Risk Management: Protecting Your Patients, Your Providers and Your Health Center

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Objectives

- What risk management is;
- Common risks involved in the practice of oral health care;
- Ways to prevent common risks;
- How the Federal Tort Claims Act (FTCA) can protect Health Centers and their providers
- How ethics and risk management work together.
Definition of Risk Management

Identification, assessment, and prioritization of risks (the effect of uncertainty) and the application of resources to minimize, monitor, and control the probability or impact of adverse events.

It specifies information needed by providers, leaders, and staff to minimize risks for their oral health programs, and next steps if an error occurs.
Where Are Your Risks?

- Credentialing/ Privileging
- Staff Orientation
- Standards of Care and Clinical Guidelines:
  - Ethics: Is your staff behaving correctly?
- Informed consent/ Refusal
- Charting Protocols
Where Are Your Risks?

- Time outs
- Patient satisfaction
- Communication
- Compliance issues
- Risk Assessment Tools
- Legal Issues
Top 10 Potential Risk Areas For Health Center Oral Health Programs

1. Lack of informed consent
2. Failure to diagnose
3. Lack of a thorough exam
4. Failure to follow-up on emergencies
5. Treatment of the wrong tooth
6. Surgical complications
7. Removable prosthetics
8. Lack of/inadequate treatment plan
9. Incomplete treatment
10. Inappropriate procedures
Top 10 Professional Issues
(State Board Perspective)

- Quality of Care
- Patient treatment
- Infection Control Standards
- Informed Consent
- Prescriptions
- Aberrant Billing – Misrepresentation/Fraud
- Aiding and abetting unlicensed practice
- Moral turpitude
- Records release
- Failure to renew license
Informed Consent

- Informed consent is required for all surgical and other invasive and/or high risk procedures.
- Know the Standards of Care in your state.
- Not required for simple or common procedures where risk is generally known.
- Must be a provider/patient conversation.
- Must include the option of no care as well.
Consent for Minors

- Know your state laws concerning minors
- Insure your front office staff understands about legal guardians, step parent issues and divorce issues
- Foster care issues- working with social workers
- Emancipated minors
- Procedures where you may want parents present regardless of what the law allows
- What to do when you don’t know what to do
Minors
Informed Refusal

- Patients do have a right to make informed decisions
- Must discuss:
  - Problem needing treatment or DX
  - All proposed treatment, medications and tests
  - Anticipated benefits, risks, adverse reactions etc.
  - Risks and potential consequences of refusing treatment
- All of the above plus education handouts must be documented in the charts
Informed Consent and Informed Refusal are irrelevant and will not protect the dentist if malpractice is done.
Periodontal Issues

- Top Risks
  - Failure to Diagnose
  - Failure to inform
  - Failure to refer
  - Failure to treat

- Periodontal charting must be done for all adult patients who have received an initial exam and at each recall
Patient Follow-up

- Emergency care follow-up
- Biopsy reports
- Great follow-up enhances patient care and the dentist patient relationship
- Poor follow-up is a huge risk issue
- Consider a Patient Call Back Log
- Document any call to or from patients
Nitrous Oxide

- Understand your State dental sedation laws
- Have written Consent: American Academy of Pediatric Dentistry (may depend on the state you're in)

Develop a nitrous oxide policy to include:
- Equipment maintenance procedures
- Record keeping requirements
- Procedures for monitor nitrous oxide
- Privileging for the use of nitrous oxide
- Nitrous abuse issues
Radiographs

- One of the basic tenants of diagnosis
- Quality (apices of the teeth; distal of canines; no overlaps)
- Refusal of radiographs
Endodontics

- Failure to diagnose the need for endodontic treatment,
- Failure to refer
- Incorrect performance of the procedure
- Failure to take reasonable precautions
- Failure to inform the patient of a separated instrument left in the canal

*CNA HealthPro Manage Your Endodonic Risks*
Risk Management
Risk Management Tools

- Privileging Form
- New Dentist Orientation Plan
- Standards of Care/Guidelines
- Chart Audits/Peer Review
- Patient Complaint Review
- Patient Satisfaction Surveys
- Equipment Maintenance Logs
Dental Privileging

- Privileging helps you determine that a dentist is practicing within their training abilities.
- You need defined education and training requirements for each procedure(s).
- Dental privileging is granted for a specified period of time typically not exceeding 2 years.
New Dentist Orientation Plan

- Critical step in risk management!!!
- Provider manual ideal
Standards of Care and Clinical Guidelines Manual

- Critical for prospective, retrospective and concurrent reviews
- Reduces the subjectivity of these types of reviews
- Defines the quality you want for your program
- Tells a dentist upfront what you expect
- Should be reviewed with each provider at the time of hire
Standard of Care

- [A dentist is] under a duty to use that degree of care and skill which is expected of a reasonably competent [dentist] acting in the same or similar circumstances.

- The standard of care can change over time based on emerging clinical practice, prevailing knowledge and court case precedent.

- Providers are advised to keep abreast of changes in dental practice.
Clinical Guideline Examples

- Oral surgery: third molar extraction selection
- Endodontic case selection: American Association of Endodontists
- Pain medications
- Etc…….
Chart Audits: Retrospective Reviews

- Very limited by the # of charts possible to review
- Can pick up radiograph diagnosis issues
- Can identify basic charting issues: i.e. BPs, periodontal charting
- Raises overall awareness to QA issues
- Chart Review Guidelines: Critical!!!!
General Chart Audit Example

![Dentist Evaluation: Q&A Chart Review Form](image)

<table>
<thead>
<tr>
<th>Item</th>
<th>Outstanding</th>
<th>Satisfactory</th>
<th>Needs Improvement</th>
<th>NA</th>
</tr>
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<tbody>
<tr>
<td>Certify appropriate radiographs</td>
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<td>Radiographic dx appropriate</td>
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<td>Trauma plans complete and appropriate</td>
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<td>Pain assessment done</td>
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<td>Clinical judgment?</td>
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<td>Blood pressure protocols followed</td>
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<td>Documentation supports diagnosis?</td>
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<tr>
<td>Follows charting protocols</td>
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<td>Patient instructions documented?</td>
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<tr>
<td>Follows medical tx protocols</td>
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<td>Appropriate use of referral?</td>
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<td>Follows protocols for patient vital signs</td>
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<tr>
<td>Appropriate use of medications?</td>
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<td>Systolic protocols followed</td>
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<tr>
<td>Appropriate emergency follow-up done</td>
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</tbody>
</table>

**Performance based on this chart review (this rating is to be transferred to the Chart Results section of the Dentist Performance Evaluation Summary Form).**

- [ ] Outstanding
- [ ] Satisfactory
- [ ] Us satisfactory
- [ ] N/A

**Comment:**

Completed by: ____________________________  Date: __/__/____  
Signature: ____________________________
Chart Audit Guideline

Sample Question

Does the documentation support the diagnosis?

This category covers diagnosis and what is needed for an appropriate and accurate diagnosis.

No Issues Found:
- There were enough clinical tests listed to make a reasonable diagnosis. Remember that a radiograph that shows a large apical lesion and a destroyed crown may need no other diagnostic tests but a tooth with decay close to the nerve and no periapical lesions may need a full array of tests.

Needs Improvement (examples):
- There are not enough diagnostic tests listed to arrive at a reasonable diagnosis.
- The symptoms do not match the diagnosis?
- There is an emergency encounter with no listed diagnosis.
Charting Protocols

- ADA standards
Record Release and Retention

- Understand your state law requirements for record release
- Failure to release records is a common complaint sent to Dental Boards
- Know who can release the records, who can you release records to and what is required before release
- Know what is included in the definition of ‘legal record’ so you release the full record
- Know what your clinic’s policy is when an attorney requests records
Patient Satisfaction

- Happy patients generally do not sue dentists even when things go wrong
- Unhappy patients do!
Addressing Patient Complaints

- Determine if there were any violations of the state dental law
- Determine any standard of care violations
- Good care/bad outcome vs poor care/bad outcome
- Understand clinic policy for when to contact an attorney
- Must make decisions and contact patient in a timely manner
Provider Action Plans

- Does your clinic have a process and policy for dealing with providers that violate standards of care?
- Possible Action Plan components:
  - Chart reviews
  - Concurrent peer review
  - Procedure mentoring
- Who do you report to?
WHAT IS A NEVER EVENT?

- Errors that should never occur in health center
- Errors or Events Which can absolutely be prevented
- Errors which cause a great deal of bad press
- Errors which insurance companies identify that they will not pay for

NEVER EVENTS ARE A SYMPTOM OF A HEALTH CARE SYSTEM THAT IS BROKEN.
What are Dental Never Events

- The removal of non-diseased tooth structure (cutting, drilling, or extraction) unless clinically appropriate for continuing care (i.e. orthodontic extractions of healthy teeth);

- The removal of non-diseased tooth structure (cutting, drilling, or extraction) without the patient’s consent unless such consent cannot be obtained due to sedation and the removal is the professionally correct thing to do;

- Performing a procedure on the wrong patient or tooth;

- A medication error or dental infection that results in death or serious injury or disability;
Time Outs

- Your entire dental team (and the patient) should know the who, what, why and where of each procedure before it is done.
- Determine which member of the team should initiate the time out.
- If anyone has a question of what needs to be done, stop and get the questions answered.
- Record the time out in the chart notes.
- Chart exercise vs true time out.
Time Out
Time Out - Example

Time Out
Patient Name: Maria Smith
Patient DOB: 5-6-1984
The Side and Site are reviewed and accepted by the following individuals who were present for the treatment: lower left first molar #19.
Patient/Guardian reviewed and received the procedure information form. Patient/Guardian given opportunity to ask questions.
Other Things to Think About
Compliance Issues

- Billing issues
- Record storage
- License: expiration
- CE requirements
- BLS
- Amalgam separators
- OSHA and CDC regulations
- DEA compliance
- HIPPA
Sexual/Relationship Issues

- Single dentists in rural areas
- Patients/ patient guardians
- Legal and ethical issues
- Time frame on when a person was a patient
- Staff relationships
Front Office Miscommunication

- Diagnosing by front office staff over the phone
- Triaging emergency patients
- Misquoting fees
- Not scheduling correct follow-up appointments or mis-scheduling of patients
- Not communicating messages from patients to the dentist
Encounter Churning

- A question of ethics!
- You don’t lose encounters by practicing quadrant dentistry
Churning: A Swirling Ring of Fire

Our mission is to improve the oral health of all.

safety net solutions

DentaQuest Institute
Churning is defined as the systematic, institutionalized practice of maximizing revenues by maximizing visits/encounters where payment is determined by number of encounters, not by number of procedures encountered.
Churning in Dental is Unethical

• One visit = One procedure without justification is an example of dental churning.

• *Patient Centric* care is determined by a patient`s needs. Churning does not take that into consideration, it primarily focuses on the financial needs of the health center.

• Dental Practices are expected to render care according to the common “Standard of Care”.

• The “Standard of Care” in dental is to provide as much care at each visit to a dental patient needed to hasten the elimination of disease with sensitive regard to patient tolerance.
Churning is Not Patient Centric

• The average time of dental appointments in “patient centric” FQHCs to accomplish the “Standard of Care” is at least 45 minutes – when multiple treatment needs are present.

• The relative value of dental care in Relative Value Units (RVUs) is a good guide to the expected provision of care in 45 minute units of care.

• Providing care to maximize visits instead of maximizing the attainment of the disease free oral health status of patients is both unethical and unprofessional.

• Maximizing visits and unbundling care in order to achieve more visits is often interpreted by auditors as fraud.
Churning May be Considered Fraud

• Fraud is not only a threat to a program, but the commission of fraud by a dentist or hygienist can result in suspension or loss of one`s license.

• Churning creates a two tiered system of care where patients receiving churned visits are getting a second and diminished level of care.

• Churning can be the result of the request of an administrator requiring dental to generate more visits due to a lack of knowledge of the difference between the dental and the medical clinical models of care.
Churning is Unprofessional

• Is there a HRSA “Policy” that states there should only be one procedure per visit? NO! That is False!

• In dental care what actually occurs in the visit is what defines the value of the visit to the patient and not the visit itself.

• The average 45 minute dental appointment under the “Common Standard of Care” includes an average of 2.5 CDT coded services.

• What service occurs in dental visits should be determined, documented, and justified by the clinical judgement of the dentist.
Churning is considered fragmented care. It is not continuous or coordinated nor does it lend toward the comprehensive care model.

Churning has a limiting time per patient goal instead of a health or care goal.

When the expected amount of clinical care does not occur in a dental visit the unique reason(s) should always be documented in the chart to justify why and to avoid the appearance of churning.

When unbundling does occur the reason care was unbundled should be documented and thus justified in the chart.
Churning Can Result in Penalties

• Factors such as patient safety, lack of cooperation during treatment, medical conditions that limit procedure time, mental or physical disabilities, and patient choice to limit treatment time are examples of justifiable reasons – and must be added to the chart!

• Avoid cookie cutter or standard justification. Each case of documented justification for deviation from the expected “Standard of Care” should be unique to the patient.

• What is not charted did not occur – from a legal defense perspective.
Federal Tort Claims Act (FTCA)

- Health Center employees treated as employees of U.S. Public Health Service for malpractice liability coverage.
- Health Center’s scope of project defines approved service sites, providers, service areas, and target population(s).
- PT contract dentists and students/residents and volunteers are NOT covered.
- Must submit annual application to continue coverage.
Volunteer and Temporary Dentists

- NOT covered by FTCA
- Free does not always mean no cost
- Are these dentists credentialed and privileged in your system?
- Are they included in your chart audits?
- What orientation do you have set up for them?
Supervision of Students and Residents

- Generally covered by the academic institution
- Deep Pocket liability: a legal concept also called joint-and-several liability. This concept means that supervising dentists are legally responsible for the care delivered by residents and students.
- Supervising dentists may be liable for residents' negligence or may be directly liable for their own negligence in supervision or administration
- Students and residents should not be viewed as another way to advance productivity
Start With Your Biggest Risks

- Identify and triage your own center’s risks
- Develop policies to mitigate those risks
Questions?

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Quality: Striving to Provide the Highest Quality Care We Can to the Populations We Serve

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Erie Family Health Center, Chicago, IL

Ryan Tuscher, DDS
PCC Community Wellness Center, Chicago, IL
Why Assess Quality?

- Section 330 of Public Health Service Act requires every Health Center to have an ongoing QI/QA program.
- Federal Tort Claim Act (FTCA) deeming application process requires submission of Health Center QI/QA plan and QI/QA committee minutes.
- Positive patient outcomes.
Overall Desired Outcome
The “Quadruple Aim”

- Improved Health
- Reduced Cost
- Improved Care
- Provider Satisfaction
Quality: A Relatively New Concept In Dentistry

Traditional Dentistry:

- Procedural driven
- Quality limited to mechanical outcomes and processes, e.g. esthetics of restorations, marginal integrity, root canal fill lengths
- Little focus on population outcomes and impact on patient health
- Limited to quantitative measures
What is 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.”
-- Institute of Medicine (IOM)
IOM Quality Domains

- Safety
- Effectiveness
- Patient-centeredness
- Timeliness
- Efficiency
- Equity
QA/QI Program Should Include:

- Clinical Director: supports the program and the provision of high quality care
- Periodic assessment of the services provided (conducted by providers, based on systemic collection and evaluation of records)
- Identify the need for change (improvement)
Quality Assurance (QA)

- Traditional approach
- Development of a set of standards - comparison of services with established standards
- If standards met, services are of adequate quality
- If deficient, plans of correction are developed to address the problem

( WHO, 1994; WHO, 1997)
QA Process

- Medical vs. dental setting
- No diagnostic codes in dental for billing
- Limited evidence-based standards
- Peer review
- IT Service tracked measures
- Subjective patient outcomes
- Adverse outcomes
Objective Dental Record
Peer Review

- Utilizes dental peers to examine and evaluate patient record
- Documentation against well-defined criteria
- Random selection of a sample of patient dental records for review by:
  - other staff dentists
  - contracted expert reviewers
<table>
<thead>
<tr>
<th>General Chart Information</th>
<th>Chart One</th>
<th>Chart Two</th>
<th>Chart Three</th>
<th>Chart Four</th>
<th>Chart Five</th>
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<tbody>
<tr>
<td>1. Patient Information complete?</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
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<tr>
<td>2. General Consent completed?</td>
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<td>3. Medical History complete?</td>
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<td>4. Medical History update complete?</td>
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<td>5. Are allergies and medical conditions documented?</td>
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<td>6. Indicators discussed: caries risk, diabetes, smoking, etc.?</td>
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Comments:

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<th>Clinical Exam Data</th>
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<th>Chart Two</th>
<th>Chart Three</th>
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<tr>
<td>1. Soft Tissue findings noted?</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
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<tr>
<td>2. Occlusal findings noted: caries, missing teeth, dental needs?</td>
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<tr>
<td>3. Periodontal findings / Classification noted?</td>
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Comments:

<table>
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<th>Radiographs</th>
<th>Chart One</th>
<th>Chart Two</th>
<th>Chart Three</th>
<th>Chart Four</th>
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<tbody>
<tr>
<td>1. Appropriate survey, type of X-rays taken?</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
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<tr>
<td>2. Adequate Film coverage, all apices covered?</td>
<td></td>
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<td>3. Any image defect: cone cuts, reworks needed?</td>
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<td>4. Number of X-rays taken documented?</td>
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Comments:

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<thead>
<tr>
<th>Problems / Diagnosis</th>
<th>Chart One</th>
<th>Chart Two</th>
<th>Chart Three</th>
<th>Chart Four</th>
<th>Chart Five</th>
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</thead>
<tbody>
<tr>
<td>1. Appropriate testing done?</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
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<tr>
<td>2. Diagnosis documented?</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>3. Appropriate consultations made, if needed?</td>
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<td>4. Referrals made if needed?</td>
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<td>5. Findings documented on treatment plan?</td>
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Comments:

<table>
<thead>
<tr>
<th>Treatment Plan / Dental Record</th>
<th>Chart One</th>
<th>Chart Two</th>
<th>Chart Three</th>
<th>Chart Four</th>
<th>Chart Five</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does Treatment Plan follow appropriate sequence?</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>2. Record is complete and appropriate for treatment rendered?</td>
<td></td>
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<td>3. Follow up appointment is indicated in clinical record?</td>
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<td>4. Documentation is complete, root canal procedure, and/or materials signed with doctor’s and assistant’s name, etc.?</td>
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Comments:

Director’s Comments

__________________________
Date

__________________________
Signature

__________________________
Dental Director

__________________________
Signature

__________________________
Date
Service Measures

 Tracked through IT
 Electronic practice management, billing, or registry systems
 HEDIS Measures
 Treatment plan completion measure
Subjective Patient Outcomes

- Validated surveys
- Oral Health Impact Profile (OHIP-14)
- Consumer Assessment of Healthcare Providers and Systems (CAPHS)
Adverse Outcomes

- Every adverse outcome is an opportunity for improvement
- Clinical incidents, patient complaints & grievances, safety lapses, risk management
- System for identification, data collection review, root cause analysis, system improvement
Quality Improvement (QI)

- **An approach** to the analysis of performance and efforts to improve it
- Measuring where you are, figuring out ways to improve
- Data collected establishes “baseline” for an aspect of the dental program, and QI process develops methods to improve from the baseline
- Avoids attributing blame
- Creates systems to increase/decrease outcome
The Chronic Care Model

Community
- Resources and Policies
  - Self-Management Support

Health Systems
- Organization of Health Care
  - Delivery System Design
  - Decision Support
  - Clinical Information Systems

Informed, Activated Patient

Productive Interactions

Prepared, Proactive Practice Team

Improved Outcomes

Developed by The MacColl Institute
Model for Improvement

- The Model for Improvement enables an organization to approach quality improvement through rapid cycles of change and continual feedback on the effectiveness of those changes.
- When used in conjunction with the Chronic Care Model, the Model for Improvement can lead to positive, sustainable changes in the quality of health care.
Opportunity for Improvement

The Gap

- Access to care (visit)
- Type of service (sealant)
- Cost (lower)
- Adverse patient event (latex allergy)
- Oral health outcomes (BP)
An Effective QI Plan

- Directly aligns services to program goals
- Provides specific measurable milestones or targets
- Identifies timelines
- Improvement decisions influenced by numerous variables including population needs, resources, motivation, Board priorities
QI the Process

- Identify a program or facility problem
  - Continuity of care
  - Access to Care (TPCR)
  - Emergency care
  - Adverse patient events
  - Medical/dental integration

- Conduct a study
- Develop and implement a plan
- Monitor and track results
- Demonstrate improvement and restudy the problem (continuously)
PDSA CYCLES

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?
Plan-Do-Study-Act Cycle

Ideas ➔ Action ➔ Learning ➔ Improvement

- Demonstrate improvement
- What changes are to be made?
- What is the next cycle?

- Complete the data analysis
- Compare data to predictions
- Summarize what was learned

- Identify problems and create a plan
- Implement the plan
- Monitor and document results
- Begin analysis of the data
Using the Cycle to Improve

- Ideas
- Very Small Scale Test
- Follow-up Tests
- Wide-Scale Tests of Change
- Implementation of Change
- Spread
- Data
- Improvement
Don’t Assume!

- First PDSAs should be small.
- There are no bad ideas!
- All improvement ideas should be able to stand up to the PDSA test.
- Always ask, “What are you trying to accomplish? How will we know the change is an improvement? How are you going to measure it?”
Case Study

- Production was low.
- No-show rates were high.
- Quality Assurance chart audit revealed that Treatment Plan Completion Rate (TPCR) was 26%.
- By the time most patients were due for their recall appts, phase I treatment had not been completed.
HRSA Quality Measure (proposed)

Percentage of all dental patients for whom the Phase I treatment plan is completed within a 12 month period.
Quality Improvement Plan

- Responds to a particular goal
- Milestones, measurements, timelines
- Needs to define data collection method and frequency
- QI team- representative of all staff involved in this particular issue.
Sample of a Project Specific QI Plan

- Project Goal: To increase the number of patients that complete phase 1 treatment in 12 months to 50%
- Project Team Leader: Dr. X
- Project Team: DA, Hygienist, Front Desk
- Baseline: 26%
- Timeline: one year
- Meeting Time: Weekly
What They Knew
What They Found Out

- Pt. satisfaction scores were low
- No-show phone survey
- Supply did not match demand
Do the Math

- 3 new patients a day per provider
- Average of 5.3 restorative appts each new patient needed to complete phase 1 treatment
- (3 new patients) X (5.3 appts) = 15.9 appts
- Recall appts were generating restorative appts
- There were only 8 restorative provider slots per day.
- Access capacity did not equal appointment demand
New Scheduling Model

- Increase the number of restorative appointments
- Decrease the number of initial exam appointments
- PDSAs – designed and implemented by the QI team
- No “bad ideas”
PDSAs

- Dentist to assistant ratio
- Chairs per provider
- Patient Education by DA
- Optimized their scheduling system
- Each provider scheduled with only one new patient each day
- Scheduling out times
- 3rd available appointment tool
- Staff satisfaction
Results

- Increase in overall production
- Decrease in no-shows
- Increase in TPCR to 67% has stayed there for over three years
- Increase in patient satisfaction
- Increase in staff satisfaction
Measures are the Key

- 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!
Case Study: Tying it Together

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

- Healthy People 2020 Goal OH-12.2

- Increase the proportion of children aged 6 to 9 years who have received dental sealants on one or more of their permanent first molar teeth from 25.5% to 28.1%
Set Baseline

- Looked back 12 months- 500 children ages 6-9 had a dental exam & 100 had a sealant procedure billed
- Unknown how many needed sealants- data was not being collected
- Went back and looked at capabilities of EDR- were able to compute that 250 children 6-9 had sealants treatment planned
- $\frac{100}{250} = 40\%$ baseline
QI Sealant Goal

- Decided to set goal of 50% of children 6-9 that had sealants treatment planned would receive them in the next 12 month measurement period.

- Strategies for system change (PDSAs)
  - Train providers on sealant indications
  - Utilize most efficient team member to apply sealants according to State regulations
  - Sealant brochures in pediatrics waiting room
Sample Process Measures

- Annual Oral Health Visit (populations)
- Treatment Plan Completed
- Topical Fluoride Treatment
- Dental Sealants
- Oral Health Education (medical setting)
- Periodontal Exam (i.e HIV, diabetic)
Sample Outcome Measures

- Percentage who have new decay at recall
- Percentage of caries free
- Percentage of patients that have moved from high to medium risk
Medical and Dental Integration

- Process measure
- Improve overall health by improving oral health
- Populations of focus (children, diabetics, pregnant women, etc.)
Case Study

- Project Goal: To increase the number of pregnant women in the Health Center medical program that get dental care to 60%.
- Project Team Leader: Dr. X
- Project Team: DA, Hygienist, Front Desk
- Baseline: 12%
- Timeline: one year
- Meeting Time: Twice a month for 1 hour
PDSAs

- Referral processes
- Dental staff education
- Medical staff education
- Patient education
What is next?

- An increasing number of entities are looking into quality measures as a way to determine whether high-quality care is being provided consistently across the healthcare delivery system (National Quality Forum, Meaningful Use)
- Disease management through risk assessment
- Diagnostic codes
NNOHA’s Resources

- **Quality Chapter** - NNOHA Operations Manual for Health Center Oral Health Programs
- Other Quality Improvement tools
Questions?

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