Digging Deeper: Quality

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Scott Wolpin, DMD- Chief Dental Officer, Eastern Shore Rural Health

National Primary Oral Health Conference
November 10, 2013
Objectives

• Recognize the factors that will drive changes in the way dental quality is assessed in Health Centers
• Understand the process for selecting appropriate quality metrics for your Health Center dental program.
• Describe how selection of measures can drive implementation of evidence-based practices
National Quality Environment

Current Initiatives that Will Affect Health Centers
HRSA Recommended Quality Initiatives

- NCQA PCMH recognition
- Joint Commission accreditation
- AAAHC accreditation (Accreditation Association for Ambulatory Health Care)
HHS- Healthy People 2020

• Science-based, 10-year national objectives for improving the health of all Americans

• UDS Quality of Care indicators based on HP 2020

• Oral Health Leading Health Indicator:
  - Persons aged 2 years and older who used the oral health care system in the past 12 months

National Quality Forum (NQF)

- 2011-2012: NQF commissioned by HRSA and Healthy People 2020 to perform a review of all known current national dental quality indicators or measures in use
- 257 oral health measures identified
- Many redundant, overlapping, ill-defined or non-standardized (repetitive concepts defined differently)
- Process or quantitative measures were most abundant and best defined
- Lack of qualitative measures

2013 CMS Stage 2
Meaningful Use CQMs

• Percentage of children, ages 0-20 years, who have had tooth decay or cavities during the measurement period.

• Percentage of children, age 0-20 years, who received a fluoride varnish application during the measurement period (dental & medical setting).
Dental Quality Alliance

- DQA – commissioned by the American Dental Association in 2008
- Composed of over 29 entities, including public representation
- Oct. 2013 Received grant to test two eMeasures for Stage 3
  1. Sealants in first permanent molar for children aged 6 – 9 years
  2. Care Continuity: Oral exam over two consecutive years
Context

• Quality measures will be tied to future payment methods
• Certification and recognition by national quality organizations necessary for payment and meeting federal standards
• For dentistry to continue as part of the Health Center clinical system it must adopt standards consistent with the system
The “Triple Aim”

- Improved Health
- Improved Care
- Reduced Cost

Don Berwick & Institute for Healthcare Improvement
Recent study compared medical costs of diabetic patients who received periodontal treatment versus no treatment over three years.

Patients commercial medical and dental insurance.

Periodontal treatment was associated with a significant decrease in hospital admissions, physician visits and overall cost of medical care in diabetics. **Savings averaged $1,814 per patient in a single year independent of age and sex.**

Quality Improvement

Measure & Move the Measure!
Quality Improvement (QI)

• **An approach** to the analysis of performance and systematic efforts to improve it
• Measuring where you are, figuring out how to improve
• Data establishes “baseline” and QI process develops methods to improve from the baseline
• Creates systems to improve outcomes
Opportunity for Improvement

Actual

Desired

The Gap

- Access to care (visit)
- Type of service (sealant)
- Cost (lower)
- Adverse patient event (hospital)
- Oral health outcomes (BP)
Populations/ Panels

• Denominator defined as needed

• Changes depending on measure
  • Total community
  • Health Center population
    – Diabetic patients
    – Perintal patients
  • Dental users
    – Age 0-5
    – Age 6-9
  • Individual provider or clinic
Types of Measures

**System**
- Number of team members
- Facilities
- Case management
- Data systems
- Use of guidelines
- Constant feedback

**Process of Care**
- Oral cancer screening
- Risk Assessment
- Fluoride
- Sealant
- Periodontal treatment
- Smoking cessation
- Tx plan completion

**Health Outcomes**
- Cancer incidence
- Caries status
- Periodontal status
- Tooth loss
- Glycemic control
- Quality of life
- Cost
Selecting Process Measures

Quality

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

Actions that “work”

• Sealants
• Fluoride
• Perinatal oral health care
• Diabetic periodontal care
Sample Process Measures

• Annual Oral Health Visit
• Treatment Plan Completed
• Topical Fluoride Treatment
• Dental Sealants
• Oral Health Education (medical setting)
• Periodontal Exam (HIV, diabetic)
Sample Service Use Measures

• HEDIS®- national measures developed for insurance plans
  – Annual dental exam measure
• Medicaid dental plans
  – Number/% beneficiaries that had a visit in a given year
Sample Outcome Measures

- Percentage who have had tooth decay or cavities in the past 6 months
- Percentage of caries free
- Cancer incidence
- ER utilization
Measures are the Key

- Allow you to individualize for your patient populations and their needs
- Allow you to collect data to show delivery of proven health care interventions
- Enable you to show improved health care outcomes
- Working towards improvement in the measures is what drives system change!
Model for Improvement

- Approach quality improvement through rapid cycles of change
- Continual feedback on the effectiveness of changes
- Used with Chronic Care Model can lead to positive, sustainable changes in the quality of health care
PDSA Cycle

- Shorthand for using the scientific method to test a change by planning it, trying it, observing the results, and acting on what is learned
Starting Out

• Select one measure
• Work out implementation systems, data gathering
• Baseline
• Trial PDSAs to create system change, move measure
• Repeat
NNOHA Resources

• **Quality Chapter** - NNOHA Operations Manual for Health Center Oral Health Programs

• Other Quality Improvement tools available at:
Conclusion

- **Always changing:** Environment in which health care/oral health care exists

- **Never changes:** Our mission to strive to provide the highest quality care we can to the populations we serve
How is Patient Scheduling Related to Quality?

Scott Wolpin, DMD
National Network for Oral Health Access
We simply can not be everything to everybody but we must for some...
Yet we Must be More than a Toothache Clinic
Three Overarching Quality Goals of Any Health Center Dental Program

1. Completing Dental Treatment Plans (Phase 1 care)
2. Focusing Service on Target Populations
3. Serving as a PCMH referral resource
Phase I Treatment

Elimination of disease includes:

- Treating cavities through basic restorative care
- Extraction of hopeless teeth
- Basic periodontal maintenance
- Treatment of acute dental disease and
- Any other basic treatments that return a patient back to a basal level of normal oral health.
How do We do it and What Does “right” Look Like?
Strategies to Increase Tx Completion Rate

• ?
• ?
• ?
Using a Template Scheduling and Quadrant Dentistry Approach We...

- Increased our case completion rate
- Afforded more “new” patients to enter the practice
- Provided “one stop shopping“ of primary care services for our health center’s patients
What Should the Panel Size and Payer Mix look like?

• 35 hours/week x 1.7 patient visits/hour = 59.5 patient visits per week

• 59.5 * 48 weeks = 2856 patient visits/2.5 visits per user = 1142 users per provider

• 60% or 685 Medicaid Insured children, pregnant women

• 30% or 342 SFS PCMH patients

• 10% or 114 private pay or commercially insured patients
## Sample Schedule

<table>
<thead>
<tr>
<th>Chair 1</th>
<th>Chair 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>MA</td>
<td>MA</td>
</tr>
<tr>
<td>SFS</td>
<td>Acute same day</td>
</tr>
<tr>
<td>MA</td>
<td>MA</td>
</tr>
<tr>
<td>Lunch</td>
<td></td>
</tr>
<tr>
<td>SFS</td>
<td>MA</td>
</tr>
<tr>
<td>MA</td>
<td>MA</td>
</tr>
<tr>
<td>CI</td>
<td>Acute same day</td>
</tr>
<tr>
<td>SFS</td>
<td>MA</td>
</tr>
<tr>
<td>MA</td>
<td>MA</td>
</tr>
</tbody>
</table>

MA = Medicaid insured children, pregnant women, WIC  
SFS = PCMH, medically complex  
CI = Commercially insured,
Direct Scheduling

Appointments are protected for target populations and made by:

- WIC DHs
- PCMH Health Educators
- Medical Program referral and support staff
- And SBDP staff
Overall Case Completion Average of Three Dental Offices

Average HRSA Benchmark

NNCOHA
National Network for Oral Health Access
2013 Q3 90 Day Action Plan – a Growth Goal

• Increase the CCHS percentage of visits by Medicaid insured dental users by 10 percentage points as of YTD April 30, 2013.
  • Baseline = 45.41%
  • Current = 59.53% (October 2013)
Payer Mix Change for Dental Program April-Aug 2013

Chart Title

- SFS
- MA
- INS

<table>
<thead>
<tr>
<th>Month</th>
<th>SFS</th>
<th>MA</th>
<th>INS</th>
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<tbody>
<tr>
<td>April</td>
<td>47.76</td>
<td>53.41</td>
<td>55.61</td>
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<tr>
<td>July</td>
<td>45.41</td>
<td>59.53</td>
<td>59.53</td>
</tr>
<tr>
<td>Aug</td>
<td>40.15</td>
<td>55.61</td>
<td>59.53</td>
</tr>
<tr>
<td>Oct</td>
<td>38.11</td>
<td>59.53</td>
<td>59.53</td>
</tr>
</tbody>
</table>

April: 47.76
July: 45.41
Aug: 40.15
Oct: 38.11

June: 53.41
July: 59.53
Aug: 55.61
Oct: 59.53

June: 5.74
July: 6.17
Aug: 6.33
Oct: 5.74
Summary

• Avoid the funnel effect – full schedules of the episodic care only patients is unhealthy for your health center and for the patients that really need to see you

• Protecting appointments for target populations will drive other important metrics (i.e. case completion rate, payer mix, revenue per visit)

• Direct scheduling is a critical component if your dental program is to contribute to the PCMH
The End

No, it isn't
Digging Deeper
Finance

Chris Shea, CEO
Cherry Street Health Services
Grand Rapids, MI
So You Want to Develop Oral Health Services...

• What?
• Why?
• For Whom?
• How?
• How Well?
Need

• Need ratio - General Population (If 0 or few dentists)
  2,000 Total population: Total FTE Dentists

• Need ratio - Low Income Population (if more dentists or more urbanized area)
  2,000 population with incomes <200% of poverty level: FTE dentists, Medicaid, discounted or free care
Demand

• Can you get them into the chair?
• 3rd next available appointment – 2 weeks out
• 50–80%? of unmet need

• Plan for the long term
## Montcalm Area Health Center

<table>
<thead>
<tr>
<th></th>
<th>Was</th>
<th>Now</th>
</tr>
</thead>
<tbody>
<tr>
<td>chairs</td>
<td>5</td>
<td>8 (+2)</td>
</tr>
<tr>
<td>pano</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>dentists</td>
<td>2</td>
<td>3.5</td>
</tr>
<tr>
<td>hygienists</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>3rd next appoint.</td>
<td>15-45 days</td>
<td>2-10 days</td>
</tr>
</tbody>
</table>
Space – Montcalm Area Health Center

Orig. Bldg. 6,600 SF       New Bldg. 16,967 SF

2007 New Access Point Funding - $15/SF Lease
2012 New $9/SF Lease – More Space/Lower Cost
2013 Purchase - USDA loan - still lower cost - Equity

New Access Point $
Spectrum Hospital Support grants (e.g. ER Diversion)
long term vacancy
Repossession of Property
USDA loan availability
Capitol Campaign (ltd. success)
bank desire to sell
## Oral Health department - productivity

<table>
<thead>
<tr>
<th></th>
<th>FTE</th>
<th>Days</th>
<th>Hours</th>
<th>Total Hrs</th>
<th>Visits/hr.</th>
<th>Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Director (patient svcs.)</td>
<td>0.6</td>
<td>240</td>
<td>7</td>
<td>1008</td>
<td>1.7</td>
<td>1,714</td>
</tr>
<tr>
<td>Dentist</td>
<td>2.0</td>
<td>240</td>
<td>7</td>
<td>3360</td>
<td>1.7</td>
<td>5,712</td>
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<tr>
<td>Dental Hygienist</td>
<td>1.0</td>
<td>240</td>
<td>7</td>
<td>1680</td>
<td>1.7</td>
<td>2,856</td>
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<tr>
<td>Dental Assistant</td>
<td>4.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</table>

<p>| | | | | | | |</p>
<table>
<thead>
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</thead>
<tbody>
<tr>
<td>Total</td>
<td>8.1</td>
<td></td>
<td></td>
<td>10,282</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total patients @2.5 visits**

- 4,500 patients

- 4,113 visits

**Improved quality - tooth decay and fluoride**

- No

**Revenue /Expense**

- 1st year: $0
- 2nd year: $0

- 1st year: -$40,135
- 2nd year: -$40,135
<table>
<thead>
<tr>
<th>Position</th>
<th>Hourly/annual</th>
<th>Wages</th>
<th>FTE</th>
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</thead>
<tbody>
<tr>
<td>Dental Director</td>
<td>$150,000</td>
<td>$150,000</td>
<td>1.0</td>
</tr>
<tr>
<td>Dentist</td>
<td>$125,000</td>
<td>$250,000</td>
<td>2.0</td>
</tr>
<tr>
<td>Dental Hygienist</td>
<td>$30.00</td>
<td>$62,400</td>
<td>1.0</td>
</tr>
<tr>
<td>Dental Assistant</td>
<td>$16.00</td>
<td>$149,760</td>
<td>4.5</td>
</tr>
<tr>
<td><strong>total wages</strong></td>
<td></td>
<td>$612,160</td>
<td></td>
</tr>
<tr>
<td><strong>fringe @26%</strong></td>
<td></td>
<td>$159,162</td>
<td></td>
</tr>
<tr>
<td><strong>Total wage and fringe</strong></td>
<td></td>
<td>$771,322</td>
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<table>
<thead>
<tr>
<th></th>
<th>1st year</th>
<th>2nd year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supplies - clinical @ $9</td>
<td>$92,534</td>
<td></td>
</tr>
<tr>
<td>Supplies - office</td>
<td>$5,000</td>
<td></td>
</tr>
<tr>
<td>repair and maintence</td>
<td>$20,800</td>
<td></td>
</tr>
<tr>
<td>Minor Equip (e.g. dent. tools, computers, licenses etc)</td>
<td>$20,600</td>
<td></td>
</tr>
<tr>
<td>Misc. (e.g. phone, travel, training)</td>
<td>$24,800</td>
<td></td>
</tr>
<tr>
<td><strong>Subtotal - direct expense</strong></td>
<td>$935,056</td>
<td></td>
</tr>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>1st year</th>
<th>2nd year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overhead - non-clinical support</td>
<td>$271,166</td>
<td></td>
</tr>
<tr>
<td>Overhead - facility costs</td>
<td>$93,506</td>
<td></td>
</tr>
<tr>
<td><strong>subtotal - expense</strong></td>
<td>$1,299,728</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>1st year</th>
<th>2nd year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 time non-capitalized exp. (startup supplies)</td>
<td>$22,000</td>
<td></td>
</tr>
<tr>
<td><strong>Total Expense</strong></td>
<td>$1,321,728</td>
<td>$1,299,728</td>
</tr>
</tbody>
</table>
### Oral Health department - income

<table>
<thead>
<tr>
<th></th>
<th>Medicaid</th>
<th>commercial</th>
<th>Uninsured</th>
<th>Total 3rd party</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visits</td>
<td>45%</td>
<td>10%</td>
<td>45%</td>
<td>100%</td>
</tr>
<tr>
<td>Visits (num)</td>
<td>4627</td>
<td>1028</td>
<td>4627</td>
<td>10282</td>
</tr>
<tr>
<td>revenue/visit</td>
<td>$160.00</td>
<td>$120.00</td>
<td>$28.00</td>
<td></td>
</tr>
<tr>
<td>patient revenue</td>
<td>$740,275</td>
<td>$123,379</td>
<td>$129,548</td>
<td>$993,203</td>
</tr>
<tr>
<td>FQHC grant allocation @ $25/visit</td>
<td></td>
<td></td>
<td></td>
<td>$257,040</td>
</tr>
<tr>
<td>Foundation 3-aim grant</td>
<td></td>
<td></td>
<td></td>
<td>$50,000</td>
</tr>
<tr>
<td>Meaningful Use $ @21K , 8K</td>
<td></td>
<td></td>
<td>$63,000</td>
<td>$24,000</td>
</tr>
<tr>
<td></td>
<td>1st year</td>
<td>2nd year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Revenue</td>
<td>$1,250,243</td>
<td>$1,250,243</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Expense</td>
<td>$1,290,377</td>
<td>$1,290,377</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenue /Expense</td>
<td>-$40,135</td>
<td>-$40,135</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Capital Cost

- Example – 2,000 SqFt, 3 Operatory
  - Total Facility Cost – leasehold $453,370
  - Total Facility Cost – build $613,370

- Example 2 – 3,000 SqFt, 6 Operatory
  - Total Facility Cost – leasehold $691,721
  - Total Facility Cost – build $931,721

The larger the expansion, the lower the capital cost per encounter.
Other Capital Funding

- Capital Campaign
- USDA loans and grants
- Commercial loans
- Community Health Center grants - capital improvement portions (NAP, Service Expansion)
- New markets tax credits
- Hospital Community Benefits
- Additional lease/purchase options
Consider...

- In FQHC setting, three required (internally competitive?) services: medical, oral health and mental health

- Up front capital cost much higher for oral health than for medical or mental health. Are your CEO, CFO and board OK with that?

- Depending on State Medicaid system, long term oral health operations may operate more profitably than medical or mental health! Do you have the CEO’s, CFO’s and board’s attention now?

- Have you thought about the financial synergies of these 3 services?
Operational Funding Factors

- Payer Mix Adjustment (women and children first)
- FQHC Medicaid PPS (results may vary)
- NHSC loan or scholarship (based on HPSA)
- State loan repayment
- Travelling School Dental Program
- Adult Volunteer Dental Program
- BX Integration grant
- School Based Health Center grants
- Special population contracts (e.g. nursing homes, State Health Department)
Leadership Question

• The financial cost and benefit of quality

- Improves Patient Experience
- Saves Cost
CHRIS SHEA, Chief Executive Officer

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Grand Rapids, MI
616-776-2129
cshea@cherryhealth.com
• DENTAL
• IMPROVEMENT
• GAME
  • G
  • I
  • N
  • G
  • D
  • E
  • E
  • P
  • R
Triple Aim

Federal

- Improved Population Health
- Improved Patient Experience
- Lower Cost

DIG Health Center

- 4,500 patients served
- Improved Quality
- Financial break even
DIGing Deeper Options

Add one dentist
- Add 1.5 D.A., productivity lag in 1st yr. due to new DDS and gradual attraction of new patients

Increase Medicaid 10%
- Additional admin. time but better payor mix

Increase Productivity by 5% through team efficiency
- Additional admin. time but productivity increase

Track Tooth Decay and Fluoride Improvements
- Additional admin. time but meaningful use payments

Foundation or Federal Funding Award
- Additional funding, but requires achieving triple aim
You Cannot win this game.

Life has conflicts.
DIGging Deeper Options

- Add one dentist
- Increase Medicaid 10%
- Increase Productivity by 5% through team efficiency
- Track Tooth Decay and Fluoride Improvements
- Foundation or Federal Funding Award

- + 1.5 D.A., -15% productivity drop 1st yr. [prod. D15=(IF Expense!D6=3,K13*.85,K13) [exp. D6=3]
- Additional admin. time but better payor mix [prod. D5= -.1 FTE] [inc. B5=55% D5=35%] [exp. B22=+1%]
- Additional admin. time but productivity increase [prod. D5= -.1FTE ; H5= 1.8] [exp. B22=+1%]
- Additional admin. time but meaningful use $ [prod. D5= -.1 FTE] [inc. D15=...(E8:E10)+D12 and E15=...(E8:E10)+D12][exp. B22=+1%]
- Additional funding, but Requires achieving triple aim [prod. D5= -.1FTE] [inc. D15=...(E8:E11) E15=...(E8:E11)] [exp.B22=+1%]