The Challenge of Medical Dental Integration

Oral health in primary care

Harkin Institute

November 15, 2019
Learning Objective(s)

Participants will gain knowledge in:

• Rationale for integration of oral health and primary care
• Scientific evidence for oral systemic relationships
• Economic data to support integration
The importance of Policy, Legislation, and education

• “For the past 50 years, the US health care system has been focused primarily on promoting and supporting the technological advancement of medicine. That focus has cured disease, enhanced therapies, and saved lives. But as that focus, and the success it has achieved, has dominated what and how we pay for health care, we have failed to appreciate the changing nature of illness, and the systemic gaps in care delivery that have been created by this approach”. House No. 4134 October 18, 2019

• The opioid epidemic is a prime example of the use of drugs rather than supportive and sustained therapy.
Events of 1973

• “What kind of doctor are you anyway? “ Patient at Mass General Hospital.

• Secretariat and the 1973 Triple Crown. Importance to State practice Acts
Growing Interest

Multiple Reports

- IOM Report Dental Education at the Crossroads 1995
- Surgeon Generals Report 2001
- 21st Century Gies Report
- Roundtable Report. National Academy
- Call for 2nd Surgeon General Report
- Sante Fe Group Medicare initiative
- Lancet Report 2019
Atul Gawande Slow Ideas

• Introduction of ether anesthesia vs. adoption of asepsis
• Dental implants vs. HIV AIDS
• Integration of oral health into general health
Commentary

**Guest Editorial**

**Our dental care system is stuck**
And here is what to do about it

Marko Vujicic, PhD

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We will not see major expansions in dental care use and sustained improvements in oral health in the coming years, especially among those with the highest needs, under the status quo model. The dental care system needs major reforms.

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<table>
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<tr>
<th>Box. Reforms needed to drive major expansions in dental care use and meaningful, sustained improvements in oral health.</th>
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<tr>
<td><strong>Address the Dental Coverage Gap</strong></td>
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<td>Consider dental care an essential health benefit for all age groups. Provide comprehensive dental coverage in public health insurance programs and as a core benefit in private health insurance coverage.</td>
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<td><strong>Define and Systematically Measure Oral Health</strong></td>
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<td>Define and systematically measure oral health in ways that are meaningful and relevant for both patients and providers, but mostly for patients. Measure what is done for patients, not just what is done to patients.</td>
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<td><strong>Tie Reimbursement, Partly, to Outcomes</strong></td>
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<td>Make some small portion of provider compensation dependent on oral health outcomes or, at a minimum, on some intermediate measures that influence outcomes and are more within the direct control of providers.</td>
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<td><strong>Reform the Care Delivery Model</strong></td>
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<td>Get dentistry out of its care delivery silo. Engage the rest of the health care system to nudge people into dental care. Rise above scope of practice turf wars fueled by fee-for-service payment.</td>
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John Kotter Leading Change

1. Increase urgency
2. Build the guiding team
3. Get the right vision
4. Communicate for buy-in
5. Empower action
6. Create short-term wins
7. Don't let up
8. Make it stick

Creating a climate for change
Engaging and enabling the whole organisation
Implementing and sustaining change
Perspectives

It Is Time for a New Gies Report

R. Bruce Donoff, D.M.D., M.D.

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Submitted for publication 12/2000; accepted 5/2006

After the Flexner report on medical education was issued in 1910, the Carnegie Foundation decided to perform the same service for dental education: survey the field, state the essential facts as they existed, and draw conclusions that might be helpful to those concerned with the profession in the United States and Canada. The process took five years and resulted in the Gies report of 1926, Dental Education in the United States and Canada. It remains to this day the most comprehensive and influential review of dental education in the context of a changing profession. Although probably less widely read than the 1995 Institute of Medicine (IOM) report, Dental Education at the Crossroads, the Gies report is still relevant today that it must form the basis of any discussions of the continuum of dental education schools are now undergoing. This experience has given me a new perspective from which to think about dental education.

Thus, any specific aims for this article are to:
1. place dentistry and dental education in the context of a constantly changing environment, drawing on general business theories of innovation and disruption; and
2. revisit the Gies report and explore the idea that another similar report is needed.

Changed Circumstances and Disruptive Innovations

When the impossible occurred and the Reformation

During World War II, the U.S. armed forces faced a surprising obstacle to recruiting sufficient field-ready personnel for the war effort: 10% of potential recruits failed service requirements related to oral health (such as having six opposing teeth), and many who met the requirements had severely compromised teeth that required tremendous resources to repair. So at the end of the war, “many dentists, military officers, political leaders, and others vowed to solve the nation’s rampant dental problems.” On June 14, 1941, President Harry Truman signed the National Dental Research Act “to improve the dental health of the people of the United States” by establishing the National Institute of Dental Research (NIDR) as the National Institute of Dental and Craniofacial Research (NIDCR).

Yet today, Americans still face serious challenges in oral health that result in lost work and school hours and impose heavy costs on the health care system and society. Furthermore, there is evidence that coordinating and integrating oral health into medical coverage and care reduces costs, especially for patients with chronic diseases such as diabetes or cardiovascular disease.2 We believe that it is time again to improve oral health in the United States, this time in a more fundamental way—by ending medicine’s artificial and harmful separation between the mouth and the rest of the body. New and compelling evidence suggests that in order to prevent disease and improve health, oral health must be a core component of comprehensive health care.

The Surgeon General’s report on oral health in 2000 concluded that oral health problems not only reflect general health conditions; they can exacerbate and sometimes even trigger them. Periodontal inflammation affects diabetes, heart disease, and chronic obstructive pulmonary disease, as well as perinatal health in mothers and infants.4 Investment in oral health improves general health and reduces medical costs.5 The 2007 case of Deanna Fritz, a 23-year-old Maryland boy who died when bacteria from an untreated tooth infection spread to his brain, generated sufficient awareness and legislative support that dental coverage for children was included in the federal reauthorization of the Children’s Health Insurance Program (CHIP) in 2009. Still, 15 years of research, reports, and recommendations addressing the dental-medical divide have resulted in little serious action to address our country’s oral health deficiencies. Although the changes to CHIP have improved access to services for disadvantaged children, we are failing to address the serious oral health needs of adults, even though an increasing percentage of Americans 65 years of age or older have chronic diseases that are affected by poor oral health. Furthermore, disparities in coverage of and access to dental care services result in the imposition of a high-cost burden on hospital emergency departments.6 We believe that a national effort is needed to integrate oral health...
Advancing Dental Education in the 21st Century

Howard L. Baillie, DMD, PhD; Allan J. Formnicola, DDS, MS

Abstract: In 2012, the Carnegie Foundation for the Advancement of Teaching published a report prepared by William J. Gries, PhD, a professor of biochemistry and founder of the Columbia University College of Dental Medicine. The Gries report examined the current status of dental education in the United States and Canada and made recommendations for a new direction. This report led to major improvements in dental education and research and was a critical factor in making dentistry a learned profession. Dental and allied dental education are now challenged by a new set of issues related to financing education, improved oral health, more effective treatment technologies, and a rapidly changing delivery system. In an effort to meet these challenges, this strategic planning project first examined the current status and future trends that are likely to impact the dental profession over the next 25 years. The project was organized into six sections, and 50 authors were invited to prepare 38 articles to address these needs.

The committee summaries for each section are being published in the August and September 2017 issues of the Journal of Dental Education, and the background articles are being published in online supplements to these issues. In the next phase of the project, information from the articles will be used to develop strategic recommendations to assist dental schools and allied dental education programs in preparing graduates for practice in 2040 and to meet their institutions’ missions for scholarship and service. This introduction presents the project rationale, provides a list of the published articles, and acknowledges the organizations that supported this effort.

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Keywords: dental education, allied dental education, strategic planning

DOI: 10.1214/18-JDE601

This is a work published in 2012 for the 21st Century. The next set of challenges face dental and allied dental education. Unlike the period of the Gries study, historic market-driven changes are currently taking place in the dental delivery system that will have a significant impact on dental education. As a result, dental leaders called for new research to set a new course for dental education. The ultimate goal of the “Advancing Dental Education in the 21st Century” project is to develop practical strategies for dental and allied dental educational institutions to address long-range challenges related to finances, education, scholarship, diversity, and changing disease and practice trends. This project is a strategic planning effort and does not follow the research model of the biomedical sciences. The time frame for this project is the next 25 years—projecting out to 2040. Dental schools and allied dental programs are complex organizations, and it will likely take 25 or more years for most to adapt to a...
Main issues for change

• Access and disparities of care
• Medical treatment of surgical disease – advanced science
• Aging of our population, increased chronic diseases
• Relieve the primary care shortage
Options for change

- Practice act change
- IPE and practice NP’s, PA’s
- Change education

Dual degree and residency
Practice of the future

- Integrated care
- Integrated financing
- True interprofessional practice
Three Teams with Shared Resources

Teamlet: 1 Dentist & 2 Clinical (Dental) Assistants

Teamlet: 1 Physician & 2 Clinical (Medical) Assistants

Teamlet: 1 Mid-level Provider & 2 Clinical (Medical) Assistants

Optometrist

Pharmacist

Nurse Care Manager

1 RN

1 MSW

1 Dental Hygienist
Primary Care

- Population Health Management and Reporting Tools*
- Quality Improvement Methodology
- Care Coordination
- Management of Chronic Diseases

Dental Care

- Restorative Treatment of Caries
- Deep Scaling and Root Planing for Periodontal Disease
- Endodontics
- Orthodontics
- Crowns and Implants

Prevention

- Medication List Management
- Risk Assessment
- Dietary Counseling
- Oral Hygiene Training
- Smoking Cessation
- Fluoride Varnish
- Fluoride Supplementation
- Antibiotic Rinses
- Screening for Oral Diseases
- Dental X-rays
- Dental Sealants
- Periodic Cleaning
- Mouth Guards

*Including structured EHR data and diagnostic codes, disease registries, and other tools
The Cleft Palate Team – A Historical Review

• In 1930 at least four factors which together or separately had a notable influence towards producing changes in the care of people with cleft palates
  • The concept of the whole child
  • The study and application of knowledge about growth and development
  • The inadequacies arising out of the rigid compartmentalization developing in specialty medical practice
  • The use of the team to deal with complex medical problems
New pathways—the future disrupts the present
• Oral health in primary care
• Nurse practitioners
• Physician assistants
• Dentists – Chronic disease management in dental practice-change in scope of practice - oral physicians
• DMD/DDS MD – family medicine / primary care (modeled after oral and maxillofacial surgery MD general surgery program of 1971)
Pulse of Longwood

For these dentists, you’re more than your mouth

MELISSA RAILEY | STAFF

A

The Boston Globe

A new integrated oral health and primary care education program in the dental student clinic

SANG E. PARK, DDS, MMEC; J. PEDICIO SADDA, MD; J. R. BRUCE DONOFF, DDS, MD
Dr. Sang E. Park is Associate Dean for Dental Education in the Office of Dental Education at the Harvard School of Dental Medicine. Dr. Fiedicito Sadda is Assistant Professor of Medicine at the Harvard Medical School. Dr. Bruce Donoff is Dean of the Harvard School of Dental Medicine.

ABSTRACT

Objective: The purpose of this study was to describe the implementation of a new program incorporating primary care education into a predoctoral dental curriculum. The Student Teaching Clinic at Harvard School of Dental Medicine (HSDM) used the primary care rotation for students in dental setting as a platform to change in our approach to patient care.

Methods: A survey of perspectives on the need for primary care medicine in dental education was distributed to all the classes of Commission on Dental Accreditation (COS) accredited dental schools in the continental U.S. for a total of 568 students.

Results: Of the 57 responses from the dental school, 47% of the responding dental schools had at least one course focused on primary care education in dental school, and 33% of the respondents were in favor of this change in curriculum. The majority of the respondents believed that primary care education should be integrated into the dental curriculum, and this change would have a positive impact on the dental students’ ability to provide comprehensive care.

Conclusion: As a result, we should consider incorporating primary care education into dental education, and this change would have a positive impact on the dental students’ ability to provide comprehensive care.

The Journal of Massachusetts Dental Society
The Future of Oral Health Care Provided by Physicians and Allied Professionals

Hugh Silk, MD, MPH

Medical providers are taught to care for the whole patient is the context of his or her community. Some health professions do a better job than others of addressing broader principles of wellness. Recently, most health care fields have begun to embrace the importance of oral health as a result of initiatives and reports such as the Institute of Medicine (IOM)’s Advancing Oral Health in America. This landmark document assessed the state of oral health in the non-dental professions including nursing, medicine, and pharmacy. A companion IOM report, Improving Access to Oral Health Care for Underserved Populations, assessed barriers, potential solutions, and changing paradigms in oral health care for patients and health care professionals.

Teledentistry
Electronic health records
Teach oral health to nurses and nurse practitioners
Teach oral health to physicians
Expanded duty oral health auxiliaries
Factors Impacting Integration

• Driving forces
  • Importance
  • Health care disparities
  • Need for oral health champion for curriculum development

• Curriculum topics
  • Smiles for Life program
  • Local faculty members

• Barriers
  • Lack of time and curricula restraints
  • Lack of buy in or faculty interest
  • Lack of dental partners and opportunities for integration
3 ideas

1. A fundamental transformation in work
2. Teaming as the engine of change
3. Joint problem-solving IS the work

Michaela J. Kerrissey, PhD, MS
Benefits with integrating oral into overall health

• ADA health Policy Institute documented a reduction of $1799 in total health care cost for individuals newly diagnosed with type 2 diabetes when they received periodontal intervention.

• Medical cost savings from United Concordia for CAD and stroke of $1090 and $5681 with periodontal treatment and maintenance.

• Savings also in hospitalizations costs.

• These led to formation of Harvard Initiative for Integration for Oral Health and medicine in 2015.
Approaches for oral and general health integration

• Facilitated referral and follow-up
• Virtual integration via EHR
• Shared financing
• Co-location
• Full integration
Medical-Dental Integration in Public Health Settings: An Environmental Scan

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Contents

Acknowledgements .................................................. 3
Executive Summary .................................................. 4
1. Introduction ...................................................... 7
2. Methods .......................................................... 8
3. Integration in Clinical Settings ................................. 11 3-1.
   Cardiovascular Disease and Oral Health .................. 12 3-2. Diabetes and Periodontal Disease ................. 17
   3-3. Maternal and Child Health .............................. 27
   3-4. Obesity, Nutrition, and Oral Health .................. 31
Multimedia Health Campaigns .................................... 37 5. Co-location of Medical and Dental Services .............. 39 6. Health Workforce Innovations ............................. 41
7. Integrated Insurance Benefits .................................. 45
8. Health Care Reform ............................................. 47
9. Conclusions ...................................................... 48 Appendix A. Data
   Extraction Form ................................................. 52 Appendix B. Survey of State
   Oral Health Programs ......................................... 57 Appendix C. Survey of State
   Chronic Disease Programs ................................. 60 Appendix D. Survey of Community Dental Programs .......... 62 Appendix E. Key Informant
   Interview Guide ................................................. 65 References ......................................................... 67
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social support, may be necessary to improve outcomes.

With five dental sites serving 18 primary care locations, Neighborcare Health (Seattle, WA) has limited its dental services to existing patients within their medical clinics. The oral health program at Neighborcare focuses on special populations: high-risk children, pregnant women, HIV patients, and patients with diabetes. For patients with diabetes, bidirectional referrals between primary care and dental care can be initiated in the shared EHR system. Three of the dental sites are co-located with medical facilities and expanded function assistants apply sealants and fluoride varnish, and also place restorations.

Medical and dental services are co-located at Salud Family Health Center’s 10 sites (Fort Lupton, CO). Salud embeds dental hygienists in the medical clinics, where they are able to provide screenings and preventive services, including fluoride varnish. Although current efforts emphasize oral health screenings for pediatric patients, the hygienists also focus on patients with diabetes (key informant interview, September 8, 2017). Future efforts are planned to specifically target and provide dental care to patients with diabetes in order to help control blood sugar. In addition to these activities in the medical setting, dental providers also test blood sugar levels on all patients with diabetes.

The United Community and Family Services organization in California implements bidirectional referrals for patients with diabetes and other chronic conditions. Care is coordinated across the FQHC system comprising three primary care practices, five behavioral health practices, and one dental clinic. In one example of integration, a dental hygienist provides screenings to 1-3 year olds during routine well-child visits at the pediatric primary care clinic.

Trillium Coordinated Care Organization (Lane County, OR) was established in 2011 and serves over 90,000 Medicaid members. Trillium is contracted with all four local dental plans to provide integrated care for Medicaid enrollees.

Conclusions

Co-location of services often refers to medical and dental providers located under one roof; alternately, it can encompass medical and dental providers working at separate facilities within a centrally managed system of care. In either model, shared EHRs facilitate bidirectional referrals and flagging records of dental patients who have chronic conditions.

Challenges

- Noted barriers to integrated care provided within the framework of co-location include limited buy-in from medical providers, funding for oral health preventive services performed in medical settings, and insurance payment for services.
- Co-location requires substantial investments in infrastructure, such as shared EHRs, shared or commonly managed facilities, and a multidisciplinary workforce.

Recommendations

1) Create professional guidelines or toolkits for integrated activities, including bidirectional referrals, in order to reduce start-up barriers to implementation, improve provider confidence, and facilitate standardization.
2) Payment models that reimburse cross-disciplinary procedures can improve sustainability.
3) Cross-training of medical providers by their dental counterparts (and vice versa) can increase buy-in and contribute to standardization of protocols for disease management.
Transforming dentistry by removing the distinction between oral and systemic health.
Oral health facts

• $1.2 billion of hospital charges incurred by patients hospitalized for a dental problem

• 154 million hours of work lost/51 millions lost hours of school- due to dental disease.

• 40% of American have no dental coverage

• Medicaid – 16 cover only pain relief, 7 don’t even cover pain and infections, low reimbursement limits dentists’ participation

• Medicaid, Medicare and ACA require no acute coverage
Discomfort of thought

• Dentistry is the only specialty in the realm of medicine taught before the doctorate is awarded. –no residency requirement

• Throughout training, the emphasis is on the perfection of methods rather than the attempt to stimulate a desire to know why the methods are necessary and what their intrinsic value is.

A. Leroy Johnson, Dentistry-As I See it Today, 1955
Key Drivers in Dental Education

- Ready to practice upon graduation
- Licensure based upon procedural exam-rather than residency
- Interprofessional care
- New workforce models - DSO
- Globalization
- Elderly and chronic disease
- Technology advances
- Personalized medicine
- Health disparities
The problem

• Historical separation of medicine and dentistry in education, practice and financing
• Oral health always the stepchild
• Yet #1 on best professions list (US News)
• Delivery system flawed-can dentistry afford to repeat its response to Medicare in 60’s
• Prevention needs more emphasis
• Address the interplay between oral disease and other health issues
• Shortage of primary care providers
• Problem of access to care
Key questions

• What models exist for integrating oral health care into the primary care setting?

• What findings on oral health care delivery in the safety net can influence the move towards the patient-centered medical home or health home model?

• What changes in health policy and healthcare reimbursement are needed to support integrated oral health and primary care?
The Case for Integration

• Increase effectiveness and efficiency of both dental and medical professionals in disease prevention, identification of precursors – IT systems key
• Raise patient awareness of importance of oral health
• Improve chronic disease management and prevention by dentists as primary care givers
• Address oral health care access issues
• Facilitate use of interdisciplinary techniques
• Provide cost savings
Methods of Care

• **Collaboration or coordination of care** – when oral health and primary care providers work with one another. Patients perceive that they are receiving a separate specialist service from a dentist who works with their physician.

• **Integration** – when oral health works within primary care. Patients perceive that they are receiving dental services that are a routine part of their health care.
How to achieve

• Continue to involve dental and non-dental providers in oral health-NP, dental therapists

• Develop innovative delivery models
  • Full integration
  • Colocation
  • Primary care provider focus
  • Cooperation and collaboration

• Insurance and financing – medical and dental insurance together

• Oral health in ACOs – bundled payments
How to achieve

• Integrated training models – oral physician program, dental residencies in dept. of primary care rather than surgery

• Medical education as part of dental education- Harvard, UConn, Columbia

• DMD new curriculum - the dentist as primary care provider – DMD, MD primary care track

• MD curriculum - essentials of oral health for medical students

• CE curriculum - dentistry and oral health for physicians, CEO’s of FQHC’s
Barriers and problems

- Reimbursement – low for Medicaid, not allowed for medical diagnosis
- Dental school /medical curriculum variances
- State practice acts – recent changes in Conn.
- Physician response – too busy
- Dentists response – not my job
- CULTURE
Prospective health care

• Shifts focus from disease management to disease prevention and health management
• Driving force – need to improve quality of care
• Impetus – safety issues, rising costs, information sharing, health homes
• Rationale – to ensure the best possible patient outcomes
A Profession in Transition

- Dental benefits erode for adults
- Benefits increase for children
- Access to care not addressed
- Will dental benefits be part of a medical plan
- Oral health for aging population – Medicare
- Increase value and reduce costs
- Opportunities to raise profile of oral health
- Engage dentists in primary care networks via interprofessional collaboration
Tomorrow’s dental practice landscape

• Provider consolidation continues
• Growth in large multisite practices
• Interest in midlevel providers continues
• Commercial plans increase use of selective networks and demand increased accountability
• Premium on good practice management
Medical education/dental education

• Separate but equal education is always separate but never equal
• Physicians become educated about us and oral health
• Bring medical model into dental education
• New opportunities to change scope of practice - engage dentists in primary care networks with increased interprofessional collaboration
Dean’s Advisory Board

• Created in 1993
• Major role in research strategic plan of late 1990’s- led to new Building
• Serve in advisory role, development
• Developed Leadership forum concept with Harvard Business School
• Establish Initiative to Integrate Oral health and Primary Care
Why integrate care

• Three major factors now push the agenda for change – advances in science and oral science, the demographic increase in the older population, and the crisis in primary care.
The Forum of October 2014

• The Economic Imperative of good Oral health
• Agenda – the soundness of insurance data
• Introduction of Initiative idea
  • To foster discussion, guide as well as develop public policy and advocacy
  • Provide interdisciplinary connection at Harvard
  • Collaborate with national, state and local partners on innovative strategies to improve oral/general health
  • Provide scholarly review of clinical and epidemiologic data on the subject
Forum Big Ideas

• Things put together that should never should have been separated or things put together that should have been kept separated- dental and medical care

• Integrating oral health with overall health insurance lowers costs

• Fee for service like selling college courses course by course vs. tuition

• What are the actionable strategies
Cost Savings

• Aetna’s Dental Medical Integration Program Report 10/4/13
  • DMI members who visited the dentist have:
    • Lowered their medical claim costs by an avg. of 17%
    • Improved diabetes control by 45%
    • Used 42% less major and basic dental services
    • Required 3.5% fewer hospital admission year over year compared to 5.4 % increase for non-members
United Healthcare
Medical Dental Integration Study

• Performed by Optum

• Net medical costs on average $1037 lower than medical costs for members who received other or no dental care

• Larger savings for diabetic patients and other chronic diseases asthma CHF, CAD COPD chronic kidney disease
Treating Gum Disease Equals Annual Cost Savings

United Concordia's landmark Oral Health Study shows that annual cost savings of $3,291, $2,956, $1,029, $3,964 and $2,430 are possible when individuals with diabetes, heart disease, cerebrovascular disease (stroke), rheumatoid arthritis and pregnancy are treated for gum disease.

* 3-year average of $1,814 in savings from reduced hospital and office visits begins in the first year of periodontal treatment. Pharmacy savings realized annually after patient receives at least 7 periodontal treatment and/or maintenance visits.

United Concordia® Dental
Links to education

• Primary care task force
• Crimson collaborative
• Oral physician residency
• Teaching oral health to medical students
• Interprofessional education and practice
  • Mass College of Pharmacy and Allied Health Sciences
  • Northeastern Bouve College- HRSA grants
Create Initiative for Integration of Oral Health and Primary Care

• Vision – to incorporate oral health as an essential part of overall health and wellbeing

• Mission – create opportunities and advocacy to include oral care as a vital component and enabler of overall wellness by demonstrating the economic and health value of complete Medical/dental care integration, thus elevating the urgency and status of dental care.
Goals

• Achieve integration of oral care into the general medical care delivery environment by 2025
• Elevate the importance of professional dental care focusing on prevention, early detection, managing patient risk, preventative self-care and dental care coverage to improve wellness and lower overall health care costs
Strategy

• Quantify opportunities (costs, outcomes) – focus efforts on the value proposition for oral health

• Identify our allies- secure support of those who can advance our cause

• Demonstrate total health equity – new partners needed to raise awareness

• Focus on adults with chronic disease and/or pregnant women as basis for determining economic value proposition
Next Steps

- Enlarge/strengthen the base of core participants in the initiative, as well as external to dentistry allies/partners from current 8 members
- Develop public affairs programming to engage leaders in politics, medicine, NGOs, business communities
- Develop memorable branding/marketing/communications campaign material
Next Steps

• Develop timelines
• Develop next Forum
• Support, disseminate and participate in additional research underscoring the importance of oral health on overall health, focusing in particular on clinical and financial outcomes.
Audience

• Public policy influencers
• Philanthropic foundation
• Health care purchasers
• Physicians
• Organized dentistry and medicine
• Influential media
• Alternate care facilities (CVS, Walmart, Target)
Current initiatives

• Commonwealth Care Pilot – research plan to answer question does good oral are impact an elderly populations’ general health

• Develop a primary care medical practice within Harvard Dental Center – Patient Centered Health Home

• Develop general dental residencies at medical centers without dental school of oral health resource
Reform Agenda

- All health insurance policies – whether provided through Medicare, Medicaid or private insurance companies – could include coverage for dental care services, regardless of enrollee’s age
- Integrate general medical and dental care in both practice and workforce education
- Ultimate goal is care not insurance
- This is about building a movement - JOIN US
Initiative for Integration of Oral Health and Medicine

• Practice of the Future
• Recruited economists
• ICHOMS
• Next Forum Sept. 27-28, 2018
• Kaiser Northwest integrated practice
• Pacific Dental integrated practice Las Vegas
• Phillips Healthcare
Through the Initiative, HSDM and partners are driving to transform dentistry. To that end we are pioneering new models for teaching, providing, and financing care as well as new methodologies for understanding the health and economic outcomes of integration. Our projects are designed to measure the impact of integration on all aspects of the health system, thereby providing us and our partners with the evidence needed to effect systems change.

— JANE BARROW
Executive Director and Assistant Dean of Global and Community Health

Our projects are designed to measure the impact of integration on all aspects of the health system, thereby providing us and our partners with the evidence needed to effect systems change. Through the Initiative, HSDM and partners are driving to transform dentistry. To that end we are pioneering new models for teaching, providing, and financing care as well as new methodologies for understanding the health and economic outcomes of integration. Our projects are designed to measure the impact of integration on all aspects of the health system, thereby providing us and our partners with the evidence needed to effect systems change.

The Harvard School of Dental Medicine’s unique position within Harvard University and the Longwood Medical area provides many opportunities for interdisciplinary and multidisciplinary learning and discovery. In the past few years, interprofessional education and practice have become important methods for improving the health of our population. We have created an academic center, the Initiative for the Integration of Oral Health and Medicine, in which education, research, and patient care occur simultaneously—each informing and improving the others. Supported by philanthropy and grants, the Initiative has the goal of making oral health care affordable, evidence based, and patient centered.

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ITINERARY BOARD MEMBERS REPRESENT LEADING ACADEMIC AND HEALTH CARE ORGANIZATIONS

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The Initiative’s objectives

The Initiative to Integrate Oral Health and Medicine emerged from the 2014 HSDM Leadership Forum, which focused on the economic imperative of oral health. Our objective is to transform dentistry and fully integrate oral health into health care education, delivery and financing. We aim to improve wellness, reduce barriers to coverage, and lower overall health care costs by promoting early detection, patient education, and preventative care.

The Initiative convenes academic and health care industry leaders to develop innovative ideas for new models that consider the perspectives of educators, patients, care providers, policy makers and insurers. The Initiative Board—consisting of industry experts and Harvard faculty—provides informed guidance.

At the core of the Initiative is our engagement in research and demonstration projects that explore new models of education, training and practice. Other projects measure outcomes and explore financial models that will demonstrate the value of integration. Additional initiative activities include policy statements, conferences and seminars.

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Impact of oral health on general health and vice versa. This approach helps both primary care and oral health providers learn about the overall health status. The classes of 2019 and 2020 fully participated and demonstrate why the oral health provider should be knowledgeable in patient’s clinical competencies into their existing practice and provide early identification and prevention of oral diseases.

WHY
To teach our next generation of Harvard trained providers to integrate oral health into preventive and general health care services for underserved populations. As the next generation of primary care providers, they become leaders in care delivery and practice as well as public health advocates.

EDUCATION
These projects create collaborative, mixed models where dentistry and primary health professional work and learn side-by-side. This interdisciplinary approach helps both primary care and oral health providers learn about the impact of oral health on general health and vice versa.

CENTER FOR INTEGRATION OF PRIMARY CARE AND ORAL HEALTH (CIPCOH)
This national center, funded by a 5-year agreement with the Health Resources and Services Administration (HRSA), promotes the training of primary care providers to deliver high-quality, cost-effective care to underserved patients who address oral health and its disparities. In collaboration with the HMS Center for Primary Care, nurses, pharmacists, physicians, and physician assistants will integrate care and oral health competencies into their existing practice and provide early detection and prevention of oral diseases.

WHY
To teach our next generation of primary care providers to have a basic understanding of oral diseases, its association with the major non-communicable diseases, and its impact on overall health.

CRIMSON CARE COLLABORATIVE (CCC)
Dental care has never been as aligned as a network of six student-faculty collaborative clinics spearheaded by the Stoeckle Center for Primary Care at Massachusetts General Hospital. Staffed with interdisciplinary health professionals, students, clinicians, and dentists, these collaborative, mixed-model clinics provide fully integrated dental care for vulnerable communities, expose dental students to primary and public health care practices, and train future primary care providers in oral health competencies. CCC’s include MGH Dawes and CCA, the Nashua Street (Jail), fully integrated care delivery at dental clinics, and a medical team, and a team of oral health professionals caring for these patients.

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COLLABORATIONS IN PRACTICE
These projects are working on developing integrated clinical models to deliver comprehensive care to patients with oral health needs.

NURSE PRACTITIONER-DENTIST MODEL (NPD)
In a new model piloted through a 3-year cooperative agreement between HSA, HSIN, and the Northeastern School of Nursing, a full-time nurse practitioner works in the Harvard Dental Center’s Teaching Practices and serves as a consultant and care provider for older adult patients with the diagnosis of hypertension or diabetes. Patients are screened for hypertension and diabetes and selected for oral health needs. If needed, patients are referred to a NP who can provide a Medication Wellness Visit, proof of care, and education and a referral to a medical team. New interventions flow from these preliminary results through the dental clinic to develop skills in oral health screening and diagnosis.

WHY
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RATIONALE
We are in a unique position as being one of the leaders in the delivery of oral health screening and care, and demonstrate why the oral health provider should be knowledgeable in patient’s clinical competencies into their existing practice and provide early identification and prevention of oral diseases.

EDUCATION
These projects are working on developing integrated clinical models to deliver comprehensive care to patients with oral health needs.

OUTCOMES
These projects focus on the value proposition and economic impact of oral health.

THE INTERNATIONAL CONSORTIUM FOR HEALTH OUTCOMES MEASUREMENT (ICHOM)
We are an open access working group member for the cost health standard set. In concert with the World Dental Federation, ICHOM has convened a group of quality and outcomes experts to define a global standard of outcomes measures that reflect what matters most to patients about their oral health and oral health care.

WHY
To teach our next generation of primary care providers to have a basic understanding of oral diseases, its association with the major non-communicable diseases, and its impact on overall health.

ADVOCACY AND OUTREACH
We have created an initiative Health Policy Fellowship in an effort to advocate and champion the benefits of integration. This fellowship collaborates closely with the Pew Charitable Trusts, Health Care for All Community, Catalyst and others to promote oral health issues and to better understand the evidence needed to support advocacy work. Our fellows, faculty and students publish a number of articles and op-eds, and have been quoted in newspapers and on the radio advocating for improved integration.

Leadership Forums bring together thought leaders and influencers from academic, health care and business who can advocate for integration and systems change.

The 2016 Leadership Forum, themed “Eating Your Money Where Your Mouth Is,” will feature speakers, panels and discussion around the idea of connecting oral health to overall health to achieve better patient outcomes and lower costs. The forum looked at integration from multiple angles — its effect on health in the workplace, in a clinical setting and as a public policy issue. The next Leadership Forum will take place in spring 2018.
CIPCOH will contribute to the improvement of primary care practice and patient outcomes through:
• conducting systems-level research on primary care training
• disseminating information, best practices and resources
• recommending and promoting primary care training enhancements
• developing community of practice plans that mobilize stakeholders to integrate oral health into primary care training and delivery.
Practice of the Future

• **What:** A comprehensive, patient-centered practice based on an integrated model that combines traditional family medicine with oral health, behavioral health, optometry and social services

• **Why:** To transform how we train health professionals and deliver care and set a new standard

• **Status:**
  • Operations plan complete
  • Business plan complete
  • Discussions underway with potential funders
  • Working on a white paper with HMS PC Center
Our World
HYBRIDS
DENTIST/PHYSICIAN
Wisdom and Knowledge shall be the stability of thy times.