Why is This Important?

• Every safety net dental program needs to know its maximum capacity and manage to that capacity
• Underachieving and overachieving capacity are both problematic
• Effective dental programs focus on outcomes—clinical, financial and access
• Providers need to have goals to achieve these outcomes, they need to understand how these goals were developed and be held accountable for goal attainment
Defining Program Capacity

• Every dental program has a finite capacity
• Capacity depends on the number and type of staff, number of dental chairs and hours of operation
• While most safety net dental programs have more demand than can be met, that is not always the case
• Many factors can negatively impact a program’s ability to maximize its potential capacity
• Very important to manage capacity strategically
Typical Factors Determining Dentist Capacity

- Level of provider experience
- Number of available operatories
- Number, type and experience of dental assistants
- Scope of services provided
- Age and type of patients
- Effectiveness of scheduling
- Failed appointment rate
- Number of expected visits/hour can vary from 1 to 2
Determine Daily Visit Capacity, Dentists (Example for Dentists)

<table>
<thead>
<tr>
<th></th>
<th># of FTE Providers</th>
<th>X 1.7 Visits/Clinical Hour</th>
<th>X # of Clinical Hours</th>
<th>Potential Visit Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mon.</td>
<td>2</td>
<td>1.7</td>
<td>15</td>
<td>26</td>
</tr>
<tr>
<td>Tues.</td>
<td>3</td>
<td>1.7</td>
<td>22.5</td>
<td>38</td>
</tr>
<tr>
<td>Wed.</td>
<td>4</td>
<td>1.7</td>
<td>30</td>
<td>51</td>
</tr>
<tr>
<td>Thurs.</td>
<td>4</td>
<td>1.7</td>
<td>30</td>
<td>51</td>
</tr>
<tr>
<td>Fri.</td>
<td>2</td>
<td>1.7</td>
<td>15</td>
<td>26</td>
</tr>
</tbody>
</table>
Typical Factors Determining Hygienist Capacity

• Level of provider experience
• Do they take x-rays? Conventional or digital?
• Do they work out of more than one room? Do they have a dedicated assistant?
• Responsiveness of dentists for exams
• Age and type of patients
• Effectiveness of scheduling
• Failed appointment rate
• Number of expected visits/hour can vary from 1 to 2
Determine Daily Visit Capacity, Hygienists (Example for Hygienists)

<table>
<thead>
<tr>
<th></th>
<th># of FTE Providers</th>
<th>X 1.2 Visits/Clinical Hour</th>
<th>X # of Clinical Hours</th>
<th>Potential Visit Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mon.</td>
<td>2</td>
<td>1.2</td>
<td>15</td>
<td>18</td>
</tr>
<tr>
<td>Tues.</td>
<td>2</td>
<td>1.2</td>
<td>15</td>
<td>18</td>
</tr>
<tr>
<td>Wed.</td>
<td>2</td>
<td>1.2</td>
<td>15</td>
<td>18</td>
</tr>
<tr>
<td>Thurs.</td>
<td>2</td>
<td>1.2</td>
<td>15</td>
<td>18</td>
</tr>
<tr>
<td>Fri.</td>
<td>1</td>
<td>1.2</td>
<td>7.5</td>
<td>9</td>
</tr>
</tbody>
</table>
Determine Daily Visit Capacity (Example)

- Monday: 26 dentist visits + 18 hygienist visits = 44 visits
- Tuesday: 38 dentist visits + 18 hygienist visits = 56 visits
- Wednesday: 51 dentist visits + 18 hygienist visits = 69 visits
- Thursday: 51 dentist visits + 18 hygienist visits = 69 visits
- Friday: 26 dentist visits + 9 hygienist visits = 35 visits

Total weekly visit capacity = 273

Total annual visit capacity (273 x 46 weeks) = 12,558

12,558 annual visits ÷ 2.5 = 5,023 unduplicated patients
SNS Dentist Benchmarks

• 1.7 visits/hour for general dentists (at least two operatories and 1.5 dental assistants)
• 1 visit/hour for general dentists (one operatory/one assistant)
• 1 visit/hour for GP residents (beginning of year)
• 1.5 visits/hour for GP residents (mid-year)
• 1.7 visits/hour for GP residents (end of year)
• 1.9 visits/hour for general dentist with 2-3 operatories, 1 EFDA and 1-2 conventional assistant
• 0.5 visit/hour for 4th year dental student (one operatory, one assistant)
SNS Hygienist Benchmarks

• 1.2 visits/hour for hygienist treating mix of adults and children (one operatory, no assistants)
• 1 visit/hour for hygienist treating primarily adults (one operatory, no assistants)
• 1.5 visits/hour for hygienist with two operatories and an assistant (mix of adults and children)
• 2 visits/hour for hygienist treating primarily children (two operatories and an assistant)
Excess Demand

• Sample program has capacity to accommodate 12,558 visits given current staffing and hours of operation
• Represents approximately 5,000 unduplicated patients
• What happens if 10,000 unduplicated patients are trying to get in for dental care?
• What happens if the practice tries to accommodate 10,000 unduplicated patients?
Excess Demand (cont.)

- Too many new patients in the daily schedule
- High rate of “emergencies” as new patients try and game the system to get into the practice
- Long waits between appointments for existing patients with identified dental problems
- High rate of patients lost to follow-up as they get frustrated and discouraged at the amount of time to get their problems resolved
- Short appointment lengths as practice tries to accommodate as many patients as possible
Excess Demand (cont.)

- Inability to complete treatments in a timely manner
- Lots of chaos in the dental department due to high volume of patients—long waits to check in, to be taken into clinical area and in dental chairs as the practice becomes overwhelmed and routinely falls behind
- Patients get fed up and leave without being seen—many unhappy patients who will badmouth the practice and seek care elsewhere
- Staff are exhausted, frustrated and stressed out—poor staff morale and high turnover rates
Managing Excess Demand

• Define maximum capacity and explain capacity determination to executive leadership and Board

• Document and demonstrate negative outcomes of failing to manage demand appropriately

• Understand and accept that the dental program has a finite capacity that cannot currently meet the demand

• Best way to increase ability to meet demand is to manage current capacity effectively to generate needed financial resources to add more providers, more operatories, more dental sites, increase hours of operation, etc.
Managing Excess Demand (cont.)

- Designate priority populations for dental care (e.g., children, pregnant women, people with chronic health conditions such as diabetes, heart disease, HIV/AIDS)
- Create designated appointments in the daily schedule to preserve and protect access for priority populations
- Use scripting to explain why access to the dental program is limited
- Consider limiting access to patients of record of the health center or those who live in the defined service area
Managing Excess Demand (cont.)

• Track completed treatments to determine the number of patients (daily, weekly, monthly) whose dental problems are eliminated—this is the number of new patients that can be brought into the dental program without bogging things down
Unmet Demand

- Empty chairs means lost revenue the dental program needs to meet operating costs
- Staff with too much free time can develop bad work habits
- Dental program can become inefficient without challenges presented by full schedules
- Good staff may leave to find more rewarding jobs elsewhere
- Inability to meet operating costs can lead to reductions in staff, operatories, sites and hours of operations
Managing Unmet Demand

• Determine root causes for lack of demand
  - Low population in need of care
  - Competition from others for your patients
  - Barriers to care (transportation issues, distance, inconvenient operating hours, cost of care, language/cultural issues, etc.)
  - What is the patient experience of care? (Look carefully at facilities, operations, wait times, length of time between appointments, number of appointments needed to complete treatment, staff attitudes, etc.). Are patients choosing to go elsewhere because their experience in your dental program is less than optimal?
Managing Unmet Demand (cont.)

- Remove barriers to care wherever possible
- Improve the patient experience of care to the extent possible
- Mine internal and external sources of referrals to dental (e.g., pediatrics, family practice, OB/GYN, WIC, Head Start, other health and human service agencies serving children and families)
- Invest in culturally and linguistically appropriate outreach workers to infiltrate service area to assist in education, relationship-building, enrollment and case management
Team Activity—15 minutes

- Using the data provided, determine the following for your program:
  1. Weekly number of dentist visits
  2. Weekly number of hygiene visits
  3. Total number of weekly visits (this is your weekly program capacity)
  4. Total annual number of visits for the dental program
  5. Divide annual visits by 2.5—this is your estimated number of unduplicated patient capacity
Defining Provider and Practice Goals

• Access goals
• Financial goals
• Outcomes goal
Access Goals

• Total number of visits
• Total number of unduplicated patients
• Total number of new patients
Financial Goals

- Gross charges
- Net patient-generated revenue
- Bottom line (revenue after expenses)
Outcomes Goals

• Number and percentage of completed treatments
• Number and percentage of children who received sealants
• Total number of sealants applied
• Many others to pick from! (HP2020, National Quality Alliance)
Establishing Goals

- Goals need to be based on desired outcomes for the dental program.
- Goals are for both individual providers and the practice as a whole.
- Goals need to be lofty but also realistic and achievable.
- Goals need to be shared with the team, success in meeting goals regularly evaluated and results shared with individual providers and the entire dental team.
- Incentives can be a powerful motivator to promote goal attainment.
Visit Goals

• Visit goals should be based on realistic assessment of each dental provider’s capabilities

• Also on the resources available to each provider (number of operatories, hours scheduled and support staff)

• Also on the scope of services provided and type of patients being served

• National benchmarks are a good starting point to work from
Benchmarks

• 2500-3200 encounters/year/FTE dentist
• 1500-1800 encounters/year/FTE hygienist
• 1.7 patients/hour or 13.6 patients per 8-hour day per dentist
• 1.2 patients/hour or 8-10 patients per 8-hour day for hygienist
• Gross Charges = >$400K per dentist per year
Financial Goals

• Financial goals should be designed to get the practice to sustainability/profitability (both with and without grant support)
• Indirect costs need to be included for dental programs that are part of a larger organization
• Financial goals are for individual providers and the practice as a whole
• Gross charges and net patient-generated revenue need to be evaluated
Outcomes Goals

• Outcomes goals are designed to demonstrate the success the dental program is having in improving the health of the communities it serves

• Outcomes goals should be set for individual providers as well as the practice as a whole
Setting Goals, Example

• Practice has two experienced full-time general dentists and one full-time hygienist
• 5 operatories
• 3 full-time dental assistants
• Clinic is open 40 hours per week
• Patient mix is 50% children and 50% adults
Maximum Capacity

- ~7,600 visits/year (accounting for some failed appointments and scheduling inefficiencies)
- Average of 33 visits/day; 163 visits/week = practice goals
- Average of 13 visits/day for each of the two dentists; 65 per week for each dentist
- Average of 7 visits/day for hygienist; 36 visits for the week
Financial Success

• Practice incurs $800,000 in direct and indirect expenses for the year
• To break-even (without grant support), practice must generate that much in net patient-generated revenue
• To achieve surplus, practice sets a goal of $900,000 in net patient-generated revenue
• $900,000 ÷ 230 days = $3913 in net patient revenue per day; $19,565 in net patient revenue per week = Practice Goals
• Practice collects 50% of what it charges; therefore, gross production goals need to be $7,826 per day and $39,130 per week
Financial Success (cont.)

• Net revenue goals for individual providers: $1,600 per day per dentist and $700 per day for hygienist (reflects different revenue potentials for dentists vs. hygienists)

• $8,000 per week per dentist and $3,500 per week for hygienist

• Based on 50% collection rate, gross charge goal of $3,200 per day per dentist and $1,400 per day for the hygienist ($16,000 per week for each dentist and $7,000 per week for hygienist)
Outcomes

• Outcomes are a measure of the dental program’s success in improving the health of its patients and the communities it serves.
• Phase I treatment completion focuses on the diagnosis, prevention and elimination of dental disease, non-surgical periodontal care and elimination of hopeless teeth.
• Goal to complete Phase I treatment on 50-75% of patients within 12 months of dental exam and formulation of treatment plan.
Outcomes

• Because sealants have a strong evidence base for value in preventing dental disease in children, they are another important quality outcome measure.

• Phase I completed treatments and sealants can be easily tracked using dummy codes.
Questions, Comments and Discussion
Digging Deeper Session 2
Using Data to Evaluate Your Dental Program

Our mission is to improve the oral health of all.
Digging Deeper with Data!

• We defined our capacity and productivity goals

What Next?

• Look at key practice management data to further evaluate our dental program
• Analyze and learn how to understand the data
• Use the data to measure dental performance and make informed decisions based on the data
• Determine if you are maximizing access, patient outcomes, revenue and meeting the vision for your dental program
Key Concepts

• You need good data to evaluate and measure dental’s performance
• Dental program performance evaluation should be part of a formal continuous quality improvement focus
• Dental program performance should also be regularly shared with staff to create a culture of accountability
• Data should be timely, meaningful and accurate
• Keep it simple!
Key Data

- Number of visits
- Number of unduplicated patients
- Number of new patients
- Gross charges
- Net revenue (including all sources of revenue)
- Payer and patient mix
- Total expenses (direct and indirect)
- No-show rate
- Emergency rate
- Transactions (procedures by ADA code)
- Percentage of completed treatments
- Percentage of children needing sealants who received sealants
- Number of FTE providers (dentists and hygienists)
- Aging report
Key Practice Data and Reports

• **Profit and Loss Statement**
  – Gross Charges
  – Net Revenue
  – Total expenses

• **Transaction or Productivity by Procedure Report**
  – Procedures by ADA code- scope of service
  – # of sealants (D1351)
  – # of completed treatments (Dummy Code)
  – New patients (D0150)
  – ER rate (D0140 or dummy code)

• **Aging Report**
  – Total outstanding money owed to practice by payer type past 90 days
Key Practice Data

• **UDS Report**
  – Visits by FTE provider
  – Total annual visits

• **Additional Reports (vary on PMS)**
  – No-Show rate
  – Emergency rate
  – Unduplicated patients
  – New patients
  – Number of visits
  – Number of FTE Providers
The Profit and Loss Statement

- Financial statement that gives operating results for a specific period, the “Actual” financial results for the year, quarter or month
- Gross charges, revenues, expenses and bottom line
- Analyze the profit and loss statement, compare it with your budget and review what the variances are

WHAT DOES THE DATA REVEAL?

- Revenue per visit
- Cost per visit
- The bottom line
- Difference between gross charges and net revenue—are there any red flags?
Analyzing the Profit and Loss Statement

Are we generating enough revenue to cover the costs to operate dental?

1. Revenue per Visit and Cost per Visit
   • Determine the cost per visit (total expenses ÷ visits)
   • Determine the revenue per visit (total net revenue ÷ visits)
   • If revenue/visit is higher than cost/visit, pat yourself on the back and keep up the good work

2. Bottom Line
   • Total Net Revenue + Grants – Total expenses = Profit or Loss
   • The difference is what the dental practice needs to make up in each visit to reach sustainability

3. Collection Rate
   • Look at your gross charges and compare to net revenue and determine the percentage of net revenue collected (Net Revenue x 100/ Gross charges)
4. Collection Rate by Payer type:
   • Determine collection rate for Medicaid, Self Pay/Sliding Fee and commercial by dividing the net revenue for each payer category and dividing that by the gross charges for each payer category
     – Gross charges Medicaid = $500,000
     – Total Net revenue Medicaid = $300,000
     – Collection rate = $300,000 x 100 / $500,000 = 60%

5. Revenue per visit by payer type
   • Divide the net revenue by number of visits for each payer type (visits are broken out by payer type at the bottom of the P&L
   • *We will refer to this information under the Payer Mix section
What Does the Data Reveal?

- Like most CHC dental programs we may not be generating enough revenue to cover our costs even with grant revenue.

Time to Dig Deeper!
Digging Deeper

- Do we see more patients? (may or may not be possible given number of providers/operatives) Is productivity where it should be?
- Do we need to generate more revenue per visit by providing more services per visit and/or increasing fees?
- Improve billing and collection processes to maximize revenue collected for services provided
- Change the payer mix?
Productivity

See more patients?

• Review current productivity in terms of annual visits and compare it with your capacity visits from previous activity.

Look at number of visits per FTE provider and divide total visits by FTE.

1. Example: Dentists: FTE 1.5 Visits: 3000 \((3000/1.5 = 2,000)\) visits per FTE Dentist for the year and then Hygienists FTE 2.0 Visits: 1000 \((1000/2.0= 500)\) visits per FTE Hygienist for the year.

• Compare with your capacity and determine if you are on track or need to improve productivity.
Common Factors Impacting Productivity

- No-shows and last-minute cancellations
- Scheduling issues
- Appointment lengths are too short
- Practice overrun with emergencies
- Insufficient support staff (dental assistants)
- Lack of goals and accountability
- Individual provider issues (unmotivated, inexperienced, health problems, life issues, etc.)
- Insufficient instruments, supplies
- Equipment issues (outdated, missing, broken)
- Lack of EDR/PMS (or not being used maximally)
# Provider Performance

## Monthly Provider Performance

<table>
<thead>
<tr>
<th>Month</th>
<th>Visits</th>
<th># of Days Worked</th>
<th>Avg. # of Visits per Day</th>
<th># Procedures</th>
<th>Procedures per Visit</th>
<th>Gross Charges</th>
<th>Net Revenue</th>
<th>Revenue Per Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month 1</td>
<td>#DIV/0!</td>
<td></td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td></td>
<td></td>
<td></td>
<td>#DIV/0!</td>
</tr>
<tr>
<td>Month 2</td>
<td>#DIV/0!</td>
<td></td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td></td>
<td></td>
<td></td>
<td>#DIV/0!</td>
</tr>
<tr>
<td>Month 3</td>
<td>#DIV/0!</td>
<td></td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td></td>
<td></td>
<td></td>
<td>#DIV/0!</td>
</tr>
<tr>
<td>Month 4</td>
<td>#DIV/0!</td>
<td></td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td></td>
<td></td>
<td></td>
<td>#DIV/0!</td>
</tr>
<tr>
<td>Month 5</td>
<td>#DIV/0!</td>
<td></td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td></td>
<td></td>
<td></td>
<td>#DIV/0!</td>
</tr>
<tr>
<td>Month 6</td>
<td>#DIV/0!</td>
<td></td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td></td>
<td></td>
<td></td>
<td>#DIV/0!</td>
</tr>
<tr>
<td>Month 7</td>
<td>#DIV/0!</td>
<td></td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td></td>
<td></td>
<td></td>
<td>#DIV/0!</td>
</tr>
<tr>
<td>Month 8</td>
<td>#DIV/0!</td>
<td></td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td></td>
<td></td>
<td></td>
<td>#DIV/0!</td>
</tr>
<tr>
<td>Month 9</td>
<td>#DIV/0!</td>
<td></td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td></td>
<td></td>
<td></td>
<td>#DIV/0!</td>
</tr>
<tr>
<td>Month 10</td>
<td>#DIV/0!</td>
<td></td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td></td>
<td></td>
<td></td>
<td>#DIV/0!</td>
</tr>
<tr>
<td>Month 11</td>
<td>#DIV/0!</td>
<td></td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td></td>
<td></td>
<td></td>
<td>#DIV/0!</td>
</tr>
<tr>
<td>Month 12</td>
<td>#DIV/0!</td>
<td></td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td></td>
<td></td>
<td></td>
<td>#DIV/0!</td>
</tr>
</tbody>
</table>
No-Shows

Are No-shows negatively impacting our productivity?

• Calculate no-shows as percentage of scheduled appointments for which the patient failed to show or cancelled at the last minute

• Don’t subtract open slots caused by no-shows/last minute cancellations that staff were able to fill with walk-ins/emergencies

• Example: 8,000 scheduled appointments, 2,400 no-shows/last minute cancellations (even if the practice managed to fill 1,800 of those open slots with emergencies/walk-ins) = 30% No-Show Rate

• Use dummy codes to track no-shows
<table>
<thead>
<tr>
<th>Month</th>
<th>Actual Visits</th>
<th>No-Shows</th>
<th>Cancellations</th>
<th>Walk-Ins</th>
<th>Scheduled Appointments</th>
<th>No Show Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month 1</td>
<td>1100</td>
<td>200</td>
<td>50</td>
<td>80</td>
<td>1270</td>
<td>20%</td>
</tr>
<tr>
<td>Month 2</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>0</td>
<td>#DIV/0!</td>
</tr>
<tr>
<td>Month 3</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
</tr>
<tr>
<td>Month 4</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
</tr>
<tr>
<td>Month 5</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
</tr>
<tr>
<td>Month 6</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
</tr>
<tr>
<td>Month 7</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
</tr>
<tr>
<td>Month 8</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
</tr>
<tr>
<td>Month 9</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
</tr>
<tr>
<td>Month 10</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
</tr>
<tr>
<td>Month 11</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
</tr>
<tr>
<td>Month 12</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
</tr>
</tbody>
</table>
Emergencies

Is our dental practice overrun with emergencies?

• Calculate emergencies using D0140 and/or D9110 (or create a dummy code to track emergencies)

• Use one of these codes in every emergency visit, even if definitive treatment is provided (eg, extraction) (or use a no-charge dummy code)

• Calculate emergency rate as percentage of overall visits

• Example: 8,000 visits; 1,500 visits were coded as emergencies = 18.8% emergency rate
Scope of Service

Do we provide more services?

Analyze the Transaction Report and determine the average number of procedures being done per visit

• Total the number of procedures by ADA code and divide that by the total number of yearly visits from UDS report (total dental + hygienist visits)
  • Red flag if you are below 2 procedures per visit
  • The target is 2-4 procedures per visit with 2.5 the ideal target

2. Determine the scope of service

• Review a transaction report provided (scope of service has been completed)

• Compare your scope of service with the “Scope of Service benchmark sheet”
Scope of Service Benchmarks

<table>
<thead>
<tr>
<th>Scope of Service</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic</td>
<td>35%</td>
</tr>
<tr>
<td>Preventive</td>
<td>33%</td>
</tr>
<tr>
<td>Restorative</td>
<td>20%</td>
</tr>
<tr>
<td>Specialty</td>
<td>2-6%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>5-10%</td>
</tr>
<tr>
<td>Emergency</td>
<td>2-6%</td>
</tr>
</tbody>
</table>
Improving the Scope of Service

• Develop clinical protocols for each patient type (new patient, recall, child, adult etc.) State in a policy
• Create a scope of service policy defining what services are offered, what services may be referred out and what patients can expect
• Create treatment plans so patients understand what needs to be done, how many visits they can expect to complete their treatment and how much they will be expected to pay
• Develop a scheduling template with defined appointment lengths
• Offer training for providers who need more experience
Scope of Service

Determining the number of procedures:

- Try to do as much as we can in the visit based on:
  - Patient need
  - Patient tolerance
  - Time
  - Providers level of competency

- Take in consideration what we are getting reimbursed and how much it costs us to see a patient; however that should not be the determining factor
## Scope of Service

<table>
<thead>
<tr>
<th></th>
<th>Quarter 1</th>
<th>Quarter 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># of Procedures</td>
<td>%</td>
</tr>
<tr>
<td>Diagnostic</td>
<td>#DIV/0!</td>
<td></td>
</tr>
<tr>
<td>Preventive</td>
<td>#DIV/0!</td>
<td></td>
</tr>
<tr>
<td>Restorative</td>
<td>#DIV/0!</td>
<td></td>
</tr>
<tr>
<td>Endodontics</td>
<td>#DIV/0!</td>
<td></td>
</tr>
<tr>
<td>Periodontics</td>
<td>#DIV/0!</td>
<td></td>
</tr>
<tr>
<td>Prosthodontics</td>
<td>#DIV/0!</td>
<td></td>
</tr>
<tr>
<td>Emergency</td>
<td>#DIV/0!</td>
<td></td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>#DIV/0!</td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>0</td>
<td>#DIV/0!</td>
</tr>
</tbody>
</table>
Billing and Collections

Do we need to improve collections?

• Review the Aging Report (See print out)
  – Accounts receivable past 90 days broken out by payer type
  – Marker for how well the billing and collection process is working
  – Marker whether the dental staff are consistently collecting co-pays at the time of the visit
  – If A/R is high in Medicaid or Commercial, look at entire billing process to determine source or sources of the problem (e.g. eligibility, registration issues, provider issues, submission of claims and management of denials)
## Analyzing the Aging Report

### SAMPLE AGING REPORT

As of 1/31/2014

<table>
<thead>
<tr>
<th></th>
<th>0-30</th>
<th>31-60</th>
<th>61-90</th>
<th>91-120</th>
<th>121-150</th>
<th>151-180</th>
<th>181-up</th>
<th>Bal Amt</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DENTAL PROGRAM</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Totals for BCBS</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$256.00</td>
<td>$256.00</td>
</tr>
<tr>
<td>Totals for Commercial</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$207.50</td>
<td>$207.50</td>
</tr>
<tr>
<td>Totals for Dental Aetna Better Health</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$97.73</td>
<td>$97.73</td>
</tr>
<tr>
<td>Totals for Dental Commercial</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$2,934.70</td>
<td>$2,934.70</td>
</tr>
<tr>
<td>Totals for Dental Medicaid</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$194.70</td>
<td>$5,891.39</td>
</tr>
<tr>
<td>Totals for Medicaid</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$206.00</td>
<td>$206.00</td>
</tr>
<tr>
<td>Totals for Medicare</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>-$25.00</td>
</tr>
<tr>
<td>Totals for Self Pay</td>
<td>-$58.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$49.50</td>
<td>$78,627.06</td>
<td>$78,618.56</td>
</tr>
<tr>
<td><strong>TOTALS FOR DENTAL PROGRAM</strong></td>
<td>-$58.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$244.20</td>
<td>$88,292.73</td>
<td>$88,478.93</td>
</tr>
</tbody>
</table>
Get Paid for What You Do

Typical reasons why dental programs leave money on the table:

• Provide services that are not covered by third party insurers
• Provide services to patients who say they have insurance coverage (but don’t)
• Practice is sloppy about obtaining or documenting all the information needed to submit a clean claim
• Billing process is flawed
• Failure to hold patients accountable for paying their share of charges at the time of the visit
What to Do?

• Know the rules and regulations of your major insurers and follow them consistently
• Patients are self-pay for non-covered services they elect to receive
• Verify patient eligibility in advance of the visit (ideally when the appointment is scheduled) and again on the day of the visit. Twice the work, yes, but worth the time
• Determine why claims are being denied; identify and resolve the root causes
• Practices that know their insurers’ rules and regulations and do the work upfront to submit clean claims can expect to achieve close to 100% collection rates
• Assemble a multidisciplinary Performance Improvement Team to review all aspects of the billing process to identify barriers to successful billing and develop strategies for removing or overcoming these barriers
Manage Your Self-Pay Patients

Self-pay patients need to understand:

• Their recommended treatment plan
• The services they have agreed to receive
• The expected cost of these services
• The amount of the discount they are being given
• Why they need to pay for services at the time of the visit
• Many patients wrongly assume that safety net dental practices are fully subsidized and are supposed to be giving services away for free—we need to educate patients that this is far from the truth!
Manage Your Self-Pay Patients

Evaluate your Fee Schedule and Sliding Fee Scales

• Many safety net dental practices undervalue charges for dental services (typically 40th percentile for UCR)
• They then apply sliding fee discounts to these low charges, which means they are virtually giving services away for free!
• We recommend setting charges at 75-80th percentile of UCR
• Generates more essential revenue but also reflects and communicates true value of services provided by program
• Slide fees from full fees based upon household income and Federal Poverty Guidelines
• FQHCs – set a nominal fee for patients at or below 100% of FPL
Payer Mix

Is our payer mix favorable or negatively impacting financial sustainability?

- Does it cover your total expenses based on your profit and loss statement?
- If not use the extra Payer Mix and Revenue Projection Tool Sheet to try a different payer mix
  - Change the payer mix percentages

- **Is the revenue per visit to low?**
  - Adjust the average revenue per visit by payer type
  - You may not be able to do this with Medicaid if you are reimbursed by an encounter rate
  - You can improve the commercial insurance collection rate and the self pay if it is too low (refer back to improving collections)
Impact of Payer Mix on Sustainability

Now (7,500 visits)
35% Medicaid (avg. revenue/visit = $100)
55% Self-Pay/SFS (avg. revenue/visit = $30)
10% Commercial (avg. revenue/visit = $125)
2,625 visits x $100 = $262,500
4,125 visits x $30 = $123,750
750 visits x $120 = $90,000
Total revenue = $476,250
Total expenses = $500,000
Operating loss = ($23,750)

Better (7,500 visits)
50% Medicaid (avg. revenue/visit = $100)
40% Self-Pay/SFS (avg. revenue/visit = $30)
10% Commercial (avg. revenue/visit = $125)
3,750 visits x 100 = $375,000
3,000 visits x $30 = $90,000
750 visits x $120 = $90,000
Total revenue = $555,000
Total expenses = $500,000
Operating surplus = $55,000
Attaining the Required Payer Mix

• In all likelihood, the practice needs to increase the number of Medicaid-covered patients to help subsidize care to uninsured patients
• Children and pregnant women should be considered priority populations for dental—there are excellent clinical reasons for this AND, as a side benefit, they typically have Medicaid dental coverage
• Develop internal and external referral relationships to drive more children and pregnant women into the dental practice
• Use designated access scheduling to ensure these priority patients have immediate access to care
• School-based oral health programs (especially comprehensive programs) can be another effective way to remove barriers to care for children and generate critical revenue for dental
<table>
<thead>
<tr>
<th>Financial Projections</th>
<th>Projected Visits</th>
<th>7084</th>
<th>* See the worksheet labeled “Calculating Project Visits”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual Visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difference</td>
<td></td>
<td>-7084</td>
<td></td>
</tr>
</tbody>
</table>

**Patient/Insurance mix:**

<table>
<thead>
<tr>
<th></th>
<th>Yearly visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent Medicaid</td>
<td>60%</td>
</tr>
<tr>
<td></td>
<td>4,250</td>
</tr>
<tr>
<td>Percent Self Pay</td>
<td>30%</td>
</tr>
<tr>
<td></td>
<td>2,125</td>
</tr>
<tr>
<td>Percent Commercial Insurance</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td>354</td>
</tr>
<tr>
<td>Percent Other</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td>354</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>7,084</td>
</tr>
</tbody>
</table>

**Reimbursement Rate (per visit):**

<table>
<thead>
<tr>
<th></th>
<th>Yearly Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>$ 531,300.00</td>
</tr>
<tr>
<td>Self Pay</td>
<td>$ 106,260.00</td>
</tr>
<tr>
<td>Commercial Insurance</td>
<td>$ 56,672.00</td>
</tr>
<tr>
<td>Other</td>
<td>$ -</td>
</tr>
<tr>
<td><strong>Total Projected Revenue</strong></td>
<td><strong>$ 694,232.00</strong></td>
</tr>
</tbody>
</table>
## Payer Mix and Collections

### Quarter 1

<table>
<thead>
<tr>
<th></th>
<th># of Visits</th>
<th>%</th>
<th>Gross Charges</th>
<th>Revenue Collected</th>
<th>Collection Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td></td>
<td></td>
<td>#DIV/0!</td>
<td></td>
<td>#DIV/0!</td>
</tr>
<tr>
<td>Self Pay</td>
<td></td>
<td></td>
<td>#DIV/0!</td>
<td></td>
<td>#DIV/0!</td>
</tr>
<tr>
<td>Sliding Fee</td>
<td></td>
<td></td>
<td>#DIV/0!</td>
<td></td>
<td>#DIV/0!</td>
</tr>
<tr>
<td>Commercial Ins.</td>
<td></td>
<td></td>
<td>#DIV/0!</td>
<td></td>
<td>#DIV/0!</td>
</tr>
<tr>
<td>Managed Care</td>
<td></td>
<td></td>
<td>#DIV/0!</td>
<td></td>
<td>#DIV/0!</td>
</tr>
<tr>
<td>Totals</td>
<td>0</td>
<td>$</td>
<td>$</td>
<td>-</td>
<td>#DIV/0!</td>
</tr>
</tbody>
</table>
ACTIVITY:

- You are the Dental Director at Big City Health Center’s dental clinic. The CEO, Mr. Big, has called you in for a meeting because he is deeply concerned with the sustainability of the dental program. Mr. Big provides you with the following data for the dental program:

  - Document 1: Profit and Loss Statement
  - Document 2: Profit and Loss Statement Analysis Activity Sheet
  - Document 3: Aging Report
  - Document 4: Dental Encounters
  - Document 5: Payer Mix

- Mr. Big asks that you review the data and explain why the dental clinic is losing so much money. Complete the activity worksheets provided. Follow the order of the documents as listed above. Each worksheet will have instructions and questions to answer.
ACTIVITY:

• If you complete the activity in less than 15 minutes start to write how you would respond to Mr. Big based on your analysis of the data.
Discussion
Contact Information

Danielle Apostolon

Danielle.Apostolon@Dentaquestinstitute.org

www.dentaquestinstitute.org
Partnering to Strengthen and Preserve the Oral Health Safety Net
What is Scheduling by Design?

Use of the dental schedule to achieve three key strategic objectives:

1. Improved oral health status for patients
2. Maximum access to care for patients
3. Financial viability of the dental program
Key Strategic Objectives

• Completion of Phase 1 Treatments
• Maximum Access for Patients
• Financial Viability—”no margin, no mission”
Completion of Phase 1 Treatments

• Important quality indicator for all safety net dental programs
• HRSA Definition: “Prevention, maintenance and/or elimination of oral pathology that results from dental caries or periodontal disease”—diagnosis and treatment planning, preventive services, emergency treatment, restorative treatment, basic (non-surgical) periodontal therapy, basic oral surgery, non-surgical endodontic therapy and space maintenance and tooth eruption guidance for the transitional dentition
• The daily schedule is an important tool for maximizing the number of patients whose Phase 1 treatment needs are completed
Maximum Patient Access

- Understand (and document) the sociodemographic make-up of your service area
- As a safety net dental provider, your mission should be to provide access to all disadvantaged patients who have difficulty getting care
- But special populations can be designated as priorities (e.g., children, pregnant women)
- The daily schedule is an important tool in maximizing access to care
Financial Viability

- Net revenue needs to be sufficient to meet total direct and indirect expenses
- Net revenue includes patient care revenue plus any ongoing, predictable grants (such as 330 grants for FQHCs)
- The daily schedule is an important tool for ensuring the generation of sufficient revenue to at least cover direct and indirect expenses (and ideally generate a surplus)
Example 1

• 9,000 visits per year

• Federally Qualified Health Center dental program in a state where Medicaid dental benefits for adults were recently eliminated

• Payer mix was 50% Medicaid, 30% Self-Pay, 10% Commercial; now 20% Medicaid, 60% Self-Pay and 10% Commercial

• Historically, average $115 per visit for Medicaid, $50 per visit for self-pay, $100 for commercial, and $80 for other

• 10% of patients have no reimbursement

• Annual 330 grant award of $250,000
## Example 1

<table>
<thead>
<tr>
<th>Description</th>
<th>Payer Mix</th>
<th>Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>9,000 visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid ($115/visit)</td>
<td>20%</td>
<td>$207,000</td>
</tr>
<tr>
<td>Self-Pay ($50/visit)</td>
<td>60%</td>
<td>$270,000</td>
</tr>
<tr>
<td>Commercial ($100/visit)</td>
<td>5%</td>
<td>$45,000</td>
</tr>
<tr>
<td>Other ($80/visit)</td>
<td>5%</td>
<td>$36,000</td>
</tr>
<tr>
<td>Unreimbursed care</td>
<td>10%</td>
<td>$0</td>
</tr>
<tr>
<td>Total Patient Care Revenue</td>
<td></td>
<td>$558,000</td>
</tr>
<tr>
<td>Grants</td>
<td></td>
<td>$250,000</td>
</tr>
<tr>
<td>Total Revenue</td>
<td></td>
<td>$808,000</td>
</tr>
<tr>
<td>Total Expenses</td>
<td></td>
<td>$950,000</td>
</tr>
<tr>
<td>Profit/(Loss)</td>
<td></td>
<td>($142,000)</td>
</tr>
</tbody>
</table>
What to Do?

1. See more patients (may or may not be possible given number of providers/operators)
2. Generate more revenue per visit by providing more services per visit (fee-for-service payers) and/or increasing fees
3. Improve billing and collection processes to maximize revenue collected for services provided
4. Change the payer mix
Attaining the Required Payer Mix

• If after following Steps 1-3, the dental practice still has not achieved financial sustainability, it has justified its need to tweak the payer mix.

• In all likelihood, the practice needs to increase the number of Medicaid-covered patients to help subsidize care to uninsured patients.

• Children and pregnant women should be considered priority populations for dental—there are excellent clinical reasons for this AND, as a side benefit, they typically have Medicaid dental coverage.

• Use designated access scheduling to ensure these priority patients have immediate access to care.
## Example 2

<table>
<thead>
<tr>
<th>Visits</th>
<th>Payer Mix</th>
<th>Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>9,500 visits</td>
<td>Payer Mix</td>
<td>Revenue</td>
</tr>
<tr>
<td>Medicaid ($115/visit)</td>
<td>50%</td>
<td>$546,250</td>
</tr>
<tr>
<td>Self-Pay ($80/visit)</td>
<td>30%</td>
<td>$228,000</td>
</tr>
<tr>
<td>Commercial ($100/visit)</td>
<td>5%</td>
<td>$47,500</td>
</tr>
<tr>
<td>Other ($80/visit)</td>
<td>5%</td>
<td>$38,000</td>
</tr>
<tr>
<td>Unreimbursed care</td>
<td>10%</td>
<td>$0</td>
</tr>
<tr>
<td>Total Patient Care Revenue</td>
<td></td>
<td>$859,750</td>
</tr>
<tr>
<td>Grants</td>
<td></td>
<td>$250,000</td>
</tr>
<tr>
<td>Total Revenue</td>
<td></td>
<td>$1,109,750</td>
</tr>
<tr>
<td>Total Expenses</td>
<td></td>
<td>$950,000</td>
</tr>
<tr>
<td>Profit/(Loss)</td>
<td></td>
<td>$159,750</td>
</tr>
</tbody>
</table>
What Happened?

• By improving efficiency (esp. stronger policies to manage no-shows and emergencies), the practice was able to increase visits slightly
• Through outreach and designated access scheduling, access for children and pregnant women was increased
• By revising the fee schedule and sliding fee scale and improving the management of self-pay patients, the practice was able to collect more of what it was owed from uninsured patients
• These strategies combined took the dental program from the red to the black!
The Art of Strategic Scheduling

1. Step 1 = determine daily revenue goal (gross or net)
2. Step 2 = determine the number of FTE providers available each day
3. Step 3 = determine the maximum capacity of the dental program for each day
4. Step 4 = determine the average number of emergencies per day
5. Step 5 = determine average revenue per payer type
6. Step 6 = use this information to create a schedule template
Step 1: Daily Revenue Goal

• Divide your total direct and indirect expenses by the number of clinic days per year (the number of days per week the clinic is open x 46 weeks)—that is the daily net revenue goal that must be achieved to break even

• For example:
  Total expenses = $950,000
  5 days per week x 46 weeks = 230 clinic days per year
  $950,000 ÷ 230 = daily net revenue goal of $4,131
Step 1: Daily Revenue Goal (cont.)

If you prefer to base your daily revenue goal on gross charges rather than net, you must look back historically to determine the percentage of gross charges that the program collects.

For example:

- In a typical year, the program bills out $1,500,000 in gross charges and collects $950,000 in net revenue.
- This is a 63% collection rate.
- Thus, to net the $4,131 per day in net revenue needed to cover direct and indirect expenses, dental needs to generate $6,557 in gross charges for each day (63% more than net).
- The actual collection rate should be checked regularly to make sure the underlying assumption of 63% is accurate.
Step 2: Provider Schedule

<table>
<thead>
<tr>
<th>Provider</th>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thu</th>
<th>Fri</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. L</td>
<td>8:30</td>
<td>5:00</td>
<td>8:30</td>
<td>1:00</td>
<td>8:30</td>
</tr>
<tr>
<td>Dr. T</td>
<td></td>
<td></td>
<td>8:30</td>
<td>5:00</td>
<td></td>
</tr>
<tr>
<td>Dr. S</td>
<td></td>
<td></td>
<td>8:30</td>
<td>5:00</td>
<td>8:30</td>
</tr>
<tr>
<td>Dr. X</td>
<td></td>
<td></td>
<td>8:30</td>
<td>5:00</td>
<td>8:30</td>
</tr>
<tr>
<td>Dr. Y</td>
<td>8:30</td>
<td>5:00</td>
<td>11:00</td>
<td>8:00</td>
<td>8:30</td>
</tr>
<tr>
<td>Dr. Z</td>
<td></td>
<td></td>
<td>8:30</td>
<td>5:00</td>
<td>8:30</td>
</tr>
<tr>
<td>KD (RDH)</td>
<td>8:30</td>
<td>5:00</td>
<td>11:00</td>
<td>8:00</td>
<td>11:00</td>
</tr>
<tr>
<td>SV (RDH)</td>
<td>8:30</td>
<td>5:00</td>
<td>8:30</td>
<td>5:00</td>
<td>8:30</td>
</tr>
</tbody>
</table>

Monday: 2 FTE dentists, 2 FTE hygienists; Tuesday: 3 FTE dentists, 2 FTE hygienists; Wednesday: 4 FTE dentists; 2 FTE hygienists; Thursday: 4 FTE dentists; 2 FTE hygienists; Friday: 2 FTE dentists; 1 FTE hygienist
Step 3: Determine Daily Visit Capacity, Dentists

<table>
<thead>
<tr>
<th></th>
<th># of FTE Providers</th>
<th>X 1.7 Visits/Clinical Hour</th>
<th>X # of Clinical Hours</th>
<th>Potential Visit Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mon.</td>
<td>2</td>
<td>1.7</td>
<td>15</td>
<td>26</td>
</tr>
<tr>
<td>Tues.</td>
<td>3</td>
<td>1.7</td>
<td>22.5</td>
<td>38</td>
</tr>
<tr>
<td>Wed.</td>
<td>4</td>
<td>1.7</td>
<td>30</td>
<td>51</td>
</tr>
<tr>
<td>Thurs.</td>
<td>4</td>
<td>1.7</td>
<td>30</td>
<td>51</td>
</tr>
<tr>
<td>Fri.</td>
<td>2</td>
<td>1.7</td>
<td>15</td>
<td>26</td>
</tr>
</tbody>
</table>
## Step 3: Determine Daily Visit Capacity, Hygienists

<table>
<thead>
<tr>
<th></th>
<th># of FTE Providers</th>
<th>X 1.2 Visits/Clinical Hour</th>
<th>X # of Clinical Hours</th>
<th>Potential Visit Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mon.</td>
<td>2</td>
<td>1.2</td>
<td>15</td>
<td>18</td>
</tr>
<tr>
<td>Tues.</td>
<td>2</td>
<td>1.2</td>
<td>15</td>
<td>18</td>
</tr>
<tr>
<td>Wed.</td>
<td>2</td>
<td>1.2</td>
<td>15</td>
<td>18</td>
</tr>
<tr>
<td>Thurs.</td>
<td>2</td>
<td>1.2</td>
<td>15</td>
<td>18</td>
</tr>
<tr>
<td>Fri.</td>
<td>1</td>
<td>1.2</td>
<td>7.5</td>
<td>9</td>
</tr>
</tbody>
</table>
Step 3: Determine Daily Visit Capacity

- Monday: 26 dentist visits + 18 hygienist visits = 44 visits
- Tuesday: 38 dentist visits + 18 hygienist visits = 56 visits
- Wednesday: 51 dentist visits + 18 hygienist visits = 69 visits
- Thursday: 51 dentist visits + 18 hygienist visits = 69 visits
- Friday: 26 dentist visits + 9 hygienist visits = 35 visits

Total weekly visit capacity = 273
Step 4: Determine Daily Demand for Emergency Care

- Do a retrospective study of sample days spread throughout a year’s time to determine the average number of emergency patients the practice can expect to see each day and develop a strategy for accommodating that number (many different strategies and no right way or wrong way)
Step 5: Determine Average Revenue per Visit per Payer Type

- Medicaid
- Commercial
- Self-Pay/SFS

This information helps in deciding what the optimum payer mix needs to be
Step 6: Building the Template

- How many visits per day for each provider?
- What is the daily revenue goal (gross or net)?
- How many emergencies can be accommodated? (And where can they be worked in?)
- How many new patients will be put in the schedule?
- How many designated access slots for priority patients?
- What does the optimum payer mix need to be?

These elements are unique to each practice and must be factored into the creation of the schedule template.
Sample Template

- Program with one FTE dentist and two hygienists
- 14 visits/day for dentist, 10 for each hygienist
- Daily revenue goal = $4,131
- 4 emergency blocks (others can be worked in if possible)
- 4 new patients/day (2 each for RDH, one in a.m. and one in p.m.)
- 18 priority slots (children and pregnant women)
- Optimum payer mix (min. 50% Medicaid, max. 30% self-pay, 20% commercial/other)
Sample Template (morning session, one dentist and two hygienists)—Daily Net Revenue Goal of $4,131

<table>
<thead>
<tr>
<th>Time</th>
<th>Operator 1—DDS</th>
<th>Operator 2—DDS</th>
<th>Operator 3—RDH1</th>
<th>Operator 4—RDH2</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00</td>
<td>Emergency ($50)</td>
<td></td>
<td>Adult new ($50)</td>
<td>Adult new ($50)</td>
</tr>
<tr>
<td>8:30</td>
<td></td>
<td>Priority TX ($140)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:00</td>
<td>TX ($140)</td>
<td></td>
<td>Priority Recall ($140)</td>
<td>Priority recall, ($140)</td>
</tr>
<tr>
<td>9:30</td>
<td></td>
<td>Priority TX ($140)</td>
<td></td>
<td>Priority recall ($100)</td>
</tr>
<tr>
<td>10:00</td>
<td>TX ($200)</td>
<td></td>
<td>Priority Recall ($140)</td>
<td>Priority Recall ($140)</td>
</tr>
<tr>
<td>10:30</td>
<td></td>
<td>Emergency ($140)</td>
<td>Priority Recall ($140)</td>
<td>Perio ($100)</td>
</tr>
<tr>
<td>11:00</td>
<td>Priority TX ($140)</td>
<td></td>
<td>Priority Recall ($140)</td>
<td></td>
</tr>
</tbody>
</table>
# Designated Access Scheduling Template (afternoon session)

<table>
<thead>
<tr>
<th>Time</th>
<th>Operatory 1--DDS</th>
<th>Operatory 2--DDS</th>
<th>Operatory 3--RDH1</th>
<th>Operatory 4--RDH2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:00</td>
<td>Emergency ($50)</td>
<td>Denture interim ($0)</td>
<td>Adult new ($50)</td>
<td>Priority new ($140)</td>
</tr>
<tr>
<td>1:30</td>
<td></td>
<td>Priority TX ($140)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2:00</td>
<td>Denture interim ($140)</td>
<td></td>
<td>Priority Recall ($140)</td>
<td>Priority recall ($140)</td>
</tr>
<tr>
<td>2:30</td>
<td></td>
<td>Priority TX ($140)</td>
<td></td>
<td>Adult recall ($100)</td>
</tr>
<tr>
<td>3:00</td>
<td>TX ($140)</td>
<td></td>
<td>Priority Recall ($140)</td>
<td></td>
</tr>
<tr>
<td>3:30</td>
<td></td>
<td>Priority TX ($140)</td>
<td>Adult Recall ($140)</td>
<td>Priority recall ($140)</td>
</tr>
<tr>
<td>4:00</td>
<td>Emergency ($140)</td>
<td></td>
<td>Priority Recall ($140)</td>
<td>Adult recall ($50)</td>
</tr>
</tbody>
</table>
How Did We Do?

- Total direct and indirect expenses = $950,000
- Daily revenue goal to break even (230 clinic days per year) = $4,131
- Dentist’s expected net revenue for the day = $1,840
- Hygienists’ expected net revenue for the day = $2,320
- Total net revenue = $4,160
- They provided maximal access, provided care that moved patients toward optimum oral health and achieved financial sustainability = all strategic goals met!
- What if they had fallen short?
How to Tweak?

If the scheduling template isn’t working, here are some strategies to address:

• Increase the average per visit revenue:
  ✓ Increase charges, increase nominal fee, improve collections, provide more services, if possible, in each visit
  ✓ Change the payer mix slightly (more Medicaid, less self-pay, perhaps)

• Work more of the higher-revenue visits into the template
Biggest Threats to Success

• For this to work, template must be followed faithfully.
• When a specific appointment type is filled for a particular day, scheduler needs to look for the next available appointment (works best if the practice doesn’t schedule out beyond 30-45 days).
• Designated slots only get filled in with other appointment types if unfilled 24 hours prior to day.
• Constant vigilance is required!
Once Defined, Document the Entire Process

- Create a formal scheduling policy
- Include scheduling templates as attachments
- Review the policy with entire staff
- Make sure staff responsible for scheduling know how to use the templates
- Monitor the process closely, provide immediate feedback when staff deviate from the process and tweak the templates as needed to ensure attainment of strategic goals
The Scheduling Policy

- How far out will appointments be scheduled?
- Only one appointment at a time (exception: procedures requiring more than one appointment to complete)
- Define how operatories will be used (how many per provider)
- Define appointment lengths for various procedures (use RVUs and time studies to establish times)
- Indicate where in each appointment type the dentist is needed vs. dental assistant time
- Indicate what types of appointments can be double-booked
The Scheduling Policy (cont.)

• Start and end times for appointments each day
• Who is authorized to schedule appointments
• Providers should always be working to the top of their license (e.g., dentists being dentists, hygienists being hygienists)
• If expanded function dental assistants are available, they should also be working to the top of their ability
Schedule Busters

• Patients who cancel at the last minute
• Patients who don’t show up
• Patients who show up late
• Double- or triple-booked patients who all show up unexpectedly
• Too many emergencies/walk-ins worked into the daily schedule
• Logjams at check-in or out
• Providers run late; practice falls behind
• Patients put in wrong appointment slots (eg, hygiene patient in dentist’s column; single restoration put in crown prep slot; multiple filling appointment put in short-procedure slot)
Address the Issues

• Implement strategies for reducing broken appointments (topic for another webinar!)
• Be strategic with double-booking
• Develop a strategy for managing emergencies/walk-ins
• Logjams at check-in/out
• Flow-chart these processes
  • Root cause analysis—why is this happening?
  • Develop and test strategies to improve patient flow (re-engineer tasks, redesign physical space, address staffing issues, etc.)
Other Operational Issues

• **Providers running late/practice falling behind**
  • Root cause analysis—why is this happening?
  • Develop and test strategies to stay on time (reconfigure operatory assignments, availability of support staff, scheduling tweaks, seating and preparing patients, workflow around x-rays, etc.)

• **Scheduling errors**
  • Root cause analysis—why is this happening?
  • Review scheduling process with current staff
  • Provide additional training if necessary
  • Review frequently to enhance accountability
Activity—15 Minutes

Looking back through your dental program data from Modules 1 and 2, identify the following key elements that need to be considered in creating a scheduling template for a Monday

1. Daily net revenue goal (hint: total direct and indirect expenses from the Profit and Loss Statement ÷ 230 clinic days)

2. Number of dentist visits and hygienist visits for Monday—maximum potential capacity

3. Number of dentists and hygienists working on Monday and the number of operatories available to be utilized (hint, this program has 10 operatories)

4. Dental assistant to dentist ratio (impacts number of potential visits for dentists)—assume each dentist has two assistants

5. Hours of operation

6. Average revenue per payer type (from Danielle’s Payer Mix Worksheet)
Activity—Answers

Looking back through your dental program data from Modules 1 and 2, identify the following key elements that need to be considered in creating a scheduling template for a Monday:

1. Daily net revenue goal (hint: total direct and indirect expenses from the Profit and Loss Statement ÷ 230 clinic days) $7,672
2. Number of dentist visits and hygienist visits for Monday—maximum potential capacity 60
3. Number of dentists and hygienists working on Monday and the number of operatories available to be utilized (hint, this program has 10 operatories) 3 dentists and 2 hygienists
4. Dental assistant to dentist ratio (impacts number of potential visits for dentists)—assume each dentist has two assistants
5. Hours of operation 8:00 a.m. to 5:00 p.m.
6. Average revenue per payer type (from Danielle’s Payer Mix Worksheet) ($135 for Medicaid, $84 for self-pay and $203.53 for Commercial)
Building the Template

- Daily net revenue goal of $7,672
- Six operatories for the three dentists, one each for the two hygienists
- 14 visits for each dentist, 8-10 for each hygienist
- Dentists also responsible for exams on hygiene patients
- At least 30 designated appointment slots for priority patients (e.g., women and children)
- Six slots for emergencies (two per dentist, one in morning and one in afternoon)
- Four slots for new patients (one in morning and one in afternoon for each hygienist)
<table>
<thead>
<tr>
<th>Time</th>
<th>Dr. A</th>
<th>Dr. A</th>
<th>Dr. B</th>
<th>Dr. B</th>
<th>Dr. C</th>
<th>Dr. C</th>
<th>RDH1</th>
<th>RDH2</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00</td>
<td>Emergency ($84)</td>
<td>Emergency (Priority)</td>
<td>Emergency (Priority)</td>
<td>Adult New (Priority)</td>
<td>Adult New (Priority)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8:30</td>
<td></td>
<td>Priority TX (Priority)</td>
<td>TX (Priority)</td>
<td>Priority TX (Priority)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:00</td>
<td>TX (Priority)</td>
<td>TX (Priority)</td>
<td>TX (Priority)</td>
<td>Priority Recall (Priority)</td>
<td>Priority Recall (Priority)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:30</td>
<td>TX (Priority)</td>
<td>TX (Priority)</td>
<td>TX (Priority)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:00</td>
<td></td>
<td>TX (Priority)</td>
<td>TX (Priority)</td>
<td>Recall (Priority)</td>
<td>Recall (Priority)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:30</td>
<td>Priority TX (Priority)</td>
<td>Priority TX (Priority)</td>
<td>Priority TX (Priority)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11:00</td>
<td>TX (Priority)</td>
<td>TX (Priority)</td>
<td>TX (Priority)</td>
<td>Priority Recall (Priority)</td>
<td>Recall (Priority)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11:30</td>
<td>Priority TX (Priority)</td>
<td>Priority TX (Priority)</td>
<td>Priority TX (Priority)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1:30</td>
<td>Emergency (Priority)</td>
<td>Emergency (Priority)</td>
<td>Emergency (Priority)</td>
<td>Recall (Priority)</td>
<td>Recall (Priority)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2:00</td>
<td>Priority TX (Priority)</td>
<td>Priority TX (Priority)</td>
<td>Priority TX (Priority)</td>
<td>Child New (Priority)</td>
<td>Child New (Priority)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2:30</td>
<td>Priority TX (Priority)</td>
<td>Priority TX (Priority)</td>
<td>Priority TX (Priority)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3:00</td>
<td>Short visit side book (Priority)</td>
<td>TX (Priority)</td>
<td>TX (Priority)</td>
<td>Child recall (Priority)</td>
<td>Child recall (Priority)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3:30</td>
<td></td>
<td></td>
<td></td>
<td>Child recall (Priority)</td>
<td>Child recall (Priority)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4:00</td>
<td>Priority TX (Priority)</td>
<td>Priority TX (Priority)</td>
<td>Priority TX (Priority)</td>
<td>Child recall (Priority)</td>
<td>Child recall (Priority)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4:30</td>
<td>TX (Priority)</td>
<td>TX (Priority)</td>
<td>TX (Priority)</td>
<td>Child recall (Priority)</td>
<td>Child recall (Priority)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5:00</td>
<td></td>
<td></td>
<td></td>
<td>Child recall (Priority)</td>
<td>Child recall (Priority)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Results

• Daily net revenue goal of $8,154
• 14 visits for each dentist, 8-10 for each hygienist
• At least 30 designated appointment slots for priority patients
• Six emergencies
• Four new patients