Change Packages for Improving Oral Health: 
A Hands-On Session to Improve Quality of Care

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Session Overview

- Improvement across Systems of Care (10 minutes)
- Identifying Drivers and Change Ideas (10 minutes)
- Table Discussions (40 minutes)
- Report Outs/Group Discussion (25 minutes)
- Wrap-Up (5 minutes)
Quality Health Care

“the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge”

-Institute of Medicine (1990)
Quality Health Care

Right Care

Right Time

Desired health outcomes

Right Patient

Right Place
Ultimate Goal (desired health outcome): Optimum Oral Health

“the ability to speak, smile, smell, taste, touch, chew, swallow, and convey a range of emotions through facial expressions with confidence and without pain, discomfort, and disease of the craniofacial complex”

-Glick et al. (2016)
How do we get there? pathway to improvement
Models for Improvement: Commonalities

Goals

Measures

Interventions/changes
Common Improvement Goals

**Access:** Connecting patients to care

**Utilization:** Use of the dental care system

**Care processes:** Evidence-based care and self management - right care, right time, right place, right patient

**Improved patient outcomes**
but system barriers (or untapped opportunities) must be addressed
“Every system is perfectly designed to get the results it gets – the only way to get different results is to change the system.”

-IHI
Envisioning the System You Want to Create

Risk-based Integrated Oral Health & Dental Care Pathway

**Dental Home Referral**

**Initial** or **Periodic Dental Evaluation**
* per applicable periodicity schedule, ideally by age 1
1. Review medical history and dental history
2. Perform Caries Risk Assessment (CRA)
   - risk/protective/clinical findings
3. Perform clinical dental examination
   - caries charting by tooth surface and activity
4. Radiographs (if indicated and possible)
5. Assess cooperation
6. Develop treatment plan (or refer, if indicated)
7. Preventive services per guidelines

**Effective Engagement & Communication: Low Risk**
8. Explain caries process and causes of ECC
9. Counseling to maintain low caries risk (diet, fluoride toothpaste)
10. Anticipatory guidance
11. Periodic follow-up visits per guidelines

**Low Risk**
- Moderate Caries Risk: 4-7 mos
- High Caries Risk: 1-3 mos

**Risk Reduction / Disease Management**
1. Explain caries process and causes of ECC
2. Disease management services per guidelines
3. Define and agree on self-management goals
4. Counseling and anticipatory guidance
5. Periodic CRA & follow-up visits per guidelines

**Notify Requirement**
1. Verify establishment and maintenance of dental home
2. Repeat well-child oral health protocol at well-child visits for children with no dental home

**Initial or Advanced Treatment Needs**

**High Caries Risk or > 3 y.o.**

**Follow Up / Care Coordination**

**Low Caries Risk and < 3 y.o.**

**Oral Health Workforce**
By James J. Crall, Nadine Pouyat, Meera Venkata, Colleen Lampros, and Richard Scovel

Improving The Oral Health Care Capacity Of Federally Qualified Health Centers

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Driver diagrams . . . are tools to help us examine our systems of care and identify the elements that enable the patient to get the right care at the right time in the right place . . . and develop a **shared theory** about **what must change** to achieve improvement.
Drivers of Change and Change Ideas

**AIM:** A clearly articulated goal or objective describing the desired outcome. It should be specific, measurable and time-bound.

**PRIMARY DRIVERS: WHAT:** Think about barriers. Structures, Processes, Systems, Norms needed to achieve the aim.

**SECONDARY DRIVERS: WHERE/WHEN:** Distinct moments in time, place where change happens.

**CHANGE IDEAS: HOW:** Specific practices or interventions; evidence/experience based; change ideas should be “tested” on a small scale.
Example: UCLA First 5 LA QI Learning Collaborative

**Aim:** To improve the health, well-being and future success of LA county children, age 0-5, by improving their access to quality oral health care and reducing their caries risk.

By June 2016:

- 95% of 0-5 year olds served at participating Health Centers will have a documented caries risk assessment.

- The caries risk status of 10% of children at elevated risk will be reduced.

- 75% of children at elevated risk will receive disease management care that is appropriate to their risk status.
**Aim:** To improve the health, well-being and future success of LA county children, age 0-5, by improving their access to quality oral health care and reducing their caries risk.

**Key Drivers**

- **Clinic Leadership drives integrated Medical and Dental care**
- **Implement Standard Risk-Based Disease Management Care Processes**
- **Support Self-Management**
- **Use Health Information & QI to Improve Population Oral Health**
- **Increase Clinic Capacity and Use Resources Efficiently**

**Secondary Drivers**

- Cultivate accountable leadership focused on population outcomes
- Clinics develop strategic alignment of integrated Medical and Dental services for oral health
- Increase provider & staff knowledge and skills for delivering risk-based oral health care
- Conduct & record risk assessment at well child visits, all dental examinations, and appropriate community-based oral health services
- Manage risk and disease status of patient population across medical and dental services based on professional guidelines and evidence
- Increase providers’ ability to effectively communicate with and motivate parents
- Increase parent and care giver knowledge and skills to manage their child’s oral health
- Enhance clinic information systems to support QI and population pediatric oral health management
- Strengthen clinic-wide QI skills and culture
- Establish sound fiscal/billing practices and improve workflow efficiency (e.g., scheduling)
- Care team expansion and re-design

**Clinics develop strategic alignment of integrated Medical and Dental services for oral health**

**Use Health Information & QI to Improve Population Oral Health**

**Increase Clinic Capacity and Use Resources Efficiently**

**Support Self-Management**

**Implement Standard Risk-Based Disease Management Care Processes**

**Clinic Leadership drives integrated Medical and Dental care**
Sample Driver Diagram

Outcomes

Primary drivers

- (P1) Active, informed families
  - Hygiene
  - Diet
  - Fluoride

- (P2) Reliable delivery of evidence-based preventive and restorative care
  - Fluoride

- (P3) Improved patient access: “dental home”

- (P4) Care coordination

Secondary drivers

- (S1) Effective patient communication and education
- (S2) Patient self-management
- (S3) Community support
  - CHCs, private dentists, pediatricians, and PCPs
  - Payers
- (S4) Early, regular risk-based evaluation and guidance
- (S5) Effective registry function
- (S6) Use of minimally invasive procedures
  - Fluoride Tx
  - IFR
  - Sealants
- (S7) OR and/or sedation referrals
- (S8) Coordination with PCPs: referrals
- (S9) Early identification, preventions, Tx
- (S10) Balancing demand and capacity

Achieving Systems Change

Think Big
Start Small
Scale Fast

Start SMALL: Test Changes

E.g., Start with one provider or one clinic or one geographic area.

Implement system-wide

Improvement tip: The PDSA model may be operationalized differently at different “levels” (program, plan, practice) within the system.
## Measuring the impact of tests of change - examples of change ideas with associated measures

<table>
<thead>
<tr>
<th>Change idea</th>
<th>Measure</th>
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<tbody>
<tr>
<td>Create referral processes between pediatric medical practices and identified dental sites</td>
<td>• % of children with a follow-up oral evaluation within x days of a well-child visit</td>
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</table>
| Identify and resolve barriers to appointment availability at identified clinics | • % of caregivers reporting they were able to get an appointment as soon as needed  
• Time to third next available appointment                                    |
Sample Measures from UCLA-First 5 LA Projects

Ph. 2 & 3 Quality Improvement Learning Collaborative

Average for Both Cohorts
Ph2 n= 7, Ph3 n=13

PM1 - % 0-5 children with a Caries Risk Assessment at Well Child Visits

Goal 95%

PM7 - % 0-5 children with 2 Fluoride applications in 12 months

Goal 50%

OM2 - % 0-5 children with caries diagnosis at periodic dental exam

Goal 10%

Lower is better!
Table Discussions
Step 1: Pick an aim to achieve by May 2020

- Increase the percentage of pregnant women who receive a comprehensive or periodic oral evaluation by 15%.
- Reduce the percentage of children aged 0-6 years with new cavitation by 25%.
- Increase the percentage of adults aged 19-64 years at elevated caries risk who receive at least two topical fluorides during the year by 30%.
- Reduce the percentage of adults aged 65 years and older with oral pain and difficulty chewing by 20%.
- Increase the percentage of children aged 7-18 years with a dental home by 40%.
- Increase the percentage of patients with diabetes and periodontal disease who receive periodontal maintenance by 35%.
Step 2: Pick a driver to focus on

- Person/family engagement and outreach
- Provider recruitment/availability
- Appointment availability
- Provider training
- Health IT infrastructure
- Enrollment
- Medical/dental collaboration/coordination
- Case management
Step 3: Discuss and identify

- Why that driver is important to effectuating systems change
- Specific change ideas - how change will occur - what specific practices or interventions (evidence-based or evidence-informed) should be “tested” on a small scale at
  - clinician/practice level
  - health/dental plan or health center level
  - Medicaid program level if applicable
  - State policy level if applicable
- Example of a test of change and how you would measure the impact of your test of change

Consider a package of change ideas that works across levels in a synergistic and mutually reinforcing way.
Large Group Discussion

Questions?

Ideas to share?

New ideas to take home?
We are working across systems of care

- Medicaid Program (macsystem)
- Medical/Dental MCOs (meso system)
- Care Site/Practice (microsystem)
Outcomes are impacted by more than care delivery

The Expanded Chronic Care Model (Barr, 2003)

## Stakeholder Engagement, Needs Assessment and Strategic Vision

<table>
<thead>
<tr>
<th>System</th>
<th>Community-Based Systems &amp; Supports</th>
<th>Care</th>
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<tbody>
<tr>
<td>Coverage Eligibility</td>
<td>Transportation</td>
<td>Appointment availability</td>
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<tr>
<td>Provider availability</td>
<td></td>
<td>Scope of services</td>
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<tr>
<td>Leadership coordination</td>
<td>Leadership coordination</td>
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<tr>
<td>Health IT Infrastructure</td>
<td>Facilitating service delivery programs in community sites</td>
<td>Service delivery partnerships in community sites</td>
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<tr>
<td>Medical-Dental Collaboration</td>
<td>Supportive environment in a medical-dental neighborhood</td>
<td>Integration and coordination of oral care services with medical care</td>
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<td>Transitions to adulthood</td>
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<tr>
<td>Provider training</td>
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<td>Provider training</td>
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<td>Scope of benefits</td>
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<td>Level of funding</td>
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<td>Contracting &amp; reimbursement</td>
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<td>Benefit policies linked with evidence</td>
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<td>Facilities and equipment</td>
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<td>Enrollment</td>
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<td>Provider Recruitment</td>
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<tr>
<td>Family Engagement/Outreach</td>
<td>Community Coordinators</td>
<td>Person/family centered care</td>
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<td>Culturally competent care</td>
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<td>Case management</td>
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<td></td>
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<td>Evidence-based care (clinical &amp; behavioral)</td>
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<td></td>
<td></td>
<td>Care Coordinator/Referral</td>
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<tr>
<td><strong>Outcomes</strong></td>
<td><strong>Improved:</strong></td>
<td></td>
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<tr>
<td></td>
<td>Oral health Status, Quality of Life, Satisfaction, Experience, Disease Status, Functional Status, Risk Status, Disparities, Health Literacy</td>
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Examples of successful QI initiatives and resources
DQA Quality Innovators Spotlight: The Inside Story

How did this project start?

The project was funded by First 5 LA to identify and address multiple barriers in access to oral health care for children 0-5 and has been implemented in Los Angeles County, beginning in 2015. The project addresses several common, critical barriers to improving the oral health of children aged 0-5 in the safety net, including:

1. Inadequate infrastructure for pediatric oral health care delivery (personnel, information technology);
2. Limited knowledge, skills, and comfort in oral health care delivery for young children among dental and primary care providers;
3. Inadequate financial incentives to provide oral health care for young children;
4. Limited integration of care delivery and collaboration among dental and medical providers;
5. Lack of leadership and champions to promote oral health care within clinic organizations and local areas; and
6. Limited awareness of the importance of oral health care and development of healthy habits for young children among parents, child care providers, and community partners.

What were the key strategies to achieve the improvement goal?

The key strategies included:

- Support for infrastructure enhancements (personnel, information technology)
- Providing clinical and motivational interviewing training for dental and medical providers
- Implementing a quality improvement learning collaborative (QILC) based on the QILC Breakthrough series model to promote system redesign and delivery of integrated care by medical and dental providers
- Supporting outreach and community systems development to promote population health approaches collaboratively with clinic outreach activities and community partners

Key drivers for the quality improvement learning collaborative included:

- Engage health care leadership to drive integrated risk-based medical and dental care
- Use information systems and quality improvement to improve population oral health
- Medical and dental providers and staff collaborate to provide integrated care
- Standardized care processes coordinated across medical & dental services
- Integrate oral health into population health activities

What improvements were achieved?

Participating PHHCs reported a 3.3-fold increase in preventive services for children ages 0-5 between January 2015 and December 2016. Reports from the second phase of the QILC reported a doubling of the number of children aged 0-5 receiving and all oral health care services, reductions in caries risk status in 33% of high-risk children, and development of reliable systems for conducting oral health assessments (86% at dental visits and 70% at well-child visits).

What were the main challenges that needed to be overcome?

- Overcoming "old school" approaches to care delivery by dental and medical providers
- Engaging with clinic leadership to create the "buy-in" for system change
- Creating time for teams to learn about and implement quality improvement

What was the overall impact of this program?

First 5 LA is a County-wide project, with over 10 million residents and over 3.6 million children under the age of 6 in Los Angeles County. This project improved multiple PHHC clinics, as well as community partners such as medical staffs and WICs. Significant funding, $11.1M, was obtained to design and implement this program, and quality improvement learning was approximately 3% of the budget for these cohorts of participating clinics.

DQA Resources: IHI-DQA QI Module for Dental Professionals

http://www.ihi.org/education/IHIOpenSchool/Courses/Pages/Dental-Quality-Alliance-DQA.aspx
Additional DQA Resources

Explore the DQA

Educational Resources

Improvement Resources

Measure Activities

Measures: Medicaid and Dental Plan Assessments

Measures: Practice Assessments

Electronic Pediatric Measures

Contact the DQA via email: dqa@ada.org
Explore the DQA website: www.ada.org/dqa
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Thank you!