Center’s Patient-Centered Health Home.
INTEGRATING DENTAL AND MEDICAL VISITS:

HOW WE CREATED A SUSTAINABLE PROGRAM? AND OTHER RANDOM THOUGHTS ABOUT INTEGRATION FROM A DENTAL PERSPECTIVE.

William Donigan DDS, MPH
Dental Director GFHS
Gaston Family Health Services, Gastonia, NC

William Donigan, DDS, MPH
Dental Director
GFHS

- 13 primary care & 5 dental sites
- 31,767 primary care users & 10,838 dental users and 1,423 behavioral health users
- Behavioral health, pharmacy, diabetes education, MAP, Parish Nursing, Senior Care, Workplace Wellness & Ryan White case management
- NCQA PCMH recognition?
Who we are and who we serve!
HRSA DEFINITION OF COMPREHENSIVE PRIMARY ORAL HEALTH CARE THAT HAS APPEARED IN POLICY AND PROGRAM GUIDANCE SINCE 1997:

PERSONAL ORAL HEALTH CARE, DELIVERED IN THE CONTEXT OF FAMILY, CULTURE, AND COMMUNITY, THAT INCLUDES ALL BUT THE MOST SPECIALIZED ORAL HEALTH NEEDS OF THE INDIVIDUALS BEING SERVED.

THE RANGE OF SERVICES SHOULD INCLUDE PREVENTIVE CARE AND EDUCATION, OUTREACH, EMERGENCY SERVICES, BASIC RESTORATIVE SERVICES, AND PERIODONTAL SERVICES.

 ADDITIONAL SERVICES MAY INCLUDE BASIC REHABILITATIVE SERVICES THAT REPLACE MISSING TEETH TO ENABLE THE INDIVIDUAL TO EAT, BENEFIT FROM ENHANCED SELF-ESTEEM, AND HAVE INCREASED EMPLOYMENT ACCEPTABILITY.
Patients need to take some responsibility for their own care!

Education!

Education!

Education!
Surgery

- **Surgery** (from the [Greek: χειρουργική cheiourgikē](http://www.dictionary.com/browse/greek-1) (composed of χείρ, "hand", and ἔργον, "work"), via [Latin: chirurgiae](http://www.dictionary.com/browse/latin-1), meaning "hand work") is an ancient [medical specialty](https://en.wikipedia.org/wiki/Medical_specialty) that uses operative manual and instrumental techniques on a [patient](https://en.wikipedia.org/wiki/Patient) to investigate and/or treat a pathological condition such as [disease](https://en.wikipedia.org/wiki/Disease) or [injury](https://en.wikipedia.org/wiki/Injury), or to help improve bodily function or appearance.

- Surgery is a technology consisting of a physical intervention on tissues.

- As a general rule, a procedure is considered surgical when it involves cutting of a patient's tissues or closure of a previously sustained wound. Other procedures may be considered surgery if they involve "common" surgical procedure or settings, such as use of a sterile environment, [anesthesia](https://en.wikipedia.org/wiki/Anesthesia), [antiseptic](https://en.wikipedia.org/wiki/Antiseptic) conditions, typical [surgical instruments](https://en.wikipedia.org/wiki/Surgical_instrument), and [suturing](https://en.wikipedia.org/wiki/Suture) or [stapling](https://en.wikipedia.org/wiki/Stapler).
Everyone wants to:

- Improve Access - Every infant and child is worthy of the opportunity to benefit from contemporary knowledge and measures that will improve his or her oral health, overall health, and health trajectory.
- Improve oral health outcomes - Oral health is the window to the entire body.
Everyone wants to:

BUT HOW?

- Increase the number of patients we see
- More children - Early evaluation and education is the key to preventing the acquisition and development of oral disease. To break the unfortunate chain of events associated with Early Childhood Caries, we must reach children at an earlier age.
Overview of Project

- Place a trained outreach worker (promotoras) in the Gaston County Health Department Pediatric Medical Clinic (Child Health)
- Have the outreach worker (promotoras) educate caregivers in oral health, explain the one year dental visit
- Schedule children in the dental clinic of choice
Why?

- 2007 vs. Today (>13,000)
- Over 10,000 children in Gaston County without a dental visit
- Sustainability!!!!!
- GFHS, GCHD, Parents (caregivers), children
Opportunities?

Opportunities

Visiting the Dentist and the Physician

108 Million
27 Million

Have a Physician Visit and no Dentist Visit
Have a Dentist Visit and no Physician Visit

Project Objectives

- Increase Patient Dental IQ
- Get children into clinic early (age 1)
- Create a broader patient base of children
- Increase number of Patients with a payer source
- Improve sustainability
Project Planning Process

- Timeline - CEO, GCHD director and medical director, providers (medical and dental)
- Unique and great relationship with HD, CEO wants the dental clinic run as if my own? So I took ownership!!!!!
CHOP (Child Health Outreach Program)

Components:
- Full time bilingual staff member
- Office space in the pediatric medical clinic
- Laptop computer
- Wireless internet (VPN), EDR capable
- Salary, benefits, and equipment funded by dental clinic
Non-tangible components:
- Hardworking and dedicated individual
- Flexibility of liaison, clinicians and staff
- “Buy-in” of clinicians with whom the liaison is working
CHOP (Child Health Outreach Program)

- Training with pediatric & general dentists in oral health
- Training with front office staff in Dentrix
- Training in data collection with PM
- Training in Fluoride Varnish placement
Benefits to the patient:

- Education about oral hygiene and diet at medical visit
- Education about the one year dental visit
- Convenience of scheduling for both caregiver and child
Benefits to the dental clinic:

- Constant influx of new patients especially 1 year olds and special needs patients.
- Liaison has quick communication with dentists if needed via e-mail or Dentrix messenger.
CHOP (Child Health Outreach Program)

How we are improving for our patients:

- Liaison is increasing her familiarity and comfort in providing oral health knowledge to parents
- As a member of the dental team, liaison attends staff meetings and meets with dental schedulers to become aware of new policies and procedures
- Liaison gives clinic no-show policy verbally and in writing to caregiver (started in 2015)
- Implementation of bOHP
- [http://www.babyoralhealthprogram.org/](http://www.babyoralhealthprogram.org/)
Success!!!!!!!!!!!!!!!!!!!!

- The income brought into our dental clinics due to the program far exceeds the salary and benefits of the liaison (115-125 new patient appointments monthly)
- Most are new patients or those who have not seen a dentist in more than a year
- No parent has declined having the liaison provide oral health education during the child’s medical visit
- The show rate of liaison scheduled patients for the first quarter of 2015 is 88% which closely approximates our dental clinic show rate
CHOP, how it all works

- Outreach staffer (promotoras) given opportunity to talk with parents during the medical visit. The pediatrician will talk with the caregiver about diet, reinforce the need for brushing and the importance of making an appointment to be seen by the dentist.

- Children are given their own toothbrush and toothpaste, and encouraged to practice at home what they have just learned during their appointment.

- Children with no teeth (infants), are given a finger toothbrush for parents to help with oral care for the infant.

- Important to note children still seen even if they are uninsured.

- Fluoride is applied to all children with parental consent and billed for through medical.

- An appointment is given at either GFHS location, based on caregiver discretion.
CHOP (Child Health Outreach Program)

- Program began in August 2012
- 914 appointments made
- 114 per month
- 512 appointments kept
- 64 new patients per month
- Now over 1400 new patients appointments kept annually with 85%+ show rate
- PowerPoint, 10 slides/bOHP
- [http://www.babyoralhealthprogram.org/](http://www.babyoralhealthprogram.org/)
# CHOP (Child Health Outreach Program)

## Child Health Oral Program 2015

<table>
<thead>
<tr>
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<td>137</td>
<td>136</td>
<td>129</td>
<td>144</td>
<td>135</td>
<td>130</td>
<td>115</td>
<td>132</td>
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<td># Appointments Kept</td>
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<td>132</td>
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<td>115</td>
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<tr>
<td># Declines</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td># Insured appointment made</td>
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<td>141</td>
<td>128</td>
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<td>112</td>
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<td># Unsured appt made</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>7</td>
<td>0</td>
<td>3</td>
<td>4</td>
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<tr>
<td>Percentage of appt kept</td>
<td>94%</td>
<td>88%</td>
<td>89%</td>
<td>91%</td>
<td>83%</td>
<td>84%</td>
<td>83%</td>
<td>87%</td>
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Opportunities

- Team builder
- Practice builder
- Integrate it into the medical appointment
- Same day appointments or very soon
Closing the loop!

- Referral from Medical
- Dental remediation of situation
- Acknowledgment of treatment back to Medical
Challenges

- Keeping it Vibrant
- Coordination of Services (billing)
- Staff Turnover (pay scales & benefits)
- Staff buy in
- Parental buy in
Lessons Learned

- Collaboration is powerful
- Implementation phase
- Sustainability/Think outside of the box
The ACA (Affordable Care Act)

- Where will we be?
- In 2012 35% utilization age 25-45 versus 2002 45% utilization same age group
- Why?
  - Where will you be in 2016?
  - How do we get there?
### By the numbers (2002/2012/2025)

<table>
<thead>
<tr>
<th>Year</th>
<th>US population</th>
<th>25-45 y/o</th>
<th>% Seeking care</th>
<th># Seeking care</th>
<th># DDS</th>
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<td>2002</td>
<td>287,000,000</td>
<td>99,800,000</td>
<td>45%</td>
<td>44,910,000</td>
<td>173K</td>
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<tr>
<td>2012</td>
<td>314,000,000</td>
<td>81,146,000</td>
<td>35%</td>
<td>28,000,000</td>
<td>190K</td>
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<tr>
<td>2025</td>
<td>335,000,000</td>
<td>&lt;by %</td>
<td>&lt;by %</td>
<td>&lt;by %</td>
<td>201K</td>
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LOVE YOUR PATIENTS
AND TREAT THEM WITH LOVING CARE...

Questions?

FOR YOU WILL ONLY KNOW THEIR VALUE WHEN YOU SEE THEIR EMPTY CHAIR...
Contact me

- William Donigan DDS, MPH
- Dental Director
- Gaston Family Health Services
  (704) 862-5376
- wdonigan@gfhs.info
Moses Lake Community Health Center

Brett L. Pack, DMD
Dental Director
Moses Lake Community Health Centers

Clinic Locations:

- Moses Lake Community Health Center: 605 S Coolidge St, Moses Lake, WA 98837, USA
- Quincy Community Health Center: 1450 1st Ave SW, Quincy, WA 98848, USA
- Ephrata Community Dental Clinic: 131 Basin St SW, Ephrata, WA 98823, USA
MLCHC Metrics

MLCHC Monthly Encounter Average

Year | Average
--- | ---
2009-2010 | 19820
2010-2011 | 21697
2011-2012 | 22603
2012-2013 | 23600
2013-2014 | 25618
2014-2015 | 31449
Quincy Community Health Center
Ephrata Community Dental Clinic
Grand Opening
MLCHC Mission and Vision Statement

- **Mission:** Committed to provide high quality, compassionate, and comprehensive primary health services for the entire family, with a special focus on the underserved and migrant farm workers in our community.

- **Vision:** Continually transform our health care delivery system to improve the health of the communities we serve. We will relentlessly pursue perfection and be driven by continuous learning and growing. We will achieve superior clinical outcomes and the highest levels of satisfaction with a patient and family-centered focus.
MLCHC Metrics

Total Unduplicated Patients

- 2011: 11,732
- 2012: 12,429
- 2013: 13,058
- 2014: 12,801
- 2015: 13,742

Linear (Qtr 1)
MLCHC Metrics

Total Migrant Patients

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<tr>
<th>Year</th>
<th>Qtr 1</th>
<th>Qtr 2</th>
<th>Qtr 3</th>
<th>Qtr 4</th>
<th>Linear (Qtr 1)</th>
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<td>2011</td>
<td>4,872</td>
<td>6,628</td>
<td>8,576</td>
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<tr>
<td>2012</td>
<td>4,943</td>
<td>6,713</td>
<td>7,836</td>
<td>8,125</td>
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<tr>
<td>2013</td>
<td>5,137</td>
<td>6,981</td>
<td>8,911</td>
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<td>2014</td>
<td>5,198</td>
<td>6,969</td>
<td>8,214</td>
<td>8,214</td>
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<tr>
<td>2015</td>
<td>5,114</td>
<td>7,215</td>
<td>8,277</td>
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MLCHC Metrics

Dental Patients

- 2011: Qtr 1 = 3,396, Qtr 2 = 6,951, Qtr 3 = 7,800, Qtr 4 = 8,866
- 2012: Qtr 1 = 4,079, Qtr 2 = 6,356, Qtr 3 = 7,940, Qtr 4 = 9,254
- 2013: Qtr 1 = 3,969, Qtr 2 = 6,234, Qtr 3 = 7,212, Qtr 4 = 9,259
- 2014: Qtr 1 = 4,493, Qtr 2 = 7,212, Qtr 3 = 9,259, Qtr 4 = 11,015
- 2015: Qtr 1 = 5,268, Qtr 2 = 8,313, Qtr 3 = 10,373

- Linear (Qtr 1)
MLCHC Metrics

Migrant Dental Patients

<table>
<thead>
<tr>
<th>Year</th>
<th>Qtr 1</th>
<th>Qtr 2</th>
<th>Qtr 3</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
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<td>3,883</td>
<td></td>
<td></td>
<td>3,883</td>
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<tr>
<td>2012</td>
<td></td>
<td>4,125</td>
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<td>4,125</td>
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<tr>
<td>2013</td>
<td></td>
<td></td>
<td>4,242</td>
<td>4,242</td>
</tr>
<tr>
<td>2014</td>
<td></td>
<td></td>
<td></td>
<td>4,658</td>
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<tr>
<td>2015</td>
<td>3249</td>
<td>2064</td>
<td></td>
<td>3941</td>
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Importance of Access & Education
Importance of Access & Education
Integration Model Development

When I started at MLCHC:

- Dental providers held differing opinions about treating patients during pregnancy
- No standard for when to establish dental care for young children
- Numerous young children being referred to OR with dental caries
- Dental and Medical Departments working completely independently
As a new Dental Director...

How can we integrate Dental and Medical?

How to prevent child OR visits?

How to direct a Dental Department?

How best to treat pregnant patients?
How can we integrate Dental and Medical?

How to prevent child OR visits?

How to direct a Dental Department?

How best to treat pregnant patients?
Dental Learning Network Meeting Topics:

- *Medical/Dental Integration
- *Quality Measures and Dental Metrics:
  - Pregnant Patient Treatment
  - Early Childhood Treatment
- Provider Incentive Programs
- Meaningful Peer Review
- Green Dental Clinics
Highlight of topics Implemented at MLCHC:

- Medical/Dental Integration
- Quality Measures and Dental Metrics:
  - Pregnant Patient Treatment
  - Early Childhood Treatment
Medical patients under 24 months with a dental exam

Medical patients under 24 months
MLCHC Initial Early Childhood Measure

1. ~17% of MLCHC/QCHC Medical patients under 24 months had a dental exam

2. Began working with WIC and MSS departments to establish dental care in targeted patient population

3. Increased measure to ~25%

Progress, but not satisfactory progress.
Next Steps

- Reached out to medical director with collaboration idea
- Presented collaboration idea to the executive team
- Created a project charter and organized an improvement team
- Developed, tested, and refined workflows
Pediatric Oral Health Initiative Improvement Team Charter

PROJECT SPONSORS:
Sheila Chilson, CEO, Executive Sponsor
Brett Pach, Dental Director, Project Sponsor

IMPROVEMENT TEAM MEMBERS:
Dr. Tahlia Moses — leader and clinical champion
Dr. Larry Verhage — clinical champion
Shandie Owens — process expert
Lisa Moreno — process expert
Elia Hunt — billing expert
Renee Torres — nursing support/process expert
Eric C. — Dental Support and data collection
Monica Zimmer — QI Support data collection

Background (project origin)
1. Washington Association of Community and Migrant Health Centers Dental Directors decided in 2010 to measure and report the percent of health center pregnant women and babies that have a dental exam.
2. Formal partnership with WIC and NNS in 2010 provided some improvement in the measures.
3. Strategic imperative to improve the health of the population we serve and to grow our dental program.
4. 15-minute office visit does not allow primary care providers sufficient time to address acute, chronic, and preventive care while building meaningful relationships with their patients.
5. Research shows 4.7—7.4 hours per working day to provide all recommended preventive care to a panel of 2,300 patients, plus 10.4 hours to manage all chronic conditions adequately (MLCHC and QCHC providers average 1200—1500).
6. MLCHC and QCHC providers report not having enough time to spend with their patients.
7. Baseline performance:
   a. Children — 17%
   b. Pregnant women — 44%

Purpose of the project
A. Develop and implement processes by which all children age 6 months to 2 years will have a coordinated medical and dental exam and have documentation of the dental exam in the medical chart.
B. Develop and implement processes by which all pregnant women will have a dental exam during their pregnancy and have documentation of the dental exam in the medical and dental chart.

Aims (measures of success)
By December 2011 the electronic medical record will show that 50% of children will have a dental exam by the age of 2 years (based on the benchmark CHC) and that 60% of pregnant women will have a dental exam during their pregnancy.

Resources:
Executive Sponsor — Sheila Chilson, CEO
Brett Pach, Dental Director, Project Sponsor
Process Improvement/Data Collection/Analysis support — Kathleen Thompson, RN, QI Director
Resource allocation — Shirley Metke, Deputy Director, Terri Wint, Quincy Nursing Supervisor and Charlisa Whitaker, Moses Lake Nursing Supervisor
Database analyst — Jared Ebert
Temporary FTEs for data collection as needed and approved by Human Resources

Constraints:
No additional permanent FTEs

Objectives and timelines:
1. Gain accurate understanding of the metrics (criteria for numerator, criteria for denominator, etc.)
2. Understand the current medical clinical processes for assessing, referring, and documenting in the EMR dental exams in children and pregnant women; understand the current dental clinical process for scheduling dental exams.
3. Understand the causes of variation in how and when these tasks (medical) are accomplished (template use; procedures, etc.)
4. Determine what action needs to be taken (change ideas) to standardize the processes for assessing, referring, and documenting dental exams (Determined by the causes of variation).
5. Test change ideas using the Model for Improvement and rapid cycle tests of change by March 2011.
6. Educate staff about tests of change and implementation.
7. Spread successful changes clinic-wide by June 2011.
8. Develop, test, and implement an accountability tool for use by supervisors by September 2011.
9. Measure success and sustain the gain.

Roles of the Team:
1. Collect and use data to clarify knowledge and inform decisions.
2. Maintain a written record of work sufficient to create a project storyboard.
3. Test ideas on a small scale using the Model for Improvement.
4. Keep the sponsor informed of progress.
5. Report progress and problems that do or could adversely impact team efforts to the Quality Improvement Committee and project sponsor.

Roles of the Sponsor:
1. Works with the team to ensure charter is understood and the team accepts ownership of the charter.
2. Help support team when needed or requested.
MA explains importance and offers Dental visit

Dentist and DA go to treatment room in Medical and complete exam and parent education

Dental prepares paperwork & materials

Dentist and DA at the ready

MA re-calls Dental when Medical provider finishes

Needed immunizations are administered by nurse

End Process

MA calls Dental on dedicated line

Dentist and DA go to treatment room in Medical and complete exam and parent education
PDSA Rapid Test Cycles

How we make improvements at MLCHC

Set Aims
Improvement requires setting aims. The aim should be time-specific and measurable; it should also define the specific population of patients that will be affected.

Establish Measures
Teams use quantitative measures to determine if a specific change actually leads to an improvement.

Select Changes
All improvement requires making changes, but not all changes result in improvement. Organizations therefore must identify the changes that are most likely to result in improvement.

Test Changes
The Plan-Do-Study-Act (PDSA) cycle is shorthand for testing a change in the real work setting — by planning it, trying it, observing the results, and acting on what is learned. This is the scientific method used for action-oriented learning.
Worksheet for a Rapid Test Cycle

Aim:
Measure:

Planning a test of change

1. What is our test of change?
2. How shall we measure the effectiveness of the planned change (What data needs to be collected)?
3. How will the data be collected? Who will collect the data?
4. When/where will the test occur?
5. Who will do what during the test?
6. Who else will be affected by this pilot test (Are the right people involved? Who is involved in the current process? Who is the customer of the process? Who are the suppliers of the process?)?
7. How will we communicate to others about the test so there will be no misinterpretations?
8. How will we monitor whether things are being done as planned?
9. What do we predict will happen?
10. What problems might occur during the pilot test?
11. And what can we do to prevent them?

Doing the Test (Fill this out after the test)

1. What happened during the test?
2. Was the testing plan followed?
3. Were needed modifications discussed with the appropriate people?
4. Was data collection timely?
5. Is the data valid?
6. What were the problems carrying out the test?

Checking the results of the test

1. What were the results of your measurement? What does the data tell us?
2. What did we learn?
3. How does this compare to our predictions?

Acting on the test

1. Are we ready to implement the change?
2. What do we need to do before the next test cycle?
3. What will the next cycle be?
EMR Template Sample

MADISON TEST
ID: TEST 52  Age: 5 years 5 months  DOB: 01/05/2008

Dental History

Dental History:

Anesthesia

08/06/13: 02:04 PM
Hospitalizations: none
PR: CESAREAN SECTION

Major Problem List:
NO ACTIVE MAJOR PROBLEMS

Current Medications:
Rx: EUCERIN 454 GMS APP AA twice daily pm, 454, Ref: 6
Rx: MEDIPLAST 40% - 9 days, 3 patches, Ref: 4
Rx: ORTHO EVRA - 9 patches, Ref: 4
Rx: ABILITY 2MG 1 TAB once daily - 30, Ref: 11
Rx: IBUPROFEN 100MG/5 5ML four times daily 3 days, 120MLS, Ref: 0

Allergies:
IODINE, NKDA, ROBITUSSIN

ASSESSMENT
Extra Oral Exam Completed
Intra Oral Exam Completed
Decay: CHARTED x NOT FOUND
CE: Caries Risk: HIGH x MEDIUM x LOW
H: Dental Exam X

PLAN
Oral Hygiene Counseling given.
Diet Counseling given.
Toothbrush Prophy: DEL x COMPLETED
Fluoride Varnish: DEL x COMPLETED
Referral Needed: YES DENTAL x NO
Outcomes (Metrics)

Total % of Medical Patients <2 with a Dental Exam
Initiative Benefits

1) Early oral health education for parents
2) Early detection of caries for high risk kids
3) Early establishment of a dental home
4) Early exposure to dental provider
5) Fluoride application for caries prevention
6) Convenient multi-purpose patient visits
7) Increased Dental patients and encounters
8) Ability to intervene in oral health of parents
High Risk 6 Year Old
Initial Visit
3 years later
Challenges

- Obtaining support from all medical teams
- Communication between departments
- Differing treatment hours between departments
- Busy schedules/timeliness
- Provider documentation
- Treatment timing
Implementation Recommendations

1) Get buy-in from leadership
2) Establish goals of initiative
3) Make program financially feasible
4) Establish a committed team
5) Plan for phased implementation
6) Educate support staff about program value
7) Track and report progress regularly
Where to go from here?

Pre-program base data was collected

Continuing to measure caries prevalence

**GOAL:**
Measurable success of our Pediatric Oral Health Initiative

Diabetic Oral Health Initiative . . .
Child Immunization Initiative . . .
Back to the Beginning
Access & Education
Possibilities
Questions?

- Brett L. Pack, DMD
- Dental Director
- (509) 766-8977 ext 3403
- bpack@mlchc.org

[Family photo]
Thank you!

Questions?