MISSION, MARGIN & LEADERSHIP

Sustaining the Safety Net Dental Practice
May 9-10, 2019
DentaQuest Partnership for Oral Health Advancement

DENTAQUEST FOUNDATION + DENTAQUEST INSTITUTE = THE DENTAQUEST PARTNERSHIP FOR ORAL HEALTH ADVANCEMENT
About Us

The DentaQuest Partnership for Oral Health Advancement, a nonprofit entity of the DentaQuest family of organizations, is passionate about and committed to revolutionizing oral health through implementation of meaningful change strategies that create an effective and equitable system that results in the improved oral health and well-being of all. We focus on strategic grantmaking, contributing to evidence-based care, and developing person-centered care programs.
Focus Areas

Pursue person-centered care through interprofessional practice and value-based transformation

A single, national oral health measurement system

Advocate for public adult dental benefit to expand access

For more information visit www.dentaquestpartnership.org. Click here to sign up for news and updates.
Today’s Focus

• Improve access to care and the financial viability of the safety net dental clinic.
• Provide solutions to thrive in today’s current healthcare landscape while preparing for a new era in healthcare.
Who is in the room today?

AUDIENCE

- Dental Directors
- Clinic Managers
- Public Health Department
- Other

Other
Agenda – Day 1

- Session One: Person-Centered Care and a Changing Oral Health Landscape
- Session Two: Laying the Groundwork for Dental Program Success
- Lunch
- Case Study: We’ve Been in Your Shoes and Survived!
- Session Three: Practice Redesign for Dental Program Financial Sustainability
- Session Four: Practice Redesign – Strategies for Increasing Access
- Closing/Wrap-Up
- Office Hours
- Reception & Dinner
Agenda – Day 2

- Office Hours
- Recap of Day 1 & Overview of Day 2
- Session Five: Outcomes and Measurement
- North Carolina Update: Integration Initiatives & Impact
- Session Six: Oral Health Interprofessional Practice
- Lunch
- Dig Deeper Session
- Closing/Wrap-Up
Office Hour Sign-Ups

Meet with DQP Faculty for 1:1 coaching sessions to enhance your program’s takeaway! (Voluntary)

Thursday 4:30-5:00 p.m.
Friday 7:30-8:00 a.m.

Sign-up sheet located at back table

- Sign up for a day and time, and include the general topic you’d like to discuss
- DQP faculty will float for best match, or you can make a specific request
- Please write cell # as contact
What are you hoping to get out of this training?
Other Housekeeping Items

• CE sign-in sheet
• Burning questions
• Benchmark worksheet
• Improvement plan worksheet
• Individual session evaluations & full training evaluation
• Location of restrooms
• Training materials
PERSON-CENTERED CARE AND A CHANGING ORAL HEALTH LANDSCAPE

Sean Boynes, DMD, MS
Status Quo

Relative Health Care System Performance and Spending in 11 High-Income Countries.

Schneider et al. Commonwealth Fund, 2017
Oral Health and a Healthy Life
The Economic Burden of Disease

ORAL DISEASE IS THE 4TH MOST EXPENSIVE DISEASE TO TREAT IN MOST INDUSTRIALIZED COUNTRIES

Creates a profound economic burden

1 2 3 4 5

Oral Disease

## Changing Priorities: The 1.0 to 3.0

<table>
<thead>
<tr>
<th>FIRST ERA - 1.0</th>
<th>SECOND ERA - 2.0</th>
<th>THIRD ERA - 3.0</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical care &amp; public health services</strong></td>
<td><strong>Health care system</strong></td>
<td><strong>Health system</strong></td>
</tr>
<tr>
<td>Goals of health system</td>
<td>Improve life expectancy</td>
<td>Reduce disability</td>
</tr>
<tr>
<td>Primary focus of services</td>
<td>Diagnose and treat acute conditions</td>
<td>Prevent and manage chronic diseases</td>
</tr>
<tr>
<td>Role of health and health care provider/organization</td>
<td>To protect from harm, cure the sick, and heal the ill</td>
<td>To prevent and control risk, manage chronic disease and improve quality of care</td>
</tr>
<tr>
<td>Role of individual and community</td>
<td>Inexperienced patient</td>
<td>Activated partners in care</td>
</tr>
</tbody>
</table>
CHANGING CONSUMERS AND EMPOWERING CONSUMERISM

Cool. The tooth fairy put a few bucks in my PayPal account last night.
What Do Patients Want?

They want convenience

- **43%**  
  Want to be able to request appointments online

- **41%**  
  Want convenient/extended hours during the week

- **38%**  
  Want to see an informative, up-to-date practice website

- **36%**  
  Want dentists to have weekend hours

- **33%**  
  Want dentists who are able to offer immediate appointments
What Do Patients Want?

To read and evaluate reviews

86% of consumers surveyed will pay more for services with higher ratings and reviews.
Increased Consumerism

Looking for Value: Asking About Pricing, Searching for Quality
Which of the following, if any, have you done in the last 12 months?

Legend
- Seniors (born 1900-45)
- Boomers (born 1946-64)
- Gen X (born 1965-81)
- Millennials (born 1982-95)

Source: Deloitte Center for Health Solutions: 2013 Survey of U.S. Healthcare Consumers
What Do Patients Want?

Family and friends’ endorsement or recommendations

• While much has changed in the dental profession over the past 20 years, one thing has remained constant:
  – The importance of word-of-mouth referrals
• Patients/Customers referred by other patients/customers have a 37% higher retention rate
• 84% of the patients solicit personal recommendations from family, friends and co-workers when they search for a new dentist.
  – This is up from 74% in 2013

McKinsey Quarterly, “A new way to measure word-of-mouth marketing,” April 2010
What Do Patients Want?

Integrated Care and Interprofessional Practice

- I feel it is very important for my physician to talk with my dentist to help coordinate my complete health care
  - 1.56 ±0.77

- I would like my medical care team to be more involved in my oral/teeth health
  - 1.50 ±1.13

- I prefer and enjoyed this process of my dental and medical care teams talking to each other during my appointments with them both.
  - 1.70 ±0.76

- I feel I have a better understanding to the importance of my oral health.
  - 1.34 ±0.58
What Do Patients Want?

Value

• The offer of preventive dental care and advice was an amazing revelation for this group of patients as they realized that dentists could practice dentistry without having to “drill and fill” their teeth.

• All patients, regardless of the practice they came from or their level of clinical risk of developing dental caries, valued having a caring dentist who respected them and listened to their concerns without “blaming” them for their oral health status.

• These patients complied with and supported the preventive care options because they were being “treated as a person not as a patient” by their dentists.
“Please, let patients help improve healthcare. Let patients help steer our decisions, strategic and practical. Let patients help define what value in medicine is.”

- DAVE DEBRONKART

Activist for healthcare transformation through participatory medicine and personal health data rights
<table>
<thead>
<tr>
<th>CATEGORY 1</th>
<th>CATEGORY 2</th>
<th>CATEGORY 3</th>
<th>CATEGORY 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>FEE FOR SERVICE - NO LINK TO QUALITY &amp; VALUE</td>
<td>FEE FOR SERVICE - LINK TO QUALITY &amp; VALUE</td>
<td>APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE</td>
<td>POPULATION - BASED PAYMENT</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>A</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>Foundational Payments for Infrastructure &amp; Operations (e.g., care coordination fees and payments for HIT investments)</td>
<td>APMs with Shared Savings (e.g., shared savings with upside risk only)</td>
<td>Condition-Specific Population-Based Payment (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>B</td>
<td>B</td>
<td></td>
</tr>
<tr>
<td>Pay for Reporting (e.g., bonuses for reporting data or penalties for not reporting data)</td>
<td>APMs with Shared Savings and Downside Risk (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)</td>
<td>Comprehensive Population-Based Payment (e.g., global budgets or full/percent of premium payments)</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>C</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>Pay-for-Performance (e.g., bonuses for quality performance)</td>
<td></td>
<td>Integrated Finance &amp; Delivery Systems (e.g., global budgets or full/percent of premium payments in integrated systems)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3N Risk Based Payments NOT Linked to Quality</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4N Capitated Payments NOT Linked to Quality</td>
<td></td>
</tr>
</tbody>
</table>
Average Payment Per Patient, by Plan Type and Age, in a National Medicaid Sample, 2015

Preliminary Analysis of IBM Watson Medicaid Marketscan Database.
“Healthcare is an exercise in interdependency - not personal heroism... a need for greater teamwork and to ask, what am I part of?”

- DON BERWICK
  President Emeritus and Senior Fellow, IHI
A Person-Centered Pathway
Disease Management Models

Disease management is a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant.

- Prevention focused
- Interprofessional/Integrated care (overlap)
- Population health
Organizing Populations for Care

**miles of smiles pediatric clinic**

Provides comprehensive dental care to children 18 years of age and younger throughout the Pee Dee Region. (Includes comprehensive emergency care.)

**oral health diabetic clinic**

Provides oral health care and education to patients diagnosed with diabetes or considered pre-diabetic currently being treated at CareSouth Carolina.

**oral health cardiovascular clinic**

Provides oral health care and education to patients diagnosed with CVD or considered pre-CVD currently being treated at CSC.

**ryan white dental care clinic**

CareSouth Carolina HIV/AIDS integrated dental medicine clinic.

**persons with special healthcare needs dental clinic**

Through partnerships and affiliation with individual county boards of the South Carolina Department of Disabilities and Special Needs to provide oral health services.

**adult dental care cooperative — dental clinic**

Provides comprehensive dental care to adults within our contracted system.

**adult oral emergency clinic**

Provides a referral base to CareSouth Carolina health providers for their patients in need of dental services.
Risk-Stratified Care and Population Health Medicine

American Academy of Family Physicians

• “Risk-stratified care management (RSCM) is the process of assigning a health risk status to a patient, and using the patient’s risk status to direct and improve care. The goal of RSCM is to help patients achieve the best health and quality of life possible by preventing chronic disease, stabilizing current chronic conditions, and preventing acceleration to higher-risk categories and higher associated costs.”
INTEGRATED CARE
• An interdisciplinary approach to health care that incorporates specific procedures of other disciplines into daily practice.

COORDINATED CARE
• Using a continual care pathway approach that allows the patient easy navigation and understanding their needs within the health care system.

- Clinical Integration
- Population & System Analysis
- Risk Stratified Care
- Patient Engagement
- HIT & Telehealth
- Referral & Care Management
Risk-Stratified Care and Population Health Medicine

- **High-Risk Patients**: 5% of patients; usually with complex disease(s), comorbidities
- **Rising-Risk Patients**: 15%-35% of patients; may have conditions not optimally managed
- **Low-Risk Patients**: 60%-80% of patients; with minor transient conditions which are easily managed

**Intensive Care Management**
- Trade high-cost services for low-cost management with Home Health monitoring

**PCMH Chronic Disease Management**
- Avoid unnecessary hospital admissions and ED visits.

**Prevention and Patient Access is Key**
- Keep patient healthy and loyal to the system
- Healthy Population

Adapted From: Health Care Advisory Board interviews and analysis.
Risk-Stratified Annual Surgical Dental Intervention Costs

Number of Patients with Surgical Dental Interventions, by Risk

- High Risk: 17,867
- Moderate Risk: 7,168
- Low Risk: 34

Box and Whisker Plot of Risk Stratified Annual Surgical Dental Intervention Costs

- Low Risk
  - Median: $271
  - IQR: $135 to $36
- Moderate Risk
  - Median: $162
  - IQR: $87 to $30
- High Risk
  - Median: $434
  - IQR: $210 to $112

MORE Care: Preliminary Analysis
Analysis of an Early Adopter Program

![Graph showing the analysis of an Early Adopter Program with bars and trend lines for Type I and Type II benefits. The graph displays the percentage of participation from 2010 to 2015 for both diagnostic and prevention services (Type I) and treatment of disease (Type II).]
What is one word/phrase you want to tell your future self about where healthcare is going?
LAYING THE GROUNDWORK

Carolyn Brown, DDS
Carolyn Brown, DDS
Consultant, Acting Director of Value-Based Care
DentaQuest Partnership for Oral Health Advancement

Consultant working with DQP, FQHCs, Primary Care Associations and Foundations advancing oral health programs
Value-Based Care and IHI Improvement Coach
Dental Director
Research, Marketing, Finance

DDS, University of Maryland School of Dentistry
BS, University of Maryland
Speaker, researcher, expert advisor, review panel
Learning Objectives

• Discuss the key elements to success for a FQHC dental program.
• Outline the essential components of developing a business plan for a FQHC dental program.
• Review national data that demonstrates what other safety net dental programs are doing.
• Review HRSA program guidelines relative to dental and how to work within them.
Where Do We Start?
Fig. 1 Consolidated flow model. A representation of individuals, roles, tasks, artifacts and interactions in the work process
*The computer was present in eight of the 12 offices. Abbreviations: pt = patient; TX = treatment. Breakdowns are indicated in red

Source: A preliminary model of work during initial examination and treatment planning appointments Irwin JH, Torres-Urquidy MH, Schleyer T, Monaco V. British Dental Journal. 2009:209, E1
## Dental Programs in the Safety Net

<table>
<thead>
<tr>
<th>Strengths/Weaknesses</th>
<th>Opportunities/Threats</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highly skilled team members</td>
<td>Dental Team</td>
</tr>
<tr>
<td>Multiple skills (clinical, admin, tech)</td>
<td>Training, Resources</td>
</tr>
<tr>
<td>Fast-paced environment</td>
<td>Time Management, Workflow</td>
</tr>
<tr>
<td>Patient flow dependent</td>
<td>Patient engagement</td>
</tr>
<tr>
<td>Complex payment systems</td>
<td>Operational impact, Finances</td>
</tr>
<tr>
<td>Complex technology</td>
<td>Interoperability</td>
</tr>
<tr>
<td>Demand – immediate and LT</td>
<td>ER and Comprehensive care</td>
</tr>
<tr>
<td>Health center alignment</td>
<td>Competing priorities w/in HC</td>
</tr>
</tbody>
</table>
Dental Leadership

As a leader….Director of a play

- Plot
- Script
- Producers (Money men)
- Actors
- Props
- Theme
- Tempo, rhythm
Five Domains to Understand and Own

1. Access
2. Finance
3. Outcomes
4. Quality
5. Governance
Top Ten Priorities for Dental

1. Understanding What Success Should Look Like in Dental
2. Compiling data that is: Accurate, Meaningful and Timely
3. Computing and understanding your actual “Capacity”
4. Setting clear Goals, Roles, Responsibilities and Timelines
5. Utilizing the dental schedule strategically
6. Having the right policy for “Everything”
7. Owning management of Broken Appointments and Emergencies
8. Creating a “Culture of Accountability”
9. Executing a CQI and QA System
10. Teaching Executive Leadership how to best enable and support Dental
MEDICAL

DENTAL

Are Different!

Different Care Plan and Different Business Plan
<table>
<thead>
<tr>
<th>Medical</th>
<th>Dental</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>80% of clinic volume</strong></td>
<td><strong>20% of clinic volume</strong></td>
</tr>
<tr>
<td>80% of visits = similar</td>
<td>80% of visits = varied</td>
</tr>
<tr>
<td>80% of visits = shorter</td>
<td>80% of visits = longer</td>
</tr>
<tr>
<td>80% of billing similar</td>
<td>80% of billing varied</td>
</tr>
<tr>
<td>80% of visits <strong>diagnostic</strong></td>
<td>80% of visits <strong>treatment</strong></td>
</tr>
<tr>
<td>80% of RVUs similar</td>
<td>80% of RVUs different</td>
</tr>
<tr>
<td><strong>100% of governance is designed around medical</strong></td>
<td><strong>0% of governance is designed around dental</strong></td>
</tr>
<tr>
<td>EMR silo</td>
<td>EDR silo</td>
</tr>
<tr>
<td>Familiar with medical model</td>
<td>Not familiar with dental model</td>
</tr>
<tr>
<td>Leadership defined, supported</td>
<td>Leadership roles not consistent</td>
</tr>
</tbody>
</table>
Primary Care Visit and Supporting Roles

- **Primary Care Patient**
- **Call Center**
- **Front Desk**
- **Eligibility Worker**
- **Triage Nurse**
- **MU Medical Assistant**
- **Rooming Medical Assistant**
- **Provider: NP, MD/DO, PA**
- **In Medical Exam Room:**
  - Triage
  - Diagnosis
  - Education
- **After Visit-Care Coordination**
- **Referral Clerk**
- **Medical Records Clerk**
- **Case Manager**
Dental Visit and Supporting Roles

**Dental Patient**

**Front Desk:**
- Phone Mngt
- Eligibility
- Intake
- Triage pt 1

**Dental Assistant:**
- Triage pt 2
- MU
- Rooming
- Education
- Radiology
- Surgical

**DDS/RDH:**
- Triage pt 3
- Diagnosis
- Education
- Surgical
- Tx Planning

**After Visit-Care Coordination**

**Front Desk:**
- Tx Planning
- Referrals
- Med. Records
- Case Mngt

**Dental Assistant:**
- Referrals
- Med. Records
- OHI
- Case Mngt.

**DDS/RDH:**
- Med. Records
- Referrals
- Case Mngt.
- Recall (RDH)

**In Dental Operatory:**

- Triage pt 1
- MU
- Rooming
- Education
- Radiology
- Surgical
- Tx Planning
Support Staff and Processes

Primary Care

Dental
Blue Zones Project

9 secrets to longevity

Power 9

Source: www.bluezonesproject.com
Productivity in Access-Finance-Outcomes

We get what we measure
We get the results we tolerate

We now establish productivity goals for the program as a unit and for each individual

Remembering: Clarity around Goals, Roles, Responsibilities and Timelines establishes how we will hold the program and each individual

Accountable
Strategies to Set Goals

Defining Capacity
Optimize Efficiency
Understand Measurement
Team, Patient Experience
Capacity = Quality
Defining Capacity

- We are limited by our structure
  - Chairs-Rooms-Operatories, Dentists, RDHs, DAs, Staff, Hours of Operation, scope of service
- Our structure determines our capacity, not our hearts
- We cannot be all things to all patients
- We only have 20% of the capacity of Medicine
- Understanding and defining capacity is essential to the creation of the dental business plan
- We need to decide WHO gets the care by creating priority populations

Equitable, quality care mandates that we work within our capacity
Five Domains to Understand and Own

1. Access
2. Finance
3. Outcomes
4. Quality
5. Governance
2017 FQHC UDS National Averages

• 27.1 million unduplicated FQHC patients
  • 84.2% accessed medical services (22.9 million patients)
  • 22.5% accessed dental services (6.1 million patients)
    – Dental capacity is a little over 1/4th of medical capacity
• 2,599 visits/year/FTE Dentist
• 1,180 visits/year/FTE Dental Hygienist
• 902 visits/year/FTE Dental Therapist
• 2.6 visits/year per unduplicated dental patient
• Average cost/visit in dental = $200 per visit
• Average admin cost allocation to dental = 12.8%
• Sealant metric average = 50.7%
Access Benchmarks- Dentist

2,500-3,200 encounters/year/FTE dentist

2,700 encounters/year with 1,100 patient base/dentist

1.7 patients/hour or 13.6 patients/day/dentist

2.6 Visits/Year/Patient

2 Chairs/dentist (3:1 is ideal)

1.5 Assistants/dentist (1 DA per chair is ideal)

DQP analysis of 2017 UDS data
Access Benchmarks - Hygienist

1,300-1,600 encounters/year/FTE hygienist

1.2 patients/hour/hygienist
or 10 patients/day/hygienist

2 ADA coded services
as the diagnostic part of a recall or comprehensive visit (exam, FMX)

230 work days/year
(or 1,600 work hours/year after holidays and vacations)

5 days/week x 46 weeks = 230 work days/year

DQP analysis of 2017 UDS data
Access Best Practice Benchmarks

15% Broken Appointment Rate

<10% Emergency Rate

30-45 days Scheduling

33% Tx Plan Completion

# New Patients/month = # Tx Plan completed/month

Designated Access Scheduling
Financial Best Practice Benchmarks

$200 average cost per dental encounter

>$500K-$600K Gross charges/dds/yr

10-15% % of total A/R +90 days

12% Allocation of H80 to DD

95% Collection Rate
Financial Best Practice Benchmarks

$40* Nominal fee

70-80% of UCR Full Fee Schedule

3 Slides 100-199% FPG
FQHC Budget Breakdown

Total Budget: 100%

- **Dental Practice Overhead**: 70-85%
  - See breakdown below*
  - Allocation for Administrative Costs: 5-10%
    - Costs for CEO, CFO, COO, etc.
  - Health Center Support Allocation: 10-20%
    - Costs for Human Resources, Security, Medical records, IT, etc.

Breakdown of the 70-85% **Dental Practice Overhead**:

- Payroll (salary, taxes, & fringe benefits): 68%
- Lab fees: 5%
- Office Supplies: 2%
- Depreciation: 4%
- Dental Supplies: 7%

- Repairs: 2%
- Marketing/Promotion: 1%
- Recruitment: 1%
- Building, Utilities, telephone: 9%
- Continuing Education: 1%
Access is everything associated with the visit:

- Services: Type – diagnostic, preventive, therapeutic, specialty
- How many services by ADA code?
- Charges for the services
- Revenue received for the charges
- Health Outcomes as a result of the services
- Quality of the services and of the customer service
- Compliance with Governance
- Safe-Equitable-Efficient-Effective-Timely-Patient Centric

Access Outcomes:

- Health Outcomes
- Oral Health Outcomes
- Financial Outcomes
- HRSA Goal Outcomes
- Treatment Plan Completion Outcomes
- Focus Population Care Outcomes
## Scope of Service Benchmarks

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Procedure Codes</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic</td>
<td>D0100-D0999 (excluding D0140)</td>
<td>30-40%</td>
</tr>
<tr>
<td>Preventive</td>
<td>D1000-D1999</td>
<td>25-35%</td>
</tr>
<tr>
<td>Restorative</td>
<td>D2000-D2999</td>
<td>18-25%</td>
</tr>
<tr>
<td>Endodontics</td>
<td>D3000-D3999</td>
<td>1-2%</td>
</tr>
<tr>
<td>Periodontics</td>
<td>D4000-D4999</td>
<td>2-5%</td>
</tr>
<tr>
<td>Removable Prostho</td>
<td>D5000-D5899</td>
<td>1-3%</td>
</tr>
<tr>
<td>Fixed Prosthodontics</td>
<td>D6200-D6999</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>D7000-D7999</td>
<td>5-10%</td>
</tr>
<tr>
<td>Emergency</td>
<td>D0140, D9110</td>
<td>2-6%</td>
</tr>
</tbody>
</table>
Success in Finance, Outcomes & Quality

**Finance**

**Vision**

Creation of a high-quality, affordable, oral health program that documents the improvement of the oral health status of the patients we treat while being financially responsible.

**Financial Plan**

What the dental practice needs to accomplish to be financially sustainable, maximize patient access and provide meaningful quality outcomes.

**If I had only one report!**

**The Profit and Loss**

**REMEMBER:** Knowing who you are and being able to define that with data; defining who you want to be and what success looks like for you; creating a simple and clear plan to achieve that success and then communicating that plan to the team and thus creating a culture of accountability is the road to accomplishing financial success.
Outcomes

- HRSA Sealant Measure Compliance for FQHCs
- Completion of phase 1 treatment plans
- Children seen 0-5 years old
- Children seen getting a preventive service
- #Fluoride Varnish applications
- Pregnant women seen and treated
- Diabetic patients with HbA1C > 7 seen
- Patients seen who have not been seen for 12 months
- Patients seen getting a Risk Assessment
- Patients with moderate or high risk who lower risk at recare
- #Sealants provided
Quality

- Quality Management System
  - Quality Assurance Policy and Tool
  - Continuous Quality Improvement Policy
- Dental Quality Compliance Officer
- Dental Representation on FQHC CQI team
- Credentialing Policy
- Privileging Policy
- Privileging Policy/Competencies
- Policy and Procedure Manual
- Patient Satisfaction Survey (At least 1X year)
Governance

• Compliance with Federal, State and Local Regulations and with the State Practice Act
• Credentialing Policies and CEU Compliance
• Privileging Policy/Competencies
• Annual Safety/Infection Control/Hazardous Waste Training
• Preparation for a OSV/Regulatory Site Visit
• After Hours Coverage Policy
• Extended Service Hours
• Malpractice, Liability Policies & Coverage/Gap Insurance
• FTCA Deeming/Annual Redeeming/Compliance
Aligning with HRSA Governance

- Scope of Services - PREVENTION
- Staffing
- Accessibility to patients
- Fees and sliding fee scale discounts
- Quality management
- Leadership
- Program performance
- Billing and collections
- Dental program budget
- Program capacity
Aligning with HRSA Governance

Accessibility to Patients

• Provides services at times and locations that assure accessibility and meet the needs of the population to be served.
• Provides professional coverage for medical emergencies during hours when the center is closed.

Fees and Sliding Fee Schedule Discounts

• System in place to determine eligibility for patient discounts adjusted on the basis of the patient’s ability to pay.

Quality Management

• Ongoing Quality Improvement/Quality Assurance (QI/QA) program that includes clinical services and management, and that maintains the confidentiality of patient records.
Aligning with HRSA Governance

Program Performance

• Systems which accurately collect and organize data for program reporting & which support management decision making.

Billing and Collections

• Systems in place to maximize collections and reimbursement for its costs in providing health services, including written billing, credit and collection policies and procedures.
Setting Goals

Access
- Total number of visits
- Number of unduplicated patients
- Number of new patients

Provider Productivity
- Visits/day
- Procedures/visit
- Expected net revenue/day

Quality Outcomes
- Percentage of completed Phase 1 treatment plans
- Percentage of high and moderate risk children ages 6-9 who received at least one sealant

Financial Outcomes
- Gross charges
- Net revenue & expenses
- Bottom line
Balancing Act

Teams and Leaders

Strategy and Operations

Mission and Margin
QUESTIONS/DISCUSSION
LUNCH
CASE STUDY: WE’VE BEEN IN YOUR SHOES AND SURVIVED

Carolyn Brown, DDS
Tess Draper, RDH
Tess Draper, RDH BS  
Clinical Integration Trainer  
DentaQuest CareGroup

Work directly with CareGroup dental clinics to implement caries disease management

Former Dental Hygiene Team Manager for Clinica Family Health, a FQHC in Denver, CO

University of Nebraska Medical Center, College of Dentistry

Member, National Network for Oral Health Access

Member, American Dental Hygienists Association
DentaQuest CareGroup Clinic

- Prevention-pilot for Dental Caries Disease Management
  - Fit DM in FFS

- Patients 0-100 yo

- Primarily Medicaid office

- Ryan White clinic
  - Access challenges
    - 1 restoration/visit

- 2 full-time DDS; 1 RDH; 2 DAs;
  - Access challenges
    - RDH turnover
    - Only DDS & RDH can place sealants

- M-F 8-5
DQ Prevention Journey

Financial/Productivity
- Target: Preventive services
- What: Sealant placement & fluoride application

Practice Management/Operations
- What did you try, with error and learning, to reduce chaos
  - Process map: include clinical & operations feedback
  - Goals help unite clinical team during turnover
    - DDS placing sealants

Interprofessional Practice
- What was it like moving to a prevention-focused practice?
  - Most believe they already are a prevention-focused practice
  - Standardize definition
  - Standardize workflows
  - Develop a clinical policies to set standard
  - Sustain

- Using Data
  - To inform, not punish
  - Every role understands
Dear Younger Self,

What did you learn during the process that surprised you the most?
• People want a specific goal to work towards

How did you promote your efforts?
• Learn their process
• Work within their timeline- Do you really need an hour lunch meeting?

What key lessons do you want someone else to know about the process of testing and implementing changes?
• What is your why?
  • Don’t change just to change
  • Transparency gains buy-in
Turn the Tables

What Matters to You?
San Francisco CA- Early 2009

- FQHC program
- 2 locations (3rd in progress)
- Comprehensive adult and child dental coverage
- Newly immigrated individuals and families, homeless, HIV, urban NA/AI
- Dental program setup:
  80/20 adult/child
  80/20 Medicaid/ self-pay + insurance
  1 DDS: 1.2 DA: 1 Front Desk  0 Hyg
  2.5 DDS + .5 Pediatric DDS per location
  Avg monthly collection $800 per location
  Pre-doc dental student rotation
  High burden of disease
    (Avg adult tx plan min 6 visits/yr)
- Silo of health services (except HIV)
- Dental Director

Comprehensive Adult Dental coverage collapsed in March 2009
CASE STUDY #2

The Quick Pivot-
The Collapse of Payment Structure
Exercise- Strategies for a Quick Pivot

Please work with groups of 2-4 people at your table

Discuss ideas to help this dental program, who is facing a MASSIVE and IMMEDIATE challenge

Discuss, for 5 minutes, ideas or places to start and be prepared to share with the room

Report out the following:
1. Low hanging fruit
2. Ideas in these buckets: Data, IPP, Finance, Operations
3. What other information would help you?
Rebound……Didn’t Happen Over Night

Financial/Productivity
- Examined capacity, processes
- Path to survival WITH A TEAM APPROACH

Operations
- To reduce chaos
  - Tightened Broken Appt policy
  - Expanded Pediatric Dentist time
  - Created Pediatric clerkships for DAs + DDS
  - Added dental assistants
  - Recall Systems- 1st time focus

Interprofessional Practice
- DentaQuest collaborative simultaneously
- Applied Disease Management with our HIV program IPP experience
- Community collaboration

Using Data
- Getting clean data that EVERYONE bought into (C-Suite)
- Shared with dental team, and CELEBRATED success
Rebound……Didn’t Happen Over Night

Financial Impact

• Looked at eligibility through claims= Revenue Cycle Management
  • Increased fees, including lab fees
  • Short term revenue from pediatric dental to fund LT changes
• Added dental residents (AEGD)
• Added dental assistants

Patient Experience Approach

• Retooling and calibration on customer service
• Esp at front desk
• Scripting, tightened revenue collection
• Synergistic with agency rethink, medical on EMR
Rebound……Didn’t Happen Over Night

Results

• Appropriate staffing ratios
• Great team morale
• Addition of PG1 dental residents, + pediatric dentists, + operatories
• Agency adding Patient Services team
• Dental in executive committees
• Dental in QI
• In SF, collecting between +$10k/month
• Launched teledentistry and school-based health
Dear Younger Self,

What did you learn during the process that surprised you the most?
• Rely on others for the BEST ideas and info
• Sit in the seat of others
• Provide vision and purpose
• Engrain vision and purpose into every decision or change

How did you promote your efforts?
• Staff meetings, started 1:1s
• Progress board
• Team building

What key lessons do you want someone else to know about the process of testing and implementing changes?
• Celebrate success
• Celebrate failures or stumbles and why
QUESTIONS/DISCUSSION
PRACTICE REDESIGN FOR DENTAL PROGRAM SUSTAINABILITY

Danielle Apostolon
Danielle Apostolon, B.A. Business Management
Oral Health Value-Based Care Training Specialist
DentaQuest Partnership for Oral Health Advancement

Junior Accountant, Computerized Bookkeeping, LLC
Accounts Payable Supervisor, W.B. Mason
Senior Project Manager, Safety Net Solutions, 2008-2018
Oral Health Value Based Care Training Specialist Present

Member, American Association of Public Health Dentistry
Associate Member, Association of State and Territorial Dental Directors
Member, National Network for Oral Health Access
Associate Editor, Safety Net Dental Clinic Manual
ONE REASON PEOPLE RESIST CHANGE IS BECAUSE THEY FOCUS ON WHAT THEY HAVE TO GIVE UP, INSTEAD OF WHAT THEY HAVE TO GAIN.

"Change does not change tradition. It strengthens it. Change is a challenge and an opportunity, not a threat."

Prince Philip of England
Where Do We Begin?
Key Data to Evaluate Program Performance

- Visits
- Unduplicated patients
- New patients
- Procedures by ADA code
- Procedures per visit
- Broken appointment rate
- Emergency rate
- Gross charges
- Expenses (direct and indirect) Net revenue (including all sources of revenue)

- Expense per visit
- Revenue per visit
- Total accounts receivable (AR)
- AR past 90 days
- % of AR out past 90 days
- Payer and patient mix
- Patient Satisfaction Surveys
Key Data to Evaluate Program Performance, Continued

- Percentage of preventive procedures
- Treatment plan completion rate
- Percentage of children needing sealants who received sealants
- HRSA sealant metric
Prioritize

What do we need to address immediately?

• Financial Sustainability
• High broken appointment rate
• Scheduling issues (types of patients)
• Insufficient support staff (dental assistants)
• Staff turnover
• Equipment issues (chairs, outdated, missing, broken)
• Billing and collections
Importance of Sustainability

• Grant funds are never sufficient
• The resources allows us to hire and keep good providers and staff
• Meet increasing operational costs due to increased demand for services
• Expand the services we provide
• How we are reimbursed may change
Create the Business Plan

What the dental practice needs to accomplish to be financially sustainable, maximize patient access and provide meaningful quality outcomes.

• Capacity
• Target population to be served
• Scope of service for the practice
• Numbers, types and lengths of appointments
• Staffing model
Key to Success for Creating a Sustainable Business Plan

- *Setting* access goals, responsibilities, timelines
- *Having* the right policies for “everything”
- *Using* data to continuously evaluate performance
Defining Capacity/Visits

- We are limited by our structure
- Option to expand outside the clinic walls
- We only have 20% of the capacity of Medicine
- We cannot be everything to every patient of the CHC
- Equitable, quality, care mandates that we work within our capacity
- We need to decide WHO gets the care
- When we understand and define capacity we then create our business plan
Benchmark Guide

Productivity Benchmark Guide

Visits/Hour Capacity Goals for General and Pediatric Dentists

<table>
<thead>
<tr>
<th>Variables</th>
<th>Number of Operatories</th>
<th>1 Operatory</th>
<th>2 Operatories</th>
<th>3 Operatories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Dental Assistants</td>
<td>1 DA</td>
<td>1.5 DA</td>
<td>2 DA</td>
<td>1 DA</td>
</tr>
<tr>
<td>General Dentist</td>
<td>1.2</td>
<td>1.4</td>
<td>1.5</td>
<td>1.4</td>
</tr>
<tr>
<td>Pediatric Dentist</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>1.7</td>
</tr>
<tr>
<td>Hygienist</td>
<td>Mix of Adults and Children</td>
<td>Majority Adults</td>
<td>1.2</td>
<td>1</td>
</tr>
</tbody>
</table>

The 1 operatory model is not recommended, however some established clinics may have only one operatory/one Dentist model so we have provided benchmarks as a reference point. This is not recommended and not a sustainable model. In standard community dental clinics a hygienist works out of one operatory without a dental assistant. The productivity benchmark for hygienists is 1-1.2 visits per hour depending on patient population rather than dental assistants.

Instructions for using the chart to determine the appropriate visit per hour benchmark:
1. Identify the number of operatories each dental provider works out of.
2. Find the number of FTE dental assistants (DAs) staffed in your clinic per provider.
3. Chose the provider type you are setting productivity goals for (either Dentist or Pediatric Dentist).
4. Follow the row of the chosen provider type and match it up with the identified number of operatories and dental assistants. This is your visit per hour benchmark.
Example

Staff and Operators:
• 2 FTE General Dentists
• 3.0 FTE Dental Assistants
• 1 FTE Hygienist
• 5 Operatories
  • Each Dentists works out of 2 Ops

Hours:
• Monday through Friday 8:00-5:00 (1 hour lunch)
  • 8 clinical hours per day
### Determining Capacity Goals Based on Our Structure

#### Table One: Visits/Hour Capacity Goals for General and Pediatric Dentists

<table>
<thead>
<tr>
<th>Variables</th>
<th>Number of Operatories</th>
<th>1 Operatory (Not Recommended)</th>
<th>2 Operatories</th>
<th>3 Operatories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Dental Assistants</td>
<td>1 DA</td>
<td>1.5 DA</td>
<td>2 DA</td>
<td>1 DA</td>
</tr>
<tr>
<td>Provider Type</td>
<td>General Dentist</td>
<td>1.2</td>
<td>1.4</td>
<td>1.5</td>
</tr>
<tr>
<td></td>
<td>Pediatric Dentist</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>
### Setting Productivity/Access Goals: Visits Potential vs. Actual – FTE Dentists

<table>
<thead>
<tr>
<th></th>
<th># of Providers</th>
<th># of total clinical hours worked</th>
<th>x recommended # of visits/clinical hour</th>
<th>Potential Daily Visit Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mon.</td>
<td>2</td>
<td>16</td>
<td>1.7</td>
<td>27</td>
</tr>
<tr>
<td>Tues.</td>
<td>2</td>
<td>16</td>
<td>1.7</td>
<td>27</td>
</tr>
<tr>
<td>Wed.</td>
<td>2</td>
<td>16</td>
<td>1.7</td>
<td>27</td>
</tr>
<tr>
<td>Thurs</td>
<td>2</td>
<td>16</td>
<td>1.7</td>
<td>27</td>
</tr>
<tr>
<td>Fri</td>
<td>2</td>
<td>16</td>
<td>1.7</td>
<td>27</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Actual Visits</th>
<th>% of Capacity Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>74%</td>
</tr>
<tr>
<td>26</td>
<td>96%</td>
</tr>
<tr>
<td>19</td>
<td>70%</td>
</tr>
<tr>
<td>18</td>
<td>66%</td>
</tr>
<tr>
<td>10</td>
<td>37%</td>
</tr>
</tbody>
</table>

Potential Weekly Capacity = 135 Dentist Visits

*At least two operatories and 1.5 dental assistants
## Setting Productivity/Access Goals: Visits Potential vs. Actual – FTE Hygienists

<table>
<thead>
<tr>
<th></th>
<th># of Providers</th>
<th># of total clinical hours worked</th>
<th>x recommended # of visits/clinical hour</th>
<th>Potential Daily Visit Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mon.</td>
<td>1</td>
<td>8</td>
<td>1.2</td>
<td>9</td>
</tr>
<tr>
<td>Tues.</td>
<td>1</td>
<td>8</td>
<td>1.2</td>
<td>9</td>
</tr>
<tr>
<td>Wed.</td>
<td>1</td>
<td>8</td>
<td>1.2</td>
<td>9</td>
</tr>
<tr>
<td>Thurs</td>
<td>1</td>
<td>8</td>
<td>1.2</td>
<td>9</td>
</tr>
<tr>
<td>Fri</td>
<td>1</td>
<td>8</td>
<td>1.2</td>
<td>9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Actual Visits</th>
<th>% of Capacity Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mon.</td>
<td>7</td>
<td>77%</td>
</tr>
<tr>
<td>Tues.</td>
<td>8</td>
<td>89%</td>
</tr>
<tr>
<td>Wed.</td>
<td>6</td>
<td>66%</td>
</tr>
<tr>
<td>Thurs</td>
<td>7</td>
<td>77%</td>
</tr>
<tr>
<td>Fri</td>
<td>6</td>
<td>66%</td>
</tr>
</tbody>
</table>

**Potential Weekly Capacity = 45 Hygiene Visits**

*Benchmark of 1.2 is ideal for a practice with a patient mix of both adults and children*
## Dental Visits Based on Capacity

<table>
<thead>
<tr>
<th>GOAL</th>
<th>CALCULATION</th>
<th>TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visits/Day</td>
<td>27 Dental Visits + 9 Hygiene Visits = 36 visits per day *same for each day</td>
<td>36</td>
</tr>
<tr>
<td>Visits/Week</td>
<td>135 Dental Visits + 45 Hygiene visits = 180 visits per week</td>
<td>180</td>
</tr>
<tr>
<td>Visits/Year</td>
<td>180 weekly visits x 46 weeks = 8,280 Visits</td>
<td>8,280</td>
</tr>
</tbody>
</table>
## Comparison

### Model 1: 2 Dentists each working out of 2 Operatories with 1 dental assistant

**Table One: Visits/Hour Capacity Goals for General and Pediatric Dentists**

<table>
<thead>
<tr>
<th>Variables</th>
<th>Number of Operatories</th>
<th>1 Operatory (Not Recommended)</th>
<th>2 Operatories</th>
<th>3 Operatories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Dental Assistants</td>
<td>1 DA</td>
<td>1.5 DA</td>
<td>2 DA</td>
<td>1 DA</td>
</tr>
<tr>
<td>Provider Type</td>
<td>General Dentist</td>
<td>1.2</td>
<td>1.4</td>
<td>1.5</td>
</tr>
<tr>
<td></td>
<td>Pediatric Dentist</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

### Model 2: 2 Dentists each working out of 2 Operatories with 1.5 dental assistant

**Table One: Visits/Hour Capacity Goals for General and Pediatric Dentists**

<table>
<thead>
<tr>
<th>Variables</th>
<th>Number of Operatories</th>
<th>1 Operatory (Not Recommended)</th>
<th>2 Operatories</th>
<th>3 Operatories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Dental Assistants</td>
<td>1 DA</td>
<td>1.5 DA</td>
<td>2 DA</td>
<td>1 DA</td>
</tr>
<tr>
<td>Provider Type</td>
<td>General Dentist</td>
<td>1.2</td>
<td>1.4</td>
<td>1.5</td>
</tr>
<tr>
<td></td>
<td>Pediatric Dentist</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>
## Impact on Access

<table>
<thead>
<tr>
<th></th>
<th># of Providers</th>
<th># of total clinical hours worked</th>
<th>x recommended # of visits/clinical hour</th>
<th>Potential Daily Visit Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mon.</td>
<td>2</td>
<td>16</td>
<td>1.4</td>
<td>22</td>
</tr>
<tr>
<td>Tues.</td>
<td>2</td>
<td>16</td>
<td>1.4</td>
<td>22</td>
</tr>
<tr>
<td>Wed.</td>
<td>2</td>
<td>16</td>
<td>1.4</td>
<td>22</td>
</tr>
<tr>
<td>Thurs</td>
<td>2</td>
<td>16</td>
<td>1.4</td>
<td>22</td>
</tr>
<tr>
<td>Fri</td>
<td>2</td>
<td>16</td>
<td>1.4</td>
<td>22</td>
</tr>
</tbody>
</table>

110 Visits per Week

<table>
<thead>
<tr>
<th></th>
<th># of Providers</th>
<th># of total clinical hours worked</th>
<th>x recommended # of visits/clinical hour</th>
<th>Potential Daily Visit Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mon.</td>
<td>2</td>
<td>16</td>
<td>1.7</td>
<td>27</td>
</tr>
<tr>
<td>Tues.</td>
<td>2</td>
<td>16</td>
<td>1.7</td>
<td>27</td>
</tr>
<tr>
<td>Wed.</td>
<td>2</td>
<td>16</td>
<td>1.7</td>
<td>27</td>
</tr>
<tr>
<td>Thurs</td>
<td>2</td>
<td>16</td>
<td>1.7</td>
<td>27</td>
</tr>
<tr>
<td>Fri</td>
<td>2</td>
<td>16</td>
<td>1.7</td>
<td>27</td>
</tr>
</tbody>
</table>

135 Visits per Week
## Cost vs. Benefit of Adding Dental Assistant

### Cost

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salary</td>
<td>$640/week</td>
</tr>
<tr>
<td>Fringe benefits @ 25%</td>
<td>$160/week</td>
</tr>
<tr>
<td>Total cost</td>
<td>$800/week</td>
</tr>
<tr>
<td>Cost of Providing Care</td>
<td></td>
</tr>
<tr>
<td>25 Visits x $10/visit (average variable supply cost per visit)</td>
<td>$250</td>
</tr>
<tr>
<td>Total Cost</td>
<td>$1,050</td>
</tr>
</tbody>
</table>

### Benefit

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 Additional Visits</td>
<td></td>
</tr>
<tr>
<td>20% Self pay visits 5 @ $40 = $200</td>
<td></td>
</tr>
<tr>
<td>65% Medicaid visits 17@ $135 = $2,295</td>
<td></td>
</tr>
<tr>
<td>10% Commercial Insurance 3 @ $165 = $495</td>
<td></td>
</tr>
<tr>
<td>5% Homeless (Free Care) = $0</td>
<td></td>
</tr>
<tr>
<td>Total Revenue</td>
<td>$2,990</td>
</tr>
</tbody>
</table>

**Weekly profit = $1,940**

**Yearly profit = $108,680**

**Increases access by providing nearly 1,150 additional visits for the year!**
86.4% of people will believe any data you put in a PowerPoint slide, even if you just totally made it up to prove your point.
## Demo Tool

### Daily Provider Visit Goals

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>General Dentist A</th>
<th>General Dentist B</th>
<th>General Dentist C</th>
<th>Pediatric Dentist</th>
<th>Resident</th>
<th>RDH A</th>
<th>RDH B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visit per Hour Benchmark</td>
<td>1.7</td>
<td>1.7</td>
<td>1.9</td>
<td>1.9</td>
<td>1.9</td>
<td>1.9</td>
<td>1.9</td>
</tr>
<tr>
<td>Daily Clinical Provider Hours</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monday</td>
<td>7</td>
<td>7</td>
<td>8</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Visits</td>
<td>11.9</td>
<td>11.9</td>
<td>0</td>
<td>15.2</td>
<td>0</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Tuesday</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Visits</td>
<td>11.9</td>
<td>11.9</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Wednesday</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Visits</td>
<td>11.9</td>
<td>11.9</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Thursday</td>
<td>7</td>
<td>9</td>
<td>9</td>
<td>9</td>
<td>9</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Visits</td>
<td>11.9</td>
<td>15.3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Friday</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Visits</td>
<td>11.9</td>
<td>11.9</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Saturday</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Visits</td>
<td>6.8</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Weekly Visits per Provider</td>
<td>66.3</td>
<td>62.9</td>
<td>0</td>
<td>15.2</td>
<td>0</td>
<td>39</td>
<td>0</td>
</tr>
</tbody>
</table>

### Clinic Productivity Goals

<table>
<thead>
<tr>
<th>Day of the Week</th>
<th>Daily Visit Goal</th>
<th>Actual Visits</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>46</td>
<td>50</td>
<td>4</td>
</tr>
<tr>
<td>Tuesday</td>
<td>30.8</td>
<td>32</td>
<td>1.2</td>
</tr>
<tr>
<td>Wednesday</td>
<td>30.8</td>
<td>33</td>
<td>2.2</td>
</tr>
<tr>
<td>Thursday</td>
<td>34.2</td>
<td>35</td>
<td>0.8</td>
</tr>
<tr>
<td>Friday</td>
<td>30.8</td>
<td>32</td>
<td>1.2</td>
</tr>
<tr>
<td>Saturday</td>
<td>10.8</td>
<td>11</td>
<td>0.2</td>
</tr>
<tr>
<td>Weekly Visit Goal</td>
<td>183.4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Enter number of weeks/year: 46

Yearly Visit Goal: 8436.4
Target Population

Underserved populations are most at risk for dental disease and have the greatest difficulty accessing care:

- Children and adolescents
- Homeless individuals
- Low-income populations
- Older adults
- Patients with special needs
- Pregnant women and new moms
- Racial and ethnic minorities
- People living in rural communities
Staffing Model

1. Identify program resources
2. Review your state Practice Act – Your providers should work to the top of their qualifications
3. Understand your patient base
4. Develop daily visit capacity and goals for each provider
Example: 6-Chair Dental Clinic

2 FTE Dentists
2 FTE Hygienists
4 FTE Assistants
2 FTE Registration/Reception Staff
1 FTE Practice Manager

Salary costs = $891,250
Other program costs = $150,000

Total Expenses of $1,041,250
### Example: Cost/Visit for Staffing Expense Only

<table>
<thead>
<tr>
<th>Clinical Team</th>
<th>Salary</th>
<th>Benefits</th>
<th>Net</th>
<th>Number FTE</th>
<th>Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff dentist</td>
<td>$300,000</td>
<td>$75,000</td>
<td>$375,000</td>
<td>2</td>
<td>6,000</td>
</tr>
<tr>
<td>Hygienist</td>
<td>$140,000</td>
<td>$35,000</td>
<td>$175,000</td>
<td>2</td>
<td>3,200</td>
</tr>
<tr>
<td>Dental Assistants</td>
<td>$140,000</td>
<td>$35,000</td>
<td>$175,000</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>9,200</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Administrative Team</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Manager</td>
<td>$65,000</td>
<td>$16,250</td>
<td>$81,250</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Reception/Registration</td>
<td>$68,000</td>
<td>$17,000</td>
<td>$85,000</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$891,250</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cost/visit Staffing expense only</th>
<th>Net Staffing Expenses</th>
<th>Divided by</th>
<th>Total number of visits</th>
<th>Equals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$891,250</td>
<td>÷</td>
<td>9,200</td>
<td>$96.88</td>
</tr>
</tbody>
</table>
## Demo Salary Tool

<table>
<thead>
<tr>
<th>Position</th>
<th>Hourly rate</th>
<th>Hours/Week</th>
<th>Weeks/Year</th>
<th>Yearly salary</th>
<th>Fringe %</th>
<th>Yearly Fringe Benefits</th>
<th>Total Salaries and Fringe Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Practice Manager</td>
<td>$0.00</td>
<td></td>
<td></td>
<td>$0.00</td>
<td></td>
<td>$ - $</td>
<td>$ - $</td>
</tr>
<tr>
<td>Dental Director</td>
<td>$0.00</td>
<td></td>
<td></td>
<td>$0.00</td>
<td></td>
<td>$ - $</td>
<td>$ - $</td>
</tr>
<tr>
<td>Hygienist A</td>
<td>$0.00</td>
<td></td>
<td></td>
<td>$0.00</td>
<td></td>
<td>$ - $</td>
<td>$ - $</td>
</tr>
<tr>
<td>Hygienist B</td>
<td>$0.00</td>
<td></td>
<td></td>
<td>$0.00</td>
<td></td>
<td>$ - $</td>
<td>$ - $</td>
</tr>
<tr>
<td>Hygienist C</td>
<td>$0.00</td>
<td></td>
<td></td>
<td>$0.00</td>
<td></td>
<td>$ - $</td>
<td>$ - $</td>
</tr>
<tr>
<td>Hygienist D</td>
<td>$0.00</td>
<td></td>
<td></td>
<td>$0.00</td>
<td></td>
<td>$ - $</td>
<td>$ - $</td>
</tr>
<tr>
<td>Dental Assistant A</td>
<td>$0.00</td>
<td></td>
<td></td>
<td>$0.00</td>
<td></td>
<td>$ - $</td>
<td>$ - $</td>
</tr>
<tr>
<td>Dental Assistant B</td>
<td>$0.00</td>
<td></td>
<td></td>
<td>$0.00</td>
<td></td>
<td>$ - $</td>
<td>$ - $</td>
</tr>
<tr>
<td>Dental Assistant C</td>
<td>$0.00</td>
<td></td>
<td></td>
<td>$0.00</td>
<td></td>
<td>$ - $</td>
<td>$ - $</td>
</tr>
</tbody>
</table>
### At Risk

- Reversible
- Irreversible

### Primary Prevention

- Dietary counseling
- Behavior modification
- Fluoride varnish
- Dental sealant

### Secondary Prevention

- Remineralization

### Tertiary Prevention

#### Primary Care

- Restorations
- Pulpotomy
- Simple endodontics
- Simply extractions

#### Specialty

- Endodontics
- Perio surgery
- Complex prosthodontics
- Oral surgery
- Orthodontics

<table>
<thead>
<tr>
<th>Non-Dentist</th>
<th>Dental Surgeon</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Assistants</strong></td>
<td></td>
</tr>
<tr>
<td>• Dental Assistant $17.13</td>
<td></td>
</tr>
<tr>
<td>• Medical Assistant $14.80</td>
<td></td>
</tr>
<tr>
<td>• Nursing Assistants $12.51</td>
<td></td>
</tr>
<tr>
<td>• Dietetic Tech $13.74</td>
<td></td>
</tr>
<tr>
<td><strong>Specialty Assistants</strong></td>
<td></td>
</tr>
<tr>
<td>• Dental Hygienist $34.39</td>
<td></td>
</tr>
<tr>
<td>• Physician Assistant $45.36</td>
<td></td>
</tr>
<tr>
<td>• Nurse Practitioner $45.71</td>
<td></td>
</tr>
<tr>
<td><strong>Income</strong></td>
<td></td>
</tr>
<tr>
<td>• General Dentist $79.12</td>
<td></td>
</tr>
<tr>
<td>• Pediatric Dentist</td>
<td></td>
</tr>
<tr>
<td><strong>Surgeons</strong></td>
<td></td>
</tr>
<tr>
<td>• Oral Surgeon $105.27</td>
<td></td>
</tr>
<tr>
<td>• Orthodontist $94.36</td>
<td></td>
</tr>
</tbody>
</table>
| (not all specialists had income captured by BLS)
## Scope of Service Benchmarks

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Procedure Codes</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic</td>
<td>D0100-D0999 (excluding D0140)</td>
<td>35%</td>
</tr>
<tr>
<td>Preventive</td>
<td>D1000-D1999</td>
<td>33%</td>
</tr>
<tr>
<td>Restorative</td>
<td>D2000-D2999</td>
<td>20%</td>
</tr>
<tr>
<td>Specialty (endo/perio/prostho)</td>
<td>D3000-D6999</td>
<td>2-6%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>D7000-D7999</td>
<td>5-10%</td>
</tr>
<tr>
<td>Emergency</td>
<td>D0140, D9110</td>
<td>2-6%</td>
</tr>
</tbody>
</table>
Procedure Analysis

Productivity by Procedure reports reveal the scope of service for the practice, as well as what is happening at the visit level

- Total number of procedures ÷ total number of visits = procedures/visit
- Break out procedures by type (diagnostic, preventive, restorative, specialty, prosthodontics, oral surgery and emergency)
- Calculate percentage of each type to reveal scope of service
Procedure Analysis

- Diagnostic 37.5%
- Preventive 6.9%
- Restorative 16.4%
- Specialty (endo/perio) 3.0%
- Oral Surgery 16.1%
- Prosthodontics 0.0%
- Emergencies 20.1%

Total: 11,242 procedures
What to Do

• Create protocols and systems to maximize the delivery of services
• Track and quantify the provision and impact of care
• If all we ever do is apply the surgical model of care, we will never be doing more than reacting to the existence and/or recurrence of disease
# SAMPLE CARE PROTOCOL 1: New Patient Child 0-3

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Codes</th>
<th>Staff Member</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam (charting, Treatment Plan)</td>
<td>D0145</td>
<td>Dentist</td>
<td>5</td>
</tr>
<tr>
<td>Caries Risk Assessment</td>
<td>D0601 or D0602 or D0603</td>
<td>Certified Dental Assistant or RDH with Dentist validation</td>
<td>5</td>
</tr>
<tr>
<td>Talking with Parent/Caregiver (risk factor reduction strategies, selection of 1-2 SMGs)</td>
<td>D9993*, D9994*, D1310, D1320, D1330</td>
<td>Dental Assistant</td>
<td>5</td>
</tr>
<tr>
<td>X-ray *PRN</td>
<td>D0210-D0330</td>
<td>Dental Assistant</td>
<td>Varies</td>
</tr>
<tr>
<td>Prophy/Cleaning</td>
<td>D1120</td>
<td>Hygienist/CDA</td>
<td>5-10</td>
</tr>
<tr>
<td>Fluoride</td>
<td>D1206, D1208</td>
<td>Hygienist/CDA</td>
<td>5</td>
</tr>
<tr>
<td>Treatment Plan discussion, next visit</td>
<td>D9991, D9992, D9993</td>
<td>Office Manager/Care Coordinator</td>
<td>10 (outside of operatory)</td>
</tr>
</tbody>
</table>

Estimated 20-30 minutes of chair time
IF THE PLAN DOESN'T WORK
CHANGE THE PLAN BUT NEVER THE GOAL
Balancing the Mission and Margin:

Expenses

Revenue
Financial Sustainability Plan

To be financially responsible, you need to understand:

• What it costs every time you see a patient
• The expected reimbursement for each patient visit
• How much your program can afford to subsidize
## Net Revenue

<table>
<thead>
<tr>
<th>Goal</th>
<th>Calculation</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue per Year</td>
<td>Break Even: Total direct and indirect expenses for the year</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>Revenue per Week</td>
<td>$1,000,000/46 weeks</td>
<td>$21,739</td>
</tr>
<tr>
<td>Revenue per Day</td>
<td>$1,000,000/230 clinic days</td>
<td>$4,348</td>
</tr>
<tr>
<td>Revenue per Visit</td>
<td>$1,000,000/8,280</td>
<td>$121</td>
</tr>
</tbody>
</table>
# Individual Production Goals

<table>
<thead>
<tr>
<th>Provider</th>
<th>FTE</th>
<th>Gross Charges</th>
<th>Net Revenue (60%)</th>
<th>Annual Days Worked</th>
<th>Charges/Day</th>
<th>Revenue/Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. D</td>
<td>1.0</td>
<td>$541,667</td>
<td>$325,000</td>
<td>230</td>
<td>$2,355</td>
<td>$1,413</td>
</tr>
<tr>
<td>Dr. G</td>
<td>1.0</td>
<td>$541,667</td>
<td>$325,000</td>
<td>230</td>
<td>$2,355</td>
<td>$1,413</td>
</tr>
<tr>
<td><strong>Total Dentist</strong></td>
<td><strong>2.0</strong></td>
<td><strong>$1,083,333</strong></td>
<td><strong>$650,000</strong></td>
<td><strong>460</strong></td>
<td><strong>$4,710</strong></td>
<td><strong>$2,826</strong></td>
</tr>
<tr>
<td>RDH</td>
<td>1.0</td>
<td>$291,667</td>
<td>$175,000</td>
<td>230</td>
<td>$1,268</td>
<td>$761</td>
</tr>
<tr>
<td>RDH</td>
<td>1.0</td>
<td>$291,667</td>
<td>$175,000</td>
<td>230</td>
<td>$1,268</td>
<td>$761</td>
</tr>
<tr>
<td><strong>Total RDH</strong></td>
<td><strong>2.0</strong></td>
<td><strong>$583,333</strong></td>
<td><strong>$350,000</strong></td>
<td><strong>460</strong></td>
<td><strong>$2,536</strong></td>
<td><strong>$1,522</strong></td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>$1,666,666</td>
<td>$1,000,000</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Predictability is Key

Ability to predict expected reimbursement based on:

- Payer Mix
- 3rd Party insurance reimbursement
- Sliding fee discounts and nominal fees
- Visits
Payer Mix

- Huge impact on financial sustainability
- Big challenge to manage
- Determine the average revenue per visit per payer type
- Use that information to create a payer mix that ensures financial sustainability while preserving access for all patients
## Impact of Payer Mix on Sustainability

<table>
<thead>
<tr>
<th>Payer Mix</th>
<th>Visits</th>
<th>Revenue</th>
<th>Expenses</th>
<th>Operating Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>7,500 visits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35% Medicaid</td>
<td>2,625</td>
<td>$262,500</td>
<td>$500,000</td>
<td>($20,000)</td>
</tr>
<tr>
<td>55% Self-Pay/SFS</td>
<td>4,125</td>
<td>$123,750</td>
<td>$500,000</td>
<td></td>
</tr>
<tr>
<td>10% Commercial</td>
<td>750</td>
<td>$93,750</td>
<td>$500,000</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>7,500</td>
<td>$480,000</td>
<td>$500,000</td>
<td>($20,000)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Payer Mix</th>
<th>Visits</th>
<th>Revenue</th>
<th>Expenses</th>
<th>Operating Surplus</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>7,500 visits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40% Medicaid</td>
<td>3,000</td>
<td>$300,000</td>
<td>$500,000</td>
<td>$6,250</td>
</tr>
<tr>
<td>50% Self-Pay/SFS</td>
<td>3,750</td>
<td>$112,500</td>
<td>$500,000</td>
<td></td>
</tr>
<tr>
<td>10% Commercial</td>
<td>750</td>
<td>$93,750</td>
<td>$500,000</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>7,500</td>
<td>$506,250</td>
<td>$500,000</td>
<td>$6,250</td>
</tr>
</tbody>
</table>
## Average Reimbursement by Payer Type

<table>
<thead>
<tr>
<th>Payer Type</th>
<th>Payer Mix %</th>
<th>Visits: 3,600</th>
<th>Revenue Collected</th>
<th>Average Reimbursement /visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>65%</td>
<td>2,340</td>
<td>$430,000</td>
<td>$183.76</td>
</tr>
<tr>
<td>Commercial</td>
<td>5%</td>
<td>180</td>
<td>$50,000</td>
<td>$277.77</td>
</tr>
<tr>
<td>Self-Pay/Sliding Fee Scale</td>
<td>30%</td>
<td>1,080</td>
<td>$25,000</td>
<td>$23.15</td>
</tr>
</tbody>
</table>
### SAMPLE CARE PROTOCOL 1: New Patient Child 0-3

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Codes</th>
<th>Staff Member</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam (charting, Treatment Plan)</td>
<td>D0145</td>
<td>Dentist</td>
<td>5</td>
</tr>
<tr>
<td>Caries Risk Assessment</td>
<td>D0601 or D0602 or D0603</td>
<td>Certified Dental Assistant or RDH with Dentist validation</td>
<td>5</td>
</tr>
<tr>
<td>Talking with Parent/Caregiver (risk factor reduction strategies, selection of 1-2 SMGs)</td>
<td>D9993*, D9994*, D1310, D1320, D1330</td>
<td>Dental Assistant</td>
<td>5</td>
</tr>
<tr>
<td>X-ray *PRN</td>
<td>D0210-D0330</td>
<td>Dental Assistant</td>
<td>Varies</td>
</tr>
<tr>
<td>Prophy/Cleaning</td>
<td>D1120</td>
<td>Hygienist/CDA</td>
<td>5-10</td>
</tr>
<tr>
<td>Fluoride</td>
<td>D1206, D1208</td>
<td>Hygienist/CDA</td>
<td>5</td>
</tr>
<tr>
<td>Treatment Plan discussion, next visit</td>
<td>D9991, D9992, D9993</td>
<td>Office Manager/Care Coordinator</td>
<td>10 (outside of operatory)</td>
</tr>
</tbody>
</table>

Add Expected Reimbursement based on our fees
## Demo Tool

### Budget Variance Tool Fiscal Year

<table>
<thead>
<tr>
<th>Financial Projections</th>
<th>Projected Visits</th>
<th>Actual Visits</th>
<th>Difference</th>
<th>Yearly visits</th>
<th>Yearly Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent Medicaid</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Percent Self Pay</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Percent Commercial Insurance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Percent Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>0%</td>
<td></td>
<td>0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Reimbursement Rate (per visit):

<table>
<thead>
<tr>
<th>Insurance Type</th>
<th>Projected Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>$</td>
</tr>
<tr>
<td>Self Pay</td>
<td>$</td>
</tr>
<tr>
<td>Commercial Insurance</td>
<td>$</td>
</tr>
<tr>
<td>Other</td>
<td>$</td>
</tr>
</tbody>
</table>

*See the worksheet labeled "Calculating Project Visits"*

*See the worksheet labeled "Payer Mix Projections"*
## Aging Report

### SAMPLE AGING REPORT

As of 1/31/2014

<table>
<thead>
<tr>
<th>DENTAL PROGRAM</th>
<th>0-30</th>
<th>31-60</th>
<th>61-90</th>
<th>91-120</th>
<th>121-150</th>
<th>151-180</th>
<th>181-up</th>
<th>Bal Amt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Totals for BCBS</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$256.00</td>
<td>$256.00</td>
</tr>
<tr>
<td>Totals for Commercial</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$207.50</td>
<td>$207.50</td>
</tr>
<tr>
<td>Totals for Dental Aetna Better Health</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$97.73</td>
<td>$97.73</td>
</tr>
<tr>
<td>Totals for Dental Commercial</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$2,934.70</td>
<td>$2,934.70</td>
</tr>
<tr>
<td>Totals for Dental Medicaid</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$194.70</td>
<td>$5,891.39</td>
<td>$6,086.09</td>
</tr>
<tr>
<td>Totals for Medicaid</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$206.00</td>
<td>$206.00</td>
</tr>
<tr>
<td>Totals for Medicare</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>-$25.00</td>
<td>-$25.00</td>
</tr>
<tr>
<td>Totals for Self Pay</td>
<td>-$58.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$49.50</td>
<td>$78,627.06</td>
<td>$78,618.56</td>
</tr>
<tr>
<td>TOTALS FOR DENTAL PROGRAM</td>
<td>-$58.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$244.20</td>
<td>$88,292.73</td>
<td>$88,478.93</td>
</tr>
</tbody>
</table>
Performance Measures

• Total number of dental claims filed by payer source
• Top reasons for Accounts Receivable past 90 days by payer source
• Amount of money written off due to denied claims by payer source and bad debt (self-pay patients or patient co-pays)
• Gross charges by payer source
• Net revenue by payer source
Tracking Performance Measures

- Aging/Credit Report
- Insurance Aging Report
- Write-Offs Due to Bad Debt
- Gross Charges vs. Net Revenue
- Percent of Collections
Key Elements

- Scripting for front desk staff for collecting payment at time of service
- Scope of service for the practice
- Appropriate fee schedule and sliding fee scale
- Track and report the success of the revenue cycle process
The End Result

- A sustainable dental program that generates “profit” which can be reinvested in the dental program
- Expansion to increase access for patients
- Improved patient outcomes
- Facilities and equipment upgrades
- Salary increases and bonuses/incentives
- Happier, more motivated staff
- Happier, more satisfied patients
YOU'VE CHANGED

we're suppose to
QUESTIONS/DISCUSSION
PRACTICE REDESIGN: STRATEGIES FOR INCREASING ACCESS

Caroline Darcy
Learning Objectives

• Develop a strategic scheduling template to maximize access, improve oral health status outcomes and dental program financial viability

• Develop effective policies and procedures for managing broken appointments and emergencies.
Caroline Darcy
Project Manager of Technical Assistance
DentaQuest Partnership for Oral Health Advancement

Works directly with safety net dental programs to provide technical assistance, coaching & motivation

Presents at national conferences on various practice management subjects

Member, National Network for Oral Health Access

Associate Member, American Association of Public Health Dentistry

Bachelor of Arts degree from Emmanuel College in Boston, MA
Strategic Objectives for the Dental Schedule

The schedule should be used to achieve three key objectives

1. Maximum access to care for patients
2. Improved oral health status for patients
3. Financial viability of the dental program
Maximum Patient Access

• Our mission is to provide care to disadvantaged patients who have difficulty getting care elsewhere
• A certain number of appointments can be designated for priority populations
  • Children
  • Pregnant women
  • Patients with chronic diseases
    ✓ Diabetes
    ✓ Heart disease
    ✓ HIV/AIDS
Improve Oral Health Status: Completion Of Phase 1 Treatments

What is Phase 1 Treatment?

*Diagnosis and treatment planning, preventive services, emergency treatment, restorative treatment, basic (non-surgical) periodontal therapy, basic oral surgery, non-surgical endodontic therapy and space maintenance and tooth eruption guidance for children*
Why Track Phase 1 Treatment Completion?

• Important quality metric

• Promotes continuous coordinated care

• Enables balance of new and existing patients
Financial Viability

Ensure sufficient revenue to at least cover direct and indirect expenses

• Ideally generate a surplus
Define the Scheduling Process

- What will be the start & end times for appointments each day?
- How many appointments per day? – Define Capacity!
  - Beware of open time in the daily schedule - 10 minutes here and there adds up!
- Who is needed in each appointment?
  - Use provider time strategically - providers should always be working to the top of their licenses
  - Don’t put hygiene appointments in the dentists’ schedules
  - Do maximize auxiliary staff with expanded functions
Define the Scheduling Process

• What are the appropriate apt lengths for various visit types?
  • Beware of appointments that are too long or too short

• What is your ideal patient mix?
  • Don’t put too many new patients into the schedule
  • How many emergencies can you reasonably have in your schedule?
  • What have you defined as your priority populations?
  • How can you use designated access to preserve those appointment slots?
Define the Scheduling Process

• What types of appointments can be double-booked?

• How far out should we schedule our appointments?
  • Scheduling out too far backfires!
  • Scheduling multiple appointments for patients

• Who is authorized to schedule appointments?
  • Be strategic about who can schedule appointments
Scheduling for Hygienists

- Easiest schedules to fill; hardest to KEEP full!
- Limit new patients in the daily schedule
- Manage how far out you’re scheduling recall visits
- Broken appointments can wreak havoc
- Develop tasks for hygienists whose patients fail to show
Scheduling for Dentists

- Minimum of two operatories and ideally two assistants
- Staggered appointments in two columns (possible use of 3rd column for overflow)
- Define workflow for each standard visit - where and for how long the dentist is needed
- Line up the blocks so the dentist’s time is maximized
- Consider each dentist’s individual characteristics but aim for standardization
### Sample Template, Dentist

#### Morning Schedule:

<table>
<thead>
<tr>
<th>Time</th>
<th>Op1</th>
<th>Op2</th>
<th>Op3 (Overflow for emergencies)</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00</td>
<td></td>
<td></td>
<td>Emergency</td>
</tr>
<tr>
<td>8:10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8:20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8:30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8:40</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8:50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:40</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:40</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11:00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11:10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11:20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11:30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11:40</td>
<td></td>
<td></td>
<td>Emergency</td>
</tr>
<tr>
<td>11:50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12:00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12:10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12:20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12:30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12:40</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12:50</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Afternoon Schedule:

<table>
<thead>
<tr>
<th>Time</th>
<th>Op1</th>
<th>Op2</th>
<th>Op3 (Overflow for emergencies)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:00</td>
<td></td>
<td></td>
<td>Emergency</td>
</tr>
<tr>
<td>1:10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1:20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1:30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1:40</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1:50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2:00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2:10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2:20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2:30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2:40</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2:50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3:00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3:10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3:20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3:30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3:40</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3:50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4:00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4:10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4:20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4:30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4:40</td>
<td></td>
<td></td>
<td>Emergency</td>
</tr>
<tr>
<td>4:50</td>
<td></td>
<td></td>
<td>HOLD</td>
</tr>
<tr>
<td>5:00</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Color Code:

- **Intake**: 10-minute appointments for medical hx review, blood pressure, etc.
- **Operative**: 40-minute appointments for Fillings/extractions. Can expand to 60 minutes for more procedures.
- **Anesthesia**: First 10 minutes of operative appointment, if anesthesia is provided, where the dentist might be available for a brief side-booked appointment (eg, denture try-in, suture removal) or to provide a POE or LOE.
- **Lunch**: 30 minutes
Sample Template - Example

- One FTE dentist and two FTE hygienists
- 14 visits/day for dentist, 10 for each hygienist
- Total direct and indirect expenses = $950,000
  - Daily revenue goal = $4,131
- 4 emergency blocks
- 4 new patients/day
- 18 priority slots (children and pregnant women)
- Optimum payer mix
  - Minimum 50% Medicaid
  - Maximum 30% self-pay
  - 20% commercial/other
Designated Access Scheduling Template
Daily Net Revenue Goal of $4,131

<table>
<thead>
<tr>
<th>Time</th>
<th>Operatory 1- DDS</th>
<th>Operatory 2- DDS</th>
<th>Operatory 3— RDH1</th>
<th>Operatory 4— RDH2</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00</td>
<td>Emergency ($50)</td>
<td></td>
<td>Adult new ($50)</td>
<td>Adult new ($50)</td>
</tr>
<tr>
<td>8:30</td>
<td></td>
<td>Priority TX ($140)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:00</td>
<td>TX ($140)</td>
<td></td>
<td>Priority Recall ($140)</td>
<td>Priority recall, ($140)</td>
</tr>
<tr>
<td>9:30</td>
<td>Priority TX ($140)</td>
<td></td>
<td>Priority recall ($100)</td>
<td></td>
</tr>
<tr>
<td>10:00</td>
<td>TX ($200)</td>
<td>Priority Recall ($140)</td>
<td>Priority Recall ($140)</td>
<td></td>
</tr>
<tr>
<td>10:30</td>
<td></td>
<td>Emergency ($140)</td>
<td>Priority Recall ($140)</td>
<td>Perio ($100)</td>
</tr>
<tr>
<td>11:00</td>
<td>Priority TX ($140)</td>
<td></td>
<td>Priority Recall ($140)</td>
<td></td>
</tr>
</tbody>
</table>

Morning session – 1 dentist & 2 hygienist
Dentist’s expected net revenue for the day = $1,840
Hygienists’ expected net revenue for the day = $2,320
Designated Access Scheduling Template
Daily Net Revenue Goal of $4,131

<table>
<thead>
<tr>
<th>Time</th>
<th>Operatory 1--DDS</th>
<th>Operatory 2--DDS</th>
<th>Operatory 3--RDH1</th>
<th>Operatory 4--RDH2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:00</td>
<td>Emergency ($50)</td>
<td>Denture interim ($0)</td>
<td>Adult new ($50)</td>
<td>Priority new ($140)</td>
</tr>
<tr>
<td>1:30</td>
<td></td>
<td>Priority TX ($140)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2:00</td>
<td>Denture interim ($140)</td>
<td>Priority Recall ($140)</td>
<td>Priority recall ($140)</td>
<td></td>
</tr>
<tr>
<td>2:30</td>
<td></td>
<td>Priority TX ($140)</td>
<td></td>
<td>Adult recall ($100)</td>
</tr>
<tr>
<td>3:00</td>
<td>TX ($140)</td>
<td>Priority Recall ($140)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3:30</td>
<td></td>
<td>Priority TX ($140)</td>
<td>Adult Recall ($140)</td>
<td>Priority recall ($140)</td>
</tr>
<tr>
<td>4:00</td>
<td>Emergency ($140)</td>
<td>Priority Recall ($140)</td>
<td></td>
<td>Adult recall ($50)</td>
</tr>
</tbody>
</table>

Afternoon session – 1 dentist & 2 hygienist
Dentist’s expected net revenue for the day = $1,840
Hygienists’ expected net revenue for the day = $2,320
How Did We Do?
Did We Set The Schedule Up For Success?

✓ Total net revenue for the day = $4,160
✓ 14 visits/day for dentist, 10 for each hygienist
✓ 4 emergency blocks
✓ 4 new patients/day
✓ 8 priority slots (children and pregnant women)

We provided maximal access, provided care that moved patients toward optimum oral health and achieved financial sustainability

All strategic goals met!
Schedule Busters

- Last minute cancellations & No-shows
- Late patients
- Too many emergencies/walk-ins
- Too many new patients
- Overbooking
- Logjams at check-in or out
- Providers who fall behind
- Not enough support staff
- Wrong appointment types
- Wrong appointment lengths
- Insufficient Instruments
- Technology issues
Create A Formal Scheduling Policy

• Practice policy: as much care as possible in time allotted
• Document *why* if patient needs separate exam visit with the dentist
• PSR first and comprehensive periodontal exam if indicated
• Include scheduling templates as attachments
• Review the policy with entire staff
• Train staff how to use the templates
• Monitor, provide feedback and tweak as necessary
MANAGING EMERGENCIES
Emergency Care Is Important But It Must Be Managed

- Treating patients with true dental emergencies is a valuable service
  - Should not negatively impact the financial viability of the practice
  - Should not negatively impact the ability to complete treatment plans for existing patients
- Careful emergency management, enables expedient treatment of emergency patients with minimal disruption of care for scheduled patients
Better Management Of Emergencies

• Define what constitutes a true emergency
  – Who decides?
  – Use objective criteria

• Using data, determine the demand
  – Reality vs. Perception

• Create a system that meets your level of need and preserves regularly schedule appointments
  – A policy
  – A triage tool
  – Training for staff on how to use the tool
Why Does it Matter?

- Dental ER or Dental Home?
- Unpredictability, chaotic, disruptive
- Unreimbursed or minimally reimbursed
- Frustrated staff
- Dissatisfied providers
- Poor oral outcomes
**Sample Triage Form**

<table>
<thead>
<tr>
<th>Ask the Patient</th>
<th>MUST BE SEEN TODAY!</th>
<th>See tomorrow or this week</th>
<th>See when available</th>
</tr>
</thead>
<tbody>
<tr>
<td>“On a scale of 1 to 10 how badly are you hurting?”</td>
<td>Pain level 7 to 10</td>
<td>Pain level 4 to 6</td>
<td>Pain level 3 or below</td>
</tr>
<tr>
<td>“How long have you been hurting?”</td>
<td>This level for a week or less</td>
<td>This level of pain for a month or less</td>
<td>Had these symptoms for over a month</td>
</tr>
<tr>
<td>“Describe the type of pain or discomfort you feel.”</td>
<td>Throbbing</td>
<td>Broken tooth, lost a filling</td>
<td>Chip tooth, broken filling</td>
</tr>
<tr>
<td>“How are you sleeping at night?”</td>
<td>Keeps me awake at night</td>
<td>Able to sleep with medication</td>
<td>Able to sleep</td>
</tr>
<tr>
<td>“What occurred to make the tooth begin to hurt?”</td>
<td>Unknown or bit down on something hard</td>
<td>Bit down on something or other cause</td>
<td>Sweets; candy causes it to hurt</td>
</tr>
<tr>
<td>“Have you noticed any other symptoms?”</td>
<td>Fever and swelling</td>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td>Two or more checkmarks in this section results in the patient needing to be seen today</td>
<td>Three or more checkmarks in this section results in the patient needing an appointment this week</td>
<td>Three or more checkmarks in this section results in the patient being given the next available standard appointment time</td>
<td></td>
</tr>
</tbody>
</table>
Strategies to Manage Emergencies

• What care will be provided? - definitive vs. palliative

• Have a morning huddle to discuss where they fit in

• Dedicate chairs or providers specifically to handle emergencies

• Ensure all providers share emergency care equally
When Demand Exceeds Capacity

- Patients of record
- Patients who can prove residency in the service area
- Waivered patient policy
- Are all area safety nets doing their part?
REDUCING BROKEN APPOINTMENTS
Broken Appointments

The number one cited problem for all safety net dental clinics!

Broken appointments negatively impact

Access to Care  Oral Health Outcomes  Staff Satisfaction  Patient Satisfaction  Financial Sustainability

We need to truly understand the depth of just how many areas are negatively impacted to understand why we need to take ownership over the problem.
Broken Appointments Affect Patients

- When patients don’t show up consistently or on time, we start to double or triple book.
- What happens when everyone shows up at the same time?
  - Patients who did show up are forced to wait longer to see their provider or to sit longer in the dental chair.
  - Frustrates faithful, prompt patients.
    - What is the incentive for a patient to show up on time if they are forced to wait?
Broken Appointments Affect Patient Outcomes

- The patient that fails to keep their appointment still has existing issues that weren’t treated
- The patient who was trying to get into the practice could not
  - Incomplete treatment plans
- Both still need care - wasted chair time - no services were delivered
- If they’re late, providers must switch to a different/faster treatment option, or provide treatment to an emergency walk-in patient, which potentially opens a whole other treatment plan
Broken Appointments Affect Staff

- Multiple patients arriving for the same appointment slot causes chaos, put stress on staff & undermine morale

- Causes front desk staff to fall behind, neglect important tasks, become overwhelmed and stressed
  - Registering new or episodic patients takes time
  - Documentation of insurance & sliding fee schedule eligibility

- Last minute changes to the schedule means the provider has no idea who will be sitting in their chair, or what their needs will be
Broken Appointments Affect Financial Sustainability

- There are many fixed costs: rent, salaries, utilities, etc.
- When an appointment is not filled, those expenses remain, yet no revenue is collected!
- Lost productivity means lost revenue
- If your program’s average cost per visit is $200. Where do you make up that loss?
- There must be revenue to cover expenses
Take Back Control

• Have a strong policy that creates reliable patients who value their appointments & abide by practice rules

• Enforce the policy consistency

• Educate patients
  • Give them the policy, have them sign it, post in several areas

• Hold patients and staff accountable
  • Show patients that you respect the policy by consistently enforcing it, they will learn to respect the policy and abide by it, too
# Broken Appointments Defined

| No-Show: | A patient is scheduled for an appointment and they do not show up for that appointment. |
| Late Cancellation: | A patient cancels an appointment less than 24 hours prior to the start of the appointment. |
| Late Arrival: | A patient does not arrive by 10 minutes after the start of their appointment. |
Most Likely to Break Appointments

New Patients
- Require new (non-emergent) patient registration prior to scheduling 1st appt.
- Limit the number of new patients/day
- Book new patient visits within 2 weeks

Recare Visits
- Teach patients to value the hygiene visit
- Consider moving to a “designated access” 2-5 week schedule for hygiene patients

Emergency Follow-up
- Require emergency patients who need follow-up care to call to schedule their next visit
A Strong BA Policy

EVERY time the policy is broken:
• Call, letter, document/flag account

STRIKE ONE
• Reminder and one and only warning

STRIKE TWO
• Consequence occurs; requires a proactive response from patient

STRIKE THREE
• Strongest consequence implemented by dental staff
“Proactive Response” Consequences:

Broken Appointment
Retraining Session

Write a Letter to the Dental Director

1. Explanation
2. Understand the impact
3. Promise never again
Stronger Consequences

Dismissal letter
- 30 days of emergency care access

Same-Day-Only Scheduling Status
- Quick call lists
- Patient required to call
Considerations For Children Under Age 18

“Dental Neglect is willful failure of parent or guardian to seek and follow through with treatment necessary to ensure a level of oral health essential for adequate function and freedom from pain and infection.”

-American Academy of Pediatric Dentistry

Strategies for Success

Provide reminder messages for upcoming appointments

✓ Text/e-mail plus phone
✓ 48 hours in advance
✓ What if: Non-working numbers
✓ What if: Voice mail
Strategies for Success

- 30-45 days out
- One appointment at a time
- New (nonemergent) patients register in advance
- Limit appointments for multiple family members
- Ask emergency patients to call for follow-up appointment
- Limit new hygiene patients
- Use alerts to warn schedulers
CDT Codes

D9986: Missed Appointment

D9987: Cancelled Appointment

D9991: Dental Case Management – addressing appointment compliance barriers
BA Rate Calculation

• The number of broken appointments ÷ number of scheduled visits

• Scheduled Visits = number of visits + number broken appointments MINUS number walk-ins
BA Rate Calculation

20 visits
  5 broken appointments
  2 walk-ins

Scheduled Visits = number of visits (20) + number broken appointments (5) MINUS number walk-ins (2) = 23

Math: the number of broken apts (5) ÷ number of scheduled visits (23) = 22%
The Five Best Practices

- Strong policy with clearly communicated consequences
- Consistent enforcement
- Patient education
- Culture of accountability for patients and staff
- Track and evaluate BA rate
QUESTIONS/DISCUSSION
CLOSING/WRAP-UP
Office Hours

Meet with DQP Faculty for 1:1 coaching sessions to enhance your program’s takeaway! (Voluntary)

4:30-5:00 p.m.

Add logistics