Getting to the Heart via Oral Health: A Medical and Dental Collaboration Summit

Thank you for joining
The event will begin at 8:30am EST

Getting to the Heart via Oral Health: A Medical and Dental Collaboration Summit

Friday, June 10, 2022
8:30 am – 2:30 pm EST

OPENING REMARKS

Andrea Boucher, MPRO

Welcome!

The purpose of this event is to increase collaboration between oral health and medical providers. This collaboration should lead to increased screenings, referrals, and diagnoses of hypertension.

Who is MPRO?

QUALITY IMPROVEMENT

Evidence based,
data-driven quality improvement insights

REVIEW SERVICES

Thoughtful, impartial utilization review and dispute resolution services

We provide innovative problem-solving solutions and technical assistance.

"HELPING HEALTHCARE GET BETTER"

Reminders

- Please submit your questions and comments in the chat box
  - For technical support, please message Devon Parrott
- Please place yourself on mute during presentations. Feel free to unmute to ask questions during Q&A and contribute to discussion
- Use “Raise Hand” function and we will unmute you
- The recording and slides will be shared with all registrants following today’s event

Ice Breaker

- We want to hear from you! Add in chat:
  - Your name
  - Organization name
  - City, State
  - Summer state of mind: what is your favorite ice cream flavor? ☺

Thank you for joining us today!

Disclosure Statements

The following speakers, planners, and coordinators have **no relevant financial relationship(s) with ineligible companies to disclose**:

- Andrea Boucher, MHSA, CPHQ
- Julee Campbell, MPH, CPHQ
- Patti Burchett, BS, SSGBC
- Kristina Dawkins, MPH
- Christine Farrell, RDH, BSDH, MPA
- Michele Kawabe, MPH, RDN, CDCES
- Sandy Sutton, RDH, B.S.
- James Mitchiner, MD, MPH

KEYNOTE: MILLION HEARTS

Hilary K. Wall, MPH – Centers for Disease Control and Prevention

Disclosure Statement

- **Hilary Wall, MPH** has no relevant financial relationship(s) with ineligible companies to disclose

BREAK

9:35 AM – 9:45 AM EST

STATUS OF HYPERTENSION IN MICHIGAN

Phillip D. Levy, MD, MPH, FAHA, FACC - Edward S Thomas Endowed Professor of Emergency Medicine and Assistant Vice President for Translational Science and Clinical Research Innovation – Wayne State University Chief Innovation Officer – Wayne Health

CARE SETTING BREAKOUT DISCUSSIONS

Dental Providers: Hypertension Chairside/Quick-Guides

Medical Providers: Clinical Inertia

Care Setting Breakout Discussions

Medical Providers: Clinical Inertia

10:45 am – 11:15 am EST

Blood Pressure Goals

- Blood pressure (BP) goals are set using a combination of factors
  - Scientific evidence
  - Clinical judgment
  - Patient tolerance
- For most people, the goal is <140 mmHg systolic and <90 mmHg diastolic

Source: Protocol for Controlling Hypertension in Adults (hhs.gov)

Blood Pressure Guideline

- The AHA, ACC, and other organizations released a new guideline for diagnosis, treatment, and prevention of hypertension
  - Lowers the target for BP treatment to 130/80 mmHg
  - Emphasizes importance of early prevention, detection and treatment to reduce future cardiovascular risk

Source: [BP Guideline | Target:BP (targetbp.org)]

Classification of Blood Pressure

TABLE 1. Classification of BP

BP Category	Systolic BP		Diastolic BP	Treatment or Follow-up
Normal	<120 mm Hg	**and**	<80 mm Hg	Evaluate yearly; encourage healthy lifestyle changes to maintain normal BP
Elevated	120-129 mm Hg	**and**	<80 mm Hg	Recommend healthy lifestyle changes and reassess in 3-6 months
Hypertension: stage 1	130-139 mm Hg	**or**	80-89 mm Hg	Assess the 10-year risk for heart disease and stroke using the atherosclerotic cardiovascular disease (ASCVD) risk calculator • If risk is less than 10%, start with healthy lifestyle recommendations and reassess in 3-6 months • If risk is greater than 10% or the patient has known clinical cardiovascular disease (CVD), diabetes mellitus, or chronic kidney disease, recommend lifestyle changes and BP-lowering medication (1 medication); reassess in 1 month for effectiveness of medication therapy – If goal is met after 1 month, reassess in 3-6 months – If goal is not met after 1 month, consider different medication or titration – Continue monthly follow-up until control is achieved
Hypertension: stage 2	≥140 mm Hg	**or**	≥90 mm Hg	Recommend healthy lifestyle changes and BP-lowering medication (2 medications of different classes); reassess in 1 month for effectiveness • If goal is met after 1 month, reassess in 3-6 months • If goal is not met after 1 month, consider different medications or titration • Continue monthly follow-up until control is achieved

Source: Guideline Hypertension Highlights | Target:BP (targetbp.org)

Achieving Blood Pressure Goals

- Lifestyle modifications should be recommended to all patients with hypertension
- Self-monitoring and requesting and reviewing readings from **home and community settings** is also encouraged for maintaining BP control
- For patients with hypertension and certain medical conditions, specific medications should be considered

Source: Protocol for Controlling Hypertension in Adults (hhs.gov)

WHAT IS CLINICAL INERTIA?

Clinical Inertia

- Also called therapeutic inertia, clinical inertia happens when a patient has uncontrolled high blood pressure, and their therapy is not intensified
- It is one of the most common factors contributing to uncontrolled hypertension

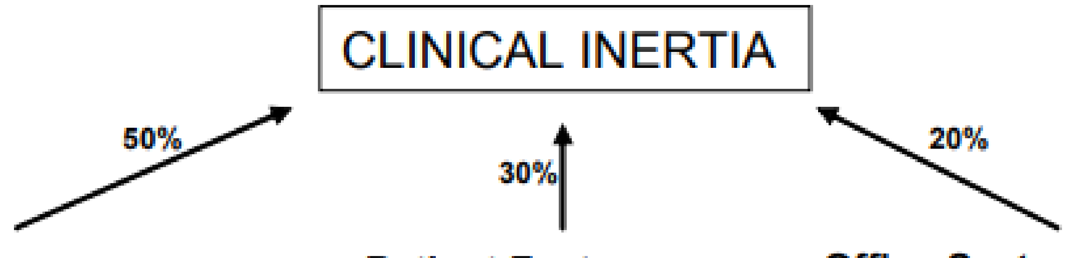
Source: Clinical Interia Assessment (ama-assn.org)

Clinical Inertia

Why does it happen? (AMA Therapeutic inertia assessment):

- Uncertainty about the patient's “true” blood pressure
- Competing priorities during visits
- Uncertainty about a patient’s medication adherence
- Patient resistance to intensifying therapy

Figure 4. Conceptual model illustrating the relative contribution of physician factors, patient factors, and office system factors to clinical inertia. Clinical inertia is defined as failure to intensify treatment in a patient who has not yet achieved evidence-based goals of care.



Physician Factors

- Goal setting pathologies
- Fail to initiate treatment
- Fail to titrate treatment until goal achieved
- Fail to identify and manage comorbid conditions (such as depression)
- Patient hijacks clinical encounter (thematic vagabonding)
- Insufficient time
- Reactive rather than proactive care

Patient Factors

- Deny having the disease
- Believe disease is not serious
- Low health literacy
- Cost of medication
- Too many medications
- Medication side effects
- Poor communication between physician and patient
- Do not trust physician
- Depression, substance abuse

Office System Factors

- No clinical guideline
- No disease registry
- No visit planning
- No active outreach
- No decision support
- No team approach to care
- Poor communication between physician and staff

Source: Clinical Inertia and Outpatient Medical Errors (ahrq.gov)
Source: Clinical Interia Assessment (ama-assn.org)

"Patients are best served when their expert knowledge of their concerns, hopes, and selves are assimilated with the clinician's knowledge of what health care has to offer to improve their short-and long-term health and function."

Source: Is 'Clinical Inertia' Blaming Without Understanding? Are Competing Demands Excuses? (nih.gov)

Finding clinical inertia

- It can be helpful to determine how often clinical inertia is occurring and what factors may be contributing at your practices
  - Act rapidly: Therapeutic inertia assessment (ama-assn.org)

Source: Clinical Interia Assessment (ama-assn.org)

DISCUSSION

Do you think clinical inertia is an issue for patients' cardiac health?

What strategies do you feel are helpful for making sure patients with high blood pressure get the treatment they need?

How do you interact with other care team members or different settings of care to address clinical inertia?

What tools or resources would be helpful to support patients reaching their blood pressure goals?

RESOURCES

Resources

- American Medical Association MAP BP Clinical Inertia Assessment:
  - Clinical Interia Assessment (ama-assn.org)
  - Purpose: review a sample of patient visits to assess therapeutic inertia and identify opportunities for improvement

Resources

- Protocol for Controlling Hypertension in Adults
  - [Protocol for Controlling Hypertension in Adults (hhs.gov)]

Source: Centers for Disease Control and Prevention. Protocol for Controlling Hypertension in Adults. Atlanta, Georgia. 2013.

The red, italicized text may be modified by the user to provide specific drug names.

Reset Form

Name of Practice

Protocol for Controlling Hypertension in Adults[1]

The blood pressure (BP) goal is set by a combination of factors including scientific evidence, clinical judgment, and patient tolerance. For most people, the goal is <140 and <90; however some individuals may be better served by other BP goals. Lifestyle modifications (LM)* should be initiated in all patients with hypertension (HTN) and patients should be assessed for target organ damage and existing cardiovascular disease. Self-monitoring is encouraged for most patients throughout their care and requesting and reviewing readings from home and community settings can help in achieving and maintaining good control. For patients with hypertension and certain medical conditions, specific medications should be considered, as listed in the box on the right below.

Systolic *140-159* or diastolic *90-99* (Stage 1 HTN)
- LM as a trial
- *Consider adding thiazide*

Re-check and review readings within 3 months[†1]

Systolic *>160* or diastolic *>100* (Stage 2 HTN)
Two drugs preferred:
- LM **and**
- *Thiazide* **and** *ACEI, ARB, or CCB*
- *Or consider ACEI and CCB*

Re-check and review readings in 2–4 weeks[†2]

BP at goal?

NO
- *Thiazide for most patients or ACEI, ARB, CCB, or combo*
- If currently on BP med(s), titrate and/or add drug from different class

Re-check and review readings in 2–4 weeks[†2]

YES
- Encourage self-monitoring and adherence to meds[3]
- Advise patient to alert office if he/she notes BP elevation or side effects
- Continue office visits as clinically appropriate

Medications to consider for patients with hypertension and certain medical conditions
- Coronary artery disease/Post MI: *BB, ACEI*
- Heart failure with reduced EF: *ACEI or ARB, BB (approved for this use), ALDO, diuretic*
- Heart failure with preserved EF: *ACEI or ARB, BB (approved for this use), diuretic*
- Diabetes: *ACEI or ARB, diuretic, BB, CCB*
- Kidney disease: *ACEI or ARB*
- Stroke or TIA: *diuretic, ACEI*

- *Optimize dosage(s)* **or** *add additional medications*
- Address adherence, advise on self-monitoring, and request readings from home and other settings
- Consider identifiable causes of HTN and referral to HTN specialist[1]

BP at goal? YES / NO

BP at goal? YES / NO

- *Optimize dosage(s)* **or** *add additional medications*
- Address adherence and advise on self-monitoring and request readings from home and other settings
- Consider identifiable causes of HTN and referral to HTN specialist[1]

Re-check and review readings in 2–4 weeks[†2]

* See page two for lifestyle modifications

† Re-check interval should be based on patient's risk of adverse outcomes

Print Form | Save Form | Next Page

(continued)

- Protocol for Controlling Hypertension in Adults
  - Protocol for Controlling Hypertension in Adults (hhs.gov)
  - Customize this template by gathering clinical staff to make consensus decisions about:
    - Specific medications to be prescribed for most patients with hypertension
    - Medications to consider for patients with hypertension and certain medical conditions
    - Starting dosages and dosage increases with each titration
    - Time intervals for follow-up and titration
  - Adopt the protocol across the practice or system and revise it over time to meet the needs of patients and staff

Source: Centers for Disease Control and Prevention. Protocol for Controlling Hypertension in Adults. Atlanta, Georgia. 2013.

Resources

- ASCVD Risk Calculator
  - 2018 Prevention Guidelines Tool CV Risk Calculator (heart.org)
  - Purpose: to estimate a patient's 10-year ASCVD risk at an initial visit to establish a reference point
  - Starting point, not final arbiter, for decision making in primary prevention of ASCVD

Source: 2018 Prevention Guidelines Tool CV Risk Calculator (heart.org)

Resources

- Act Rapidly Pre-assessment
  - Act Rapidly Pre-assessment | Target:BP (targetbp.org)
  - Purpose: to help identify areas of opportunity to better diagnose and manage hypertension
    - Flagging high blood pressure – notify provider of high BPs, flag high BPs in the EHR
    - Having treatment protocols in place
    - Using medical records – EHR reports of patients with uncontrolled high BP, schedule follow-up visits, SMBP, etc.

Source: Act Rapidly Pre-assessment | Target:BP (targetbp.org)

Resources

What Can I Do To Improve My High Blood Pressure?

Modification	Recommendation	Approximate SBP Reduction Range
Weight reduction	Maintain normal body weight (BMI=18.5-24.9 kg/m²)	5 mm Hg
DASH eating plan	Diet rich in fruits, vegetables, low fat dairy and reduced in fat	11 mm Hg
Restrict sodium intake	<1500 mg of sodium per day	5-6 mm Hg
Physical activity	Be more physically active. Aim for at least 90 to 150 minutes of moderate-intensity activity per week.*	5-8 mm Hg
Moderation of alcohol consumption	No more than 2 drinks/day for men and 1 drink/day for women	4 mm Hg

*Adults should also do muscle-strengthening activities 2 or more days per week.
BP = Blood pressure, BMI = Body mass index, SBP = Systolic blood pressure, DASH = Dietary Approaches to Stop Hypertension

Best Proven Nonpharmacologic Interventions for Prevention and Treatment of Hypertension
According to 2017 Hypertension Clinical Practice Guideline

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Source: [What Can I Do To Improve My High Blood Pressure? | Target:BP (targetbp.org)](targetbp.org)

Thank you!

Please join us back in the main session

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BREAK

11:15 AM – 11:30 AM EST

IMPORTANCE OF HYPERTENSION SCREENING BY DENTAL PROVIDERS

Lisa L. Knowles, D.D.S. – Blue Cross Blue Shield of Michigan

Disclosure Statement

- **Lisa Knowles, D.D.S.** has no relevant financial relationship(s) with ineligible companies to disclose

LUNCH

12:15 PM – 12:45 PM EST

IMPLEMENTING BLOOD PRESSURE SCREENING IN THE DENTAL SETTING

Michele Kawabe – MDHHS

Kimberly Singh – My Community Dental Centers

Disclosure Statements

- **Michele Kawabe, MPH, RDN, CDCES** has no relevant financial relationship(s) with ineligible companies to disclose
- **Kimberly Singh, MA, CHES** has no relevant financial relationship(s) with ineligible companies to disclose

INTEGRATED CARE SETTING BREAKOUT DISCUSSIONS

Kristina Dawkins, MDHHS
Julee Campbell, MPRO
Andrea Boucher, MPRO
Patti Burchett, MPRO

Integrated Care Setting Breakout Discussions

1:30 pm – 2:25 pm EST

WHY SHOULD WE COLLABORATE?

Team-based care to improve BP control

For prevention of cardiovascular disease, team-based care involves a multidisciplinary team to:

Maintain an ongoing dialog with patients about their health and care

Prescribe and modify treatments

Identify risk factors for disease

Educate patients

Source: Promoting Team-Based Care to Improve High Blood Pressure Control | CDC | DHDSP

Team-based care (continued)

Patient

Doctors

Nurses

Pharmacists

Community Paramedics

Primary Care Providers

Community Health Workers

Oral Health Professionals

Source: [Promoting Team-Based Care to Improve High Blood Pressure Control | CDC | DHDSP]

Impact of team-based care

Hypertension Management

- Significantly improved hypertension control
- Lowered systolic and diastolic BP levels
- Improved patient adherence to hypertensive medication

Health Disparities

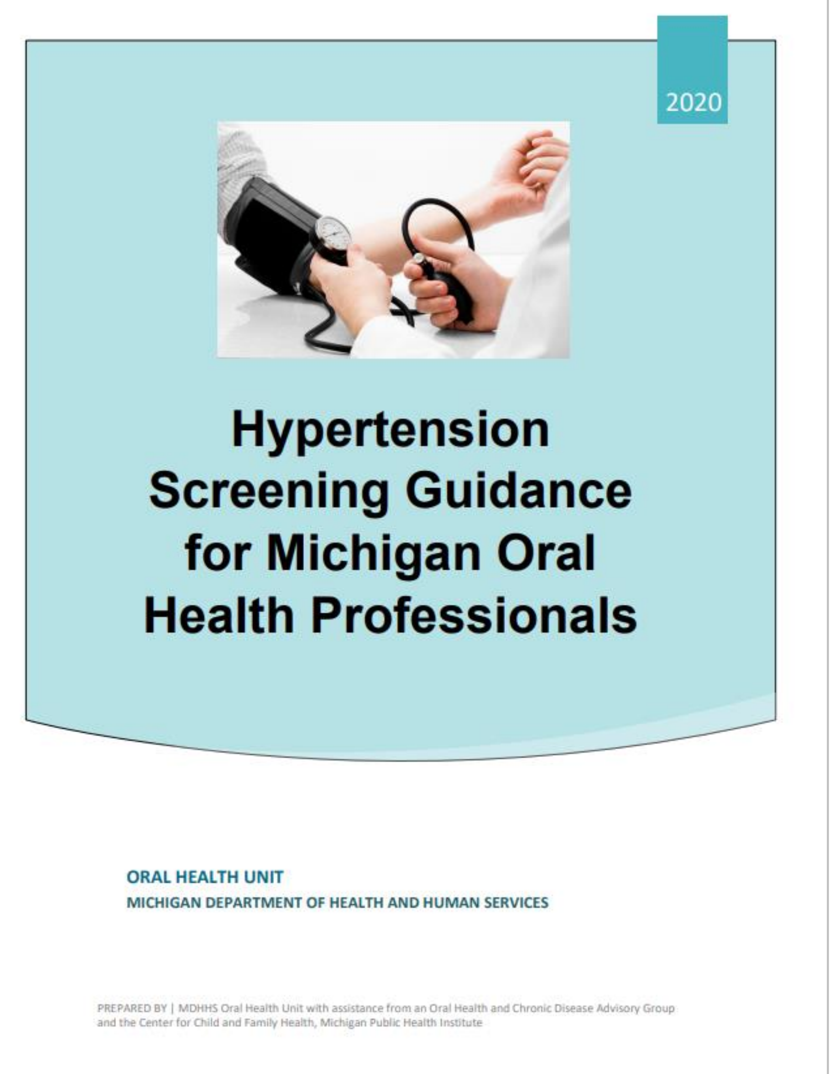
- Team-based care has been found effective when used among diverse patient populations, including:
  - Those with members of different racial and ethnic groups
  - Among patients with multiple health conditions
  - Low-income populations

Economic

- **$355 per person per year** = median total cost for providing team-based care for hypertension control
- **$25.3 billion** = averted disease costs modeled with nationwide adoption of team-based care for hypertension over 10 years
  - **$5.8 billion** = estimated net cost savings to Medicare with nationwide adoption over this same time period

Care setting collaboration

If the patient's blood pressure readings are high, oral health professionals should inform the patient, provide a referral to the patient's primary care provider, and follow up to ensure needed care was obtained to prevent long-term consequences of hypertension



Source: Hypertension Screening Guidance for Michigan Oral Health Professionals

Stories from the field

Stories from the Field
Team-Based Care

Team-Based Care at WinMed Health Services

WinMed Health Services, an FQHC in Cincinnati, Ohio, is a 2014 Million Hearts® Hypertension Control Champion that successfully incorporated team-based care to help achieve hypertension control among its patients. To ensure a continuum of complete patient care, WinMed's care teams include physicians, pharmacists, and behavioral and dental professionals. WinMed focuses on increasing health care providers' expertise and skills, providing opportunities for patient education, ensuring that patient care is team-based, and using registry-based information systems. The WinMed care teams use electronic health records to increase proper communication between patients and the different providers. By improving community ties and patient education, encouraging greater patient engagement, and adding pharmacists and patient assisters to the health care team, WinMed achieved a 7% increase in hypertension control among its patients from 2013 to 2014.

Learn more.

Source: Promoting Team-Based Care to Improve High Blood Pressure Control | CDC | DHDSP

Stories from the field

Success Story: FQHCs Use a Medical Home Model for Underserved Populations

Download this story [PDF – 271 KB]

Lorain County Health & Dentistry (Lorain, Ohio) and North Hudson Community Action Corporation (West New York, New Jersey) (2017)

In previous rounds of the Hypertension Control Challenge, Million Hearts® established a benchmark of 70% hypertension control for applicants' adult populations. This 2017 success story reflects the earlier benchmark.

- Lorain County is a multidisciplinary health center, offering services in women's health optometry, podiatry, **primary care**, pediatrics, and **dentistry**
  - Within each discipline, the health care team checks patients' blood pressure, **helping ensure no cases of hypertension are left hiding in plain sight**

Stories from the field

Success Story: Pawhuska Indian Health Center Achieves Success for its Population

Pawhuska Indian Health Center, Pawhuska, Oklahoma (2013)

Download this story [PDF – 300 KB]

In previous rounds of the Hypertension Control Challenge, Million Hearts® established a benchmark of 70% hypertension control for applicants' adult populations. This 2013 success story reflects the earlier benchmark.

- PHIC used the Improving Patient Care program, a patient-centered approach supporting a strong collaboration among nurses, physicians and patients
  - Other PIHC departments, such as **dentistry** and optometry, used the same EHR system and, when treating a patient with high blood pressure, **easily identified and referred at-risk patients to the care team for follow-up**
  - PIHC's strong internal communication across primary care, pharmacy, **dentistry** and optometry helped reduce the risk that patients might fall through the cracks and **provided additional opportunities for blood pressure checks**

Source: Success Story: FQHCs Use a Medical Home Model for Underserved Populations | Million Hearts® (hhs.gov)

Challenges and strategies

- Electronic medical and dental records may not be interfacing
  - Referral generation
  - Bidirectional communication
- Talking with patients about risks of dental procedures with unknown hypertension

DISCUSSION

What works best for cross-setting communication?

- Example: Sample referral form
  - Reason for referral
  - Patient's information
  - BP readings

Source: Hypertension Screening Guidance for Michigan Oral Health Professionals

Appendix B: Sample Referral Form

Dental Provider Logo	Dental Provider Contact Information

Medical Consultation/Referral for Hypertension

To: ______________________________ Date: ______________

Address: ______________________________

____

Dear ______________,

Your patient, listed below, has presented to us for oral health care. To ensure appropriate management of the health of this person, we are asking you to follow up with an assessment for hypertension.

Patient's Name: ______________________________

Patient's Address: ______________________________

____

The patient presented today with blood pressure readings as follows:

1st reading: ___/___mm Hg *2nd reading*: ___/___mm Hg mm Hg *3rd reading*: ___/___mm Hg

Comments: ______________________________

Please evaluate the patient and inform us of your findings, treatment, and recommendations. We normally do not provide any dental treatment on patients with a blood pressure reading of >180 mm Hg systolic or >110 mm Hg diastolic.

Dental Provider notes: ______________________________

Dentist's Signature: ______________________________Date: ______________

Please fax reply to: (XXX) XXX-XXXX

Physician's reply: ______________________________

Physician's Signature: ______________________________Date: ______________

Dental Provider/Patient follow-up:

Date:__________ Note:______________________________

Date:__________ Note:______________________________

Date:__________ Note:______________________________

How should communication between oral health and primary care settings happen?

Should this be two-way communication to determine if the patient received follow-up care?

What barriers do you see to this cross-setting collaboration?

What information needs to be exchanged so that providers in both medical and oral healthcare settings have the information they need?

What education should be happening with patients about high blood pressure in oral health and medical settings?

What impacts will collaboration between oral health and medical providers have on patients?

What should next steps be if a patient does not have a primary care provider?

As more patients have their blood pressure measured in oral healthcare settings, how do you see this informing patients’ treatment?

What will your next steps for collaboration be after today's Summit?

Thank you!

Please join us back in the main session

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248-465-7300 | mpro.org

CLOSING REMARKS

Julee Campbell, MPRO

Is changing its name to…

Thank you!

- Please complete the event evaluation!
- Process for obtaining CEs
- The recording, presentation slides, and remaining Q&A will be shared with all registrants following today's event

Additional Questions?

Interested in more events and resources?

Contact: jcampbel@mpro.org

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