Practice Enhancement Recommendations for the Oral Health Program at

Cabarrus Health Alliance

Executive Summary

Established in 1911, the Cabarrus County Health Department is one of the oldest local health departments in the United States. In 1997, the Cabarrus County Health Department re-organized to become the Cabarrus Health Alliance (CHA), an independent governmental entity that is designated as a Public Health Authority, one of only two in North Carolina. CHA provides programs and services targeted to low-income/underserved residents and those who experience health disparities. CHA has two dental clinics located in Concord & Kannapolis; Serves children and limited adults. The approximate number of patients seen per year is 16,955 and associated Payer sources are 88% Medicaid, 7% self-pay (sliding fee scale), and 4% private insurance.

CHA joined with the Guilford County Department of Health as part of a Robert Wood Johnson grant. The two entities selected the name "Project Smile" for this initiative. It was through this project that a practice assessment was completed. The assessment of CHA's dental program was completed in August 2013 by Chief Consultant, Sean Boynes, DMD, MS and lead analyst, Amah Riley, RDH as part of Dental Medicine Consulting (DMC). The assessment included an in-depth analysis of dental practice data, followed by a site visit. During the site visit, the DMC team met with executive management, senior leadership, as well as clinical and front office personnel. Charts were reviewed, data confirmed, and an exit interview conducted.

At the site visit, administrative leadership expressed the need to maximize access while maintaining financial sustainability. The administrative leadership also stated a strong desire to increase the number of new patients into the dental program and expanding capacity. Administrative and dental staff unanimously agreed that they needed to see improvements with marketing and community involvement. Everyone also agreed that no-shows were an issue for the dental program, hindering productivity and creating unpredictability in the daily schedule.

Cabarrus Health Alliance's dental program is a valuable asset for the people who live and work in Charlotte, NC corridor. Given its current size, the dental program needs to be maximally efficient and effective. The strategies outlined in the following pages are designed help to guide CHA as they work to make their dental program stronger and more effective.

Recommendations

Area	Issue	Recommendation	Action Step	Due Date
No-Shows/Last-Minute Cancellations	Patients who fail to keep their scheduled appointments are the biggest issue facing the dental program. In the data provided, the no-show rate was approximately 22%. As a result, some providers take issue due to the production based salary. In FY2011, the clinic was only able to achieve approximately 80% of its potential capacity, which means a shortfall of over 2,000-2,500 visits. This means that at least 1100 area residents who needed dental care were unable to receive it because appointments had been reserved for patients who failed to honor their commitment to the clinic.	LCHD should RE-develop a strong no-show policy and enforce it consistently to weed out the patients who do not value the opportunity they are being given as patients of the dental clinic. The goal is to develop a stable base of patients who understand the value of the care they are being offered and are willing to abide by practice rules.	RE-Create a strong no-show policy	
		In the month before the new policy goes into effect, begin educating staff and patients. Post the new policy in patient waiting areas and provide written copies to new and returning patients. Include the new policy in all new patient materials, require patients to review and sign off on the policy and place the signed document in their chart.	Post the new policy in all patient waiting areas; provide copies of the new policy to all new and returning patients; have new patients review and sign off on the policy and place the signed document in their charts	
			Do not schedule multiple family members on the same day unless these are	

					established patients with a proven track record of reliability. Never do this for new patients as they are at highest risk of being no-shows	
				Right now, the responsibility for making reminder calls is not well defined nor is they tracked (i.e. lack of accountability). There is some time issues with current staf as well. As a result, no one "owns" this critical task and it is not being done consistently. On a pilot basis, designate a non-clinical staff person to own the responsibility for making confirmation calls as well as act a leader to hold other staff accountable for making calls for 3 months and monitor the impact on the failed appointment rate to demonstrate the return on investment	Designate the staff responsible for making reminder calls	
					Make reminder calls 24 or 48 hours in advance. Consider removing appointments for patients who don't have a working phone.	
					When forced to leave a voice mail message, require the patient to call back no less than 24 hours before their scheduled appointment to confirm their intention to keep the appointment. Remove appointments for patients who fail to call back in time.	
				Emergency patients are also at very high risk for not keeping scheduled appointments. To limit this risk, consider not giving emergency patients follow-up appointments the day of the emergency visit. Give patients a card with the clinic number and ask them to call back when they've had a chance to check their calendars and are ready to schedule their follow-up care. Many will never call back, but these patients would most likely have failed to keep those	Ask emergency patients needing follow-up care to call back when they are ready to schedule their follow-up appointment.	

				scheduled appointments. If the dentist feels the emergency patient's clinical situation warrants a follow-up appointment is scheduled before they leave the clinic, which should be done. If an emergency patient asks to be given an appointment before they leave, that should be done as well. In either event, the patient needs to be reminded about the no-show policy and counseled about the consequences of failing to keep the scheduled appointment or provide more than 24 hours' notice of cancellation.		
				No-shows should be tracked as the percentage of scheduled appointments for which the patient failed to show or cancelled with less than 24 hours' notice. The goal should be to decrease the no-show rate to **15%-18%.**	Track the no-show rate as a performance improvement initiative	Ongoing
					Patients who commit more than two no shows in a one year period should be placed on a quick call wait list. They can be placed back in good standing with coming in on short notice to fill any last minute appointment times.	
Dental Program Capacity / Ensuring Appropriate Growth				To determine the number of new patients that can be incorporated into the practice on a weekly or monthly basis, run reports on the treatment completed dummy code. If 10 treatment plans were completed in a given month, that is	Run monthly reports on the treatment completed dummy code to determine the number of new patient appointments that are available (e.g., run the report for the month of January to determine how	

				the number of new patients that can be given appointments	many new patient spots are available in February)	
		Currently the number of patients with private insurance is negligible if not non-existent.		Private insurance carriers are a decreasing commodity in dentistry however a number of the “working poor” have limited coverage. By accepting private insurance you can provide a great service for patients in need of care that have coverage but need assistance with fee schedule payments.	Evaluate accepting private insurance (decide if GC will be an in network or out of network provider as well as gauge the interprofessional politics of such a decision)	
		Currently uninsured patients do not have an opportunity to be enrolled in Medicaid on site. This results in a missed opportunity for income as well as a missed opportunity to improve the patient experience.		An on-site Medicaid intake specialist can provide the patient with an opportunity to have coverage for medical and dental. This will result in a better experience and possibility of new patients coming in the door for this service.	Evaluate the possibility of having a staff member become a certified intake specialist.	
Quality Management		There is no formal quality assurance and quality improvement focus in the dental program.		Create a quality management policy for dental detailing all aspects of quality assurance and quality improvement. This policy will spell out the essential elements to be included in all charting of patient visits.	Create quality management policy (DMC can provide sample)	
				The dental program should identify at least one quality outcome indicator to track and report. Recommend it be completed treatments as	Track completed treatments as a formal quality outcome measure. Outcome goals relating to clinical aspects should be created and tracked	

				discussed above	by the dental manager.	
				Additional tracking of outcomes such as a failure rate of fillings can be tracked on a quarterly basis at least once a year.	Use dummy codes for adverse events such as replacement of filling prior to two years and track to evaluate the quality of the fillings being placed (this should be entered chairside by an assistant only)	
		There is currently a limited evaluation of chart integrity. No formal chart auditing process is present.		Chart auditing at even a minimum of annually provides decrease liability and appropriate checks and balances to improve the patient experience.	Create a formal chart auditing procedure that includes peer review.	
					Consider using an independent agency or organization for chart review (DMC or through Project Smile)	
Capacity Expansion/School Based Care		Currently, the dental program is not fully utilizing its mobile dental equipment or its strong relationship with the area school district. The school board is anxious to provide dental care to its students and desires CHA to be a partner in this care. CHA must act abruptly in order to prevent a missed opportunity.				
					Use school nurse system to decrease liability and as oral health promotion specialists who can act as educators and promoters of the school based care system.	
					Hire additional dentist and necessary staff. Possible	

					opportunity to share dentist with Guilford County as school based care builds. Possible 12 month share program.	
Patient Growth		Administrative concerns state that an increase in the number of new patients in the system is desirable.		Evaluate different plans to enhance the number of new dental patients.	Consider opening a specific portion (time and/or day) to families of the children seen for dental care.	
					Consider implementing Project Smile findings into daily operations.	
Medical-Dental Integration		The current payer mix leaves room for enhancement. The best way to manage the payer mix is to identify priority populations for care in the dental clinic. Evaluation of patient's that can use CHA for multiple uses demonstrates low numbers of total use.		Add questions to the medical health history, WIC, etc..: do you have a regular dentist? (Y/N) When was the last time you received dental care? Train medical staff to review this question and offer to make a referral to the dental program for priority patients without an ongoing dental home.	Add questions to the medical health history and in-service staff on how to make referrals to dental	
					Track referrals from medical to dental and vice versa as a health center-wide performance improvement initiative	
		CHA currently has an outstanding Diabetes related health grant. This project has seen limitations with enrollment using its current protocol.		The Dental Program has an approximate 30% of patients with Type II Diabetes at the Kannapolis site that have not been utilized to provide enrollment in the study.	Place grant related personnel at Kannapolis dental site to improve enrollment.	
					Evaluate and implement any procedures that can be added to the grant with oral health implementation (i.e. tracking	

					A1Cs with regular dental visits or evaluate the impact of dental based health education for diabetics)	
					Share and engage information with Guilford County.	
Marketing/Community Outreach		Leadership and staff both expressed a desire for stronger marketing and community involvement.		Development of a CHA oral health education program. (Project Smile)	*See Project Smile Enhancement Plan*	
				Provide community outreach with schools, health fairs	Set a yearly goal of number of community fairs or school programs to provide education programs.	
				Strengthen CHA "in house" partnerships for improving the patient experience.	Ensure and develop a quality control system to track that other CHA programs are providing information and informing patients of the dental program.	
Scheduling		The schedule is the single most important strategic tool for achieving practice goals, and yet in many safety net dental programs, it is often done without much thought or planning.		Create a formal scheduling tracking policy that rewards or recognizes front office for filling incomplete schedules or last minute no shows.	Track daily schedule fills rates (i.e. what percentage of unfilled time slots were scheduled at the end of the day)	
					Track patient demographics on who is likely to no show and who is likely to come in for a last minute appointment.	
Dental Supply Ordering		The current process for the ordering of dental supplies is adding to the cost of supplies. This practice also can result in poorer quality materials which results in using more materials. Currently staff fills out a sheet of paper when they need new supplies.		Establish a leadership role to track and verify ordering as well as provide an opportunity to create continuity in ordering supplies.	Create a leadership role among dental auxiliaries that will track and create continuity to the ordering process.	

					Create new system for dental supply ordering for all sites (including the mobile teams) that will provide a timeline for ordering as well as take advantage of any bulk ordering that may be available.	
Accountability and Buy-In		The entire dental staff needs to understand the current situation, what it costs to run the dental program, where the opportunities lie and what the goals for the program are going to be. They have to understand that participation in the departmental improvement initiative is not optional, and that their individual and collective performance will be measured and reported (CHA currently does a great job with this)		Share the proposed goals with all staff ensuring that all team members understand their role in the success of the program	Educate dental staff; set program goals; monitor progress and provide regular feedback to staff; reward success and coach setbacks	
Rewarding Performance		Financial rewards can be a powerful incentive to make change happen. We recommend that the entire dental team be rewarded when the program reaches financial sustainability as this fosters teamwork and shared accountability.		When financial sustainability is reached, the entire dental staff should be rewarded. Rewards can be a percentage of salary or a straight cash bonus. Staff should know this reward is available once sustainability is reached	Create an incentive plan for the entire dental team.	