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

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2018 NNOHA Conference
Objectives

- To define what risk management is
- To discuss ways to prevent common risks and protect patient and staff safety
- To review how compliance standards guide health center risk management protocols
- To describe how ethics and professionalism guide risk management protocols
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.
Sentinal Events

Errors that:
• are serious (causing disability or death).
• can absolutely be prevented.
• are clearly definable and measurable.
• are typically unexpected and iatrogenic.

https://psnet.ahrq.gov/primers/primer/3/never-events
Examples of Dental Sentinel Event

• 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 that results in death or serious injury or disability.
Format of Presentation

- Quality Assurance
- Compliance
- Ethics and Professionalism

Life Alert symbols:
Quality Assurance
Informed Consent & Refusal

• Process of providing the patient or appropriate guardians with relevant information regarding diagnosis and treatment needs so that an educated decision regarding treatment can be made.

• Includes:
  • Conversation between provider and decision-maker.
  • Description of dental problem.
  • Nature or proposed treatment.
  • Potential benefits and risks.
  • Alternatives to proposed treatment, including no treatment.
  • Documentation of education and informed refusal, if applicable.
Informed Consent & Refusal

• Meet state laws, set individual health center standards, and train staff on:
  • Implied or waived consent.
  • Written or verbal consent.
  • Known/common procedures vs. invasive/high risk procedures.
• Consent for Minors
  • Guardians: Divorced Parents, Legal Guardians, Foster Parents
  • Emancipated Minors
  • When you what a higher level of consent or parental involvement regardless of what the law allows.
• What to do when your staff don’t know what to do.
Informed Consent and Informed Refusal are irrelevant and will not protect the dentist if malpractice is done
Patient Follow-up

• Factors contributing to greater need for patient follow-up:
  • Medical Complexity
  • Dental Complexity
  • Social Determinants

• Establish standards for routine follow-up for:
  • Emergency Care
  • Biopsy Reports
  • Complex Surgical Care
  • Medically Fragile Patients
  • Provider Discretion

• Best Practices
  • Develop written procedures for follow-up care, including patient logs or registries.
  • Leverage the team for efficiencies within state practice act rules.
  • Document calls to/from patients.
New Dental Provider Orientation Plan

- Orientation is a critical step in risk management.
- Having a provider manual is 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 providers upfront expectations for their practice within the health center.
- 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.
# Standard of Care (Examples)

<table>
<thead>
<tr>
<th>Standard of Care</th>
<th>Content to Include &amp; Best Practices</th>
<th>Clinical Guideline Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiography</td>
<td>Quality, Quantity, Pt Refusal, Documentation</td>
<td><a href="https://www.ada.org/~/media/ADA/Member%20Center/Files/Dental_Radiographic_Examinations_2012.pdf">https://www.ada.org/~/media/ADA/Member%20Center/Files/Dental_Radiographic_Examinations_2012.pdf</a></td>
</tr>
</tbody>
</table>
Standard of Care

• Diagnosis & Examination
  • First line in patient safety and in a provider’s defense is the work done at the comprehensive examination.
  • Requirements:
    • Medical & Dental History
    • Occlusion
    • Periodontal Exam, Charting, and Diagnosis
    • Soft Tissue & Oral Cancer Evaluation
    • Appropriate Diagnostic Procedures & Consultations: Radiographs, Pulp Testing, Referrals to Other Health Professionals, Etc.
    • Recording of All Findings, Procedures Completed, and Treatment Recommended
Chart Audits: Retrospective Reviews

- Very limited by the # of charts possible to review.
- Can identify basic charting issues that may not comply with Standards of Care or where gaps in guidelines may exist for the program.
- Raises overall awareness to QA issues.
- Chart Review Guidelines: Critical!!!!
Chart Audit Guideline

Sample Question

Does the documentation supports 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
Documentation

If it isn’t documented, then it didn’t happen.

ADA Documentation Standards
http://www.ada.org/~/media/ADA/Public%20Programs/Files/MPRG_Dental_Records.pdf?la=en
Patient Satisfaction

- Happy patients generally do not take action to report even when things go wrong.

- Example Survey Tools
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?
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.
COMPLIANCE
Common Compliance Issues

- Billing issues
- Record storage
- License: expiration
- CE requirements
- BLS
- Amalgam separators
- OSHA and CDC regulations
- DEA compliance
- HIPPA
Supervision of Students and Residents

• Need to have a formal arrangement with the teaching institution

• Students must practice within the supervising dentist’s approved privileging

• Student liability normally covered by the academic institution

• Supervising dentists may be liable for residents' negligence or may be directly liable for their own negligence in supervision or administration
  • Need to understand how FTCA works

• Students and residents should not be viewed as another way to advance productivity
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.
Compliance

- Community Health Centers have to be compliant with regulations from multiple organizations such as:
  - State Dental Practice Act
  - OHSA and CDC
  - HIPAA
  - HRSA

- Community Health Centers normally have a Compliance Officer and a Compliance Committee to focus on this topic
  - Ideally your Compliance Committee would have dental representation or knowledge
HIPAA

• The Health Insurance Portability and Accountability Act (HIPAA)

• According to the HHS website, these are the most common issues reported (according to frequency):
  • Misuse and disclosures of PHI
  • No protection in place of health information
  • Patient unable to access their health information
  • Using or disclosing more than the minimum necessary protected health information
  • No safeguards of electronic protected health information.

• Failure to comply with HIPAA regulations can result in fines and even criminal charges or lawsuits.
Infection Prevention and Control (IPC)

- Food and Drink Policy
- Surface Disinfection of Common Areas
- Hand Hygiene Policy
- Personal Protective Equipment (PPE)
- Dental Operatory Disinfection
- Offsite Dental Infection Prevention and Control
- Safe Injection Practices (SIP)
- Dental Unit Waterline Quality (DUWLQ)

- Dental Sterilization
- Spore Testing/Failed Spore Testing
- Immunization/Vaccination Policy
- Post Exposure Prophylaxis
- Hazardous/Regulated Waste
- Dental Radiation Safety
- Spill Protocol
- Incident Reporting
HRSA Compliance

Health Center Program Compliance Manual

Last updated: August 20, 2018

Health Center Program Site Visit Protocol

Last updated: August 20, 2018
Credentialing is the process of assessing and confirming the license or certification, education, training, and other qualifications of a licensed or certified health care practitioner.

- Is granted for a specified period of time, typically not exceeding 2 years
- The health center must have operating procedures for the initial and recurring review of credentials for all clinical staff members
Dental Privileging

Privileging is the process of authorizing a health care practitioner’s specific scope and content of patient care services.

• Defines education, training, and assessment requirements for each procedure(s) performed in the dental program

• Is granted for a specified period of time, typically not exceeding 2 years (periodic privileging is recommended)
Volunteer and Temporary Dentists

- Volunteers can be covered by FTCA
- Free does not always mean no cost
- Dentists and hygienists must be credentialed and privileged in your system
- They should be included in your chart audits
- An orientation plan should be established for them
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).
- Part time contract dentists and students/residents are NOT covered.
- Volunteer dentists can get FTCA coverage.
- Must submit annual application to continue coverage.
Federal Tort Claims Act (FTCA)

- HRSA may conduct a site visit, randomly or for cause, to any initial applicant or deemed grantee to ensure implementation
  - FTCA has been doing site visits for the last 8 years
  - Approximately 20-22 site visits per year

- If a site visit results in a finding of a lack of implementation of the FTCA program requirements, this may be grounds for not receiving FTCA deeming or redeeming and may receive conditions upon their Health Center Program award
Federal Tort Claims Act (FTCA)

- Factors that may prompt a site visit may include:
  - Submission of an initial FTCA deeming application
  - Documentation indicating non-compliance with requirements during the review of the health center’s FTCA application
  - The need for follow-up based on prior site visit findings
  - History of repeated conditions, or current conditions, placed by HRSA on the health center’s Health Center Program grant, as documented on the health center’s associated Notice of Award
  - History of medical malpractice claims
PROFESSIONALISM AND ETHICS
ADA Principles of Ethics

- Patient Autonomy
- Non-maleficence
- Beneficence
- Justice
- Veracity
Ethical Patient Care

• Focus on patient autonomy and respect their barriers to care
  • Your patients won’t always be able to afford the “ideal” treatment
  • Some patients won’t be able to make it to every appointment due to barriers
  • Don’t rush to label the patient as “non-compliant”

• Diagnose the patient
  • You must inform the patient of his/her diagnosis
  • If you cannot treat the patient’s needs, then you must offer a referral to someone who can
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
**Encounter Churning**

**Churning** = systematic, institutionalized practice of maximizing revenues by maximizing visits/encounters

- Unethical
- Not patient centric
  - Average patient centric appointment time is 45 minutes
- Not standard of care
  - Must document justification for deviation from the expected “Standard of Care” when that scenario arises
- Can be considered fraud
- Creates a two tiered system
Examples of Churning

• One visit = One procedure without justification
• Separation of exam & imaging procedures
• Separation of exam, imaging & P&F for children
• Lack of quadrant dentistry, especially if small restorations
• Separation of sealants
• Lack of definitive treatment for emergencies
• 15 minute restorative appointments
Medicaid Audits

• Most Common Audit Findings:
  • Lack of documentation or inadequate documentation
  • Claim an unusually large number of services per day
  • High payments per child
  • Do not always verify or document medical necessity
  • Improper claims - Services not rendered
  • Improper coding
  • Unbundling services
Start With Your Biggest Risks

• Identify and triage your own center’s risks
• Develop policies to mitigate those risks
NNOHA Dental Program Operations Resources

- Operations Manual for Health Center Oral Health Programs
- Fundamentals
- Leadership
- Financials
- Risk Management
- Workforce and Staffing
- Quality

http://www.nnoha.org/resources/operations-manual/
Questions?

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Quality:
Striving to Provide the Highest Quality Care Possible

Lisa Kearney, DDS
Ryan Tuscher, DDS
2018 NNOHA Annual Conference
In 1 word, what do you think about when you hear the word, "Quality?"
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) – National Academy of Medicine
IOM Quality Domains

- Safety
- Effectiveness
- Patient-centeredness
- Timeliness
- Efficiency
- Equity
What is driving the emphasis on quality?

- Increasing cost of healthcare without improvement of health
- Problems with fragmented health system
- Profound healthcare disparities in population
- Increasing awareness of these problems in the age of consumer empowerment

Evidence of Drivers

• As a nation, we spend much more of our gross domestic product on health care than the rest of the developed world and have poorer health outcomes.

Evidence of Drivers

- IOM report To Err is Human: Building a Safer health System and Crossing the Quality Chasm highlighted the problems with the US Health Care system in the areas
  1) patient safety
  2) inefficient use of resources
  3) fragmentation of the delivery system
  4) need to re-design the way healthcare is delivered.


All your labs are back. They show a serious overuse of unnecessary and inappropriate tests and procedures.
What is driving quality in oral health?

• 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

• Focus on population health
The Triple Aim

• Better care (improve quality of care, more patient centered, increased patient satisfaction)

• Improve health of the population

• Reduce cost
## Evolution of the Changing Landscape

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Centric</td>
<td>Patient Centric/Consumer</td>
</tr>
<tr>
<td>Value Blind Reimbursement</td>
<td>Value-based Reimbursement and Accountability</td>
</tr>
<tr>
<td>Episodic Fragmented Care</td>
<td>Continuous and Coordinated</td>
</tr>
<tr>
<td>Inpatient-Focused</td>
<td>Amulatory/Office/Home Focused</td>
</tr>
<tr>
<td>Individuals</td>
<td>Population Based</td>
</tr>
<tr>
<td>Disease and Treatment</td>
<td>Health/Wellness Prevention</td>
</tr>
<tr>
<td>FOCUS</td>
<td>VALUE</td>
</tr>
<tr>
<td>PATIENT FLOW</td>
<td>DELIVERY SETTING</td>
</tr>
<tr>
<td>APPROACH</td>
<td>OBJECTIVE</td>
</tr>
</tbody>
</table>

Dentistry and Quality

• Quality assessment in dental care is in a relatively primitive state, and the measures used for such assessments are little changed in the past three decades.

Bader.J. Challenges in quality assessment of dental care. JADA 2009:140;1456-1464
Reasons for limited quality assurance in dentistry

• Emphasis on surgical treatment
  • Evaluation is on clinician rather than the effect of clinician’s effort on improving patient health

• Professional isolation

• Limited evidence based guidelines

• Lack of diagnostic codes

• No standard measures of meaningful treatment outcomes

• Limited ability of information systems of dental plans and practices to capture, transmit and share reliable information
Albert Einstein

“Everything that can be counted does not necessarily count; everything that counts cannot necessarily be counted.”
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
QA continued

• If deficient, plans of correction are developed to address the problem
  
  (WHO, 1994; WHO, 1997)

• QA programs ensure Health Center compliance with quality standards and provide quantifiable performance assessments.
Answer Questions Like:

• How are we performing?
• Are we meeting our goals?
• How do we compare to our benchmarks?
• Are we providing the highest possible quality services to our community?
• Are we focused on the patient experience for the first contact until case completion?
• Are we utilizing the proper follow-up procedures?
Examples of Quality Assurance

• Peer Review
• Service measures
  • Treatment plan completion
  • HEDIS measures
• Subjective patient outcomes
  • Oral Health Impact Profile (OHIP-14)
  • Consumer Assessment of Healthcare Providers and Systems (CAPHS)
• Adverse outcomes
# Health Center Health Services

## Dental Provider Performance Review From

<table>
<thead>
<tr>
<th>Quarterly Chart review</th>
<th>Date of Review:</th>
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<tbody>
<tr>
<td></td>
<td>Reviewing Dentist:</td>
</tr>
<tr>
<td></td>
<td>Dental Reviewed:</td>
</tr>
</tbody>
</table>

### GENERAL CHART INFORMATION

<table>
<thead>
<tr>
<th></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.</td>
<td>Patient Information complete?</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>2.</td>
<td>General Consent complete?</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>3.</td>
<td>Medical History complete?</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>4.</td>
<td>Medical History update complete?</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>5.</td>
<td>Are Allergies and Medical conditions documented?</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>6.</td>
<td>Indicators discussed: caries risk, Diabetes, smoking, etc.?</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

**Comments:**

### CLINICAL EXAM DATA

<table>
<thead>
<tr>
<th></th>
<th>CHART ONE</th>
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<th>CHART FOUR</th>
<th>CHART FIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Soft Tissue findings noted?</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>2.</td>
<td>Occlusal findings noted: caries, missing teeth, dental needs?</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>3.</td>
<td>Periodontal findings / Classification noted?</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
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</table>

**Comments:**

### RADIOGRAPHICS

<table>
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<tr>
<th></th>
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<th>CHART FOUR</th>
<th>CHART FIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Appropriate Survey; type of X-rays taken?</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>2.</td>
<td>Adequate Film coverage, all apices covered?</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>3.</td>
<td>Any image defect: cone cuts, retakes needed?</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>4.</td>
<td>Number of X-rays taken documented?</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

**Comments:**

### PROBLEMS / DIAGNOSIS

<table>
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<tr>
<th></th>
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<th>CHART FOUR</th>
<th>CHART FIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Appropriate testing done:</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>2.</td>
<td>Diagnoses documented?</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>3.</td>
<td>Appropriate consultations made, if needed?</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>4.</td>
<td>Referrals made if needed?</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>5.</td>
<td>Findings documented on treatment plan?</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

**Comments:**

### TREATMENT PLAN / DENTAL RECORD

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<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Does Treatment Plan follow appropriate sequence.</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>2.</td>
<td>Record is complete and appropriate for treatment rendered?</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>3.</td>
<td>Follow up appointment is indicated in clinical record?</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>4.</td>
<td>Documentation is complete, tooth, area, anesthetic, procedure and/or materials, signed with Dentist’s and Assistant’s names, etc.?</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

**Comments:**

**Director’s Comments**

__________________________

Dental Director

__________________________

Signature

__________________________

Date
Quality Committee

Every adverse outcome is an opportunity for improvement

• QI team made up of members from various departments

• Clinical incidents, patient complaints & grievances, safety lapses, risk management

• System for identification, data collection review, root cause analysis, system improvement
Is a member of the oral health team on your health center's quality committee?

- Yes
- No
- I don't know
Quality and Information Systems

Health Information Technology

- Data must be measurable, trackable and able to be extracted from the patient record

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>More data vs sample measure</td>
<td>System limitations</td>
</tr>
<tr>
<td>Easier/Faster to access data</td>
<td>Each EDR is different</td>
</tr>
<tr>
<td>Information sharing opportunities</td>
<td>Getting accurate and complete data</td>
</tr>
<tr>
<td>Improved care coordination</td>
<td>EDR/EMR communication</td>
</tr>
</tbody>
</table>
“You can’t change what you don’t measure.”

But you can’t measure unless you make it easy.
History

2013
Convening of Expert Advisors

2015
Launch of Health Center Dental Dashboard© User’s Guide and data collection tool

2017
Updates to User’s Guide and new data collection tool developed
Development

Participants from:

• CMS
• NNOHA
• Institute for Oral Health
• Colorado and Washington CHCs working on oral health
• Arcora (Formerly WA Dental Service Foundation)
• Delta Dental of Colorado Foundation
• Primary Care Associations
## Individual Dashboard Measures

The dashboard consists of 15 measures that are organized into three categories:

- Population health.
- Fiscal and operational sustainability.
- Patient satisfaction.

### Population Health

<table>
<thead>
<tr>
<th>Caries at Recall</th>
<th>Topical Fluoride</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of patients who complete a periodic oral evaluation and have a caries diagnosis.</td>
<td>% of 0-5 year old children (dental and medical) who receive topical fluoride application.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Assessment of all Dental Patients</th>
<th>Self-Management Goal Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of all dental patients who have had an oral health risk assessment.</td>
<td>% of dental patients who have at least one oral health self-management goal set by their care team.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Oral Evaluation and/or Risk Assessment of all Primary Care Patients</th>
<th>Self-Management Goal Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of all health center patients who have an oral evaluation and/or risk assessment performed by a medical provider.</td>
<td>% of health center patients who have oral health self-management goals reviewed by their care team.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sealants (6-9 year olds)</th>
<th>Sealants (10-14 year olds)</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of 6-9 year old children, at moderate to high risk, who receive a sealant on one or more permanent first molar teeth.</td>
<td>% of 10-14 year old children, at moderate to high risk, who receive a sealant on one or more permanent molar teeth.</td>
</tr>
</tbody>
</table>

### Fiscal & Operational Sustainability

<table>
<thead>
<tr>
<th>Recall Rates</th>
<th>No Shows</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross Charges (Production) per Encounter</td>
<td>Encounters per Hour</td>
</tr>
<tr>
<td>Direct Cost per Visit</td>
<td></td>
</tr>
</tbody>
</table>

### Patient Satisfaction

<table>
<thead>
<tr>
<th>Recommendation to Family and Friends</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of patients who would recommend health center services to family and friends.</td>
</tr>
</tbody>
</table>
Summary of Initiatives Utilizing the Dashboard©

- **Learning Collaborative Pilot (2016)**
  - 5 Health Centers, customized subset of Dashboard© measures used for Quality Improvement (QI)

- **Dashboard Learning Collaborative (2016-2017)**
  - 26 Health Centers, customized subset of Dashboard© measures used for Quality Improvement (QI)

- **Benchmarking Initiative (2017)**
  - Health Centers, customized subset of Dashboard© measures used for Benchmarking

- **Oral Health Improvement Collaborative (2017-2018)**
  - 39 Health Centers, customized subset of Dashboard© measures used for Quality Improvement (QI)
NNOHA Dental Dashboard


“Quality measurement implementation needs to be easy in routine practice for clinicians with measures captured as part of the clinical workflow”.

-The Future of Quality Measurement for Improvement and Accountability
If you have the data, what do you do now?

- Summarize data
- Celebrate successes
- Identify areas for improvement
- Share data and make it visual
  - LT, Board, Dental Team, Patients, Other dental centers
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
• Proactive prevention approach
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
ACP-ASEM Journals and Books
The Chronic Care Model

1) Health Care Organization
2) Community Resources and Policies
3) Self-Management Support
4) Delivery System Design
5) Decision Support
6) Clinical Information
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

Actual

Desired

- 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
Plan-Do-Study-Act Cycle

Ideas ➔ Action ➔ Learning ➔ Improvement

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

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

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

- **Ideas**
  - Very Small Scale Test
  - Follow-up Tests
  - Wide-Scale Tests of Change
  - Implementation of Change
  - Spread
  - Improvement
Erie Family Health Center

• NNOHA Dental Benchmarking Initiative

• % of 10-14 year old children who receive a sealant on all eligible permanent molar teeth
  • Denominator: number of unique 10-14 year old patients who come to the dental clinic for any reason during the measurement month and have one or more permanent molar teeth eligible for sealants (This measure includes 1st and 2nd molars)
  • Numerator: number of patients in the denominator who received a sealant on ALL permanent molar teeth
Erie Family Health Center QI plan for Sealants

• Project goal: To increase the number of 10-14 year old patients that receive sealants from baseline to 60% during course of initiative

• Project Team Leader: Dr Lisa Kearney

• Project Team: Cathy Arista, Dr Christina Bosak, Melissa Maldenado, Rolando Paz

• Established baseline - 28%

• Timeframe – course of initiative
  • 3 months

• Meeting time: discuss at morning huddle
Erie Family Health Center - PDSAs

- Train providers on the importance of placing sealants
- Smart code for tracking exclusions for 10-14 year olds
- Placing sealants at recall visits
- Utilizing DAs to place sealants
Erie Family Health Center

% of 10 - 14 yo that receive a sealant on all eligible molar teeth at EFHC

% of 10 - 14 yo that received sealants at EFHC
PCC’s PDSA: Medical-Dental Integration Process Measure

• Problem Identified: several prenatal patients seeking emergent care

• Project Goal: To Increase the number of prenatal patients with an oral examination

• Team: Dr. Tuscher, Crystal, Stefanie, Dr. Mark

• Established Baseline: 4% of prenatal patients seen for D0150 or D0120

• Timeline: 6 months

• Team Meeting Schedule: monthly
PCC’s PDSA first steps

• **Plan**
  - Plan: Provider engagement and education provided at general medical staff meetings to increase prenatal referrals for oral examination

• **Do**
  - Collected data from the EDR
  - Ensured access in schedule
  - Checked in at monthly meetings
PCC’s PDSA Continued

• Study
  • Result: 9%
  • Some patients already had a dental home
  • Engaging the Nurse Midwives had big impact
  • Provider awareness generated more referrals
  • Patients rely on providers to give guidance and referral
  • Track referrals completed versus patients seen?

• Act
  • Did we demonstrate improvement?
  • Changes we needed to make? Shorter measurement period.
  • What’s next? Future PDSAs
    • Add prenatal referral into medical workflow
    • Same day visits with OB visits
    • OH education at group medical visits
    • Dental Assistants handing out OH brochures
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 patients that are caries free
- Percentage of patients that have moved from high to medium risk
Who will create and define oral health quality measures?

- Nationally defined measures:
  - HEDIS measures
  - National Quality Forum
  - Meaningful use measures
  - NNOHA Dashboard
  - Healthy People 2020
  - Dental Quality Alliance

- All include different measures and different definitions of those measures
Raise your hand!

- What oral health quality measures are you currently tracking in your health center?
  - HRSA sealant measure
  - Treatment plan completion rate
  - Caries at recall
  - Medical patients that have a dental appointment
  - No-show rates
  - Current oral health exam
  - Pregnant patients with a dental appointment
  - Caries risk assessment
  - Self-management goals
  - Medical providers doing caries risk assessments
  - Medical providers placing fluoride
Nationally defined measure: HRSA Sealant Measure

- Numerator: number of dental patients 6-9 years old who received a sealant on the permanent first molar in the calendar year

- Denominator: number of dental patients 6-9 years old who had a comprehensive or periodic exam and an elevated caries risk who needed a sealant on their permanent first molar in the calendar year

- Is this our best oral health measure?
Questions about the sealant measure

• Are you doing a Caries Risk Assessment?
• No standard CRA
• Can you track the exclusions with your EDR?
• Sealants are a preventive measure – should all kids should receive sealants regardless of risk?
• Skewed results due to school sealant programs
• Measure exclusively for pediatric patients
What will our future oral health measures look like?

• WE NEED YOU!
Is your HC currently receiving value-based payments for your patient visits?

- Medical only
- Dental only
- Medical and Dental
- Neither medical or dental
- I don't know
Shift from Volume to Value

• Examples
  • Shared savings and shared risk methodologies
  • Bundled payments
  • Pay for performance
  • Inclusion of children’s dental services in global payment models

• ~8 states are participating in some sort of value based payment initiatives
Example: Children’s Oral Health Initiative
Value-Based Payment Technical Support

- The Centers for Medicare & Medicaid Services’ (CMS) Medicaid Innovation Accelerator Program (IAP) created the program
  - New technical support opportunity for state Medicaid/CHIP agencies to select, design, and test Value-Based Payment approaches that will sustain children’s oral health care delivery models that are showing results.
  - Opportunity for community health centers to work with state Medicaid offices to design and test value-based payment methods
What is the future of Quality?

• Standardization
  • Of measures
  • Of benchmarks
  • Of reporting

• Value-based reimbursement

• Ethics and professionalism

• Improvements in health information systems
NNOHA’s Resources

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

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# Breakout Sessions – Napoleon A/B

<table>
<thead>
<tr>
<th>Topics</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee Schedule/Sliding Fee</td>
<td>Janet Bozzone</td>
</tr>
<tr>
<td>Governance/FTCA</td>
<td>Mark Doherty</td>
</tr>
<tr>
<td>No Shows</td>
<td>Nick Pfannenstiel</td>
</tr>
<tr>
<td>Medical/Dental Integration</td>
<td>An Nguyen</td>
</tr>
<tr>
<td>Infection Control</td>
<td>Debby Myers, Ethan Kerns, Tena Springer</td>
</tr>
<tr>
<td>Managing Pts Experiencing Substance Abuse</td>
<td>Scott Wolpin</td>
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<tr>
<td>School-Based</td>
<td>Clifton Bush</td>
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<tr>
<td>Peer Review</td>
<td>Lisa Kearney</td>
</tr>
<tr>
<td>Health IT</td>
<td>Ernest Meshack-Hart</td>
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<tr>
<td>Workforce</td>
<td>Ryan Tuscher</td>
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