

ORAL HEALTH, INTEGRATION, AND INTERPROFESSIONAL PRACTICE

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*The DentaQuest Partnership for Oral
Health Advancement*

DentaQuest 

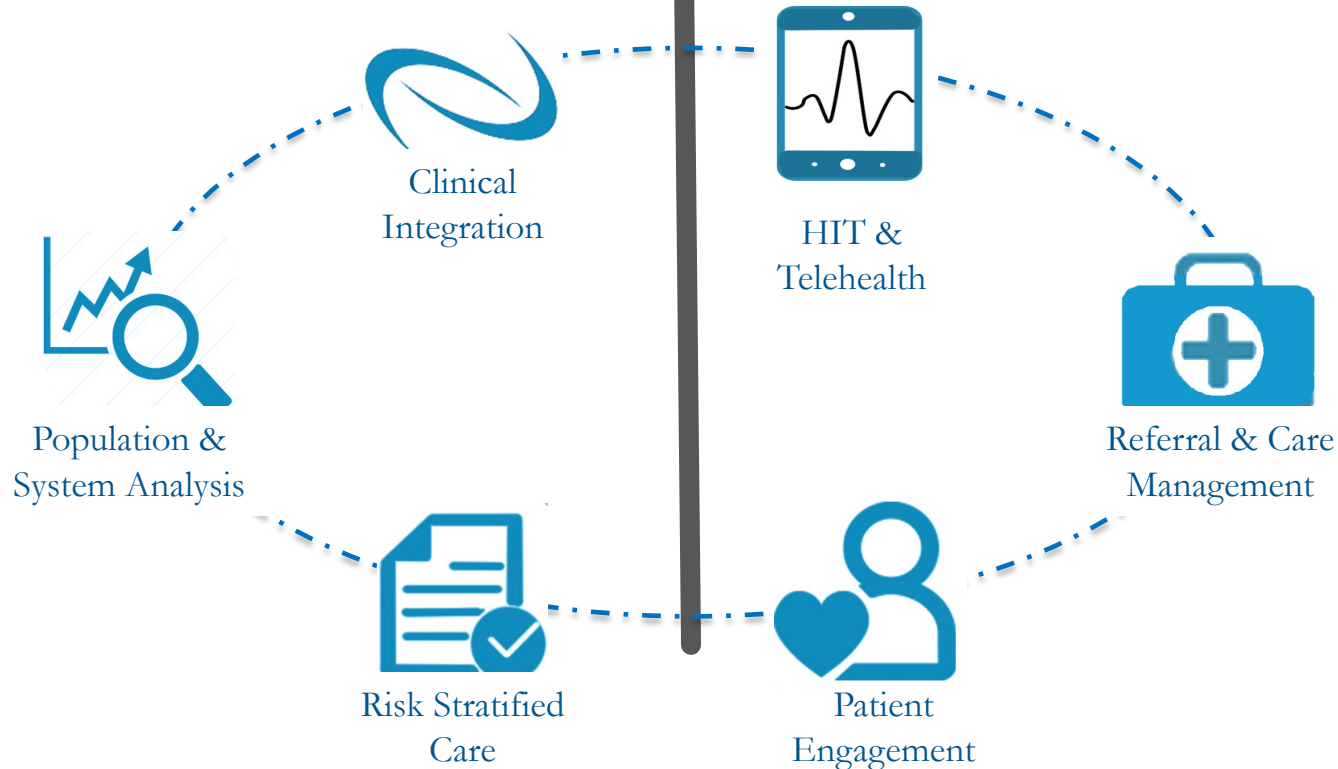
INTERPROFESSIONAL PRACTICE

INTEGRATED CARE

- An interdisciplinary approach to health care that incorporates specific procedures of other disciplines into daily practice.

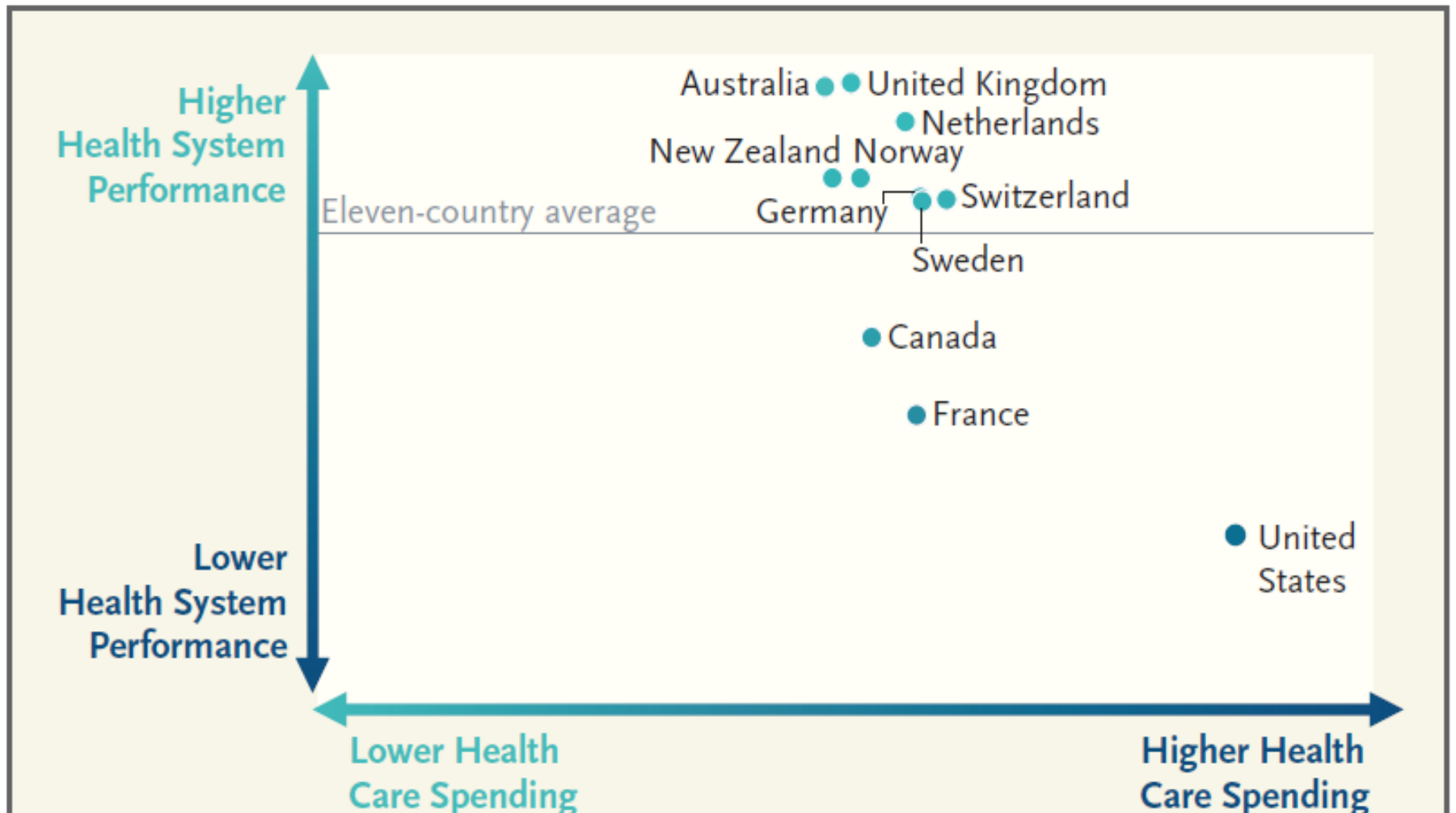
COORDINATED CARE

- Using a continual care pathway approach that allows the patient easy navigation and understanding their needs within the health care system.



**“Healthcare is an exercise in interdependency-
not personal heroism... a need for greater
teamwork and to ask, what am I part of?”**

- DON BERWICK
President Emeritus and Senior Fellow, IHI



-Dr. Don Berwick, IHI [NOSORH Annual Session 2016]

| From | To |
|------------------------------|-----------------------|
| Fragmented Payment | Unified Budget |
| Hospital as the Center | Home as the Hub |
| Excellent Soloists | High Performing Teams |
| Moving People | Moving Knowledge |
| What is the Matter with You? | What Matters to You? |

ORAL HEALTH AND A HEALTHY LIFE

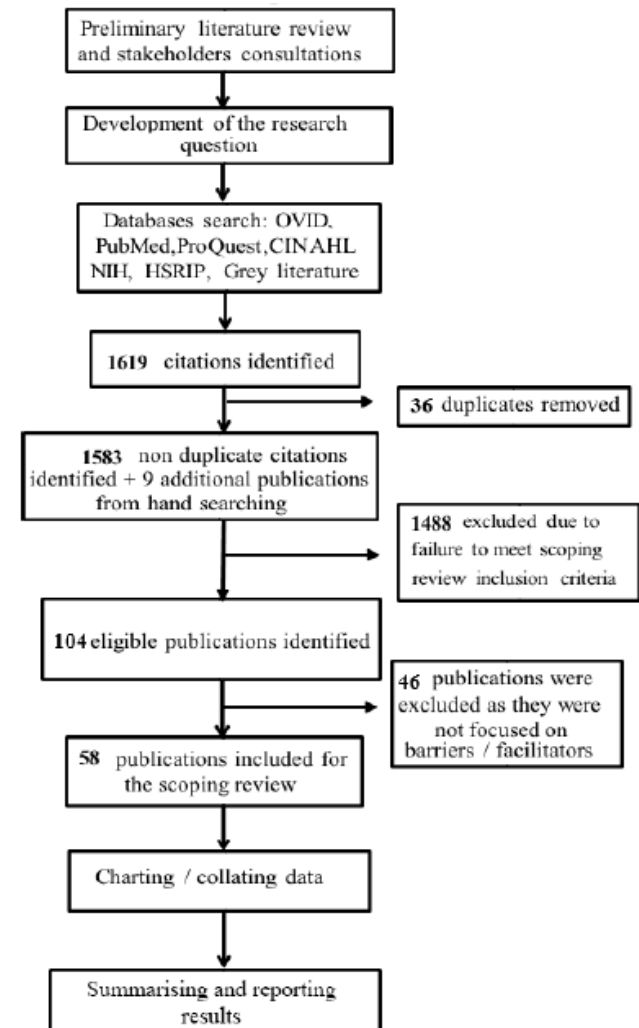


“Often when you think you’re at the end of something, you’re at the beginning of something else.”

- FRED ROGERS

**AMERICAN TELEVISION PERSONALITY, MUSICIAN, PUPPETEER,
WRITER, PRODUCER, AND PRESBYTERIAN MINISTER**

“What are the barriers and the facilitators of integration of oral health into primary care in various healthcare settings across the world?”



BARRIERS

Lack of political leadership and healthcare policies

- Poor understanding
- Separate medical and dental insurance
- Separate specific policy interest

Patient's oral healthcare needs

- Patient's decision to accept or refuse care based on their need perception rather than the assessment of healthcare providers.

Lack of effective interprofessional education

Lack of continuity of care / silo practice structures

Implementation challenges

- Deficient administrative infrastructure
- HIT

Overcoming the Medical Hidden Curriculum

Medical and dental professionals are educated and trained separately --- then they practice how they are trained - separately.

The “hidden curriculum” about oral health in medical training:

- Oral health means teeth
- Teeth are the domain of dentistry
- I know very little about teeth
- Dentists know little about the rest of the body
- Why are you (dentist) asking me about something related to teeth?
- Why is this patient coming to ME about their mouth?
- Why can't I get a dentist to see this patient?

Overcoming the Dental Hidden Curriculum

Medical and dental professionals are educated and trained separately and then they practice how they are trained - separately.

The “hidden curriculum” about oral health in dental training:

- Oral health means dental care
- Teeth are the domain of dentists
- I do not see a need to know about treating systemic diseases
- Physicians consider us as an inferior “doctor”
- Surgical intervention gets me to graduation & pays the bills after
- Why is this patient coming to ME about their health?
- Team, what team? I’m holding my own suction over here.

FACILITATORS

Financial and technical support from governments, stakeholders and non-profit organizations.

Interprofessional education (non-dental providers)

Collaborative practices

- Perceived responsibility and role identification
- Case management
- Incremental approach

Local strategic leaders (champions)

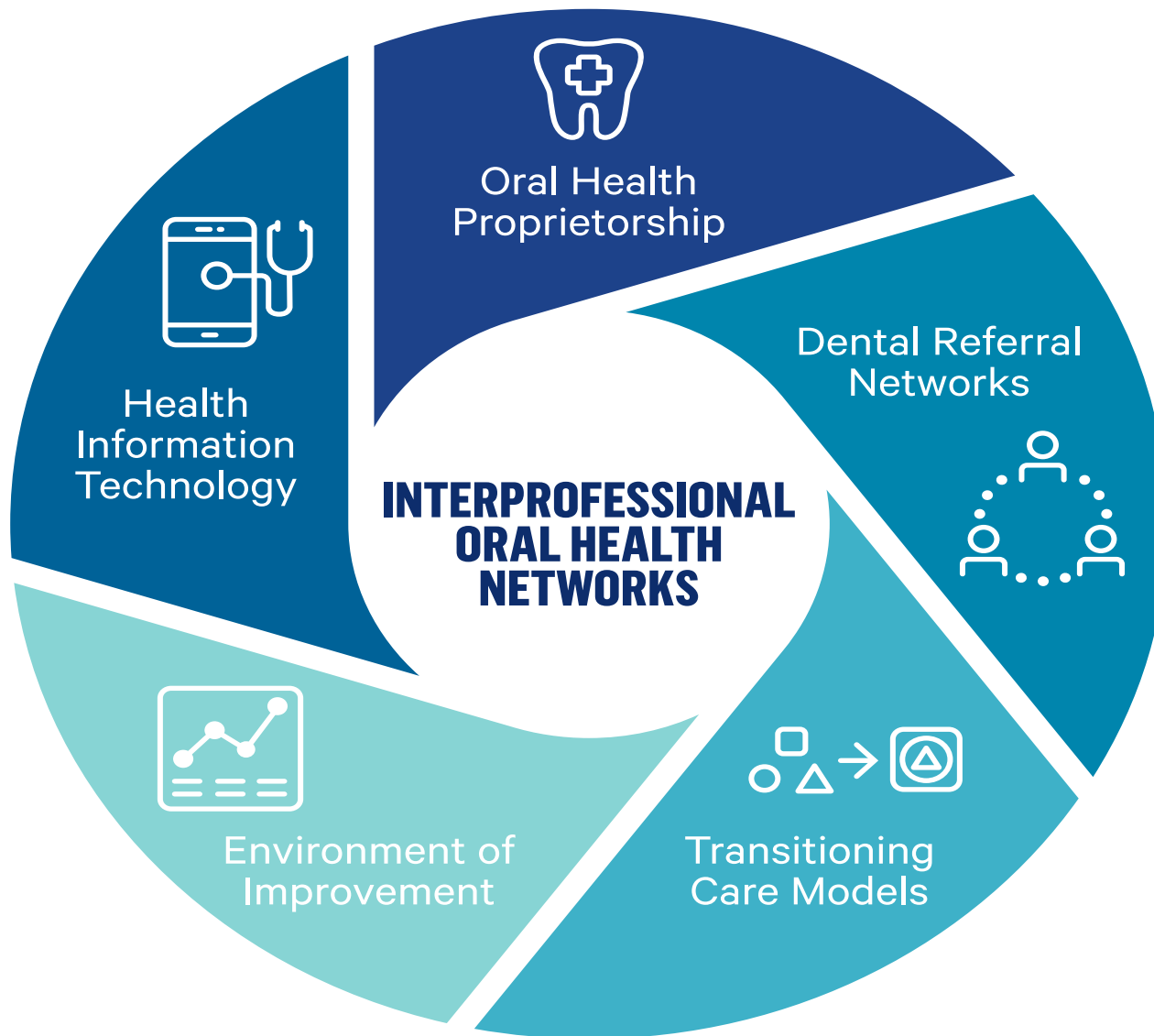
Proximity / Convenience

- Increasing consumerism

“The best creative solutions don’t come from finding good answers to the questions that are presented... They come from inventing new questions.”

**- SETH GODIN
AMERICAN AUTHOR AND FORMER DOTCOM EXECUTIVE**

CREATING AN INTERPROFESSIONAL ORAL HEALTH NETWORK



CORRELATING INTEGRATION LEVERS

A total of 673 people participated in the study.

- Resulting sample sizes were 559 and 560

Demographics

- **Dental: 60%; Medical: 40%;**
- **Rural: 43%; Suburban: 32%; Urban: 25%**
- **Clinical care: 30%; Leadership: 13%;
Support staff, FLHWs: 57%**

Motivated population

The last 9 questions were dichotomized to Agree (Agree, Strongly Agree) and Disagree (Disagree, Strongly Disagree, Neutral)

- **Unknown and N/A answers were discarded**



The Dependability of Coordination

Business Model

| Indicator | | Odds Ratio | Confidence Interval | P Value |
|------------------------|--|------------|---------------------|---------|
| Organization variables | Organization type (<i>RHC as referent group</i>) | | | |
| | ACO | 5.72 | 1.66-19.74 | < .001 |
| | FQHC | 3.04 | 1.13-8.17 | |
| | Private Practice | 2.07 | 0.68-6.35 | |

Satisfaction and ease of Electronic Health Record use

| Indicator | | Odds Ratio | Confidence Interval | P Value |
|--------------------|--|------------|---------------------|---------|
| Referral variables | Ease of EHR for making dental referral (<i>Agree/strongly agree as referent group</i>) | | | |
| | Disagree/strongly disagree | 6.67 | 3.61-12.17 | < .0001 |

No-Show Rate (15% or more)

| | | | | |
|---|----------------------------|------|-----------|-----|
| Issue with no shows (<i>Agree/strongly agree as referent group</i>) | | | | |
| | Disagree/strongly disagree | 1.99 | 1.29-3.10 | .01 |

The Dependability of Integration (Medical)

Health Information Technology / Electronic Health Record

- Respondents who reported EHR ease were **2.4 times** more likely to administer fluoride varnish and conduct risk assessments
 - Embedded risk assessment
 - Ease of reporting and monitoring

| | | | |
|---|-------------|-------------|---------|
| Referral system variable: Type of agreement with the following statement: “Our electronic health record makes medical-to-dental referrals easy” | | | <0.0001 |
| Agree | 19 (14.5%) | 112 (85.5%) | |
| Disagree | 156 (36.4%) | 272 (63.6%) | |

The Dependability of Integration (Medical)

Medical to dental referral capability

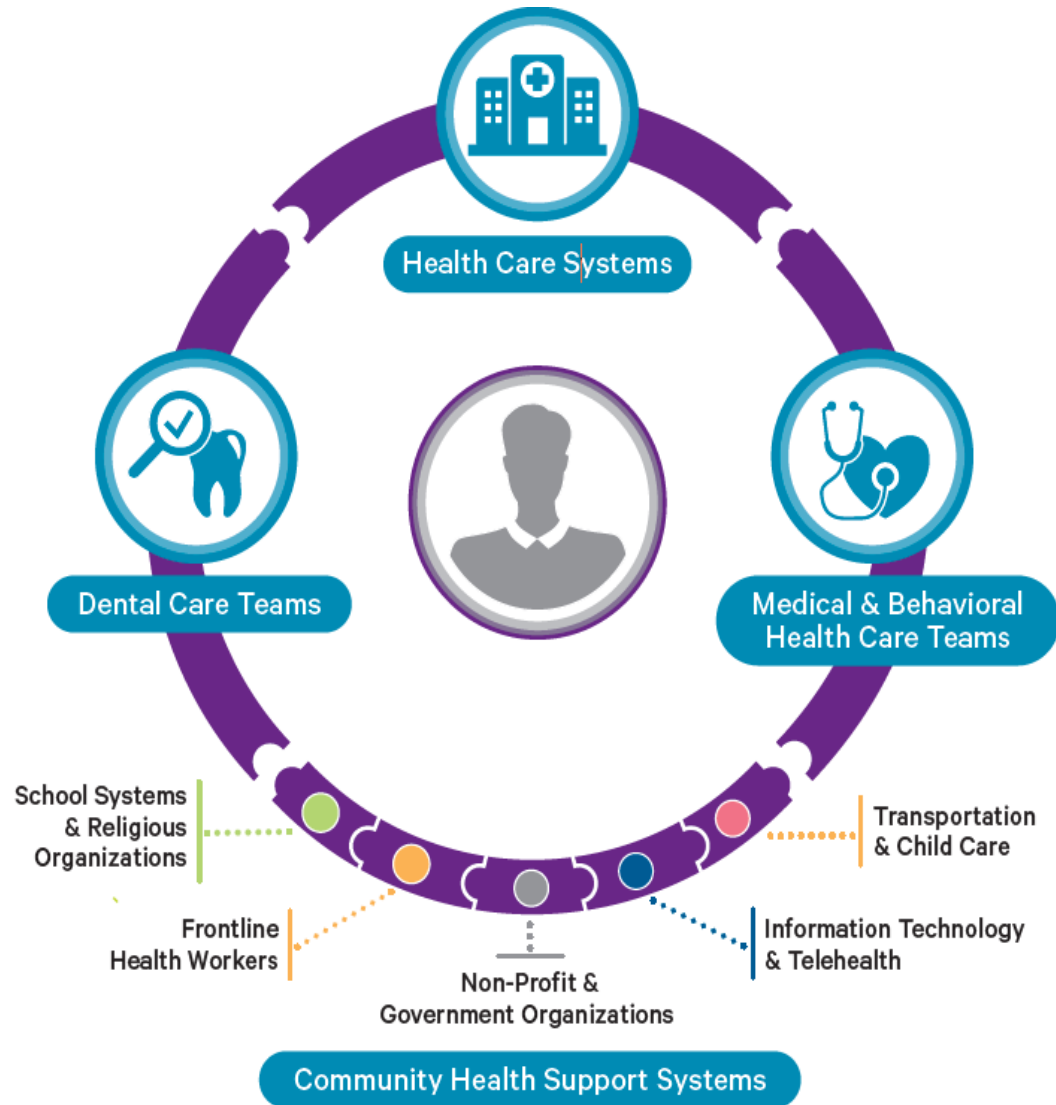
- Respondents signifying a dependable medical to dental referral system were **4.5 times** more likely to administer FL/RA/SM

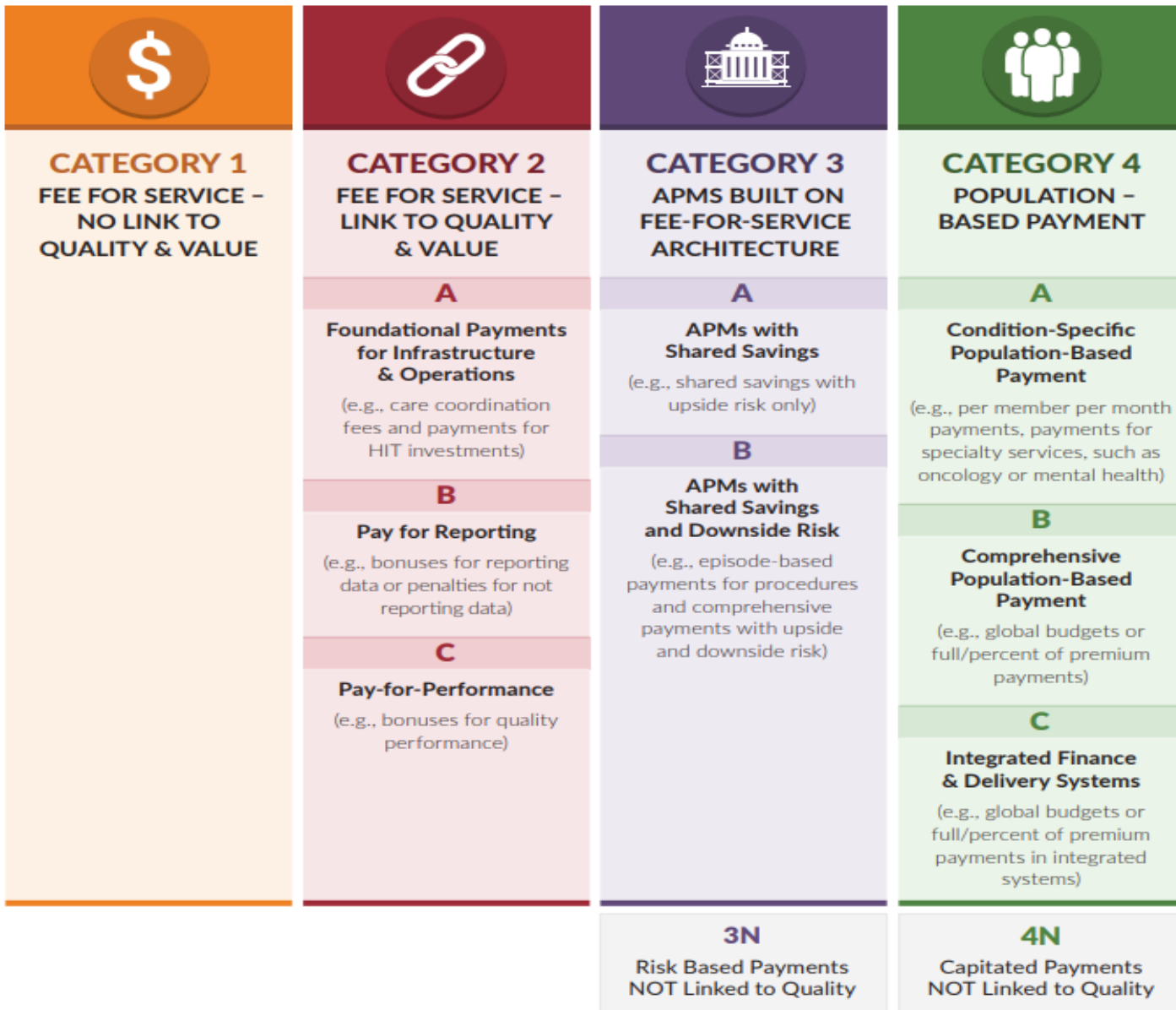
| | | | |
|----------------------------|--|------|-----------|
| Referral system attributes | Has a successful network for medical-to-dental referrals (disagree/strongly disagree as referent group) | | <0.0001 |
| | Agree/strongly agree | 4.54 | 2.79–7.39 |
| | Referral directionality (one directional, medical to dental only as referent group) | | 0.7826 |
| | No referral system | 0.65 | 0.18–2.39 |
| | Bidirectional | 0.91 | 0.50–1.63 |
| | Referral method (electronic health record as referent group) | | 0.0009 |
| | Warm handoff | 0.22 | 0.10–0.51 |
| | All other methods | 0.26 | 0.12–0.54 |
| | No method | 0.54 | 0.13–2.29 |
| | Ease of electronic health record use for making dental referral (disagree/strongly disagree as referent group) | | 0.0054 |
| | Agree/strongly agree | 2.37 | 1.29–4.37 |

“Progress is impossible without change, and those who cannot change their minds cannot change anything.”

**- GEORGE BERNARD SHAW
IRISH PLAYWRIGHT, CRITIC, POLEMICIST AND
POLITICAL ACTIVIST**

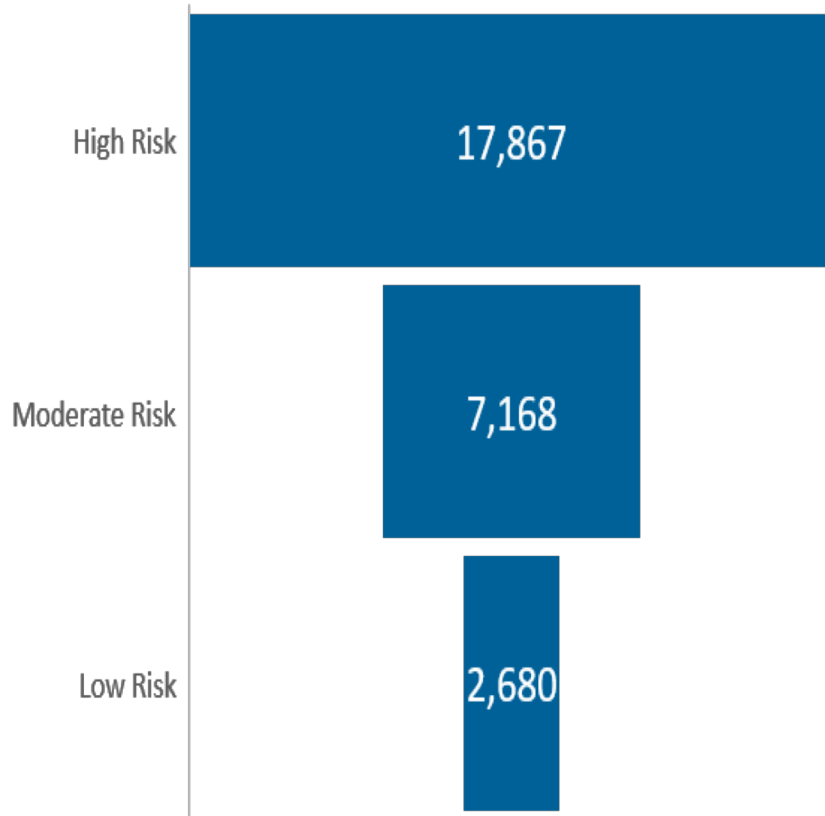
A PERSON-CENTERED PATHWAY





RISK STRATIFIED ANNUAL SURGICAL DENTAL INTERVENTION COSTS

Number of Patients with Surgical Dental Interventions, by Risk



Box and Whisker Plot of Risk Stratified Annual Surgical Dental Intervention Costs

