Easing the Pain: Strategies for Maximizing Dental Clinic Efficiency

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What Exactly is the *Pain*?

- Reduced reimbursements
- An expectation to be financially viable
- Treating a population that bears the heaviest burden of disease
- Pressure to see more patients
- Quality indicators which drive completed treatments within an environment of care that is often compromised
- Limited scopes of service due to regulations
- Accomplishing our mission in a compromised economy
“The financial viability of core safety net providers is even more at risk today than in the past.

...Failure to support these essential providers could have a devastating impact not only on the populations who depend on them for care but also on the safety net to care for patients whom they are unable or unwilling to serve.”

Institute of Medicine: America’s Health Care Safety Net, Intact but Endangered, 2000
The IOM Report continues:

“…to **preserve** our network of safety net providers, we **must enhance and coordinate technical assistance** programs targeted to improving the **operations** and competitive position of safety net providers…including improvements in **management information systems**, appointment scheduling systems… efforts to **streamline operations**, and reengineering of services so that they are more responsive to patients.”
There is an Imbalance!

- Safety Net Mission
- Safety Net Business
SNS Assessments and the Data Show That Safety Net Clinics:

- Are extremely focused on the provision of service but are inefficient in relation to effective operations and systems.
- Often present with an inaccurate or partial understanding of their practice and opportunities within.
- Compile or receive inadequate data to properly evaluate the practice.
- Lack business accountability, strategic planning and/or guidance.
- Are challenged by inadequate resources for Safety Net practice management consulting and reference.
SNS Mission

Partnering with Safety Net oral health programs to provide technical assistance and support that enhances community-based oral health care and creates programs that are mission-driven and financially-sustainable, assuring the long-term viability of the safety net.
Balance

Safety Net Mission

Safety Net Business
The Safety Net Solutions Process

1. Practice Analysis
   - Practice Management
   - Data Survey
   - Key Practice Data
   - Site Visit

2. Findings and Discussions
   - Presentation
   - Education
   - Strategy

3. Enhancement Plan
   - Action steps
   - Roadmap
   - Foundation

4. Supported Implementation
   - Coaching
   - Guidance
   - Motivation
SNS Improvement Model

Phase 1: Practice Analysis –
Practice Management Data Survey

✓ Profiles
✓ Demographics
✓ Staffing
✓ Front end [registration] and back end [billing]
✓ Scheduling
✓ No-show policy
✓ Emergency policy
✓ Services provided
SNS Improvement Model

Phase 1: Practice Analysis – Key Practice Data

✓ Profit and Loss
✓ Fee schedule
✓ Aging report
✓ Encounter form
SNS Improvement Model

Phase 1: Practice Analysis – Site Visit to Assess

- Morale
- Physical environment and layout
- Patients and staff
- Operations, systems and workflow
- Administrative leadership
- Clinical services in action
SNS Improvement Model
Phase 2: Findings and Discussion

• All data analyzed with attention to local environment of care
• Findings presented in a collaborative, non-threatening way to senior and dental leadership using an open format discussion
• Priorities identified for strategic planning
• Final deliverable is a customized practice enhancement plan
SNS Improvement Model
Phase 3: Practice Enhancement Plan

- Specific action steps
- Road map for practice success
- Short- and long-term strategies
- Short-term items chosen and designed for early success
- Early positive results fosters staff commitment and buy-in
- Success breeds success
SNS Improvement Model
Phase 4: Supported Implementation

• Assistance during implementation
• Coaching
• Guidance
• Motivation
• Education
• Solutions to specific problems
SNS Improvement Model
Final Phase
Evaluation
SNS Improvement Model
From Start to Finish: The SNS Practice Assessment Process

Choose a Site

Locate Funding (if necessary)

Execute a Contract/MOU

Initiate a Launch Call

Assess practice environment of care: reimbursement environment, Primary Insurers, etc.

Send out PMDS and Key Practice Data To safety net dental program

Gather data

Perform site visit and meeting

Conduct practice analysis

Develop Findings and Discussions Presentation and conduct meeting

Develop Practice Enhancement Plan to SN practice w/ timelines and accountability

Provide oversight and guidance during implementation

Encourage participation in SNS Learning Collaboratives & online resources

Collect evaluation data at 6, 12, & 24 months

Send evaluation data to Safety Net Solutions Central Office for analysis and reporting
Enhancement Plan is Often: *Strategic Planning*

- Strategic Planning identifies where we are, where we want to go and how we are going to get there
- It is a *road map*
- Comprised of *short- and long-term strategies*
- Operational, business and clinical strategies
- Series of action steps
Initiate Strategic Planning to Maximize Clinical Efficiency by:

**Gathering Data**

- In order to plan strategically, you first have to define your practice. *Where is the practice?*
- Pertinent practice data does not lie, and it defines the practice well....on paper
- Data provides the information needed to create a strategic plan
- Information is knowledge and knowledge is power
Practice Management Data Survey

- The Practice Management Data Survey is a compilation of facts and figures related to the dental practice
Practice Management Data Survey

PMDS is used to create a representation of the practice, mostly through numbers, including:

- Treatment rooms
- Funding
- Patient demographics
- Staffing issues
- Documentation of eligibility
- Billing operations
- Reconciling charges against revenue collected
- Scheduling
- Gross charges
- Emergencies
- No-show policy
- Quality
- Sliding fee
- Payer and patient mix
- Transactions
Profile of Center

Number of Operatories: ________________________________

Hours of Operation (dental services only)

Monday: ____________________  Thursday: _________________
Tuesday:____________________  Friday: __________________
Wednesday:__________________  Saturday: __________________

Are the hours of operation for overall CHC different than dental?  Yes
No
If so, how do they differ? ________________________________

1. Are you a federally qualified CHC?    Yes    No

2. If you are an FQHC, are you paid on a Fee For Service basis or an encounter rate for Medicaid?
   Fee For Service    Encounter Rate

3. If you are paid on an Encounter Rate, what is your current rate? ________
8. What percentage of dental claims are paid after the first submission? (please estimate)
   - Less than 10%
   - 11 – 25%
   - 26 – 50 %
   - 51 – 75 %
   - More than 75%

9. What percentage of denied dental claims are paid subsequent to resubmission? (please estimate)
   - Less than 10%
   - 11 – 25%
   - 26 – 50 %
   - 51 – 75 %
   - More than 75%

10. What percentage of rejected claims are written off?
    - Less than 10%
    - 11 – 25%
    - 26 – 50 %
    - 51 – 75 %
    - More than 75%

11. **Why are claims written off?**

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage of written off claims</th>
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</thead>
<tbody>
<tr>
<td>Service not covered</td>
<td>________________ %</td>
</tr>
<tr>
<td>Duplication of service</td>
<td>________________ %</td>
</tr>
<tr>
<td>Patient ineligibility</td>
<td>________________ %</td>
</tr>
<tr>
<td>Claim submitted too late</td>
<td>________________ %</td>
</tr>
<tr>
<td>Prior authorizations not obtained</td>
<td>________________ %</td>
</tr>
<tr>
<td>No process for resubmission</td>
<td>________________ %</td>
</tr>
<tr>
<td>No staff for resubmission</td>
<td>________________ %</td>
</tr>
<tr>
<td>Unfamiliar with resubmission process</td>
<td>________________ %</td>
</tr>
<tr>
<td>Other</td>
<td>________________ %</td>
</tr>
</tbody>
</table>
Key Practice Data

Includes:

- Number of total dental visits
- Number of total scheduled visits
- Number of total unduplicated patients
- Number of new dental patients
- Number of emergency patients
- Profit and Loss (expense and revenue) statement
- Copy of current dental fee schedule
- Copy of sliding fee schedule
- List of dental quality health indicators used to monitor dental health outcomes (i.e. number of Phase 1 completed treatments, number of preventive services provided per patient, number of new patients introduced to the practice, etc.)
- Number of Phase 1 Completed Treatments

- Copy of current dental encounter form
- Sample schedule for dental that shows actual patient appointments for each of your operatories (for a typical week).
- A productivity report by ADA code.
- Number of unique dental patients by payer and age (under 21 and over 21)
- Dental policies for no-shows, emergencies and sliding fee scale
- An aging report that shows the number and dollar amount of unpaid claims extending out 30, 60, and 90 days (broken out by payer mix).
- No-show rate for Dental and Health Center
- Current state Medicaid regulations and fee schedule
What Can That Data Tell Us?

- If expenses are greater then revenue
- The cost per visit (expenses/visits)
- The revenue per visit (revenue/visits)
- If we are accomplishing our mission (completed treatments)
- If we are controlling chaos (% no-Shows, # emergencies)
- What our opportunities are (payer mix) and how well we are using the mix to expand our access
What Are the Best Practices Which all Community Practices Should Include?

1. Staffing patterns to meet need and capacity
2. Efficient scheduling policies
3. Proper handling of emergencies
4. An effective no-show policy
5. Expected treatment protocols
6. A proper and well thought out fee schedule
7. A well-planned sliding fee scale
8. Consistent documentation of eligibility policies
Best Practices (cont.)

9. An efficient and effective billing system
10. Practice and user-friendly encounter form
11. Smooth transfer of billing information
12. Flow chart of billing procedure for all users
13. Defined system for reconciliation of remittances
14. Policy and system to handle denials
15. Policy for managing the prior approval process
Creation of a Business-Educated Department

- Staff should know and understand the environment of care
- Understand and practice to the limits of the state practice act
- Use Dental Informatics equal to those utilized in private practice in the service area
Think and Plan at the Level of the Visit
The Visit is What We Understand

- Clinically
- Financially
- Strategically
- Practically
The Visit

- Build and create strategic plans around the visit
- Eliminate chaos involved with the visit
- Create business plans using the visit as the basic building block
Major Factors That Maximize Clinic Efficiency

- Managing Emergencies
- Managing No-Shows
- Scheduling
- Clinical Protocols
Managing Emergencies

• Define what constitutes a true emergency
• Create an emergency management system that meets the level of need, but preserves regularly scheduled appointments
• Develop and implement an emergency policy, and stick to it
• Provide training for registration and reception staff
Managing No-Shows

• Create and distribute no-show policy
• Enforce the no-show policy consistently

• Track:
  – No-shows
  – Cancellations
  – Fill-ins
  – Scheduled visits vs. actual appointments
Managing No-Shows (cont.)

• Other potential strategies for managing no-shows:
  – Have patients sign the no-show policy
  – Provide reminder messages for upcoming appointments
  – Schedule appointments no further out than 30-45 days
  – Schedule one follow-up appointment at a time
  – 48 hour check-in rule
Scheduling

Some factors that affect scheduling policies:

- Demographics of the patient population
- How far in advance appointments are scheduled
- Appointment lengths
- Number of appointments available
Scheduling Best Practices

• Schedule appointments no further out than 30-45 days

• Schedule appointments one at a time
  – Exception: patients undergoing complex procedures that require multiple visits to complete

• Determine basic appointment length by service provided: 30-45-60 minutes
  – Additional 10-15 minute increments for procedures requiring additional time
Scheduling with EFDAs

- Can be used strategically to expand the capacity of the dental program
- The functions that EFDAs can perform varies from state to state
- There are many ways in which EFDAs can be scheduled to maximize productivity
Scheduling with EFDAs

- Example: “Restorative Days”
- Schedule an afternoon with patients who need routine quadrant fillings
  - Work as a team with as many chairs as possible
  - Dentist gives anesthesia and preps teeth
  - EFDA places restorations while Dentist gives anesthesia or preps another patient
  - Dentist returns to first patient to check the work and adjust occlusion
Preparing to Utilize EFDAs

• Research the State Practice Act
• Strategic Plan
• Train Dentists and EFDAs
• Set Goals and Revisit in 3 Months
• Engage a Consultant if the Concept Feels Foreign
Common Scheduling Practices That Create Chaos

- Double-booking
- Triple-booking
- Over-booking
  - Can create patient and staff dissatisfaction
  - Can disrupt clinic flow
  - Are an Admission of Inefficiency or Lack of Control
Developing Clinical Protocols

- Define what should be done at each visit type
- Protocols directed toward the completion of Phase One treatment
  - 12-month timeline (or earlier, depending on practice goals)
- Develop a tracking system for practices to use to document the completion of Phase 1 Treatments [dummy codes]
Additional Dental Practice Issues that Affect Sustainability

- Staffing
- Sliding Fee Scale
- Documentation of Encounters
- Documentation of Eligibility
Staffing

• Cross-train all support staff (receptionists, registration clerks, schedules, billers, dental assistants) to fill in as needed

• Consider incentive programs to reward the dental team and increase access

• Use dental assistants and hygienists efficiently
Fee Schedule and Sliding Fee Scale

- Determine Usual and Customary Fees for the region before setting the fee schedule
- Compare the current fee schedule with reimbursement provided by each insurer
- Sliding fee discounts based on Federal Poverty Guidelines
- High enough fees to capture all potential revenue from insurers, but low enough to be affordable for uninsured patients
- Establish a nominal fee for patients at or below 100% FPL
Encounters Forms

• Create a user-friendly encounter form that covers the procedures within the scope of service of the practice
• Goal: Easily interpreted by non-dental staff to result in the filing of a clean claim
• Should include ADA code, tooth numbers, surfaces, or quadrants, where applicable.
Documentation of Eligibility

Keys to Effective Documentation

• Verify patient’s eligibility for specific services to be provided at every visit
• Obtain prior authorizations for all services that require them before providing the service
• Develop formal policy for dealing with non-emergent patients without proper documentation of eligibility
Handling of Self-Pays and Co-Pays

• Established policy for self-pay patients
• Co-pays collected at the time of the visit
• Give the right message and the same message to all
• Policies drive expectations
• Lack of policies leads to failure
Effective Billing Practices

• A well-designed encounter form
• A process for the transfer of information from dental to billing and built-in accountability
• Flow charts to give a visual of accountability for the process
• A system for the reconciliation of remittances
• A policy and accountability for handling of denials and resubmissions
• A policy for prior approvals
• Orientation, flow chart and guidebook for billing staff
Patient calls for appointment

Registration clerk asks for insurance information

Registration clerk goes on-line or calls insurer if possible to verify coverage

Eligibility Confirmed

Appointment made; patient told to bring insurance card to visit

Patient shows up for appointment and presents card

Registration clerk verifies coverage again

Eligibility Confirmed

Patient is seen

Eligibility Denied

Patient has option to receive care as self-pay or, if eligible, apply for Medicaid and get appointment when enrolled

If patient elects to receive care on a self-pay basis, they are given an estimate of what the costs will be for their visit when the appointment is made and informed that they will be required to pay at the time of the visit

Eligibility Denied

Patient has option to come as self-pay or, if eligible, apply for Medicaid and get appointment when enrolled

If covered by Medicaid or agree to be self-pay, appointment is made

If patient elects to receive care on a self-pay basis, they are given an estimate of what the costs will be for their visit when the appointment is made and informed that they will be required to pay at the time of the visit
Billing
Process Flow
Chart

Patient calls for appointment; registration documents eligibility and schedules appointment

Patient comes in for appointment; eligibility is checked again; patient is asked to pay any co-pays due at the time of the visit

Encounter form is generated; patient sits in chair; provider sees patient and documents services on encounter form

For Medicaid patients, DA takes encounter form and puts it in holding cart

Encounter form goes to billing, where it is reviewed by dental specialist

Patients with co-payments (self-pay or commercial insurance) take encounter form to registration and check out

Patient meets with patient accounts specialist to review follow-up care needed and estimated costs

If patient agrees to care plan, next appointment is made

Patient accounts specialist takes encounter form

Commercial insurance

Encounter form goes to billing, where it is reviewed by dental specialist

Claim is filed

Claim is paid or denied

Paid

Reconciled against patient account

Denied

Investigated, corrected and rebilled

Claim is paid or denied

Paid

Reconciled against patient account

Still Hope

Submitted for payment again

Self-Pay

Encounter form goes to billing, where it is reviewed and patient invoice is generated for balance due, if any

Patient gets bill and pays or continues to get billed

Account is either paid in full or written off as bad debt

Hopeless

Written off
Create a Business-Educated Department

- Know and discuss the environment of care and what it allows
- Define the scope of service with a system of checks, balances and accountability
- Know the state practice act and wherever possible expand staff duties to take advantage of possibilities
- Orient all new staff formally
Dental Informatics

- Plan well and completely for the integration of the EDR and E-practice management
- If in doubt: Hire a Consultant
- Whenever and wherever possible, entertain the possibilities of digital radiography for the practice
Strategic Planning

• After establishing where you are, now the practice needs to figure out where they are going and how they will get there
  – Define the practice’s mission and explore scope of service
  – Develop an action plan to get the practice to achieve the goals of:
    • The dental practice’s mission
    • The overall health center mission
    • Quality dental health indicators
    • Completion of Phase 1 Treatments

• Develop policies, procedures, and operations that foster the attainment of the dental practice’s goals
• Develop long- and short-term goals and action steps
Evaluation Data Gathered

<table>
<thead>
<tr>
<th>Category</th>
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<tbody>
<tr>
<td>Gross Charges</td>
</tr>
<tr>
<td>Net Revenue</td>
</tr>
<tr>
<td>Expenses (Direct and Indirect)</td>
</tr>
<tr>
<td>Total Number of Visits</td>
</tr>
<tr>
<td>Revenue per visit</td>
</tr>
<tr>
<td>Cost per visit</td>
</tr>
<tr>
<td>Number of Completed Phase 1 Treatments</td>
</tr>
<tr>
<td>Number of Unduplicated Patients</td>
</tr>
<tr>
<td>Number of Transactions</td>
</tr>
<tr>
<td>No-Show Rate</td>
</tr>
<tr>
<td>Emergency Rate</td>
</tr>
<tr>
<td>Number of FTE Dentists</td>
</tr>
<tr>
<td>Number of FTE Hygienists</td>
</tr>
<tr>
<td>Number of FTE Dental Support Staff</td>
</tr>
<tr>
<td>Any Change in Scope of Service?</td>
</tr>
<tr>
<td>Any Change in hours of operation?</td>
</tr>
<tr>
<td>Number of New Patients</td>
</tr>
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# Monthly Progress Reports

<table>
<thead>
<tr>
<th>Opportunity</th>
<th>Enhancement Plan Recommendation</th>
<th>Due Date</th>
<th>On Track for Timely Completion? (If no, please provide revised due date)</th>
<th>Clinic Progress Update</th>
<th>Any Barriers to completion of recommendation?</th>
<th>Assistance Requested?</th>
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<tbody>
<tr>
<td>Emergencies</td>
<td>Implement a new emergency policy</td>
<td>8/15/2009</td>
<td>Yes</td>
<td>E.P. has been created and is being reviewed by our board</td>
<td>No</td>
<td>No</td>
</tr>
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Case Study 1: 2-Chair Southern MA FQHC

<table>
<thead>
<tr>
<th></th>
<th>FY20 06</th>
<th>FY20 07</th>
</tr>
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<tbody>
<tr>
<td><strong>Clinical Productivity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Visits</td>
<td>3,391</td>
<td>5,642</td>
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<tr>
<td><strong>Financial Productivity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net Revenue</td>
<td>$249,761</td>
<td>$598,052</td>
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<tr>
<td>Revenue per Visit</td>
<td>$71</td>
<td>$106</td>
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<tr>
<td>Expenses</td>
<td>$315,363</td>
<td>$490,854</td>
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<td>Cost per Visit</td>
<td>$93</td>
<td>$87</td>
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<tr>
<td>Operating loss/surplus</td>
<td>$74,602 loss</td>
<td>$107,198 gain</td>
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</table>

This clinic added two part-time dentists for evening, Saturday & Sunday hours. The total clinic hours serving patients went from 35 to 52 per week.
## Case Study 2: 7-chair FQHC, Urban MA

<table>
<thead>
<tr>
<th></th>
<th>FY 2004</th>
<th>FY 2005</th>
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<tbody>
<tr>
<td><strong>Clinical Productivity</strong></td>
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<tr>
<td>Total Visits</td>
<td>7,528</td>
<td>9,805</td>
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<tr>
<td><strong>Financial Productivity</strong></td>
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<tr>
<td>Net Revenue</td>
<td>$564,600</td>
<td>$1,568,800</td>
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<tr>
<td>Revenue per Visit</td>
<td>$75</td>
<td>$160</td>
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<td>Expenses</td>
<td>$1,194,000</td>
<td>$1,318,800</td>
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<tr>
<td>Cost per Visit</td>
<td>$159</td>
<td>$135</td>
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<tr>
<td>Operating loss/surplus</td>
<td>$629,400 loss</td>
<td>$250,000 gain</td>
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</table>

This clinic had not revised its fee schedule in over 5 years. It was immediately updated to the current MassHealth dental schedule.
**Case Study 3: Rural Maine**

<table>
<thead>
<tr>
<th></th>
<th>FY2006</th>
<th>FY2007</th>
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<tbody>
<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>Total Visits</td>
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<td>4,464</td>
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<tr>
<td><strong>Financial Productivity</strong></td>
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</tr>
<tr>
<td>Net Revenue</td>
<td>$435,381</td>
<td>$566,928</td>
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<tr>
<td>Revenue per Visit</td>
<td>$103</td>
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<tr>
<td>Total Expenses</td>
<td>$596,007</td>
<td>$535,007</td>
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<tr>
<td>Cost per Visit</td>
<td>$141</td>
<td>$120</td>
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<tr>
<td>Operating loss/surplus</td>
<td>$160,626 loss</td>
<td>$31,248 gain</td>
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</table>

This clinic had two part-time retired dentists so the improvement focus was to maximize visits & services per day per chair. It recently added 1 FTE dentist.
## Case Study 4: 7-Chair FQHC

<table>
<thead>
<tr>
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<th>FY 2006</th>
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<tbody>
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<td>8,406</td>
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<tr>
<td><strong>Financial Productivity</strong></td>
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<td></td>
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<tr>
<td>Net Revenue</td>
<td>$1,233,904</td>
<td>$1,572,009</td>
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<tr>
<td>Revenue per Visit</td>
<td>$139</td>
<td>$187</td>
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<tr>
<td>Expenses</td>
<td>$1,642,091</td>
<td>$1,467,093</td>
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<tr>
<td>Cost per Visit</td>
<td>$185</td>
<td>$175</td>
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<tr>
<td>Operating loss/surplus</td>
<td><strong>$408,187</strong> loss</td>
<td><strong>$104,916</strong> gain</td>
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</tbody>
</table>
Safety Net Solutions
Partnering to Strengthen and Preserve the Oral Health Safety Net

http://www.dentaquestinstitute.org/safetynetsolutions