CARILION PEDIATRIC DENTAL PROGRAM

Models That Made It

Over 129,000 additional children have enrolled in Virginia's FAMIS
and FAMIS Plus (Medicaid) programs since 2002. All now have dental insurance –
many for the first time. Unfortunately, few have been able
to use their new insurance to obtain dental care.
In FY04, only 24 percent of all children enrolled in Virginia's FAMIS programs
visited a dentist. Many others couldn't find one who would see them.

To help address this problem and fill the void of dental care for FAMIS kids,
a growing number of communities are establishing
nonprofit pediatric dental programs. There are several models
from which a community can choose. The best example of a hospital-based,
community supported operation is the Carilion Pediatric Dental Program.

The Carilion model provides an innovative approach
to dental service delivery via a partnership between a benevolent sponsor
and a community coalition. The Coalition provides ongoing recommendations
on policies for clinic operation to best meet the public's needs.

The hospital is able to capitalize on its size and efficiencies to absorb the costs
of providing infrastructure support services. Infrastructure includes things
such as rent and depreciation, building maintenance, housekeeping,
utilities (including telephone), accounting, purchasing, security, human resources
support services, legal services, liability insurance, and much more.

Dental procedures are performed on pediatric patients, and claims
for reimbursement for professional fees under the state's FAMIS programs
are submitted to the state or its agent for claims processing. Ongoing revenues
generated from professional fee reimbursements exceed expenses
for salaries and non-salary items not absorbed by the hospital,
and any excess revenues can be used to upgrade or replace capital equipment.

Background and Model Description

In 1992 the Community Based Health Care Coalition (the Coalition), meeting in Roanoke, began to attack the crisis in access to dental care for uninsured and underinsured children in Southwest Virginia. After years of struggling to find a solution to the problem, the Coalition requested and received help from not-for-profit Carilion Health System (Carilion). Carilion generously agreed to provide infrastructure support and to operate a pediatric dental clinic in rent-free hospital space. With funding from Virginia Health Care Foundation and a number of local foundations, the Carilion Pediatric Dental Program was opened in April 2001 to serve children and young people with disabilities or from low-income families living in Southwest Virginia.

The goal of the Program, serving children from birth to age 21, was simple: To increase access to and improve the oral health of children who are uninsured or underinsured or who are medically, physically or developmentally disabled.

Accomplishments

When the Carilion Pediatric Dental Program celebrated its third birthday in 2004, it had served approximately 6,500 children with more than 17,000 patient visits. More than 90 percent of parents reported a high degree of satisfaction with services and said the clinic had improved their children's access to dental care and improved their oral health (statistically verified). Schools, pediatricians and emergency room doctors say the number of children suffering from tooth pain is down. In 2003 there were 25,199 billable dental procedures performed, valued at $1.5 million. Promoting good oral health habits and correcting oral health problems while they are small will result in fewer large, systemic medical problems and reduced costs in future years.

Steps To Implementing A Pediatric Dental Program

Step 1.
Assess whether a dental program would be viable and valuable in your community.

A Needs Assessment is necessary in order to identify target populations and gaps in service, and to evaluate support among local dental health care providers.

The Needs Assessment process may involve:

- Analysis of state and local reports on access to dental care such as the Virginia Department of Health (VDH), local health departments, other social service agencies;

- Discussions with local dental professionals and others in the local health care community;

- Interviews and focus groups with parents of children enrolled in FAMIS/FAMIS Plus.

The following sources were reviewed or consulted in determining the need for a pediatric dental program:

- VDH designation as a Dental Health Professional Shortage Area (HPSA);

- Reports from the VDH Dental Division as well as city and county health departments in the region;

- Discussions with individuals including dentists, physicians, Total Action Against Poverty/Head Start, Child Health Investment Partnership, refugee and immigration officials, school nurses and local health and human service agencies serving children from low-income families without dental insurance;

- Contact with low income, uninsured patients using hospital emergency departments and pediatric clinics.

Important indicators that may be produced by the needs assessment include, for uninsured and underinsured patients:

- The estimated number of area residents;

- The number of hospital emergency department visits for dental problems;

- The most common dental problems;

- Common barriers to dental care;

- The number of local dentists who serve or may be willing to serve this population.

Step 2.
Obtain community support.

Community commitment must be a priority during program development, and remain a priority as the program evolves. Many funders require documentation of ongoing community support to demonstrate willingness to share in project costs and organizational work.

Initial Community Support

The fact that the impetus for establishing a pediatric dental clinic in Roanoke was a coalition with diverse representation made it easy to show community support. Coalition members helped gather letters of support from local dental societies, hospitals, schools, elected officials, other non-profit agencies and more.

Initial Provider Support

Local dentists should be systematically approached early on, individually and through dental societies, and educated about the extent of need for dental care among targeted patients. In Southwest and Southside Virginia, for many reasons, there are few dentists who are willing to be FAMIS and FAMIS Plus participating providers. In fact, Roanoke dentists and dental societies did not view a clinic for uninsured and FAMIS children as competition, but openly embraced the concept and were among the strongest supporters.

Ongoing Support

Community support must continue after the Dental Program opens its doors. Before awarding grant funds for new projects, most foundations want to be assured of continuing community support and sustainability of the project.

Coalition members remain dedicated and active to the project to this day, and continue to recommend how to best meet community needs. They participate in program evaluation and offer advice on things such as "no show" policy, patient mix, appointment priorities, unmanageable patients, program publicity, etc. Additionally, they are part of a multi-faceted communications plan that keeps the needs and accomplishments of the Dental Program before the public.

Step 3.
Design the program.

Once the target population has been identified and initial community support is obtained, a number of program design decisions must be made.

Give High Priority to Meeting the Dentist's Needs

Perhaps the most important design principle is to *respect and appreciate the time and talents of the dentist.* The work of the dentist is intricate, precise, stressful and often time-consuming. If the program is to be successful, the dentist must be adequately compensated, assisted, equipped and supplied. This means that staffing and operatories must be carefully planned. Likewise, referral and appointment scheduling must be efficient so that the dentist does not lose blocks of time due to no-shows, or become overwhelmed due to overbooking. The needs of the dentist should be given high priority during program planning and throughout the operation of the program.

Design the Overall Approach

The importance of the design of the dental service delivery model cannot be overemphasized. Will you hire a pediatric dentist, or a general dentist who treats children? A dental clinic can be located in a trailer or a strip mall, a school or a hospital. Each type of dentist and each location alternative has distinct advantages and disadvantages. The location must be easily accessible to the public. For optimal efficiency the facility should provide at least four dental operatories for each full-time-in-office dentist. Dentists may prefer left side, right side or behind the head delivery, and operatories should allow for this without being cramped.

Recruit and Retain Provider(s)

There is a nationwide shortage of pediatric dentists, and recruiting one of these specialists can be expected to take a year or more. A general dentist who treats children and adolescents may be a more reasonable and less expensive alternative. Successful recruitment is often a community effort, and it is important to sell the area and the job to anyone who would be relocating with the dentist. It may be necessary to offer significant incentives to attract the right individual. A program with no dentist is unable to function. *(See page 11 for factors to consider when determining to hire a pediatric or general dentist.)*

Lessons learned:

Carefully design the program to meet practice needs. This is essential for recruiting and retaining dentist(s) and support staff and for efficient operation of the clinic.

Involve practicing dentists in the planning process.

The most important decision in designing a practice is whether to hire a general dentist, a pediatric dentist or both.

A program without a dentist is "dead in the water." There are many dental programs in the US that have all the necessary resources except a dentist.

Other key design factors include the provision of good dental equipment and adequate support staff.

Efficiency of operation is directly affected by practice policies and procedures, so strong office management is essential to achieving success.

It is wise to consult with other similar programs and obtain legal review when developing policies, procedures and forms.

Once the dentist is on board, it is important to keep him/her happy. Continual review of "job satisfiers" is essential. A hospital based program has the advantage of offering intellectual stimulation through interaction with physicians and other health professionals. Involvement with schools of dentistry and dental hygiene is an added attraction.

Design the Referral and Delivery Systems

Referrals. New patients may be referred by physicians, dentists, hospitals, health departments, health and human service agencies, faith communities, and/or civic organizations. Informational brochures can be helpful. In the weeks before the clinic opens and for several months after it starts offering services, it is helpful to inform the community and all potential referral sources about the services it provides, the target population and any referral protocols. This can occur via letters, presentations, one-on-one outreach or a combination of these methods.

To ensure that all key organizations/people are aware, it is a good idea to make a list of all who should be notified, determine the best way to communicate with each and identify who will make each contact.

Eligibility. It is important to develop eligibility policies. At the Carilion Program, true dental emergencies are seen immediately regardless of insurance coverage or ability to pay. Most other patients are required to have public or private insurance or the ability to pay. At each scheduled visit a card must be presented showing the child's current FAMIS or FAMIS Plus coverage. Existing coverage also can be verified rapidly by telephone or Internet.

Uninsured patients are referred to their local department of social services or are provided a toll free number to contact centralized enrollment services currently located in Richmond. For revenue enhancement and economic viability, the Carilion Program clinic accepts a small number of patients who are self pay or have private dental insurance.

Appointments. It is important to be mindful of your patient population when establishing appointment policies. After trying a number of approaches, a great reduction in the no-show rate was achieved by making appointments (excluding six-month recalls) only one month in advance. It was also mutually beneficial to establish block times for groups that offer outreach for parental authorization, chaperonage and transportation. The Coalition was very helpful in vetting different approaches.

Fees. After reviewing federal and state law, each clinic must decide if any administrative or user fees will be charged and whether or not co-pays will be collected.

Step 4.
Design the program evaluation.

It is important to assess the costs, revenues, productivity and impact of the program and to have some form of quality assurance. Tools are available to assess costs as they relate to time in Relative Value Units or Weighted Work Units, but this is probably more sophisticated than is necessary. A new program would be well served by tracking the following indicators per period of time:

- *Productivity measures:* number of patient visits; number of individual children seen (unduplicated headcount); average number of visits per child; most frequently performed dental procedures by American Dental Association (ADA) code; number of preventive and diagnostic vs. operative/restorative procedures; value of procedures performed.

- *Financial results:* revenues by category, (e.g., grants and donations, professional fees, co-pays, merchandise sales); expenses by category, (e.g., salaries, benefits, supplies, dental laboratory, etc.); revenues and expenses per procedure; revenues and expenses per patient; reimbursement by source, (i.e., FAMIS, FAMIS Plus, commercial insurance, private pay); reimbursement and collections as a percent of billings; procedures for which reimbursement is denied.

- *Patient satisfaction* (compare actual data to parent perceptions in surveys): wait time for clinic appointment, wait time for O.R. appointment, wait time to be seen after arrival, helpful educational information received, believes clinic has improved access, believes oral health of child has improved thanks to clinic, overall satisfaction with services provided.

Attempting to run a practice without computers and a good dental software program would be unthinkable. Ongoing training to use these programs is important.

Quality assurance can be accomplished by an internal or external committee or unbiased peer review. Dentists or dental hygienists should be involved in monitoring and evaluating program performance, policies and procedures, and assuring compliance with acceptable standards of dental care by patient chart review and, preferably, by personal observation of a sampling of work performed.

Lessons learned:

Develop a program evaluation work plan as part of the overall program design.

Build the data collection system into your routine policies and procedures so that data are collected as you go.

It pays dividends to invest in good computers, proprietary dental software, a backup system and training of operators.

Good data collection produces good reports and makes it easy to evaluate the program and make decisions on needed policy changes.

The Carilion Program obtained better results by breaking away from hospital physician billing and hiring our own billing specialist.

Dental hygienists can be very helpful in Quality Assurance and chart review, and dentists from the community are likely available to volunteer for peer review.

Plan how oral health improvement will be measured so the patient charts will contain the information needed to document progress. Many clinics use the "d,m,f" scale, count applications of fluoride and sealants placed and/or statistically verify reduction of caries in returning patients.

Step 5.
Prepare a budget and obtain funding.

Budget. The clinic's budget can be prepared as mutually agreed by the community partners. In the Carilion model, expenses are allocated as shown below. Any excess revenue from operations is plowed back into capital equipment purchase:

- **Hospital:** building expense, depreciation, building maintenance, housekeeping, utilities, telephone, insurance, accounting, purchasing, security, human resources support, legal services, other infrastructure

- **Clinic:** dentist recruitment, salaries, benefits, supplies and postage, dental supplies, dental laboratory, repairs and maintenance, contracts, pagers and cell phones, laundry and purchased services, travel and education, dues, subscriptions, books, billing and collections

Funding. The funding plan must be agreed upon by the hospital or sponsor and the community coalition. The Carilion Pediatric Dental Program received grant funding from Virginia Health Care Foundation, Carilion Foundation, Maupin-Sizemore Foundation, Delta Dental Plan of Virginia and individual donors.

Even in times of economic downturn, some large foundations generally have challenge funds available for projects to improve the health of uninsured populations, but most require demonstrated commitment by donations from corporations and individuals in the area to be served.

Many projects gain support by involving numerous community organizations in the initial discussions and planning for the project. Often a committee or task force of knowledgeable and influential individuals is appointed to plan fundraising efforts and address program sustainability. Funding plans may include strategies for seeking foundation grants and donations from civic organizations, businesses, faith communities, local governments, personal solicitations, and an annual mail campaign.

A Communications Plan should be developed to publicize the program through newspapers, radio, television, brochures, direct mail and local speaking engagements. Make maximum use of public service announcements.

Step 6.
Implement and maintain your dental program.

Starting a dental program requires careful planning to align funding, facility construction or renovation and certification, purchasing, recruiting, training, publicity, intake, prescreening, scheduling and service delivery. If local businesses do not provide volunteer help in project planning, tools are available free on the Internet. Program Evaluation and Review Technique (PERT) charts and Gantt charts can be especially helpful. Key steps may include:

- Carefully reviewing the results of the needs assessment with your core group of dental professionals to make sure that the program has adequate facilities, equipment, and staff to meet the expected demand for services.

- Allowing enough time between receipt of cash funding and the grand opening to shop for, obtain, and install the equipment and supplies needed for on-site services.

- Before you start, having in place a system for collecting and managing data on patient referrals, appointments, visits, procedures.

- Staying in frequent communication with program volunteers and referral sources to gauge how the program is working early on.

- Establishing an appropriate committee structure with board members and health professionals to oversee program resource development and quality assurance.

Lessons learned:

Hands-on management must be provided during the life of the project, and particularly when the clinic first opens.

Be fair and consistent, but don't be afraid to change policies. It may take months or even a year or two for operations to gel.

Emphasize customer service again and again! The clinic is there to provide a service.

Unfortunately, some parents and teenagers may not appreciate the services the clinic offers and their behavior may be disheartening to dentists and staff.

Someone needs to be a cheerleader to remind everyone of the wonderful service they are providing.

Believe in Murphy's Law. Many things will go wrong.
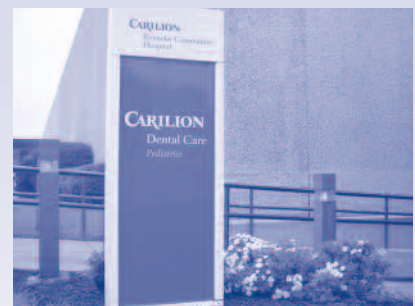
Helpful Tips I Wish Somebody Had Told Me
by Tom Adams, Carilion Dental Care Coordinator

- You can find out where dental treatment is provided in the state by contacting the Virginia Dental Association, Virginia Department of Health, Virginia Association of Free Clinics, Virginia Primary Care Association, and the Virginia Health Care Foundation.

- An abundance of information is available on the Internet so you can do a lot of research in comfort. Virginia Health Care Foundation is a great place to start. Other excellent sources of information about children's dental programs are www.cdhp.org, www.signupnowva.org, www.vakids.org, and www.dentalclinicmanual.com.

- The hardest part about starting a new dental program for underserved children is recruiting the dentist(s).

- It may take several months for a dentist to obtain a Medicaid Provider Number, to be approved by insurance companies and/or to gain hospital privileges.

- "A lot for a little, or a little for a lot"—before the clinic opens, decide if the practice will focus on seeing as many patients as possible versus fully restoring fewer patients.

- Clinics that see mostly FAMIS Plus (Medicaid) patients may be able to negotiate a higher rate of reimbursement for professional fees from Virginia Department of Medical Assistance Services or its agent.

- A new clinic may expect great pent-up demand for services; one Monday the Carilion Pediatric Dental Clinic received 238 phone calls in one hour.

- If you have the luxury of designing your clinic's floor space and patient flow, helpful samples may be available at www.henryschein.com

- Although it can be squeezed into something smaller, a 4-chair children's dental clinic requires about 2,000 square feet of space.

- Waiting rooms and rest rooms require constant attention.

- A separate clinic entrance is recommended, with an open, covered overflow waiting area outside for large extended family and neighbors. If you build it, they will come. If you don't build it, they will come anyway.

- Those waiting outside may smoke and/or use smokeless tobacco. Place this area away from the clinic's air intake, avoid combustible ground covers such as mulch or peat moss and arrange for routine clean-up.

- Waiting room chairs without arms will better accommodate large people.

- A wall-mounted TV in the Waiting Room and each dental operatory is a wonderful thing (can be used for education in addition to cartoons).

- There should be access to drinking water, but select the location carefully or it will become a messy plaything for kids.

- Good parenting skills today are rarely in evidence, and it may be necessary for the receptionist to ask parents to control their children or children to control their parents.

- Parents love and are fiercely protective of their children and will not hesitate to be verbally abusive to doctors, staff, and particularly receptionists at the slightest perceived provocation.

- Arrangements should be made for rapid response by security officers or police when called.

- The vast majority of FAMIS Plus patients are good, thankful people who may be temporarily out of work and are struggling to provide for their families.

- Some children may vomit or soil themselves without warning, and everyone will be thankful for effective deodorizers and cans of Lysol® spray or the equivalent.

- Arrangements should be made for rapid response by housekeeping personnel if affordable.

- Have a plan and be prepared to deal with nits and pesky head lice.

- Toys should be selected with safety in mind. Wall-mounted (molly bolted) action toys are great. All should be easily cleanable. Keep disinfectant handy.

- Don't forget to arrange for removal of grass, leaves, mud and snow, and de-icing and salting of parking areas and entrances/exits.

- Many clients seem to have cellphones, so a nearby pay phone probably is not necessary.

- "No shows" are a constant problem, but rates can be reduced with concerted effort.

- The number of cases best treated by use of adjunctive nitrous oxide or procedural sedation in the clinic will be higher than you expect.

- The number of unmanageable patients and cases of severe decay that require treatment under general anesthesia in the Hospital Operating Room will be greater than you think it will.

- As a practice matures there will be a shift from more diagnostic and preventive procedures toward more operative and restorative procedures, and an attendant increase in visits per patient per year and reduction in number of individual children seen (unduplicated headcount) per year.

- Although they may feel physically and mentally exhausted at the end of the day, doctors and staff will feel good about what they are doing.

- Virginians for Improved Access to Dental Care (VIADC) has accomplished much. If it still exists when you are reading this, designate a representative to attend their meetings.

Should You Hire a Pediatric Dentist or a General Dentist?

Decide whether to hire a pediatric dentist or a general dentist. Pediatric dentists are highly trained specialists, but their skill sets may not allow them to perform root canals, crown and bridge work and some surgical extractions. Experienced general dentists often are more capable of handling these procedures, especially on teenagers, but occasionally they may have to refer patients to a dental specialist such as an endodontist or an orthodontist.

Some characteristics of each type are shown below. *Remember: These are generalizations!*

Pediatric Dentist

- Practices in specialty experiencing nationwide shortage

- Is highly educated, highly trained, able to command high salaries and benefits

- Has completed formal residency in pediatric dentistry

- Generally prefers to see children up to about age 10 when permanent teeth are coming in

- Is used to working in small mouths

- Is frequently characterized as strongly caring and concerned for the welfare of children

- Usually has infinite patience and remains calm under stress

- Is trained in dealing with behavior management

- Generally sees more patients than a general dentist

- Frequently is uncomfortable treating adolescents and teens

- Generally is not skilled in performing root canals, complex extractions and some surgical procedures

- Is accustomed to referring some difficult cases to endodontists and orthodontists

- Often is skilled in hospital dentistry and accustomed to seeing patients in hospital O.R. with anesthesiologist or nurse anesthetist administering general anesthesia

- Often is skilled in performing in-clinic oral sedation

- Usually is accustomed to administering nitrous oxide in clinic

- Has a reputation for disliking administrative duties

General Dentist

- May or may not have completed formal specialized training after dental school

- Generally is not trained in behavior management of small children

- Frequently is more comfortable dealing with youths whose permanent teeth have come in

- May or may not be able to administer adjunctive nitrous oxide

- May or may not be able to handle oral sedation cases

- Usually is not accustomed to practicing in hospital O.R.

- Sees fewer patients because dental procedures generally take longer to perform on adolescents and teens compared to younger children

- Generally is skilled in performing root canals, complex extractions and some surgical procedures

- Frequently is able to perform restorative procedures and create prosthetics rather than refer cases to dental specialists

Checklist for Implementing a Dental Program

Step 1.
Assess whether a dental program would be viable and valuable in your community.

❑ Include local dentists early in the needs assessment process.

❑ Convene a working group that includes members of the local dental care and health care community.
Work group members may include:
- Dentists, dental hygienists, dental assistants, dental lab specialists
- Representatives of local professional dental societies
- Pediatricians, other physicians, nurses, other health care providers
- Local hospital personnel, including administrators
- Local health department representatives
- Representatives of social service agencies, schools and faith based programs
- Business and community leaders
- Representatives of dental professional training programs
- Local government representatives

❑ Collect information on the need for dental care among low-income, uninsured residents.
- Review information from state and local reports on access to dental care.
- Interview providers who serve uninsured and underinsured patients including community dentists and physicians, local health department staff, local hospital Emergency Department and Pediatrics Department staff.
- Interview members of the low-income, uninsured population. Start with individuals who already access free clinic, health department, and other community services.

❑ Develop indicators of need.
- Check with the Virginia Department of Health to see if the region qualifies as a Dental Health Professional Shortage Area (Dental HPSA).
- Research the number of area residents with low income and no dental insurance coverage.
- Estimate the number of local hospital Emergency Department visits for uninsured and underinsured patients with dental problems.
- Describe common barriers to care for uninsured and underinsured patients, including transportation, language, time management and other factors.

❑ Collect information on community resources that might be available to help support the program. This includes private practice dentists and other dental professionals, public health departments, local dental training schools and otherresources.

❑ Compile the Needs Assessment data into a report or presentation that can be used to educate the community.

Step 2.
Obtain community support.

❑ Continue the working group convened for the Needs Assessment, and add members as necessary to form a community coalition interested in local health access issues.

❑ Educate the community coalition about the need for a dental program. Include:
- dental provider groups
- physician groups
- local hospitals

- health and human service agencies within the target area
- accessible education and training programs
- businesses
- local government officials
- faith communities
- patients
- volunteers
- dental managed care organization(s) serving the area.

☐ Identify local dental providers interested in serving low-income, uninsured patients. Ask them for their advice on how to effectively structure a new dental program.

☐ Identify local health and human service agencies that could act as referral agents for a new dental program.

☐ Identify prospects for cash and in-kind contributions.

☐ Ask all contacts for letters of support to be included in funding requests for the program.

Step 3.
Design the program.

☐ Send a delegation to visit an existing program similar to the one envisioned for your community, obtain a copy of their policies and procedures manual and secure contact information for the dentist and the practice manager of their clinic.

☐ Distribute copies of policies and procedures manual to local work group members and ask them to read it so they will be knowledgeable in making recommendations for new clinic policies.

☐ Carefully design the program to meet your dentist's practice needs. Space, equipment, supplies, support staff, appointment scheduling, and other aspects of the program should be designed to meet the specific needs of the dentist.

☐ Decide program eligibility criteria in terms of age, level of income, and insurance status. Remember that some people with health insurance may in fact lack dental coverage and be low-income.

☐ Decide whether to provide services at remote locations.

☐ Design the service delivery system.
- Determine the approximate capacity of the program in terms of the number of patients and visits that can be accommodated.
- Contact all local dentists by mail and through the dental societies to educate them about community needs and inform them about the program.
- Contact local dental training programs to provide information and evaluate their interest in providing in-kind services and training opportunities for their students.

☐ Design the on-site service facility.
- Work with local dental society or individual dentists to determine the types of dental services that are needed by the target population.
- Obtain professional help for architectural design through donated services or in cooperation with the hospital or benevolent partner.
- With participation by a volunteer pediatric dentist, carefully design the facility to meet the needs of the patients, dentists and staff.
- If your hospital or clinic offers a pharmacy program, develop internal mechanisms to provide timely dispensing of medications for dental patients.

☐ Design the administrative structure of the program.
- Determine personnel positions needed to support the dentist, developjob descriptions, supervisory relationships, evaluation procedures, and a staffing plan.
- Decide whether volunteer support will be needed for intake management, appointment management and data collection, and plan accordingly.
- Investigate current policies applicable to processing of FAMIS and FAMIS Plus patients to incorporate into clinic policies.
- Establish appropriate fees for dental procedures that will be performed. This information will be submitted to insurance carriers and will be used to inform self pay patients.
- Design an appointment system that will be fair and effective. To reduce the no-show rate, consider block scheduling with a stand-by list.
- Design a pre-screening system to determine whether patients meet the program eligibility criteria.
- Design a system for making and receiving referrals.

Step 4.
Design the program evaluation.

☐ Develop the program evaluation simultaneously with the program design.

☐ Develop a work plan for tracking productivity, patient satisfaction, and financial indicators to aid in analysis and change.

☐ For each indicator, specify in the work plan the data source, who will collect the data, how the data will be collected and when the data will be collected.

☐ Consider including the quantifiable indicators shown below. These also will be useful in establishing desired outcomes for the project.
- Number of patient visits and number of individual patients seen
- Average number of visits per child
- Number of dental procedures performed by ADA code and category
- Dollar value of procedures performed
- Revenues and expenses by category
- Revenues and expenses per procedure
- Revenue and expenses per patient and per patient visit
- Revenues and reimbursement by source
- Reimbursement and collections as a percent of billings
- Procedures for which reimbursement is denied
- Wait time for clinic and O.R. appointment
- Wait time to be seen after arrival in clinic
- Various indicators of patient satisfaction
- Trend in number/proportion of appointment no-shows
- Trend in number/proportion of emergency visits

☐ Consult with vendors and select a data collection system to help manage, monitor, and evaluate the program as you have designed it.
- Evaluate commercial software packages such as EagleSoft, SoftDent and Dentrix.
- Ensure that program software has the capacity to support patient tracking, appointment management, service tracking, billing and management reporting.
- Evaluate the management reporting component to ensure that it will produce information for daily operations, periodic reports and overall program evaluation.
- Work closely with dentists to develop an efficient process for collecting and entering data into patient charts and into the system.

□ Develop satisfaction survey tools for patients, providers, and community partners. Establish a schedule for implementation and review of results (e.g., quarterly, semiannually, and annually).

□ If your clinic offers pharmacy services, be sure to collect data on dental-related pharmaceuticals dispensed.

□ Determine a schedule for regularly monitoring and evaluating all data, comparing like periods of time.

Step 5.
Prepare a budget and obtain funding.

□ Develop an initial cash or accrual budget that addresses the services to be offered. Possible expense budget items include:
  • Salaries and benefits for dentist(s) and support staff
  • Facility space, housekeeping, utilities, dental equipment and supplies, office equipment and supplies and much more
  • Indirect costs, e.g., fund raising, recruiting, administration

□ Identify possible revenue sources and obtain information about funding requirements. Include:
  • Reimbursement from Virginia Department of Medical Assistance Services for dental procedures covered under FAMIS or FAMIS Plus
  • Other insurance reimbursement, user fees and co-pays when appropriate
  • United Way
  • Foundations
  • Civic and fraternal organizations
  • Local businesses and regional and national corporations such as banks and suppliers of medical/dental supplies and equipment
  • County and municipal governments
  • Health care providers
  • Faith communities
  • Personal solicitations

□ Obtain letters of support from community providers, agencies, and political entities.

□ Determine funding opportunities from local governments for services provided to their residents such as sharing in federal rural health grants or block grants.

□ Prepare both sustaining and development proposals based on the Needs Assessment and the program design.

□ Work with your community coalition members to identify in-kind support that will assist in minimizing expenses.

□ Track the value of in-kind donations of time, equipment, and supplies.

□ Develop a Communications Plan to promote the program in the community not only when it opens, but throughout the year.

Step 6.
Implement and maintain your Dental Program.

☐ Conduct a final planning review to ensure that the program has adequate facilities, equipment and staff to meet the expected demand for services.

☐ Execute employment agreements or contracts with dentists and terms of employment with staff (usually serving in "at will" status in Virginia).

☐ Finalize referral agreements with local referral organizations. Provide information and orientation on an ongoing basis.

☐ Allow enough time to obtain needed equipment and supplies.

☐ Establish and test the system for collecting and managing data on patient referrals, appointments, visits, procedures, and hours of operation.

☐ Conduct a continuous publicity campaign for community awareness even though the program may be inundated with requests for appointments.

☐ Establish an appropriate committee structure including board members, community members, or other interested parties to oversee/monitor the program's productivity, quality assurance, and to help with "troubleshooting" when necessary.

☐ Start the program.

☐ Cultivate and maintain good working relationships with both the provider community and the community at large.

☐ Continue to seek out funding opportunities at the local, state, and community level.

☐ Review evaluation results on a quarterly basis and make improvements as necessary.