Wisconsin Medical Dental Integration

Advancing a Healthier Wisconsin at the Medical College of Wisconsin

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Your Collaborative Team

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Topic

Access to primary preventive dental services for patients at well visits will increase through integration of a dental hygienist in the primary care setting.

- Describe the gap between current and possible performance
  - According to the Centers for Medicaid and Medicare Services, in 2016 only 1 in 5 Wisconsin Medicaid eligible children ages 0-5 years received preventive dental services
  - In Wisconsin there are approximately 100,000 children enrolled in Medicaid who visit their physician before age 5 who do not receive dental care. (info-graphic next slide)
  - We know that by the time children in head start are 5 years old, half of them have developed this preventive disease and 1 in 3 have developed it by age 3 so we must reach kids earlier and more often. (info-graphic on next slide)
  - Children visit a physician up to 8 times between ages 6 months and 5 years giving ample opportunity to prevent dental disease early.
DECAY BY THE NUMBERS

1 in 5
One in five Head Start children, ages 3 to 5, have early childhood tooth decay.

1 in 4
One in four Head Start children have untreated tooth decay and need treatment.

1 in 2
By age five, one in two Head Start children have had tooth decay.

Each year, nearly 100,000 Wisconsin Medicaid children under age 5 visit a physician but not a dentist.
Is there evidence base or best practice describing ideas to close the gap? Describe this.

- Colorado Medical Dental Integration pioneered this work with a feasibility study that concluded: Co-locating RDHs into medical practices is feasible and an innovative model to provide preventive oral health services to disadvantaged children.
Why is this important to do now? (For patients, your organization, the potential teams)

- Wisconsin Act 20 expanded the settings where a dental hygienist can practice without the authorization or supervision of a Dentist, including primary care clinics.

What is the business case for organizations that participate in this Collaborative?

- Dental hygienists are credentialed to bill Wisconsin Medicaid and some third party payers and can bill for dental hygiene services provided. This model is financially sustainable through billable services provided by the hygienist.

Expected start and end date of your collaborative

- Wave I: September 2019
- Wave II: July 2020
Collaborative Driver Diagram

- Do your best to describe your early theory of what changes the teams will need to test, adapt, and implement in order to reach the Collaborative aim.
- Use the Driver Diagram Template that follows (template, definitions, and examples included)
Driver Diagram Definitions:

- A Driver Diagram is an improvement tool used to organize theories and ideas in an improvement effort. It displays visually, our theory about why things are the way they are and/or potential areas we can leverage to change the status quo. The driver diagram is often used to scope or size a project and to clarify the plan for reaching the aim.

- **Primary Drivers**: major processes, operating rules, or structures that will contribute to moving towards the aim

- **Secondary Drivers**: elements or portions of the primary drivers. The secondary drivers are system components necessary in order to impact primary drivers, and thus reach project aim.

- **Specific changes/Change concepts**: Specific changes are concrete actionable ideas to test. Change concepts are broad concepts (e.g. move steps in the process closer together) that are not yet specific enough to be actionable but which will be used to generate specific ideas for change.
  - Note: measures can be indicated on the DD as it becomes more mature.
## Improve Oral Health for Children in Wisconsin

### Primary Drivers
- **Engaged System and Clinic Leadership**
- **Engaged Medical Providers and Staff**
- **Team based care principals**
- **Quality Improvement Activities**
- **Reliable delivery of integrated evidence based dental hygiene care**
- **Engaged patients**
- **Financial Sustainability**

### Secondary Drivers
- **AIM**
  - Increase access to primary preventive dental services for patients at well visits through integration of a dental hygienist in the primary care setting.
  - By December 2021, increase the percent of patients that receive preventive oral health services at a well visit.

### Specific Ideas to Test or Change Concepts
- **Fjdfksj**
- **Fksjdflk**
- **skdfj**

## Quality Improvement Activities
- Workflows
- Electronic Health Record Integration
- Referral Sources
- Appropriate hygienist
- Quality care

## Team based care principals
- Team members take on roles appropriate to the full scope of their license or training

## Quality Improvement Activities
- Ongoing data collection
- Participation in learning collaborative

## Reliable delivery of integrated evidence based dental hygiene care
- Workflows
- Electronic Health Record Integration
- Referral Sources
- Appropriate hygienist
- Quality care

## Engaged System and Clinic Leadership
- Explain the ‘why’ to staff and providers
- Actively participate in strategy development
- Establish teams to implement work
- Give staff time needed to participate
- Update job descriptions/ hire staff

## Engaged Medical Providers and Staff
- Participation on QI teams in the learning collaborative

## Financial Sustainability
- Credentialing of hygienist
- Billing and scheduling support staff

## Secondary Drivers
- Support for integration from; scheduling, insurance verification,
- Screening questions
- Recall patient reminder phone calls

## Specific Ideas to Test or Change Concepts
- **Fjdfksj**
- **Fksjdflk**
- **skdfj**

## Clinic surveys to understand patient perspectives
- Workflow that maximizes patient seen.
- Billing
AIM
Increase access to primary preventive dental services for patients at well visits through integration of a dental hygienist in the primary care setting.

By December 2021, increase the percent of patients that receive preventive oral health services at a well visit.
AIM
Reduce CAUTI by 30% compared to the 2010 baseline by August 31, 2013

Primary Drivers
- Correct indications
- Daily reviews
- Effective infection control
- Prompt removal
- Engaged leaders

Secondary Drivers
- Document decisions
- Identify failures
- Hardwired process
- Teamwork
- Communication
- Hand hygiene
- Sterile technique
- Collection bag positioning
- Sample collection
- Forcing functions
- Reduce reactheterization
- Failures “front of mind”
- Attention to improvements

Specific Ideas to Test or Change Concepts
- Standardize order forms
- Daily huddles
- Script rounds/daily huddles
- Involve pts/caregivers
- Visible reminders for aseptic technique
- Assemble insertion kits
- Educate ancillary staff
- Make post-op removal the default option
- Develop contingency plans for retention
- Report CAUTIs monthly
- Present patient stories
- Leadership reality rounding
- Make results visible on units
EXAMPLE
IMMUNIZATION RATES - DRIVER DIAGRAM

Primary Drivers
- Level of immunization awareness
- Availability & accessibility of immunization services
- Robustness of information systems
- Design and coordination of care
- Community Partnerships

Secondary Drivers
- Media coverage
- Clinic location/hours
- Interfaces w/ other systems
- Care planning & coord
- Communication

Change Ideas to Test
- Hand out information sheets that highlight childhood immunizations to all patients coming in for any type of visit - #27
- Distribute immunizations info as a part of EH community contact - #27
- Provide some kind of "incentive" to parents to immunize their children (prizes, dinner for two, etc.) - #36
- Use media (Internet, newspaper, TV, radio) to disseminate information about immunizations - #27
- Set up an immunizations information phone line with a direct dial number
- Review materials for literacy level and cultural appropriateness -
- Increase, or make more convenient, the hours during which vaccination services are provided
- Coordinate vaccination services with WIC visits
- Deliver vaccinations in settings previously not used
- Reduce administrative barriers to vaccination (e.g., drop-in clinics or express lane vaccination services)
- Reduce distance patients must travel to receive vaccination services
- Do mail and/or telephone reminders
- Write standing orders for immunizations
- Use EPIC Immunizations Tracking Tools (in conjunction with standing orders and historical immunizations)
- Modify the EHR "Preference List" browser to include a sub-section specifically for ordering childhood immunizations
- Evaluate/beta test immunization registry interface between OCHIN and ALERT
- Use reporting tools to fill workflow gaps (e.g., if the EPIC workflow doesn't have useful tools for identifying late starts, write a report to fill the gap)
- Scrub chart prior to patient arrival and identify immunizations opportunities
- Use panels/huddles for communication re: immunizations
- Partner with other internal providers for referrals to Imms (WIC, Cacoon, MH, etc.)
- Develop and document protocols for standing orders
Your Teams and Faculty

- Who are the potential teams you would invite to join (for example, from mental health clinics, primary care clinics, etc.)?
  - Health Systems: Children’s Hospital of Wisconsin, Advocate Aurora, Gunderson Health System, Ascension, UW Health/AFCH, HSHS/St. Vincent's Children’s Hospital
  - FQHC: NorthLakes CHC and 16 Street CHC

- Who might your faculty be?
  - Wisconsin Chapter -AAP, WI Dental Hygiene Association, WDA, WPHCA, WAFP, CMS? (someone for billing), Dental Records (EHR) representative, Consultant from CO (Patty Braun, RDH?), Quality Control (equipment, infection, best practices/EBD), Families
Spread Planning

- Do you expect to spread the work of your Collaborative teams to the rest of your organization? yes
- What is the timetable for this?
  - 18-24 months post learning collaborative
  - Development of integrated care toolkit
- What (or who) are the appropriate "units" for adopting changes from your change package?
  - Physician care team (MA, RN)
  - Clinics within health system
  - System leadership/ Administration (who works across clinics)

Who will make the decision to begin using the new ideas in their practice?
- Health system leadership (executive team) ready to lead spread within their organization.
Spread Planning

- How many total units do you intend to spread to? (This could be all eligible units or some defined subset of them.)
  - Total 13-18 clinics will have implemented WI MDI at end of 2021
- How many units will you select to attend your initial Collaborative? What percentage of the total units is this?
  - 3-5 clinics per Wave of Learning Collaborative
  - 45-55% of total units will participate in LC
- How will you select these initial units?
  - Wave I was recruited during grant proposal writing
  - Colorado MDI Model Readiness Assessment
    - Red/yellow/green rating system of readiness
    - Clinics who are early adopters
**AIM:**
Increase access to primary preventive dental services for patients at well visits through integration of a dental hygienist in the primary care setting.

By December 2021, increase the percent of patients that receive preventive oral health services at a well visit.

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<thead>
<tr>
<th>Primary Drivers</th>
<th>Secondary Drivers</th>
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| Engaged System and Clinic Leadership | • Active participation in strategy development  
• Establish teams to implement work  
• Give staff time to participate  
• Update job descriptions/ hire staff  
• Establish updated workflow/ standard work  
• Spread integrated models within clinics and across system  
• Provide training | • Explain the ‘why’ to staff and providers  
• Agree upon, document and communicate goals of the initiative  
• Establish new roles and tasks for staff  
• Bi-weekly/monthly clinic meetings  
• Dedicate resources toward educating staff and improving systems  
• Spread ideas through professional orgs. |
| Engaged Medical Providers and Staff | • Participation on QI teams and in the learning collaborative  
• Staff have time to learn new information | • Bi-weekly/month clinic meetings  
• Cultivate oral health champions |
| Team based care principles | • Team members take on roles appropriate to the full scope of their license or training  
• Participation in multidisciplinary work teams  
• Hygienist office near medical team offices | • Support for integration from scheduling, insurance verification, billing, coordinating patient flow through clinic, closing referrals  
• Daily huddles/ provider meetings |
| Reliable delivery of integrated evidence based dental hygiene care | • Develop ideal workflows  
• Electronic Health Record integration  
• Appropriate hygienist  
• Quality care  
• Deliver evidence based dental hygiene care  
• Referral sources  
• Equipment and supplies available | • Self-management goal setting  
• Risk assessment  
• Standardize process roles and responsibilities  
• Assure practice has incorporated oral health elements into EHR  
• Referral networks for restorative care |
| QI Activities | • QI team includes representation from all members of care team  
• Team participation in learning collaborative  
• Ongoing data collection  
• Standardize tested and proven processes | • Test components of the plan using PDSA cycles  
• Track and review data for attainment of goals |
| Engaged patients | • Quality care  
• Barriers to system  
• Information sources | • Clinic surveys to understand patient perspectives  
• Representation on project teams |
| Financial Sustainability | • Credentialing of hygienist  
• Support staff for billing and scheduling  
• Reimbursement by different dental insurers | • Workflow that maximizes # patients seen  
• EHR supports billing  
• Partner with different dental insurers to credential hygienists |