

Sustainable Safety Net Dental Clinics in Virginia

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DELTA DENTAL

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CONTINUING EDUCATION RECOGNITION PROGRAM



Points to be covered

- Overview of the Oral Health Capacity Building Project
- General Observations
- Create a Strategic Plan
- Key Elements to Sustainability
- Measure and Evaluate Productivity
- Set Appropriate Fees
- Benchmarking and Best Practices
- Broken Appointments
- Managing the Schedule
- Productivity Issues

Overview of the Oral Health Capacity Building Project

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Oral Health Capacity Building Project Sponsoring Agencies

The Anthem Foundation of Ohio

Sisters of Charity Foundation of Canton

The Osteopathic Heritage Foundation

The United Way of Central Ohio

The Ohio Department of Health

Overview of the Oral Health Capacity Building Project Why have a Capacity Building Project?

Funding agencies and foundations have invested significant resources in SNDCs

These agencies have limited resources and want to invest in long-term solutions to providing dental services to the safety net populations

Safety Net Dental Clinics (SNDCs) are not the same as private practices.

They need to find a balance between their Public Health mission and healthy business practices, not letting either aspect take precedence over the other, so as to not jeopardize their own sustainability

Overview of the Oral Health Capacity Building Project

OHCB Participants

- County Public Health Departments - 5
- Community Action Agencies - 1
- Community Hospitals - 2
- Stand Alone Safety Net Dental Clinics - 1
- Federally Qualified Health Centers – 4

- Size range from 3 to 14 Operatories and from 1 to 3 sites

Overview of the Oral Health Capacity Building Project

- Prepare a practice assessment tool/pre-visit questionnaire consisting of key indicators and data elements;
- Pilot test the assessment tool by having each participating safety net provider fill out the questionnaire

Overview of the Oral Health Capacity Building Project

Site visit with each participating program to gain a better understanding of each program's unique circumstances.

- Interviews with key employees
- Facility tours and
- Final data collection.

Prepare an assessment of each practice

Overview of the Oral Health Capacity Building Project

Based on the practice assessments, do the following:

- Prepare practice-specific action plans to improve their efficiency and financial sustainability, and on which to base future funding requests
- Finalize the assessment tool based upon the responses from the practices and the Capacity Building Project steering committee, and make the tool available on the internet

General Observations about Safety Net Dental Clinics from the OHCB Project

General Observations

When you've seen one Safety Net Dental
Clinic...

General Observations

When you've seen one Safety Net Dental
Clinic...

You've seen one Safety Net Dental Clinic!

General Observations

- Recruitment and retention of qualified dentists was a concern for all SNDCs
- Broken appointments dramatically impact SNDC efficiency and effectiveness
 - Double and triple bookings to compensate
 - Impacts services provided to patients when everyone shows up
 - Incentive is to provide fewer services per visit in case patients do not show up
 - Increases tear down and set up time...less patient care time

General Observations (Cont'd)

- Older, non-functional/inefficient equipment
- Emergencies and walk-ins
 - Fills holes in schedule from BAs
 - Impacts patient care when everyone shows up similar to BAs
- Space is an issue for most SNDCs
 - Not enough
 - Poor layout
 - Patient flow
 - Access to X-Ray, patient records storage, small room size
- Patient privacy...Huge problem in some clinics!

General Observations (Cont'd)

- **Bottlenecks at front desk**
 - Phone calls
 - Patient check-in
 - Inadequate communication with dental staff
 - Slow down in processing patients, new patients, charting
 - Patient check-out
 - Appropriate scheduling of patients
 - Collecting amounts due at time of service
- **Billing**
 - Initial billing is usually completed in a timely fashion
 - Follow-up on denied and returned bills is often inadequate
 - Often (not always) fee schedules are lower than prevailing rates

General Observations (Cont'd)

All clinics had dedicated, caring and compassionate staff who believe in the need for the services that they are providing!!!

**Does your organization have a
Strategic Plan?**

Strategic Plan

If you don't know where
you are going...

Strategic Plan

If you don't know where
you are going...

**You'll never know when you
get there.**

Elements of Strategic Plan Strategic Plan

- Mission Statement
- Vision
- Critical Success Factors

Strategic Plan Mission Statement

- describes the business we are in
- it is the organization's reason for being
- describes what the organization wants to become in a way that sets high aspirations
- only a clear definition of the mission makes possible clear and realistic business objectives
- mission reflects the highest purpose of the organization - values people associate with what they consider to be good not only for the organization, but for the world beyond the organization's boundaries

Strategic Plan Vision Statement

- a description of what the organization will look like when it is fulfilling its mission
- provides a framework for planning
- considerations in developing a vision of the external environment:
 - what trends or changes are expected in your industry
 - what changes are expected in your customers
 - what changes are expected in your competition
 - what opportunities exist in the expected changes
- considerations in developing a vision of the internal environment
 - what trends and changes are expected in financial and physical resources
 - what changes are anticipated in your workforce
 - what management practices and values do you want to be known for in ten years

Strategic plan

Critical Success Factors

- Maintaining quality standards
- Finding needed resources
- Staying in touch with your target population's needs
- Establishing effective internal and external communication standards
- Providing cost effective services
- Establish policy and procedure documentation for training and measurement purposes
- Develop a plan for adequate cash flow

Strategic Plan Critical Success Factors (cont.)

- Develop a plan for measuring performance
 - Communicate expectations to staff
 - Include staff in developing achievable goals
- Involve staff in the development of a strategic plan
 - Assigning the implementation of a strategic plan to staff who have not been involved in the planning is a recipe for failure

Key Elements to Sustainability

Key Elements to Sustainability

- There are four interrelated economic determinants that an oral health program should focus on; productivity, revenue, cost, and quality.
- There are two outcomes that have to drive the program; improved oral health status of the patient population served and a financially viable delivery system.

Key Elements to Sustainability

Develop a Set of Good Key Indicators

- Key Indicators: Data driven measurements
- Ratios that compare costs, revenues, and productivity, etc.:
 - Charges, net revenue, costs per period of time (Hour, Day, Week, Month, Quarter, Year)
 - Numbers of visits, procedures, or RVUs per period of time
 - Charges, net revenue, costs, visits, procedures per personnel unit Payer mix
- Key indicators should be selected based on:
 - Available data
 - Purpose
 - Board reporting
 - Grant applications
 - Determining the impact of decision making - Changes in operations
 - Identifying problems early

Key Elements to Sustainability Essential data and indicators

- Patient visits*
- Gross charges*
- Patient visits per provider*
- Gross charges per provider*
- Charges per visit*
- Broken appointments*
- Procedures per visit
- Revenue*
- Revenue per visit*
- Expenses*
- Cost per visit*
- Broken appointments per provider
- Average length of time that the clinic is fully scheduled in advance

*Monthly, Quarterly, and Annually

Key Elements for Sustainability

Essential elements

- Appropriate fee schedule (should not be below Medicaid)
- Well designed encounter form/superbill that easily collects the data needed for billing and reporting
- A well-designed and uniformly-enforced Broken Appointment policy (don't let BAs run the schedule)
- An emergency/walk-in policy compatible with the appointment system (don't let emergencies run the appointment book)
- Efficient system for patient registration/eligibility documentation and updating
- Appointment system that allows multiple procedures (e.g., quadrant dentistry) to be done when appropriate
- Patient Satisfaction
- Billing success of 95% of expected collections

Key Elements for Sustainability

What do I mean by Expected Collections?

- Expected collections are gross charges minus all write-offs
- Expected collections depend on payer mix, sliding fee schedule, minimum fees, etc.

For Example

- Gross charges for 10 procedures, each at \$100 on the fee scale = \$1000
- If each of the 10 patients is self-pay at 50% on the sliding scale the expected collections are only \$500
- Expected collections provide a more realistic basis for budgetary planning

Key Elements for Sustainability

Practice Parameters

- Effective recruitment
- Pay, benefits, and working conditions that promote staff retention
- Written Policies and Procedures that support the efficient provision of oral health care services and are adhered to
- Ongoing, prospective professional peer review
- Staff accountability for both the quality of their work and the revenue they produce
- Effective communications among staff and between the dental staff and the program's administration

Measure and Evaluate Productivity

Measure and Evaluate Productivity

- **Many factors are involved with productivity, and no single measure provides a complete view.**
- **Sites should be reviewing productivity from many perspectives.**

Measure and Evaluate Productivity

Which is better; the dentist who generates 1,800 visits per year and \$300,000 in patient charges or a dentist who generates 2,300 visits per year and \$300,000 in patient charges? Without some additional knowledge and understanding of other production indicators, the answer is usually, “It all depends...”

By developing a variety of key indicators clinic management will be able to measure and monitor various data, including:

- More accurate measurement of the impact of managerial decisions in a timely fashion
- Provision of feedback to employees regarding personal performance
- Generation of rationale for budgetary adjustments
- Provision of data for annual budget preparation and justification
- Identification of changes in production that require managerial intervention

Measure and Evaluate Productivity

- By individual dentist/hygienist
- By payer type
- By clinic site (if more than one clinic site)
- By user (defined as a patient who uses the service in a 12-month period)
- By hour, day, week, or year

Measure and Evaluate Productivity

- By gross charges
- By net collections
- By visits
- By services provided
- By Relative Value Units (RVUs)

Measure and Evaluate Productivity

Relative Value Units (RVUs)

- RVUs are numerical values assigned to each procedure code based on the following factors:
 - Time necessary to perform the procedure
 - Skills necessary to perform the procedure
 - Risk to the patient
 - Legal risk to the dentist
 - Severity of the problem
 - Expendable supplies that are not billed separately
- RVU data can be purchased from Relative Value Systems, Inc.
www.rvs.com -\$100/yr

Measure and Evaluate Productivity

Using RVUs

- Consider using RVUs to measure productivity in the same manner as you would gross charges
- You will need reports that provide CDT code data, including:
 - Code number
 - Number of procedures per code
 - Total charges per code
 - Broken out by payer, practitioner, period of time, and so on

Measure and Evaluate Productivity

Suggested Productivity Standards from Jay Anderson at HRSA and Bob Russell, Iowa Department of Health

- Based on UDS Data a health center program with one-dentist needs to collect approximately **\$300,000** to break even. This sum includes funds collected from patient care services as well as grant subsidies.
- Average gross charges, presuming that the fees are market rate fees, should exceed \$400,000/dentist/year
- The average cost per encounter is about \$117, so you would need 2564 encounters to break even or reach \$300,000 annually.

Measure and Evaluate Productivity

Suggested Productivity Standards from Jay Anderson at HRSA
and Bob Russell, Iowa Department of Health

Assuming roughly 200 work days per year (or 1,600 work hours per year after holidays and vacations):

- The average number of encounters per Dentist FTE would be 1.7 patients per hour or 13.5 patients per day for 2700 encounters in a 200 day work year.
- Many sites have 220 days of care/FTE, so the math would be 1.54 patients per hour or 12.3 patients/day for 2700 encounters per year.

Measure and Evaluate Productivity

Suggested Productivity Standards from Jay Anderson at HRSA
and Bob Russell, Iowa Department of Health

- 1.7 patients per hour means an average length of 35.5 minutes per appointment (200 day/year)
- 1.54 patients per hour means an average length of 39 minutes per appointment (220 day/year)
- It is not necessary to schedule 15 or 20 minute appointments to achieve 2700 encounters if your broken appointments are under control

Set Appropriate Fees

Set Appropriate Fees

If any significant proportion of your service population is self-pay at the 100% level or has insurance, then a fee schedule that is too low means you are leaving money on the table

One clinic that we reviewed, with only 5.6% of its users having insurance, would have potentially collected an additional \$22,000 last year if their fee schedule had been at the 80th percentile for their area.

Set Appropriate Fees

- Compared to Medicaid fees
 - Never less than Medicaid
- Compared to fees in the region
 - Shoot for the 80th percentile of regional fees
 - Adjust sliding scale for economically disadvantaged patients
- Compared to each other in relationship to resource intensity
- Adjust fees annually

Set Appropriate Fees

Using Relative Value Units

RVU Fee Schedule Conversion Factor

Code	Description	Dental Clinic Standard Fees	RVU (RVS, inc)	Charge Per RVU Adjustment # (RVS, inc)	Conversion Factor (RVS, inc)
0150	comprehensive oral evaluation - new or established patient	\$ 32.89	1.00	\$ 32.89	
7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$ 132.61	2.20	\$ 60.28	
1203	topical application of fluoride (prophylaxis not included) - child	\$ 27.58	0.50	\$ 55.16	
1120	prophylaxis - child	\$ 46.68	1.00	\$ 46.68	
0120	periodic oral evaluation n established patient	\$ 32.89	0.70	\$ 46.99	
0274	bitewings - four films	\$ 45.62	1.00	\$ 45.62	
2140	amalgam - one surface, primary or permanent	\$ 97.60	2.00	\$ 48.80	
1110	prophylaxis - adult	\$ 61.53	1.50	\$ 41.02	
0330	panoramic film	\$ 84.66	1.60	\$ 52.91	
0220	intraoral - periapical first film	\$ 20.16	0.50	\$ 40.32	
0272	bitewings - two films	\$ 30.77	0.60	\$ 51.28	
0140	limited oral evaluation - problem focused	\$ 59.41	1.00	\$ 59.41	
2150	amalgam - two surfaces, primary or permanent	\$ 116.70	2.20	\$ 53.05	
1351	sealant - per tooth	\$ 38.19	0.80	\$ 47.74	
0230	intraoral - periapical each additional film	\$ 16.97	0.25	\$ 67.88	
Totals		\$ 844.26	16.85		\$ 50.10

To calculate the RVU Conversion Factor,
divide sum of individual procedure,
standard clinic fees by sum of individual procedure RVUs.

$$\text{\$844.26} \div 16.85 = 50.10 \text{ Average Fee/ 1.0 RVU}$$

Set Appropriate Fees

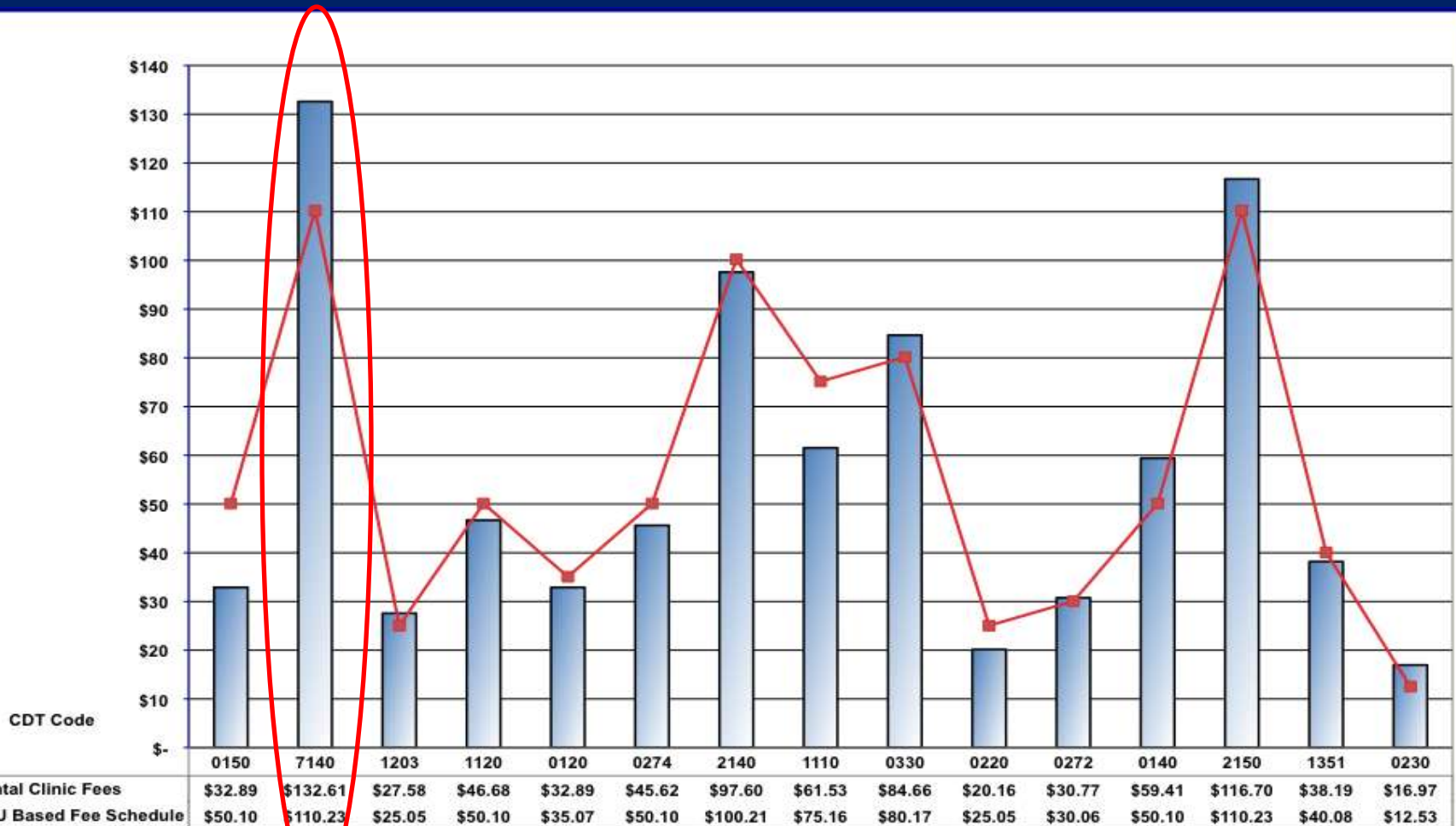
Using RVUs

- Calculate the RVU Based Fees
 - RVU Conversion Factor *multiplied times each procedure's RVU*
 - *Example for Code 7140: \$50.10 CF X 2.2 RVU = \$110.23*

Code	Description	RVU (RVS, Inc)	Dental Clinic Fees	RVU Based Fee Schedule
0150	comprehensive oral evaluation - new or established patient	1.00	\$ 32.89	\$ 50.10
7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	2.20	\$ 132.61	\$ 110.23
1203	topical application of fluoride (prophylaxis not included) - child	0.50	\$ 27.58	\$ 25.05
1120	prophylaxis - child	1.00	\$ 46.68	\$ 50.10
0120	periodic oral evaluation in established patient	0.70	\$ 32.89	\$ 35.07
0274	bitewings - four films	1.00	\$ 45.62	\$ 50.10
2140	amalgam - one surface, primary or permanent	2.00	\$ 97.60	\$ 100.21
1110	prophylaxis - adult	1.50	\$ 61.53	\$ 75.16
0330	panoramic film	1.60	\$ 84.66	\$ 80.17
0220	intraoral - periapical first film	0.50	\$ 20.16	\$ 25.05
0272	bitewings - two films	0.60	\$ 30.77	\$ 30.06
0140	limited oral evaluation - problem focused	1.00	\$ 59.41	\$ 50.10
2150	amalgam - two surfaces, primary or permanent	2.20	\$ 116.70	\$ 110.23
1351	sealant - per tooth	0.80	\$ 38.19	\$ 40.08
0230	intraoral - periapical each additional film	0.25	\$ 16.97	\$ 12.53

Set Appropriate Fees

Comparison of Standard (clinic's) Fees to RVUs Based Fees



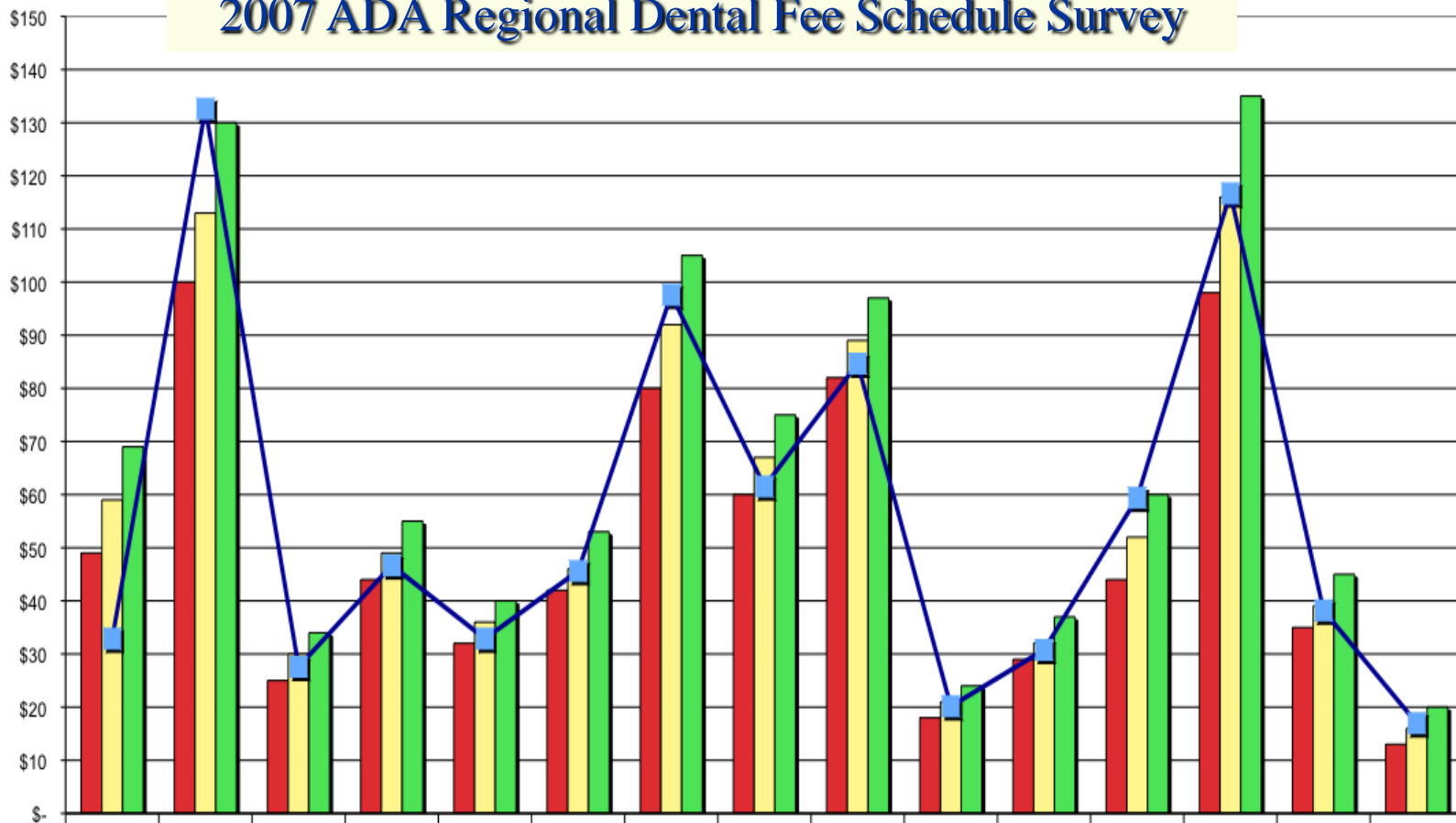
Set Appropriate Fees

- The RVU-Based Fee Comparison does not tell you that your fee schedule is adequate (high or low)
- It only tells you the relationship of an individual charge for one of your procedures compared with an average of your most used procedures
- In order to determine if your fees are adequate you need to compare your fees to a survey of fees, national, regional or local

Set Appropriate Fees

How do the clinic's fees compare with community averages?

2007 ADA Regional Dental Fee Schedule Survey



Fee Survey 25th Percentile	\$49	\$100	\$25	\$44	\$32	\$42	\$80	\$60	\$82	\$18	\$29	\$44	\$98	\$35	\$13
Fee Survey Median	\$59	\$113	\$30	\$49	\$36	\$46	\$92	\$67	\$89	\$21	\$32	\$52	\$116	\$39	\$16
Fee Survey 75th Percentile	\$69	\$130	\$34	\$55	\$40	\$53	\$105	\$75	\$97	\$24	\$37	\$60	\$135	\$45	\$20
Dental Clinic Fees	\$32.89	\$132.61	\$27.58	\$46.68	\$32.89	\$45.62	\$97.60	\$61.53	\$84.66	\$20.16	\$30.77	\$59.41	\$116.70	\$38.19	\$16.97

Set Appropriate Fees

How do the clinic's fees compare with community averages?

- Annual ADA Fee Survey, https://siebel.ada.org/ecustomer_enu/start.swe?SWECmd=Start&SWEHo=siebel.ada.org
- or
- The National Dental Advisory Service Comprehensive Fee Report for 2009 will be available in December. Go to www.ndas.com.
 - Based on CDT 2009-2010 Codes and Nomenclature
 - Allows You to Compare Your Fees with NDAS 40th, 50th, 60th, 70th, 80th, 90th and 95th Percentile Fees, with Geographic Multipliers for all U.S. 3-digit Zip Code Prefixes.



Bench Marking and Best Practices

- From our experience there are no good bench marking standards for SNDCs
- FQHCs are using as a standard the number of visits as reported on their Uniform Data System (UDS) reports
 - 2,700 visits or 1,100 users (patients) per 1.0 FTE
 - Best practices...No, just average from reports
- Until uniform benchmarks come along, establish practice specific benchmarks and track these to measure performance in relation to history

Bench Marking and Best Practices

Catalyst Institute/Safety Net Solution's Benchmarks

- 1000 – 1200 visits per operatory per year
- 3 – 9 procedures per patient per visit, depending on age
- Less than 15% Broken appointments
- 300 – 600 unduplicated patients per operatory per year

Bench Marking and Best Practices

Suggested Best Practices, OHCB Project and Catalyst Institute

- Schedule appointments no more than 30 days in advance (CI), 15 working days (OHCB)
- Assign standard lengths for procedures with additional 10 to 15 minute increments for complex appointments
- Eliminate double booking
- Schedule individual appointments rather than a series for each patient, with some exceptions
- Establish appointment and BA policies
- Inform patients of appt. and BA policies/patient contract
- Enforce the BA policy universally

Bench Marking and Best Practices

Suggested Best Practices, OHCBC Project and Catalyst Institute

- Block out protected times for care that cannot wait
- Schedule by payer mix to improve bottom line
- Quadrant dentistry
- Manage emergency care (palliative vs. permanent treatment)
- Use practice management software to manage the appointment book, and make sure that the software allows adequate data reporting to support the management of the program

Bench Marking and Best Practices

Suggested Best Practices, OHCB Project and Catalyst Institute

- Document and verify eligibility before each visit
- Monitor and actively manage Accounts Receivable (OHCB suggested benchmark of 55 days in AR)
 - The calculation for the days in accounts receivable is:
$$\frac{((Total\ Accounts\ Receivable\ minus\ Bad\ Debt) \div Net\ Patient\ Revenue) \times 365\ days}{}$$
- Digital radiography can be a major time saver in busy clinics
- Minimum clinical staffing of 2 DA per Dentist (2.5 is better) and minimum of 2 chairs per Dentist (2.5 better, 3 with EFDAs)

ORAL HEALTH CAPACITY BUILDING PROJECT

Most Common Problems in Clinic Operations

- Broken Appointments
- Front Desk Logjam
- Appointment Issues

Broken Appointments

The Problems

- The number one barrier to access in most of the programs we reviewed
- Most programs averaged between 20 and 50 percent
- High levels usually lead to double and triple booking, which become a nightmare if most patients show up

Broken Appointments

The Problems

- Many programs attempt to compensate for BAs by scheduling shorter appointments to minimize the down time when BAs occur.
- This usually leads to fewer services being provided per visit
- This also punishes the patients who do show up by requiring them to come in more times to complete treatment. Many SNDC patients cannot afford to miss work many times to come in, so they in turn miss appointments.

Broken Appointments

Solutions

- Establish an effective BA policy that can and will be universally enforced.
- Consider a signed contract with all patients that spells out their rights and responsibilities within the system, and enforce the contract.
- Consider having patients come in and complete all paperwork before they are given their first appointment. This investment of time may make it less likely for them to miss their exam appointment.

Broken Appointments

Solutions

- Confirm all appointments, including recall and hygiene appointments, the day before the appointment, or
- Consider requiring patients to call in and confirm their own appointments the day before the visit or face losing the slot to someone else.

Broken Appointments

Solutions

- After one, two or three (you choose the number) BAs within a certain time frame, consider discharging the patient from the practice and allowing them to be seen for emergencies only (or only as a walk-in, depending on your scheduling procedures) for a period of time (often six months or a year).
 - Patients with multiple BAs cannot be allowed to jeopardize the sustainability of the clinic for all patients.

Broken Appointments

Solutions

- One SNDC in Ohio averages 10 to 14 percent BAs by having a zero tolerance policy – patients are excluded from appointments for 6 months after only 1 BA (they can still be seen as walk-ins).

Broken Appointments

Solutions

- Decrease the amount of time that the clinic is fully scheduled in advance. Evidence from the Indian Health Service indicates that the rate of BAs increases dramatically whenever the appointment book is filled more than 3 weeks (i.e., 15 working days) in advance.
- Schedule families together for those who have a history of showing up for their appointments, but limit the number of family members that can be scheduled either concurrently or consecutively for those with a history of BAs. If one family member BAs, they all usually BA.

Broken Appointments

Solutions

- Emergency patients tend to have a higher BA rate than comprehensive-care patients if they are scheduled into the appointment system at the completion of the treatment of their “emergency.”
 - This can be prevented by asking them to call back the next day to let the clinic know how they are doing and to schedule an appointment for a routine exam.
 - Those who want routine care will call in, and those who only wanted their immediate problem treated (and are more likely to break an appointment that they didn’t seek in the first place) will not.

Broken Appointments

Solutions

- Schedule single appointments for each patient instead of a series of appointments for the entire treatment plan
 - A series of appointments pushes a crowded appointment book further into the future
 - Exceptions can be made for insurance benefits that are running out or for multiple appointment procedures such as prosthodontics
 - If a series is scheduled and the patient breaks an appointment, the remainder of the series should be cancelled.

Front Desk Issues

The Problems

- Patient Registration for new patients can take up to a half hour, and benefits updating at each appointment often takes 10 to 15 minutes to complete
 - Unless the patient comes in early to complete the paperwork, this time eats into the clinical appointment
- Patients checking in for their appointments compete for the receptionist(s)' time with those checking out after the completion of their appointment

Front Desk Issues

Solutions

- Have patients come in 15 to 30 minutes prior to the start of the clinical appointment
- Have patients pre-register prior to scheduling the initial appointment
- Have different people checking patients in and checking patients out

Appointment Issues

- To limit down time when the broken appointment rate is high, many clinics schedule short appointments (15 to 20 minutes) regardless of the procedure(s) scheduled

Appointment Issues

- Short appointments usually mean that only one (or 2 at the most) procedures are completed at each visit
- This requires multiple visits per treatment plan, which increases the risk of BAs
- Short appointments also have higher marginal costs

Appointment Issues

Costs of Short Appointments

- Set-up, Clean-up, Sterilization time are repeated for each appointment
- Disposable supplies are repeated for each appointment
- Anesthesia time is repeated for each appointment
- All of these can account for 10 or more minutes per appointment

Appointment Issues

Quadrant Dentistry Should be the Standard for a SNDC

- Unbundling procedures is not consistent with a quality encounter when such procedures are usually done in one appointment rather than spread out over a series of appointments.
- Providing single services at each appointment so as to increase collections (e.g., minimum fee patients, or FQHC reimbursement per encounter) violates the ethical principle of beneficence, which gives priority to the needs and benefit of the patient.

Beneficence (ADA Code of Ethics)

- *“Under this principle, the dentist’s primary obligation is service to the patient and the public-at-large. The most important aspect of this obligation is the competent and timely delivery of dental care within the bounds of clinical circumstances presented by the patient, with due consideration being given to the needs, desires and values of the patient. The same ethical considerations apply whether the dentist engages in fee-for-service, managed care or some other practice arrangement. Dentists may choose to enter into contracts governing the provision of care to a group of patients; however, contract obligations do not excuse dentists from their ethical duty to put the patient's welfare first.”*

Appointment Issues

Quadrant Dentistry, Impact Analysis

Impact Analysis of Increasing Services per Visit for a Patient with 12 Cavities, 3 in each Quadrant
Actual 2006 Program Statistics from a Sample SNDC

Appointment Issues

Impact Analysis of Increasing Services per Visit for a Patient with 12 Cavities, 3 in each Quadrant, continued

- Currently, the average cost per visit is \$60.74, and the average cost per service hour to run the clinic is \$84 (\$105 for a 1.25 hour appointment).
- This means that for a patient who pays \$20 for a visit, the clinic loses \$40.74 per visit for the standard 15 minute appointment.
- If such a patient required 3 restorations per quadrant (12 fillings), the clinic would lose \$489 if twelve 15 minute appointments were used.

Appointment Issues

Impact Analysis of Increasing Services per Visit for a Patient with 12 Cavities, 3 in each Quadrant, continued

- If the same patient received 4 hour-long appointments and had full quadrants restored at each visit, the patient would be completed in 4 visits, and the clinic would lose only \$256, for a savings of \$233 over the course of the treatment plan.
- Even if 1 hour 15 minute appointments were required to perform quadrant dentistry, the 5 hours required to complete treatment would lead to losses of \$340 compared with the \$489 at 1 procedure per 15 minute appointment, or a savings of \$149 for the treatment plan.

Appointment Issues

Impact Analysis of Increasing Services per Visit for a Patient with 12 Cavities, 3 in each Quadrant, continued

	15 Minute Appointment	Hour-Long Appointment, Quadrant Dentistry		1.25 Hour-Long appointment	
	Per Visit, 1 Service per Visit	Per Visit, Quadrant Dentistry	Savings from Increased Services Per Visit	Per visit, Quadrant Dentistry	Savings From Increased Services Per Visit
Total Cost per visit	\$60.74	\$84.00		\$105.00	
Collections @ \$20/Visit	\$20.00	\$20.00		\$20.00	
Loss per Visit	\$40.74	\$64.00		\$85.00	
Required visits to completion of treatment	12	4		4	
Loss/Treatment Plan	\$489.00	\$256.00	\$233.00	\$340.00	\$149.00

Management of the Appointment Schedule

Levels of Care

- Limit services to Emergency, Preventive, and Routine Restorative services when resources are severely restricted; this maximizes access because these services routinely take the least amount of time
- Add “limited” higher level services (such as crowns, root canals, dentures, etc., which are more time-consuming) as more resources become available;
- Charge enough for high level services to cover all lab and supply costs even if sliding fee discount or minimum fee is applied.

Appointments and Productivity

- Use of EFDAs can significantly increase the marginal rate of return on investment and increase productivity.

Ways to Improve “Bottom Line”

- Focus on services covered by Medicaid programs, i.e., consider payer mix in scheduling
- Seek grants for specific targeted groups like maternal care and patients with disabilities
- Target the greater balance of total services toward revenue generation if the revenue is needed to keep the doors open
- Lower supply and overhead costs.

Bottom Line

- Actively Promote Your Program
 - SNDCs must actively promote their services to target population to assure adequate patient flow in all demographic and payer categories.
 - Promotions must be culturally relevant and focused toward major social outlets utilized by target population.

Bottom Line

- While services may be limited under tight budgets, **there are no services if you are not open.**

NO MONEY, NO MISSION

- Limited access to good quality care is great when the alternative is no care at all.
- “We can’t be or give all things to all people,” or, stated somewhat differently;
- Unless you can accommodate everyone who seeks care at your clinic, the decision to do one thing for one patient is also the decision to **not do** something else for another patient.

Resources for Safety Net Dental Clinics

- Safety Net Dental Clinic Manual
 - www.dentalclinicmanual.com
- Dental Management Coalition
 - www.dentalmanagementcoalition.org/
- Ohio Dental Safety Net Information Center
 - www.ohiodentalclinics.com/
- Dental Public Health Listserv
 - www.aaphd.org/default.asp?page=listserve.htm

Resources for Safety Net Dental Clinics

- Virginia Health Care Foundation
 - <http://www.vhcf.org/dental/index.php>
- The Good Practice, Treating Underserved Dental Patients While Staying Afloat
 - <http://www.chcf.org/topics/view.cfm?itemID=133706>
- National Network for Oral Health Access white paper on Health Information Technology
 - http://www.nnoha.org/PDFs/NNOHA%20HIT%20White%20Paper_FINAL.pdf

Sustainable Safety Net Dental Clinics

“Oral Health Isn’t Optional”

John F. Neale, DDS, MPH