

Growing and Sustaining a Dental Clinic within the Primary Care “Safety Net”

FQHC Dental Clinic Operations in a Changing Environment

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Primary Oral Health Care

- **HRSA's BPHC has adopted the following definition of Comprehensive Primary Oral Health Care that has appeared in Policy and Program Guidance since 1997:**
- Comprehensive primary oral health services is defined as personal oral health care, delivered in the context of family, culture, and community, that includes all but the most specialized oral health needs of the individuals being served.
- The range of services should include preventive care and education, outreach, emergency services, basic restorative services, and periodontal services.
- Additional services may include basic rehabilitative services that replace missing teeth to enable the individual to eat, benefit from enhanced self-esteem, and have increased employment acceptability.

Setting Priorities in Primary Care Dental Programs

- While individual patients pay for private practice dental services, health centers and public health dental practices are financed through a budget approved by a public or private funding agency;
- **A Population-based focus**; both in individual patient treatment planning and surveillance of the total population, must be part of an efficient health center dental program;
- Service and treatment option priorities must be based on **availability of resources, service prioritization, size of the target population, disease pattern, demand of the population, and a reasonable definition of dental health verses ideal restoration.**

Food for Thought:

WARNING: A Community Health Center Dental Clinic is NOT the same as a private practice.

Valuable on-line resources:

www.dentalclinicmanual.com

“safety net” dental clinic manual

www.rvsdata.com

Relative Value Studies Incorporated

Issues of Concern for Health Centers

Environmental/financial challenges

- Federal/state regulations
- Payer mix
- Competition for patients
- Competition for staff

Issues of Concern for Health Centers

Other clinical challenges

- Population-based practice
- High-risk dentistry vs. ideal
- Public health concerns
- Social needs of population

Priorities in Primary Care Dental Programs

- *The focus of a health center dental program must be to **decrease** the existing dental disease burden in the target population and **prevent** disease from starting in the youngest members of the population.*

Build and Maintain State and Community Partnerships

- Helps in determining community profile and demographic areas of need.
- Build local political goodwill and support.
- Partnerships help sustain the clinic over time.
- Identifies local resources and referral networks.

Productivity

- Many factors are involved with productivity, and no single measure will provide an accurate view.
- Sites should be reviewing productivity from many perspectives.
- 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.

Productivity

- **The facilities can influence productivity, if there are insufficient numbers of units/dentist.**
- **Clearly support staff, both numbers and experience can influence productivity.**
- **Sites providing comprehensive services may have visits that are lower, and collections/charges that are higher than average.**
- **The important factor to consider is that the site should be fiscally viable and that patients have their oral health care needs met.**

Productivity

- BPHC's requirement for dental productivity is that the program be financially viable and provide quality care.

Productivity

- Based on UDS Data a health center program with one-dentist needs to **collect** approximately \$300,000 to break even. **It should be noted that this sum is includes funds collected from patient care services as well as grant subsidies to cover uninsured and underinsured patients. Sites should calculate the gross productivity, utilizing full fee charges as one measure of productivity. Average gross charges, presuming that the fees are market rate fees, should exceed \$400,000/dentist/year**

Productivity, Encounters

- The average cost per encounter is about \$117, so you would need 2564 encounters to break even.
- Assume roughly 200 work days per year (or 1600 work hrs per year after holidays and vacations).

Productivity, Encounters

- Based on 2005 UDS stats Nationwide, the average number of encounters per full time dentist were 2700 per year or 1100 patients.

The average number of encounters per Dentist FTE per hour would be 1.7 patients per hour or 13.5 patients per day for 2700 encounters/200days/yr.

- **Many sites have 220 days of care/FTE, so the math would be 1.53 patients per hour (8 hour day) or 12.3 patients/day.**
- You may want to benchmark the productivity of your current program to see if greater efficiency can occur that would allow you to see new patients.

Productivity

- A dentist should utilize a minimum of two chairs and 1.5 dental assists to achieve these productivity aims.
- This is for minimum efficiency.
- Use of additional operatories and assistant staff significantly increase the marginal rate of return on investment and increase productivity.

Productivity

- Evaluate your encounter rates as follows:
 - <2100 per FTE dentist is poor,
 - 2100-2400 below average,
 - 2400-2700 average,
 - 2700-3200 above average, and
 - 3200 and above outstanding. .

Productivity, Hygienist

- For dental hygienist the comparative 1.0FTE encounters range from
- <800 poor,
- 800-1100 below average,
- 1100-1400 average, 1400-1800 above average,
- >1800 outstanding.
- The same work assumptions 40 hr workweek, 200 work days.

Productivity: RVU's

- **Another measure of productivity is Relative Value Units. Utilizing the system employed in Region II, dentists should exceed 42 RVU's/day.**
- RVU's are usually given in 10 minute units i.e. a 30 minute procedure would have 3 RVU value units.
- If all service encounters averaged 3 RVU's, this would average out as 14 encounters per day given an 8 hour work day.

***Service Prioritization
in Health Center
Dental Programs***

OPR Dental Measure

- **An excellent measure to monitor quality of patient care outcomes is “% of phase I treatment plans completed per year.**

Phase I Treatment Plan (Numerator)

- Number of patients that complete Phase 1* treatment within 12 months of initiating a treatment plan.
- Phase 1 = Prevention, maintenance and/or elimination of oral pathology that results from dental caries or periodontal disease.
- This includes: oral cancer prevention and early diagnosis; prevention education and services; emergency treatment; diagnostic services and treatment planning; restorative treatment; basic periodontal therapy (non surgical); basic oral surgery that includes simple extractions and biopsy; non-surgical endodontic therapy; and space maintenance and tooth eruption guidance for transitional dentition.

Phase II Dental Care

- Phase 2 = rehabilitative services, such as dentures, partials, crown and bridge, elective oral surgical procedures, periodontal surgery, and orthodontics. (Elective dental procedures.).

Denominator

- Number of patients that receive a comprehensive oral exam (ADA code 0110) or a periodic recall (ADA code 0120) oral exam.

National Goal

- The goal of the Health Disparities Collaborative for this performance measure is 60% or 6 Phase I service completions/10 comp. or recare examinations.
- The BPHC Oral Health Collaborative Pilot is in the planning and testing phase.
- This goal was recommended to by Dr. Jay Anderson, chief dental officer for BPHC, and the HRSA regional dental consultants.

Data Sources and Data Issues:

- From Registry or EHR/EMR if available.
- If Chart Audit, then sample from the sample frame of persons meeting denominator criteria.
- The data needed to support this performance measure can be accessed through a MIS search, dental productivity reports or a random sample chart audit.
- Many health centers have already implemented a specific “dummy code” to signify when patient treatment is completed

Public Health Dentistry

- ***Treatment services that alleviate pain or prevent disease are given higher priority than services that correct damage caused by disease.***

Prioritization of Services Phase I

- **It is recommended that 75% of care be Phase I care**
- **Level One Emergency Care**
- **Level Two Primary (Prevention)**
- **Level Three Secondary Prevention**
- **Restorative Care**

Prioritization of Services Phase II

- **Level Four** **Limited Rehabilitation**
- **Level Five** **Rehabilitation**
- **Level Six** **Complex Rehabilitation**

Prospective Payment System (PPS).

- Many health centers are reimbursed by State Medicaid programs through a Prospective Payment System (PPS).
- In this system health centers are paid an all inclusive rate per patient encounter.
- The expectation is that the quality and content of that encounter would be consistent with standards of practice and care in the community.
- **Quadrant Dentistry is the standard of care for health center dental programs.**

Quadrant Dentistry is the Gold Standard of Care for Health Center Programs

- 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.
- As a matter of fact “Increasing units of service, which are subject to a payment rate” is considered fraud by both State and Federal Medicaid/Medicare Regulations.
- It is recommend that the health center use relative value units or some other form of quality assurance program to assure that the appropriate quality and quantity of patient services are given during a patient encounter.

Level One – Urgent Care Services

- **These are services necessary to relieve or control acute oral conditions, such as serious bleeding, a threat to life, maxillo-facial fractures, swelling, severe pain or other signs of infection.**
- **prosthodontic repairs may also require urgent attention.**

Level One Service Examples

- **Emergency oral examination – problem focused**
- **Problem focused x-rays**
- **Simple tooth extractions**
- **Temporary or sedative restorations**
- **Palliative treatment**
- **Prescription medications for pain and infection**
- **Draining of oral abscesses**
- **Denture repairs and other urgent repairs**

Level Two- Preventive Dental Care

- **Primary preventive services that prevent the onset of disease.**

Level Two Service Examples

- **Adult prophylaxis with or without topical fluoride**
- **Child prophylaxis with or without topical fluoride**
- **Sealant by tooth and quadrant**
- **Preventive self-care patient education**
- **Periodontal recall or maintenance procedures**
- **Athletic mouthguards**
- **Water fluoridation activities**
- **Group oral health education programs**

Other Level Two Service Examples

- **Application of fluoride varnish and/or fluoride supplements**
- **Xylitol gum distribution and education activities**
- **Chlorohexidine rinse and therapeutic medicaments**

Level Three- Secondary Prevention and Early Restorative Services

- **Secondary prevention services are necessary for routine diagnosis and treatment to control the early stages of disease.**

Level Three Services Examples

- Initial or periodic oral exam
- Full mouth x-rays, bitewings and panoramic radiographs
- Diagnostic casts
- Space maintainers
- Amalgam and composite restorations (up to 3 surfaces)
- Stainless steel crowns on primary teeth
- Therapeutic pulpotomy of primary teeth
- Anterior root canal (one canal)
- Periodontal scaling/root planing
- Biopsy, excision of small lesion

Level Four - Limited Rehabilitation

- **Limited rehabilitative services restore oral structure after extensive disease damage. These services are more complex and costly to provide than level three services.**

Level Four Services Examples

- **Cast onlays, inlays or crowns with or without porcelain**
- **Post and core restorations**
- **Crown build-ups**
- **Laser and cryo dental applications**
- **Maryland type acid etch bridge**
- **Bicuspid two-canal root canals**
- **Apicoectomy and retrograde filling**
- **Gingivoplasty**
- **Limited/interceptive orthodontics**
- **Surgical extraction, root recovery procedure - uncomplicated**

Level Five - Rehabilitation

- **Rehabilitation services require multiple appointments, complex treatment of extensive areas of the mouth, more clinical chair time, and higher service costs.**

Level Five Service Examples

- Molar root canals (3 or more canals)
- Periodontal surgery (mucogingival and osseous)
- Periodontal splints
- Complete and partial dentures
- Denture rebase (laboratory)
- Fixed bridgework (retainers and pontics)
- Multiple teeth surgical extractions and removal of soft tissue (impacted teeth)

Level Six – Complex Rehabilitation

- **Complex rehabilitation services require advanced skill, usually involve specialty referral, and are costly. These services may not predictably improve a patients overall prognosis, and may be risky to perform. Careful patient selection is required.**

Level Six Service Examples

- Full mouth or quadrant occlusal adjustments
- Periodontal surgery (flap, osseous, soft tissue grafts)
- Overdentures
- Precision attachment prosthetics
- Comprehensive orthodontics
- Complex surgical extractions (bone impacted, sinus fistula closures, large excisions, osseous bone grafts)
- Intravenous sedation and general anesthesia
- Specialty service consultation
- Cephalometric and TMJ radiographs
- TMJ therapeutic procedures

Level Seven: Exclusions

- **Services that are not evidence-based on unreliable, have highly variable success rates, are strictly cosmetic , non-billable services under Medicaid or insurance plans, controversial, and extremely costly to perform.**

Level Seven Service Examples

- **Unbillable procedures per payment plan**
- **Direct pulp caps**
- **Endodontic implants**
- **Unilateral cast partial dentures**
- **Implants**
- **Silicate restorations**
- **Caries susceptibility tests**
- **Sargenti root canals**
- **Pulpotomy in permanent teeth**

Prioritization of Services

The advantages of the first three categories of service are:

- **Shorter chair time requirements.**
- **Most Medicaid plans reimburse for these services.**
- **Higher revenue generating potential under “Prospective Payment Systems” (PPS).**

Prioritization of Services

- **Low cost, (minimizing charges against the health centers 330 grant for sliding fee write-offs and uninsured patients).**
- **Provides the greatest health benefit to the greatest number of people for the longest time.**
- **Allows more adaptability to changes in economic environment cycles**

Successful Practice Profile

- The health center dental program concentrate on **Phase I Dental Services**
- If the program provides **Phase II Services**, patients are charged enough to cover dental lab and supply costs without using 330 grant revenues.

*Financial Strategies in
Sustaining “Safety Net” Dental
Programs*

Fiscal Policy Management

- **A financial analysis and formula should:**
 - **be developed by the health center's financial management with guidance for the dental director**
 - **Establish minimum ratios or percentage of payer mix needed to maintain operations.**

Payer Mix Ratios

- 30-40% Medicaid
- 30-40% Sliding Fee
- 10-20% Grant
- 10% Other Sources

***Constant Evaluation of the
Environment is the Key to
Survival***

Challenges to Health Center Fiscal Policy

- **Environmental drift**

- ***The reality that communities are vital entities in motion that change over time and sometimes suddenly in regards to demographic make-up, employment, resources, and needs.***

Bureau of Primary Health Care Policy

- **Access to services defined within their scope must be made available to all health center users regardless of ability to pay.**
- **Health centers must be able to justify why services and/or populations are excluded from the scope of practice, if the scope of services are limited and/or less than comprehensive.**

Managing Environmental Drift - *Justification*

- **Combine population financial profile and demographic data with the health center's financial "bottom line" indicators necessary to sustain the facility;**
- **Manage patient access by essentially matching clinic access with the combined profile data.**

Managing Environmental Drift - *Justification*

- **Matching available resources to population demographics is considered adequate justification.**
- **Good data helps the dental clinic avoid the potential of appearing selective or “**cherry picking**” for the sake of financial gain only.**

Managing Environmental Drift

Develop a Good Needs Assessment Plan

- **The Primary Oral Health Care Plan should be established on:**
 - **What is feasible**
 - **The program's projected revenue, other resources and grant support**

Oral Health Needs Assessment Criteria

- **1. An estimate number of users. (specify critical mass of dental patients for the program).**
- **2. A description of existing providers and resources in the community as well as an assessment of unmet need.**
- **3. predominant characteristics of service population such as race, sex, age, ethnicity, primary language, income, etc.**

Oral Health Needs Assessment Criteria

- **4. Oral health status, prevention, and treatment needs of the population**
- **5. Barriers to access/availability to comprehensive oral health care services**
- **6. Description of needs and treatment of special populations. (HIV, homeless, migrants...)**

Managing Environmental Drift

- ***Key points in addressing environmental drift:***
 - ***Manage all practice resources, **scheduling, chair time** and **patient flow** consistent with practice mission objectives;***
 - ***Base financial limitations on support data that provides justification for exclusions and service limitations.***

Balance is the Key

- Health centers are required to assure that services shall be available to the service population without regard to method of payment or health status.

Balance is the Key

- **At the same time, health centers are expected to maximize revenue from third party payers and from patients to the extent they are able to pay.**

What to do?

- **Link the budget with the goals and objectives specified in the oral health project plan and overall Health Center mission.**
- **Identify specific cost such as salaries, equipment, supplies, rent, etc.**
- **Provide a budget forecast for future years which demonstrates increasing potential for program**

Example:

- Health Center “X” average monthly revenue proportions for minimum program viability must be 40% Medicaid, 30% SFS, 10% insured and 20% uncompensated care uninsured write-offs.

Example:

■ Service Area Population:

- Demographic data reflect a similar ratio: **40% Medicaid; 30% low-income employed; 10% insured; and 20% uninsured.**
- **Both demographic and minimal bottom-line financial restraints match.**

Example: Practical Application

- **In this scenario, the clinic can assign available appointment slots to match financial demographic expectations:**
 - 40% Medicaid
 - 30% Sliding Fee Scale discount
 - 10% Insurance
 - 20% write-off at zero%

Example: Rationale

- ***Chair time slots can be restricted to:***
 - ***A specific patient age group (child, adult);***
 - ***AND payer category ratios in total scheduled chair time and assigned based on available appointments, call/walk-in capacity of clinic;***
 - ***Ratios must be supported by demographic data.***

Application Limitations

- **Do not restrict emergency access based on payer category or patient type. Emergency access must remain “open”.**
- **Only appointment slots, new patient routine care and comprehensive exams can be managed chair time.**

Managing Clinic Appointments

- **Limit all services to Phase I when revenue sources are restricted;**
- **Add “limited” additional service types as more resources become available;**
- **Charge enough for services above Phase II to cover all lab and supply costs even if sliding fee discount applied.**

Managing Clinic Appointments

- **Emergency access is managed by limiting the total number seen per day**
- **Emergencies can be absorbed in your uncompensated care appointment ratio or “write- offs” if revenue collections are minimal**

Managing Clinic Appointments

- **Managed appointment scheduling works best with electronic dental record scheduling and three chairs per FTE dental provider**
- **Two chairs are “appointment” chairs with the third unscheduled for emergencies.**

Managing Clinic Appointments

- **KNOW YOUR SERVICE
AREA POPULATION!!!**

Leverage Resources

- **During a federal review audit, evidence of the following must be available:**
 - **Demographic support data**
and;
 - **Documented attempts to locate additional resources**

Set Realistic Financial and Productivity Goals

- **Services provided should be less than actual cost per patient/encounter.**
- **Comprehensive mix of services should emphasize basic therapeutically acceptable care options. More “bang for the buck.”**
- **Productivity goals based on practice objectives: services vs. time (encounters).**
- **2500 to 2700 encounters/yr. X FTE Dentist**
- **1300 encounter/yr. X FTE Hygienist**

Ways to Improve “Bottom Line”

- **Maximize triage and short emergency visits;**
- **Focus on services covered by Medicaid and/or state S-CHIP programs;**
- **Seek local charity grants for specific targeted groups like maternal care and disabilities;**
- **Seek to perform the greater balance of total services toward revenue generation;**
- **Lower supply and overhead costs.**

“No Margin, No Mission” Rule

- **While services may be limited under tight budgets, there is no service if you are not open.**
- **Those that survive today get to “play” tomorrow when times are better.**
- **While good quality care is the goal, limited good quality is great when the alternative is no care at all.**
- **We can't be or give all things to all people.**

QUESTIONS?
