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

FQHC Dental Clinic Operations in a Changing Environment

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125 YEARS Advancing Health Through the Generations

Primary Oral Health Care

- **<u>HRSA's BPHC has adopted the following definition of Comprehensive Primary Oral Health Care that has appeared in Policy and Program Guidance since 1997:</u>**
- 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.**

Service Prioritization in Health Center Dental Programs

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 and Restorative Care**

Level One Services

- **Services necessary to relieve pain 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 (denture) repair may also be considered urgent care services.**

Level Two- Preventive Dental Care

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

Level Two Service - Examples

- **Activities:**
  - **professional oral health assessment,**
  - **dental sealants,**
  - **professional applied topical fluorides**
  - **oral prophylaxis**
  - **patient/community education on self maintenance and disease prevention**
  - **pediatric dental screening to assess need.**

LEVEL III SERVICES - Treatment of Dental Disease/Early Intervention Services

- **Activities**:
  - Restorative services which include dental fillings and single unit crowns
  - Periodontal maintenance services such as periodontal scaling, non-surgical periodontal therapy
  - Space maintenance procedures to prevent orthodontic complications for patients
  - Endodontic therapy to prevent tooth loss

Level Four - Limited Rehabilitation

- **Limited rehabilitative services restore oral structure after extensive disease damage.**
- **These services are more complex, time consuming, and costly to provide than level three services.**
- **Example: Dentures/Partials**

Level Five - Rehabilitation

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

Level Six and Higher Services – 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.**

Prioritization of Services

The advantages of the first three levels 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 levels one, two, and three dental services.**
- **If the program provides level four or higher services, patients are charged enough to cover dental lab and supply costs without using 330 grant revenues.**

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.

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.**

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 patterns 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 <u>without regard to method of payment or health status</u>.**

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.***

Active Promotions

- Health Centers must actively promote their services to target population to assure adequate patient flow in <u>all demographic and payer categories.</u>
- <u>Promotions must be culturally relevant and focused toward major social outlets utilized by target population.</u>

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 Types one, two and three when revenue sources are severely restricted;**
- **Add "limited" additional level four and above services as more resources become available;**
- **Charge enough for services above Type three level to cover all lab and supply costs even if sliding fee discount applied.**

Managing Clinic Appointments

- **Emergency access is managed by limiting the total numbers seen per day**
- **Emergencies can be absorbed in your uncompensated care appointment ratio or “write- offs” if revenue collections for these types of services 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 and walk-ins.**

Managing Clinic Appointments

- KNOW YOUR SERVICE AREA POPULATION!!!

Leverage Resources

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

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 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 or reach $300,000 annually.
- Assuming 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 1.54 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- 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.

Set Realistic Financial and Productivity Goals

- **Services provided (average) should be <u>less</u> 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 are no services 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?

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