California HealthCare Foundation

The Good Practice: Treating Underserved Dental Patients While Staying Afloat

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by
Mary Kate Scott, M.B.A.
Dori Bingham, B.A.
Mark Doherty, D.D.S., M.P.H.

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About the Authors

Mary Kate Scott is the principal at Scott & Company, Inc., a consulting firm that specializes in health care strategy. Dori Bingham is associate director and Mark Doherty is the project director of Safety Net Solutions, a program of the Catalyst Institute.

About the Foundation

The **California HealthCare Foundation** is an independent philanthropy committed to improving the way health care is delivered and financed in California. By promoting innovations in care and broader access to information, our goal is to ensure that all Californians can get the care they need, when they need it, at a price they can afford. For more information on CHCF, visit us online at www.chcf.org.

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Overview

MANY COMMUNITY DENTAL PRACTICES IN CALIFORNIA and elsewhere face a big challenge: how to provide services to patients—especially Medicaid beneficiaries and the uninsured—while maintaining or improving the bottom line. At first glance, given low reimbursements from public payers, the challenge might seem insurmountable.

However, as this guide explains, providers can increase patient capacity and generate higher revenue if they follow best practices in designing, redesigning, and streamlining operations to boost efficiency and productivity. The primary beneficiaries of such efforts are patients, who gain better access to the services they need for optimum oral health—a key issue for children and other underserved populations.

The objective of this guide is to help community dental practices—federally qualified health centers, public health clinics, private practices, and others—design or enhance clinical and business operations in ways that will improve the efficiency and effectiveness of the services they deliver. Specifically, the guide explains how to:

- Create a strategic plan;
- Produce a smooth patient flow;
- Design an optimal staffing pattern;
- Create efficient and effective business systems; and
- Consider efforts, such as outreach and prevention programs aimed at children, that could help expand the patient base.

The hope is that by adopting best practices, providers will increase access to dental services—especially for children and other underserved populations—and also become more financially viable.

I. Background

Community dental practices whose patient mix includes the underserved often have limited resources and restricted capacity. California's example is a case in point: While Denti-Cal, California's Medicaid dental program, covers the cost of services for more than 8.5 million impoverished, elderly, and disabled people, the ability to actually obtain those services remains a major problem, particularly for pregnant women and children.[1]

Dental practices can improve access for this population by strategically altering the way they design and deliver services. Reconfiguring a practice to accomplish this important goal while simultaneously maintaining or improving financial sustainability involves a variety of processes—from creating a strategic plan and smoothing the patient flow to optimizing the staffing pattern and implementing effective and efficient business systems.

Dental practices that accept Denti-Cal patients receive much less fee-for-service reimbursement than dentists who do not, and far less than the national average for dentists generally. Fewer than half of private practice dentists in California accept Denti-Cal, and of these, most offer only general dentistry services. Indeed, the low reimbursement rate is the primary hurdle in obtaining dental services for the underserved.

California has some of the lowest Medicaid dental reimbursement rates in the country. While the size of its Medicaid population is comparable to that of other states, those with higher reimbursement rates have better access and utilization of services. Because of low reimbursement, many practices in California cannot afford or choose not to accept Denti-Cal patients, with the result that many of these patients do not receive care.

Reimbursement for federally qualified health centers is apportioned by the visit rather than by the procedure. This creates challenges—but also opportunities—for dental practices as they try to balance costs, reimbursement, and revenue. The approaches described in this guide for improving dental practice efficiency and access apply to all practices, regardless of whether they accept Medicaid patients. While low reimbursement is not a primary focus, it is an important issue that needs to be addressed. Evidence

clearly shows that increasing dental reimbursement rates in California would reduce access barriers for the Medicaid population.[2]

The recommendations that follow are based on interviews with more than two dozen national dental experts (Appendix A). In addition, the authors visited a number of high-volume, high-efficiency, and high-productivity practices, both private and nonprofit, multiple times to learn about successful revamping strategies and tactics, and conducted two online surveys. More than 300 private and clinic-based dentists, patient advocates, and others responded to these surveys.

II. Creating a Strategic Plan

EVERY DENTAL PRACTICE NEEDS A STRATEGIC PLAN, which defines where the practice stands, where it will go, and how it will get there. It consists of short- and long-term strategies that provide a clear blueprint for determining which patients to serve and which business and care models to use.

Defining the Scope of Services

In creating a strategic plan, a practice must first define its scope of services, taking into account its staffing, types of patients (public versus private), and payer sources and classes, including age or coverage limitations. Then it can estimate the revenue it expects to receive for each covered service.

A scope of service that focuses on reimbursable procedures maximizes the practice's financial sustainability. Revenue generated by reimbursable services must offset free care. Ultimately, a financially viable dental practice can serve more uninsured patients.

Getting Reliable Data

Reliable data are the cornerstone of strategic planning (see box below and checklist on page 8). Robust, accessible data enable

Taking a Snapshot of Current Operations

The first thing a practice should do in assessing current operations is calculate the cost and revenue per visit for the reporting period. It can divide net revenue by the number of visits to get the revenue/visit ratio, and divide the total direct and indirect expenses by the number of visits to get the cost/visit ratio.

In financially sustainable practices, the revenue/visit ratio is greater than the cost/visit ratio. If the cost/visit ratio is greater, it is important to determine why. The practice can consult the transaction report, which lists the quantity of services provided during the reporting period (broken out by ADA code). Are providers:

- Performing unreimbursed procedures?
- Performing procedures without getting prior authorization?
- Failing to provide all of the services spelled out in the practice's clinical protocols?

Taking a Snapshot of Current Operations, continued

Examining what is happening at the patient-visit level usually pinpoints problems that undermine financial sustainability.

The next step is to look at the no-show rate, as empty chairs mean lost productivity and revenue. Is there the right balance of patients to maintain financial sustainability? If a practice manages appointment types and payer mix, it will ensure that sufficient revenue comes in to at least cover the cost of providing services.

a practice to monitor its progress toward meeting departmental goals. Key data relate to operational, business, and systems efficiencies.

It is important to (1) obtain, analyze, and report these data and compare them to practice goals monthly, quarterly, and annually, and (2) to share the findings with the dental staff regularly. First-rate strategic planning requires knowing the cost and revenue of each patient visit and whether the practice generates more revenue than it spends.

Understanding the Payer Mix

A practice must understand its payer mix and, more importantly, the ideal payer mix necessary to ensure financial sustainability and provide maximum patient access, including to the uninsured.

It is important to know the reimbursement structure for each payer (Denti-Cal, the State Children's Health Insurance Program, other public programs, and commercial insurers), the percentage of revenue from each, and how payer mix affects the financial sustainability of the practice. In addition, administrators and dental practice leaders must know how to adjust the payer mix to ensure sustainability through designated access scheduling (discussed in greater detail below).

Data Checklist (in order of importance)

1. Number of visits
   (Benchmark: 1,000–1,200 visits per operatory per year.)
2. Profit and loss statement:
   - Gross charges
   - Net revenue
   - Direct/indirect expenses
   - Cost per visit
   - Revenue per visit
   - Difference between cost per visit and revenue per visit
3. Transactions—i.e., services based on the American Dental Association (ADA) code
   (Benchmark: 3–9 procedures per patient per visit, depending on age.)
4. Number and percentage of no-shows
   (Benchmark: less than 15 percent.)
5. Number of emergency visits and percentage of all visits that are emergencies
6. Number of unduplicated patients
   (Benchmark: 300–600 patients per operatory per year.)
7. Number of new patients
8. Payer mix
   (Revenue by payer source and percentage of total practice revenue each payer represents)
9. For each provider:
   - Number of visits
   - Net revenue per visit
   - Gross charges per visit
     (or total claims submitted)
   - Number of services per visit
     (procedures based on ADA code)

CASE STUDY: **Standardizing Protocols**

A practice had four full-time equivalent dentists and two FTE hygienists. All six provided services to new pediatric Medicaid patients.

Care was not standardized. Some children received an exam and x-rays, some got x-rays only, and some got prophylaxis and a fluoride application. The practice established a protocol calling for all of these children to receive x-rays according to guidelines from the American Academy of Pediatric Dentistry and the ADA, an exam and treatment plan, and prophylaxis and a fluoride application.

Thanks to this standardization, remuneration for patient visits became predictable and there was less need for follow-up appointments because most of the diagnostic and preventive care was done in one visit.

Understanding Payers' Rules and Regulations

Staff members also must understand the rules and regulations of the reimbursement environment in which they operate. This is especially true regarding Medicaid because it is often the largest payer for community dental practices.

What services are covered and for whom? For example, is reimbursement available only for patients under 21 years old or all patients? What services require prior authorization? What other limitations exist? Providers and the dental billing staff must communicate and work well together to ensure maximum efficiency and minimal denials. Documentation has to be complete and accurate.

It is imperative that all new providers and staff members receive formal training regarding the rules and regulations of a practice's major payers, and that they receive updates as rules and regulations change. To ensure that such rules are adhered to, administrators and dental practice leaders must monitor claims data (write-offs and denials). Incorporating protocols regarding the length of appointments, quality assurance, and what a specific payer's regulations allow ensures good planning and predictable productivity.

Developing Business Savvy

For long-term sustainability and growth, a community dental practice must balance its mission (providing services to those in greatest need) with good business practices that maximize revenue opportunities. Providing subsidized care to uninsured patients requires taking advantage of every revenue opportunity—typically, Medicaid plus a small percentage of commercial insurance.

This means determining how much unreimbursed care the practice can subsidize and both remain financially solvent and meet all regulatory requirements. Optimizing the business component enables the practice to expand the mission and thereby improve patient access by adding operatories, providers, hours of operation, and care sites.

CASE STUDY: **Educating Staff**

An exceptional dentist who had recently joined a community dental practice did not follow proper procedures for obtaining prior authorizations, which were not required in the post-doctoral program he had just completed.

As a result, Medicaid denied claims the practice submitted; in effect, the practice was providing these services for free. The dental director met with this dentist at the end of his first month on the job and explained how much it cost to see a patient and how much revenue the dentist had generated per visit. Clearly, due to the multiple claim denials, the discrepancy was unsustainable.

Once the dentist began adhering to procedures for prior authorization, the large revenue losses turned into significant gains. He never would have known how his former behavior negatively affected the practice if the director had not monitored costs and revenues, and discussed this information with each provider every month.

The Profit and Loss Statement

The basic building block of the strategic plan is the profit-and-loss statement. With appropriate profit and loss information, a practice can determine costs versus revenue per patient visit. This information reveals if the practice is financially sustainable.

If it is not financially sustainable, analyses will show how much the practice loses per patient visit, a gauge of how much it must earn to break even.

Educating Staff and Achieving Buy-in

It is important that providers understand the steps necessary to deliver quality service, complete treatment plans, maximize revenue, and balance the practice's mission with its financial sustainability. Departmental meetings are an opportunity to educate the staff about the challenges, opportunities, strategies, and goals the practice must pursue to ensure its longevity and improve patient access.

CASE STUDY: **Achieving Buy-in**

A dental practice in a federally qualified health center lost its dental director. The practice manager, who was superb in managing day-to-day operations, did not have any financial oversight training.

Because no one was monitoring the clinic's financial performance, staff had no idea if the clinic was operating in the black. There were lots of patients, but, in fact, the clinic was losing more than $50,000 a month.

The practice brought in a consultant to assess it and develop a turnaround plan that would put the practice back on its financial feet. The consultant gathered operations data, then met with the entire dental staff to share the data and discuss strategies to reduce the huge monthly deficit.

Once staff understood the situation, they willingly supported the turnaround plan. Subsequently, the consultant, who served as interim dental director, met regularly with the entire dental staff to present departmental progress reports, including financial and productivity data.

Obtaining the buy-in and commitment of all staff members helps a practice meet the goals in its strategic plan. Everyone must know why the cost/revenue equation is important and have the data that objectively reveal whether revenues are sufficient to cover costs.

Administrators and practice leaders are responsible for obtaining the staff's commitment to a shared vision and goals, for motivating and guiding them to work toward those goals, for recognizing and rewarding successes, and ultimately for holding each staff member accountable for his or her role in the department's success.

Orienting New Staff to the Business Goals

All new staff members at a community dental practice must be oriented to the practice's business goals because this optimizes efficiency and effectiveness. Orientation familiarizes dentists and others with the scope of services, quality and productivity expectations, and financial goals—and with the crucial role these play in the practice's overall sustainability.

Motivating and Leading the Dental Staff

Collaboration and consultation with the staff has replaced the paternal "my way or the highway" approach to leadership. Dental practice leaders facilitate growth in the number of visits and patients, as well as revenues, by educating, motivating, and communicating openly with staff members and encouraging them to participate in establishing departmental goals.

Sharing data with the staff facilitates understanding of leadership expectations; a clear organizational structure establishes an accountability chain that everyone understands and accepts. Encouraging staff members and resolving conflicts helps secure workplace trust. Once the practice leaders gain commitment and accountability from their staff, they can lead by example according to the strategic plan.

CASE STUDY: **The Practice Enhancement Plan**

A seven-chair dental clinic in a federally qualified health center was incurring significant operating losses when an independent consultant assessed it. The losses prompted the health center's board of trustees to consider closing the practice.

The consultant identified numerous problems, including:

- A lack of dental staff accountability
- An outdated fee schedule
- Low productivity
- No emergency or no-show policy
- No specific practice goals
- No strategic plan to improve operations

The practice developed an enhancement plan, which included:

- Reviewing the dental program's strategic plan
- Revising the fee schedule
- Instituting clinical protocols to standardize patient care and maximize provider productivity
- Creating policies to address emergencies and no-shows
- Setting financial and productivity goals, such as the number of visits per day, productivity per visit, and revenue per visit
- Holding weekly meetings to educate and motivate the dental staff, foster accountability, and achieve buy-in for the turnaround plan

	BEFORE THE PLAN	AFTER THE PLAN	IMPROVEMENT
Annual visits	7,528	9,805	30%
Operating loss/surplus	–$628K	+$250K	+$878K
Revenue per visit	$97	$160	68%

III. Producing a Smooth Patient Flow

THE ULTIMATE GOAL OF A COMMUNITY DENTAL PRACTICE is to develop an operational plan that will create a "family practice" with the look and feel of a private dental practice.

Ideally, the practice atmosphere is calm, controlled, and efficient and has an orderly and predictable daily schedule. Patients understand how the practice operates, willingly abide by its governing principles, arrive promptly for scheduled appointments, and providers see them on time. Patients and the staff respect each other. Staff members provide high-quality dentistry that supports the completion of treatment plans for a maximum number of patients. The practice manages emergencies carefully, enabling expedient treatment with minimal disruption of the clinic's care for scheduled patients.

All of this stems from "principles of practice" that specify how to manage scheduling, no-shows, and emergencies.

CASE STUDY: **Specialty Services in a Medicaid Environment**

A New England community dental practice receiving limited Medicaid reimbursement for periodontal services hired a periodontist to provide general dentistry. However, he provided periodontal services exclusively.

The medical director met with the periodontist and explained that, if this continued, the practice could not continue to employ him. He could stay, the director said, if he created a periodontal treatment protocol within the scope of Medicaid services supplemented by general dentistry reimbursement. Together, the periodontist and director created such a protocol.

Although limited by the constraints of Medicaid reimbursement, this protocol enabled the practice to provide excellent service to patients. Indeed, community dental practices throughout Massachusetts use it as a model for periodontal treatment.

Scheduling

Proper scheduling is one of the most important controls in a dental practice. Numerous factors—such as the patient population (age, education, public versus private pay, uninsured) and practice size—drive scheduling policies. It is important to identify and

discuss these factors, and decide how to manage them. The overriding best practice is to create a formal policy that defines the elements of the scheduling system—such as how far in advance to schedule appointments and whether to provide one or more treatments per visit—and specifies the proper way to handle each one.

Scheduling-related best practices that can improve a practice's efficiency, effectiveness, and financial sustainability include:

- **Schedule appointments no more than 30 days out.** Many community dental practices have long waiting lists and struggle to accommodate patients who need follow-up care to complete their treatment plan. Scheduling appointments no more than 30 days in advance eliminates long waiting lists and limited appointment availability.

  When appointments are scheduled more than a month ahead, the number of no-shows increases, which eliminates opportunities to schedule other patients. Staff time is also lost to rescheduling and sending out reminders. Because many people have difficulty remembering appointments that are more than 30 days away, shortening the span between appointment scheduling and date of treatment reduces the number of cancellations and forgotten appointments. In addition, the shorter scheduling window creates an incentive for patients to take advantage of the limited time available, rewards them for demonstrating initiative and responsibility, and reduces disruptions caused by no-shows.

- **Assign standard appointment lengths for procedures.** The standard appointment length in a community dental practice is 30 minutes, with additional 10- to 15-minute increments allotted for complex procedures such as root canals, dentures, posts and cores, and crowns or bridges.

- **Eliminate double-booking and avoid overbooking.** A proper scheduling system minimizes no-shows and accommodates emergencies. It excludes double- and triple-booking, which signals that the practice is not in control.

  Many community dental practices overbook patients in anticipation of no-shows. But this does not address the true problem. Clinic flow, customer service, and public relations problems arise when double- and triple-booked patients arrive simultaneously. Moreover, multiple arrivals cause chaos in the dental department, put tremendous stress on the staff, undermine morale and retention, and demonstrate a lack of respect for patients. A sure way to lose faithful, prompt patients is to force them to wait or sit longer than necessary in a dental chair due to overbooking.

  Patients should be required to show up on time. If a practice develops a strong no-show policy, educates patients about it, and enforces the policy consistently, patients will understand they are accountable. The goal is to establish a core of prompt, reliable patients who appreciate the value of dental appointments and who call at least 24 hours in advance if they must reschedule.

- **Schedule individual appointments.** In community dental practices, it is best to make one appointment at a time. At the first and each subsequent visit, patients can make an appointment for the next visit until the treatment plan is completed. This fosters patient responsibility and accountability. It also creates a sense of appointment value and makes the practice less vulnerable to the disruptions and losses caused by no-shows.

  The only exception to this policy is patients who will need a series of visits for purposes such as dentures, crowns, or endodontics. However, these patients must understand that if they miss an appointment, the practice will cancel all scheduled appointments in the series and that they will have to meet with the practice manager or dental director to arrange individual visits in the future. At the time of multiple bookings, it is

best if patients sign a document indicating they understand and agree to abide by the policy.

- **Inform patients about policies regarding appointments, no-shows, and emergencies.** Patients must be held accountable for abiding by the principles of practice that create an efficient, effective, and pleasant environment for both them and the staff. But before a practice imposes such accountability, it needs to tell patients which behaviors apply and what the consequences will be if they do not meet their responsibilities.

- **Schedule protected days and times.** This involves setting aside protected blocks of unscheduled time—typically the last afternoon of each work week—for care that "cannot wait."

  Scheduling appointments during these periods requires a supervisor's approval. An appointment is warranted when, for example, a first exam reveals a problem or emergency that warrants immediate follow-up; lab work must be redone; the patient's dental insurance is due to expire at the end of the week; or the patient has special needs.

  If a protected block is not completely booked 24 hours in advance, a staff member can begin scheduling routine appointments for the available times.

- **Use scheduling software and technology.** Electronic dental practice management systems that include template modules for scheduling can help a practice become more efficient and effective.

- **Designate and train staff to handle scheduling.** Giving scheduling authority only to staff members who have been designated and appropriately trained ensures uniform scheduling and limits tampering by others. Ideally, the scheduler will be a person who understands how the dental practice operates, not someone on the health center staff who is also responsible for scheduling medical, vision, and other appointments.

- **Create a schedule that accommodates different payer groups.** Designated access scheduling, or "scheduling by design," enables a practice to manage patient and payer mix for maximum access and financial sustainability. A percentage of each day's available appointments is "protected" for particular classes of payers (public or private) and free care.

  An example would be a practice whose strategic planning revealed that, to remain financially sustainable, 60 percent of the patients it sees daily must be covered by Medicaid and 10 percent must be commercially insured. This means the practice can designate 30 percent of its time each day for treating uninsured patients—care it subsidizes with revenue from Medicaid and commercially insured populations. If an uninsured patient seeks care on a day when the time available for treating the uninsured is already committed, the staff can schedule the patient for the next available appointment during a period designated for that purpose. If the practice does not book appointments more than 30 days in advance, the longest an uninsured patient would have to wait for an appointment is 31 days, because new slots open up each day in the 30-day schedule.

  The key point is that the practice never turns away patients because of their insurance status or inability to pay. The longest any patient has to wait for the next available appointment for non-urgent care is 31 days. All patients needing urgent or emergency care receive it as quickly as possible according to the practice's emergency policy.

Managing Missed Appointments

Patients who do not show up, are more than 15 minutes late for an appointment, or fail to cancel an appointment 24 hours (preferably 48 hours) in advance can have the greatest negative impact on

a community dental practice. Below are steps that successful practices take to minimize these problems.

- **Establish and distribute a no-show policy.** This is the first step. The practice requires new and existing patients to physically sign an acknowledgment of the policy and adds it to the dental chart. Or, if the records are electronic, patients check off an acknowledgment while registering. Copies of the policy conspicuously posted in the waiting room and at the registration desk are further evidence of the practice's commitment in this regard.

  No-show policies vary, but the basic tenet is that patients can miss one, two, or three appointments in a set period—for example, two appointments within six months or three within a year. After the first missed appointment, patients receive a verbal or written warning about the consequences of a second. When patients reach the threshold of missed appointments, they receive a written notice informing them that they are no longer patients of record and can no longer make appointments, but that the practice will see them if there is a genuine dental emergency as defined in its emergency policy.

- **Enforce the no-show policy universally and consistently.** Successful practices do this regardless of how angrily or to whom any patient complains. For the policy to be effective, everyone affiliated with the practice, including board members and senior administrators, must agree to and support it.

  When the policy is consistently enforced, patients quickly realize that missed appointments are not tolerated. A standard script that the staff or anyone else associated with the practice can recite in response to patients is: "I'm very sorry, but we have found that it is in the best interest of our staff members and patients to adopt this policy regarding patients who fail to keep appointments. Patient appointments in the dental practice are limited, and we must use them for patients who are able to show up for their scheduled appointments."

- **Establish a benchmark no-show rate.** A reliable electronic or manual system for documenting no-shows enables a practice to track the no-show rate. Ideal rates are between 13 percent and 15 percent, which any practice can achieve if it develops, communicates, and consistently enforces a strong no-show policy.

- **Consider other strategies.**

  1. Contracts educate patients, secure their commitment, and make them accountable. This in turn often makes them more responsible and reliable about keeping appointments. A practice also connects with patients by letting them know that the staff cares about and respects them.

  2. Phone calls, e-mail, or text messages to remind patients of appointments can help, but they are time-consuming for the staff and have little influence on no-show rates. People who patronize a community dental practice may not have a phone or computer, or they might move often, making it difficult to maintain up-to-date contact information. Moreover, such contacts can make patients lazy and provide them with an excuse for missing an appointment ("I didn't get the call/e-mail/text message"). Overall, practices that hold patients accountable for remembering appointments are more efficient and have lower no-show rates.

  3. Flagging the charts of patients who breach the no-show policy, issuing written warnings, and verbally reinforcing the importance of showing up for appointments keeps the policy in the forefront and reminds patients that missed appointments are not tolerated.

  4. A practice must explain the no-show policy to new employees during orientation so enforcement is universal, consistent, and strong.

Managing Emergency Patients

A well-designed and clearly written emergency policy is imperative, especially because community dental practices are never large enough to be a true dental home and provide complete treatment plans for everyone in their catchment areas. Without a policy, emergency treatment would overrun most practices and quickly turn them into chaotic, Band-Aid providers that rarely complete treatment plans, seldom return patients to optimal oral health, and leave dentists feeling frustrated and dissatisfied.

The following steps will help practices develop an effective emergency policy.

- **Define "emergency patient."** First, what does the practice consider to be dental emergencies? These cases may involve pain, swelling, fever, hemorrhage, or dental trauma. The next step is to create an emergency management system that is consistent with the practice's history and preserves scheduled appointments for continuing care. Such a system means the practice recognizes the importance of providing quality dentistry in a limited amount of time.
- **Assess the magnitude of the challenge.** By reviewing records for the previous 90 days, a practice can determine how many emergencies it manages. Knowing the size of the challenge—the number of patients per day, the average amount of time it takes to treat them, and the types of emergencies—enables appropriate solutions. Solutions based on guessing the amount of time needed for emergency treatment may be inefficient.
- **Specify how emergencies will be accommodated.** Practices must make room in their schedules for bona fide emergencies and then manage them efficiently and effectively within their scope of service. This is an important part of the mission and a tremendous source of community goodwill. Dedicating providers, chairs, and times of the day to emergency care are among the ways to blend such care into the schedule. All of these strategies work if they are a good fit for the practice, staff, and patients. Predictability and control are essential.
- **Do not schedule follow-ups during emergency visits.** Emergency patients are less likely than other patients to return for follow-up care, particularly if, after their pain, infection, or other immediate problem has been resolved, they believe that follow-up is not important. Unlike regular patients, episodic patients are not a good fit for community dental practice that endeavors to serve the comprehensive needs of a stable and committed patient base.

Tips for Improving Dental Emergency Management

- Practices that do not have providers or chairs dedicated to emergencies can organize daily staff meetings (five to ten minutes long) to review the schedule and decide how to accommodate emergency patients that day without disrupting other patients. This requires a willingness on the part of all practice members to share the emergency burden equally.
- Triage training for reception and registration staff gives them the skills they need to determine which callers and walk-in patients are true emergencies. When staff have a robust list of questions—such as "How long have you had this pain?" "Do you have a temperature?" "Is your face swollen or hot when you touch it?"—they feel more confident about their decisions.

  Patients who the front desk determines are emergencies must be willing to come in for treatment at a time determined by the practice, not necessarily at a convenient time for them. The goal during emergency visits is to alleviate pain, treat infection, and diagnose the underlying problem.
- Only palliative treatment should be provided in emergency cases, unless the day's schedule allows for more permanent treatment. Whenever possible, it is important to honor the appointed times of regularly scheduled patients.

Emergency patients who require follow-up care should call later and make an appointment. This gives them an opportunity to decide if follow-up is personally important (if it is, they will call to schedule) and allows the practice to reserve appointments for those patients who sincerely want them.

Ensuring a Positive Waiting Experience

The first priority in ensuring a positive waiting experience is to remain on schedule. When a practice runs late due to unforeseen circumstances, it must inform patients and tell them when they can expect service. If a patient cannot wait, staff members may offer to reschedule the appointment during the "protected" weekly session or earlier.

Good communication among the staff and exemplary customer service can usually rectify even the worst delay. Smiling faces; clean, bright, roomy waiting areas with relevant, up-to-date reading material; and a separate waiting area for children that is stocked with toys, books, and audiovisual materials all contribute to a positive waiting experience.

Optimizing Patient Volume

Expanding service beyond the clinic walls is a marketing tool that can contribute both to the financial health of a practice and increased access for patients. School outreach programs introduce staff members and educate children who may not know about regular oral hygiene or routine dental care.

Another option is to bring dental care to children and adults in areas where access or transportation is especially challenging. If planned strategically and executed correctly, portable dentistry can improve access and help make a practice financially successful.

CASE STUDY: **Increasing Revenues and Reducing Costs at a Federally Qualified Health Center**

A dental practice at a federally qualified health center operated in the red for several years. As a result, the board of directors reduced its size from four chairs to two. The board analyzed the practice and proposed strategies to improve operations, including:

- Adoption of clinical protocols to increase productivity and standardize treatment;
- Implemention of designated access scheduling to improve the payer mix;
- Refinement of no-show and emergency policies;
- Education of dental staff to foster accountability and buy-in; and
- Establishment of financial and productivity goals for the number of visits per day, productivity per visit, and revenue per visit.

These and other changes produced a significant gain in operating revenues. In addition, they increased productivity per visit, the number of dentists in the practice, the hours of operation, and, most importantly, access to dental care. They also preserved the local dental safety net.

	BEFORE FY2006	AFTER FY2007	IMPROVEMENT
Annual visits	3,391	5,642	66%
Operating loss/surplus	–$75K	+$105K	+$180K
Revenue per visit	$71	$106	49%
Cost per visit	$93	$87	6%

IV. Designing an Optimal Staffing Pattern

Before it addresses staffing, a practice must define its scope of services and the environment in which they are delivered, including the service area, the socioeconomic demographics of patients, payer mix, and reimbursement. Then it can match the practice's and patients' needs with the correct staffing mix to maximize efficiency and financial sustainability.

Important questions to ask about the practice include:

- How many chairs does it have?
- What are the hours of operation?
- Who are its patients?
- What types of services will it provide?
- What is the care environment in which it operates? For example, if most of the patients are children, should the clinic recruit pediatric dentists? Or is it better to have general dentists who are comfortable treating children?
- Do registered hygienists fit into the practice model?
- If the state allows expanded-function dental assistants or hygienists, what role will they play?
- What is the ideal number of dental assistants per dentist or per operatory?
- How many support staff does the practice need to operate successfully?

Staffing Based on Patient Type and Other Factors

The number and types of dentists and hygienists a practice needs depend on the kinds of patients it treats, the services it provides, the payer mix, and available workspace. For example, in geographic areas where there are few pediatric dentists, practices can train general dentists to treat children, applying strategies targeted to this special population.

CASE STUDY:

The Importance of Business Support

A community dental practice whose providers were efficient and subject to quality controls was extremely busy and productive. However, it operated in the red.

Investigation revealed that the billing department was collecting on only a fraction of delivered services, and incorrectly billing for them. In addition, the payment reconciliation process was faulty and inconsistent, staff did not correct and resubmit claims that had been denied, and dentists provided care regardless of patients' insurance eligibility.

Because business operations were poorly structured and there was a lack of accountability, the practice did not receive the compensation it deserved—resources it could have used to improve patient access to dental care.

Using Dental Assistants and Hygienists Strategically

Dental assistants enhance the productivity of dentists. A "one dentist-two assistant" model is preferable in practices with enough treatment rooms and staff, and the appropriate care environment, to support it. In larger practices, extra dental assistants may serve as floaters, oversee infection control and lab services, and manage inventory.

Depending on state regulations, expanded-function or expanded-duty dental hygienists and assistants can provide additional services that improve access, treatment protocols, and productivity. The key is to use personnel effectively, maximizing their time through good planning and accountability.

CASE STUDY: **Increasing Revenues and Reducing Costs at a Rural Practice**

A rural, four-chair dental clinic had operated in the red since its inception. Due to a scarcity of local dentists, it limped along with two part-time dentists and two full-time hygienists.

The parent organization's board of directors was just two weeks away from voting on whether to eliminate the clinic when, in a last-ditch rescue effort, it hired a dental practice management consulting firm to evaluate the situation. The clinic implemented several of the firm's proposed strategies, which included:

- Adopt clinical protocols to increase productivity and standardize treatment
- Implement designated access scheduling to improve the payer mix
- Increase fees
- Revise the patient encounter form
- Develop policies and procedures to address scheduling, no-shows, and emergencies
- Educate the dental staff in order to foster accountability and buy-in
- Set financial and productivity goals, including the number of visits per day, productivity per visit, and revenue per visit

In one year, the clinic saw revenue losses turn to significant gains. It accomplished this largely by increasing productivity and improving the payer mix. A newly graduated dentist joined the practice in May 2008 as a full-time dentist and dental director.

	BEFORE FY2006	AFTER FY2007	IMPROVEMENT
Annual visits	4,227	4,464	6%
Operating loss/surplus	–$159K	+$30K	+$189K
Revenue per visit	$103	$127	23%
Cost per visit	$141	$120	15%

Understanding How Flat-Rate Reimbursement Affects Care at FQHCs

A federally qualified health center (FQHC) receives a flat $130 for treating, on one visit, a child covered by Medicaid. For this amount, it can do an exam, a few bitewing x-rays, and a cleaning, as well as apply fluoride and two sealants. Fee-for-service reimbursement for these services is $107.

If the flat-rate reimbursement were $100, the center would likely need to limit the visit to an exam, x-rays, a cleaning, and fluoride; schedule another visit to apply sealants; and plan subsequent visits for any necessary restorations.

For restorative care under the $130 flat rate, the FQHC could probably afford to do a few restorations at a time rather than one per visit. However, it could not afford to do more complex and costly procedures, such as root canals; for these, fee-for-service reimbursement is much greater.

The bottom line is that FQHCs must work within the constraints of flat-rate reimbursement. While this may not appear to be in the best interests of patients, the alternative—reducing or eliminating services because of operating losses—is far worse.

Skimping on Business Support Staff—a Bad Idea

Given their responsibility for registration, reception, billing, and collections, business support staff are the backbone of a practice's finances. The services they provide—documenting and determining insurance eligibility, updating patient information, collecting copayments, handling prior authorizations, filing claims quickly and accurately, posting remittances, following up on denials, and more—are essential in ensuring prompt and adequate payment. Skimping on these positions is penny-wise but pound-foolish.

Remaining Open-Minded and Flexible About Staffing

Workforce challenges related to recruiting and retaining dentists require flexibility, creativity, and open-mindedness. Practices can consider job-sharing arrangements and hiring part-time staff and retired dentists. No possibility should be overlooked.

There are many incentives for recruiting and retaining dentists, some based on individual production and others on a combination of individual production and dental department performance. Incentives motivate providers to be as productive as possible and help bridge the gap between the earnings of dentists in private practice and those in community practices.

Implementing Clinical Techniques and Strategies

Quadrant Dentistry

In fee-for-service settings, quadrant dentistry—performing more than one procedure during a visit—is a best practice that can increase provider productivity and foster timely completion of treatment plans. It reduces the number of patient visits, which increases the likelihood that providers will complete treatment plans before they lose patients. Reducing the number of visits necessary to complete treatment plans increases appointment availability for other patients, enhancing overall access.

Quadrant dentistry may not be feasible for federally qualified health centers that receive reimbursement (prospective payment) based on a per-visit flat rate. They may need to spread treatment plans over more visits to cover costs. While more visits might seem counterproductive from an efficiency standpoint, this approach can help ensure a practice's financial viability.[3]

Clinical Protocols

Clinical protocols are effective tools for standardizing care. They eliminate inconsistencies due to individual provider preferences, maximize provider productivity, and foster the completion of treatment plans. Sound protocols define the care for all patients, be they new patients, continuing

Behavior Guidance for Uncooperative Pediatric Patients

Uncooperative children can disrupt a practice's schedule, reduce productivity, and test the skills of the most tolerant practitioner. There are many techniques for managing these patients, including behavior guidance and postponing care until another time.

In behavior guidance, providers encourage patients' cooperation while building trust. This is how the American Academy of Pediatric Dentistry describes behavior guidance:

- It is a clinical art form and a skill built on a scientific foundation. It requires not only an understanding of the scientific principles on which it is based, but also communication, empathy, coaching, and listening skills.
- It seeks to establish communication, alleviate fear and anxiety, deliver quality dental care, build a trusting relationship between provider and patient, and promote a positive attitude toward oral health and dental care.
- In some cases, deferring or modifying treatment may be the most appropriate action until the practice can provide routine care using appropriate behavior guidance techniques.
- Deciding which behavior guidance techniques to use involves weighing the risks and benefits of each. Dentists must explain their recommended techniques to parents, and parents must understand and accept them, as well as participate in the decision.
- Training enables dental staff to support dentists' behavior guidance efforts. Staff should welcome children and parents into a child-friendly dental environment that facilitates behavior guidance and a positive visit.

care patients, children, adults, or those who need restoration, oral surgery, or emergency treatment.

When a practice develops clinical protocols, it must know who its major payers are and whether reimbursement is based on fee-for-service, a flat rate, or, as is the case for many dental practices, both. The strategic value of protocols for community dental practices is enormous because protocols foster predictability and efficiency, maximize revenue, and provide a road map toward completion of treatment plans and achieving optimum oral health.

A protocol for pediatric patients, for example, calls for all new patients to receive a comprehensive oral exam, x-rays according to ADA guidelines, a treatment plan, prophylaxis when indicated, a fluoride application, and oral health education and home care instruction. The expectation is that all such patients will receive these services from all providers.

The Role of Technology

Technology is becoming increasingly important in dentistry. It enables practices to become more efficient, which can lead to increased patient access, higher revenue, and better financial sustainability.

The two technologies that provide the greatest return on investment for community dental practices are digital radiography and the electronic dental record/practice management system (EDR/PMS). Other more specialized and expensive technologies, such as lasers, generate far lower returns on investment.

Investing in digital radiography and EDR/PMS has the dual benefit of both making the practice look and feel like a private dentist's office and ensuring that the safety-net standard of care measures up to the community standard of care. This can greatly help with staff recruitment and retention by leveling the playing field between private and community dental practices. Most recent dental school graduates have been exposed to the latest technologies, and many prefer to join practices that use them.

However, practices that acquire a technology without fully understanding the opportunities and challenges it presents can end up making costly mistakes. They must know the technology's capabilities and limitations before investing. The Internet, trade shows, articles in professional publications, observations of other practices, and

product demonstrations are all sources of helpful information.

Digital Radiography

This technology plays a vital role in the modern dental practice. Digital radiography is superior to conventional x-rays because it reduces radiation exposure and eliminates the need for film developing equipment and chemicals. In addition, patients can see their oral problems firsthand, which may foster acceptance of treatment plans; providers can digitally manipulate images, which enhances their diagnostic capability; and the images are managed, stored, and transmitted electronically.

In acquiring digital radiography, an important factor is the type of software it uses. Does it interface with the practice's EDR/PMS? Does it offer the features the practice needs? What type of image management software does the digital radiography system require? What kind of digital radiography hardware—sensors, workstations, servers, scanners—will be necessary and how much does it cost?

CASE STUDY: **New Software Poses Challenges**

A community dental practice was expanding from six to 12 chairs, which required building and moving to a new facility. To accommodate this expansion, it decided to upgrade from the electronic dental practice management system it had been using to one designed specifically for community dental practices.

Representatives from this practice spoke with the major EDR/PMS software vendors at a dental conference and watched product demonstrations. After careful review, they selected the Dentrix Enterprise system.

The new system went live on the same day the practice moved to its new location. This may have been overly ambitious. "Implementing all modules of Dentrix during the move and start-up of the new facility added to the overall stress and disruption," the practice manager said. "It probably would have been better to implement just the administrative modules first and add the clinical features after a few months when things had settled down."

For about the first three months, the practice experienced a downturn in productivity as staff struggled to master the new software. The practice manager continuously monitored the information being entered into the system and met every two weeks with providers and administrative staff to discuss problems and re-educate everyone on proper use of the software.

The staff is now comfortable with Dentrix Enterprise. However, the practice manager reports that while some of the software features are better than those in the old system, others are not. "It's really important to do your homework and become as familiar as possible with the system you are considering," she said.

The overall set-up of a practice is a key factor in how well a EDR/PMS works. As this practice manager noted, "When you are configuring the software to fit your practice, the people who need the data should be involved in making the decisions about how the fields and tables are constructed. Otherwise, once you go live and start generating reports, you may realize, as I did, that they do not give you the information you need. The day we went live, I was at work until midnight reconfiguring all the data tables so we could generate reports the way we needed them."

Training is an expensive part of the cost of implementing an EDR/PMS. A temptation may be to eliminate training to save money—a big mistake, according to this practice manager.

"Take advantage of all the training opportunities," she advised. "It's expensive, but if the staff doesn't know how to use the software properly, you'll spend all your time trying to figure out why problems are occurring and how to fix them."

The manager recently organized a users group in which representatives from a number of dental practices that use Dentrix Enterprise can discuss problems, solutions, and best practices.

Among other new technologies that warrant attention are digital x-ray sensors, digital phosphor plate systems, or a hybrid of the two. Both offer similar image quality, are easy to use, and they require minimal training.

Digital x-ray sensors are more technique-sensitive, yield images more quickly, and require less equipment. On the other hand, they are expensive ($5,000 to $14,000), costly to maintain, and have a useful life of about three years.

Phosphor plate systems use a technique similar to the one for obtaining conventional x-rays, but the technician must scan the images before reading them.

Although these systems are a bit slower than sensors and eventually need to be replaced, they cost much less (about $25).

Electronic Dental Records and Practice Management Systems

All efficient, effective, and financially sustainable dental practices need up-to-date and appropriate data. EDR/PMS provide an easy, user-friendly way to manage, track, and report key data, including the number of visits, patient demographics, productivity, gross charges, charges per payer type, the number and types of services provided, the number of treatment plans completed, and the number of emergency visits and no-shows.

Armed with good data, administrators and dental practice leaders can monitor the dental department's success in meeting strategic financial and productivity goals to ensure financial viability and identify areas that need quick improvement. Retrieving data from a medical practice management system may require sifting through multiple, often incomplete reports. Or, if the practice is paper-based, it may require tabulating data manually. Both of these methods are time-consuming, tedious, and notoriously unreliable.

The ultimate goal of using an EDR/PMS is to enhance communication inside and outside the practice. Unlike a paper-based practice, an electronic practice does not waste time locating and pulling patient charts before each visit and filing them again later. It also does not have to deal with lost or misfiled information. It can immediately retrieve patient information from any internal workstation or from any outside site to which it is electronically linked. If the practice refers patients to outside specialists, it can transmit pertinent clinical information electronically; there is no need to copy, fax, or mail records. Furthermore, an EDR/PMS streamlines communication within a practice because all providers use the same tool for patient charting and treatment planning. And the system eliminates potential errors caused by poor penmanship or individual variations in charting technique.

An EDR/PMS designed specifically for community dental practices is a best-practice system. It can help a practice meet data reporting requirements of public and private agencies, such as the Health Resources and Services Administration. All sites in a multiple-site practice use the same database; patient, clinical, and practice information is readily available at any location.

Before choosing an EDR/PMS, it is extremely important to assess the needs of the practice and determine if a given product can fulfill them. Which software features—patient registration, scheduling, treatment planning, claims processing, recall patient management, reports, and others—are most important?

An efficient way to do this is to develop a list of needs, put them in a request for proposal (RFP), and then invite major software vendors to respond. The RFP can instruct vendors to explain how their product meets the specified needs and to estimate how much full integration will cost. The practice can also request a product demonstration.

In addition, the software vendor should provide contact information for other local dental practices that have implemented its product. Visiting practices that use the software, seeing it in action, talking with the staff about the implementation process, and assessing overall satisfaction with the EDR/PMS can produce valuable information.

It is essential that an EDR/PMS can be integrated with digital radiography system a practice has in place or plans to purchase. Images and data must move seamlessly between the two systems. Most EDR/PMS software works with particular digital radiography systems.

Other important questions for vendors are:

How often do they issue software updates?

- What are the recurring expenses, such as annual fees and service and support costs?
- How do they provide technical and product support? By telephone or online? Around the clock or just during business hours?
- Does the technology a practice already has in place, or technology it plans to implement, raise any compatibility issues?
- What additional hardware — PCs, monitors, scanners, servers, etc. — is necessary?
- What new software features might they offer in the future?

V. Creating Efficient and Effective Business Systems

To maximize efficiency, effectiveness, and financial sustainability, dental practices must have streamlined business systems. Vital elements of the business infrastructure include:

- The registration process;
- The process for documenting eligibility;
- An efficient scheduling policy;
- A requirement that new patients arrive 30 minutes before a scheduled appointment to complete paperwork;
- A requirement that parents or guardians accompany children to initial visits to ensure consent; and
- Well-designed encounter forms and dental charts.

Practices with a good business infrastructure can expect to collect 95 percent of all claims they submit.

Ensuring Appropriate Payer Mix and Payment Flow

Practices must understand payer mix and, most importantly, the right payer mix to ensure financial sustainability and provide maximum patient access. The more financially sustainable the practice, the more unreimbursed care it can afford to provide to uninsured patients.

Staff members need to be familiar with the reimbursement structure for each payer (Medicaid, the State Children's Health Insurance Program, other public programs, commercial insurers, and sliding-scale self-pay), the percentage of revenue each payer contributes to the practice, and what effect the current payer mix has on the practice's financial sustainability. Administrators and dental practice leaders must know how to adjust the payer mix to ensure sustainability through designated access scheduling.

Knowing How Much Payers Are Willing to Pay

After a practice identifies its primary payers, it must review the schedules of allowable fees for each payer and compare those to its own fee schedule to ensure that charges are equal to or greater than allowable fees. Practices need to set fees high enough so they can

capture all potential revenue from public and private insurers, but low enough so uninsured patients can afford them.

Because Medicaid is typically the largest payer at community dental practices, they must stay abreast of the services Medicaid covers for patients under and over age 21 and be aware of which procedures require prior authorization. At least once per year, they should compare their fee schedule with insurers' reimbursement rates to ensure the schedule is up to date.

In the course of a self-assessment, one community dental practice discovered that it had not updated its fee schedule for several years. Thirty-three percent of its fees were lower than those that Medicaid paid. By simply readjusting the schedule, this practice increased its revenue by $120,000 (7 percent of total revenue) over six months.

Developing a Sustainable Sliding-Fee Scale That Aligns with the Mission

Sliding-fee scales enable patients to receive dental services they otherwise could not afford. Before a practice creates such a scale, it must thoroughly analyze its scope of services and calculate how much care it can afford to subsidize. Best-practice sliding-fee scales are based on data-driven analyses.

Implementing Solid Policies and Systems to Manage Sliding-Fee-Scale and Self-Pay Patients

In return for receiving high-quality dental care at an affordable price, sliding-fee-scale and other self-pay patients must fulfill their obligation to pay for services. Patients need thorough information about their financial responsibilities before they receive comprehensive services. Those who cannot pay for care or make copayments at the time of the visit should receive only emergency care until their account is up to date.

Practices can hold their staff accountable for collecting copayments by using performance evaluation forms and competency checklists. A script such as "And how will you be paying for your copayment today?" will help front desk staff fulfill this responsibility. If the staff are hesitant to request copayments, their task will be easier if they explain to patients that the availability of affordable services depends on patients paying what they owe.

A practice also may offer discounted rates to low-income patients, whose qualification for a discount is typically based on the Federal Poverty Level Guidelines. All uninsured patients who meet eligibility guidelines must complete a sliding fee application and furnish proof of income before they receive dental services. Some practices require such patients to complete all paperwork before they can make non-emergency appointments.

Sliding-fee-scale and other self-pay patients must pay their charges at each visit, as it is extremely difficult to collect copayments afterward. Community dental practices commonly write off many thousands of dollars annually as uncollectible bad debt owed by these patients.

When formulating treatment plans, practices should be sensitive to each patient's ability to pay. They can prioritize services to address a patient's most critical needs first and less critical needs later, which makes care more affordable. Cost estimates give patients a clearer understanding of out-of-pocket expenses, and payment plans can ease their financial burden.

Using the Encounter Form Strategically

Most community dental practices perform about 40 types of procedures. User-friendly encounter forms for providers help ensure complete and accurate documentation. The best forms cover the major types of care, including diagnosis, prevention, restorations, endodontics, periodontics, prosthodontics, oral surgery, and adjunctive treatment. The forms specifically address procedures within the practice's scope of service.

Practices with mostly Medicaid patients may create an encounter form targeted to covered services. This ensures that dentists and hygienists provide unreimbursed services only after they make an informed decision to do so, perhaps after obtaining administrative approval.

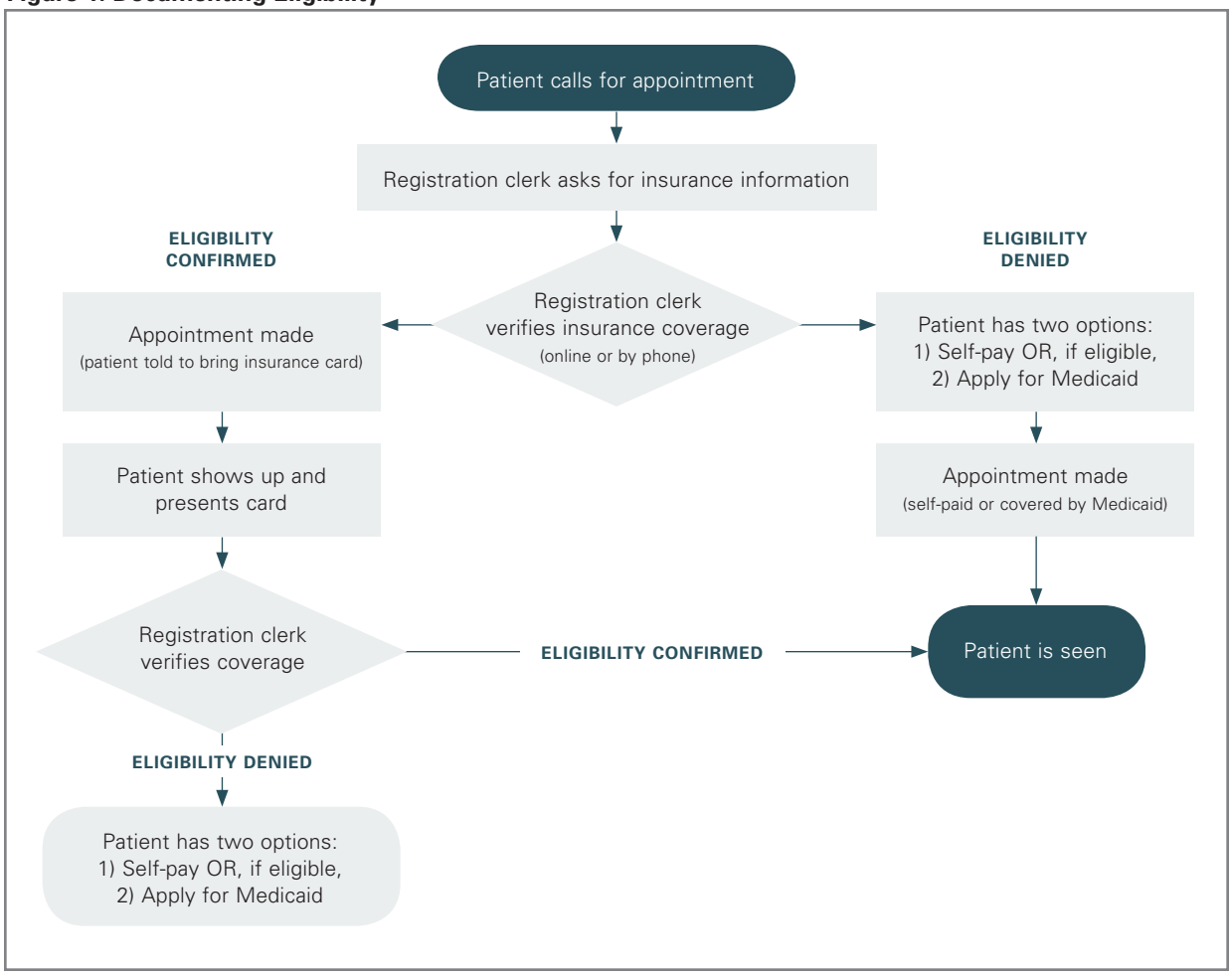
Because practices with large Medicaid populations must understand which services Medicaid covers for which age groups and which procedures need prior authorization, a best practice is to build visual cues and reminders into the encounter form to alert providers to these requirements. The practice manager and dental director should review the encounter form at least annually to make sure the codes are still accurate and complete.

The number of claim denials due to errors or omissions will decline if someone who is familiar with the care process reviews each encounter form for accuracy and completeness before claims are filed. An EDR/PMS reduces the potential for human error, but it relies on correctly configured software that reflects the practice's scope of services. It also relies on providers who thoroughly understand how to use the software for treatment planning and documentation.

Documenting and Verifying Eligibility Before Every Patient Visit

A formal process for documenting eligibility ensures that the practice will be reimbursed. If efficient, it also enables the practice to predict financial outcomes with precision. Figure 1 illustrates how this process works.

Figure 1. Documenting Eligibility

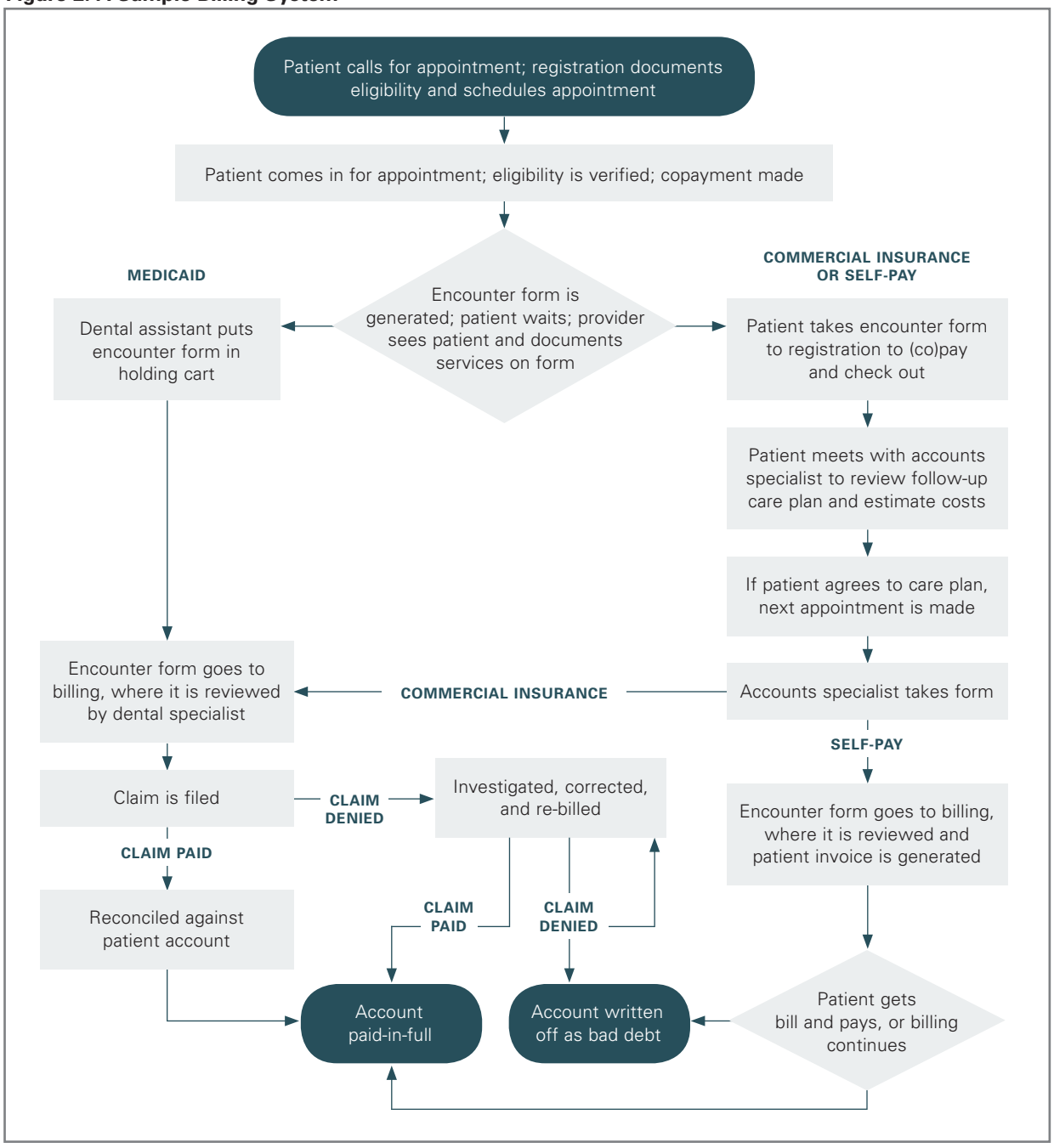


Understanding the Entire Billing Process

A thorough understanding of the billing process includes these elements:

- Determining and documenting eligibility;
- Enrolling patients in Medicaid;
- Determining eligibility for the sliding fee scale;
- Collecting copayments;
- Documenting patient encounters;
- Submitting claims;
- Posting remittances; and
- Managing denials.

Figure 2. A Sample Billing System



It is often helpful to create a flow chart of the billing process (Figure 2 on page 28). Such a chart enables a practice to document how billing actually works and to identify barriers or necessary improvements.

Dedicating Staff to Key Billing Tasks

Dedicating staff members to handle prior authorizations is a best practice. A clear understanding of the prior authorization process is critical. The process includes completing and submitting the appropriate form(s), documenting acceptance or denial, transferring information to the patient and practitioner, billing, and providing related services.

Specific staff members also may be assigned to manage claim reconciliations. This involves posting remittances to patient accounts and investigating, correcting, and resubmitting denied claims.

To foster successful management of prior authorizations, practices can set quantifiable performance standards. They can also foster successful claims reconciliation by holding the staff accountable for this task in annual evaluations.

Monitoring How Much Money Is Due

A proxy for how well the billing process works is the account aging report. Broken down by payer, it details how much money is currently due (0 to 30 days) and past due (31 to 60 days, 61 to 90 days, and more than 90 days). Because most insurers pay long before 90 days, any past due accounts exceeding that time frame usually indicate a problem—namely, uncollectible claims as a result of insurance denials or debts owed by uninsured patients.

Practices can reduce debt from uninsured patients by offering a discount to those who prepay at the

CASE STUDY: **Increasing Access in a Rural Federally Qualified Health Center**

A rural, five-chair dental clinic in a federally qualified health center had been operating in the red for some time. A funding entity that helped support the practice hired a management consultant to evaluate its operations and develop an action plan.

The consultant's recommendations included:

- Implement clinical protocols to standardize patient care and maximize provider productivity;
- Implement designated access design scheduling to improve the payer mix;
- Revise the encounter form and fee schedule;
- Improve the billing process;
- Address the issue of no-shows;
- Educate staff to foster accountability and buy-in; and
- Establish financial and productivity goals, such as the number of visits per day, productivity per visit, and revenue per visit.

A change in dental practice leadership delayed the turnaround plan for several months. However, the clinic now has a dynamic dental director who is guiding it toward financial sustainability.

The practice improved its no-show rate, increased its scope of service, and increased patient access by adding hours, including evening hours four nights a week. It is becoming a clinical training site for externs and residents from a local university's dental school. The positive financial trends will likely continue, given the practice's strong and effective leadership.

	BEFORE FY2006	AFTER FY2007	IMPROVEMENT
Operating loss/surplus	–$58K	+$19K	+$77K
Revenue per visit	$96	$117	22%

time of service and, until an account is up to date, by denying non-emergency care to those who owe money. Primary strategies for reducing uncollectible claims caused by insurance denials include scrupulously verifying eligibility before making appointments, checking eligibility again at the time of the visit, and following rules and regulations about covered services.

Reducing Overhead

Group Purchasing Programs

Group purchasing programs can effectively reduce the cost of dental supplies and equipment. Many organizations, such as state primary care associations and dental societies, offer group purchasing discounts to members. For example, the National Association of Community Health Centers has a business affiliation with Community Health Ventures (www.communityhealthventures.com), a not-for-profit foundation that supports community health centers nationally. The foundation's group purchasing service enables affiliated practices to save 16 to 60 percent on supply and equipment costs.

Another example is the Massachusetts League of Community Health Centers. It meets annually with the two largest dental suppliers to agree on an institutional cost structure for all dental supplies and equipment. League members can take advantage of these prices.

Council Connections, based in Southern California, allows member clinics to save on purchases of dental supplies and equipment, as well as the Dentrix practice management system (www.councilconnections.com).

Large dental practices, by virtue of the high volume of supplies and equipment they need, sometimes can negotiate good discounts with suppliers on their own.

Energy Efficiency and Savings Programs

Because community dental practices tend to have low profit margins, they can benefit from energy conservation and efficiency programs. Such programs are a relatively easy way to reduce expenses. Practices can develop an energy conservation plan by:

- Auditing their facilities to identify cost-saving opportunities. Many utility companies do audits (or can recommend independent auditors) and recommend strategies for conserving energy. Among the common targets for conservation and greater efficiency are heating and air conditioning systems, lighting, and office equipment. Additional options include alternative or renewable energy sources and employee outreach and involvement.
- Creating an action plan to reduce energy costs, based on audit findings. Practices should first focus on strategies that are the easiest, least expensive to implement, and that yield the biggest potential savings.
- Identifying funding sources that may be willing to help offset the cost of conservation efforts. Many local utilities and state agencies offer energy-saving incentives and rebates.
- Monitoring and measuring the results of such programs by obtaining baseline and follow-up metrics, such as energy usage, costs, and savings. These metrics should be tracked and reported regularly.

VI. Prevention and Early Intervention Programs

Possibilities for Expansion

Practices can provide additional services that, in addition to improving oral health, may increase the number of patients they treat over the long term and improve the efficiency of care. These services include early interventions in oral health care, prevention programs, and partnerships with physicians.

More than 40 percent of children have primary tooth decay by the time they enter kindergarten. The problem is especially acute among low-income and minority children who are victims of oral health disparities. A growing number of states are considering reimbursing pediatric primary care physicians for providing anticipatory guidance and fluoride varnish applications during well-child visits.

Early intervention programs focus on children from birth through age five. They reduce the development of caries by identifying at-risk children, providing anticipatory guidance to parents, and applying fluoride varnish to teeth as soon as possible after caries erupt. Goals include preventing the occurrence of dental disease, thus reducing the need for potentially expensive treatment in the future, and teaching parents the importance of lifestyle behaviors that promote optimum oral health in children.

Delivering services such as sealant and fluoride applications in settings that include public schools, Head Start or Early Head Start programs, other preschool programs, low-income housing complexes, and other community sites where some of the children might not have a regular dental home maximizes the effectiveness of early-intervention and prevention efforts. It also is an opportunity for practices to expand their patient base.

Research shows that certain children and adults are predisposed to caries because of lifestyle factors, individual susceptibility, and exposure to disease-causing bacteria. Techniques for managing caries increasingly emphasize risk assessments to identify these individuals. Dental practices use resources most effectively by focusing surveillance, intervention, and education on higher-risk patients.

Phase III clinical trials are under way to determine the effectiveness of chlorhexidine varnish in preventing caries in high-risk adults. This is the final step before the Food and Drug Administration considers approving the varnish. If approved, chlorhexidine would give dentists another tool for keeping adult teeth healthy and precluding costly treatment.

Semi-Annual Versus Annual Check-Ups

For generations, the prevailing belief was that patients must visit the dentist every six months for an exam and cleaning. Research now shows that patients who have good oral hygiene and a low risk of developing dental disease need only one annual visit to maintain optimum oral health.

How often patients should visit their dentist is best determined according to individual needs. But if dental practices adhered to the one-yearly-visit protocol when appropriate, it would free up vast resources—dentists, chairs, appointments, and benefits—that could be devoted to higher-risk patients or those with disease.

Finding Partners in the Medical Community

There may be opportunities for dental practices to increase referrals and ensure patient volume by working closely with the medical community. Some medical providers have access to dental schedules and can book dental appointments directly. The medical-dental partnership is crucial because when physicians recommend a dental visit, patients are more likely to follow up.

VII. Conclusion

Clearly, there are opportunities for all dental practices—including those that serve the safety-net population—to become more efficient. By implementing the best practices cited in this guide, practitioners will see improved efficiency translate into increased access. Given the volume of safety-net patients who need dental care and the limited number of providers available to serve them, applying best practices is vital. In addition, having an effective and stable operation may make it easier to recruit and retain dentists, hygienists, and business staff.

Improving efficiency and productivity is not the only solution to low reimbursement. But it is an immediate and practical step that community dental practices can take to increase patient access and make the delivery of essential services more financially sustainable.

Endnotes

1. California HealthCare Foundation, *Denti-Cal Facts and Figures. A Look at California's Medicaid Dental Program,* May 2007 (www.chcf.org/documents/policy/DentiCalFactsAndFigures.pdf).
2. California HealthCare Foundation. *Increasing Access to Dental Care in Medicaid: Does Raising Provider Rates Work?,* March 2008. (www.chcf.org/documents/policy/IncreasingAccessToDentalCareInMedicaidIB.pdf).
3. Federally qualified health centers are not always limited to one service per visit. The number of services depends on a center's cost-per-visit ratio and its flat-rate reimbursement per visit.

Appendix A: Interviewees

Louis Amendola, D.D.S.	Chief Dental Director, Western Dental, Orange, CA
Linda Bien, M.P.H.	Chief Executive Officer, NorthEast Medical Services, San Francisco, CA
Carolyn Brown, D.D.S.	Dental Director, Native American Health Center, San Francisco, CA
Sam Burg, D.D.S.	Private Practice Dentist, Santa Maria, CA
Joe Criscione	Consultant and legislative advocate Western Dental, Sacramento, CA
Joel Diringer, JD, M.P.H.	Principal, Diringer and Associates, San Luis Obispo, CA
Burton Edelstein, D.D.S., M.P.H.	Chair, Social and Behavioral Sciences; Professor of Clinical Dentistry, Columbia University, New York, NY
John Fehmer	Chief Operating Officer, Children's Dental Group, Los Angeles, CA
Jared Fine D.D.S., M.P.H.	Dental Health Administrator, Alameda County Department of Public Health, Oakland, CA
Michael Flores, D.D.S.	Dental Director, AltaMed , Los Angeles CA
Sam Gruenbaum	Chief Executive Officer, Western Dental, Orange, CA
Jeff Hagen, D.D.S., M.P.H.	Oral Health Consultant; Retired, Indian Health Services, Yakima, WA
Lawrence Hill, D.D.S., M.P.H.	Dental Director, Cincinnati Health Department, Cincinnati, OH
Irene Hilton, D.D.S., M.P.H.	Staff Dentist, La Clinica de la Raza, Oakland, CA
Robert Isman, D.D.S., M.P.H.	Consultant, Medi-Cal Dental Services Branch, Department of Health Care Services, Sacramento, CA
Scott Jacks, D.D.S.	President, Children's Dental Group, Los Angeles, CA
Emile Khalili, D.D.S.	Dentist serving the safety net population
Kenneth Kirsch, D.D.S.	Director of Recruitment , Western Dental, Orange CA
Colleen Lampron, M.P.H.	Executive Director, National Network for Oral Health Access, Denver, CO
Michelle Marks	Chief, Medi-Cal Dental Services Branch, Department of Health Care Services, Sacramento, CA
Len Matuszak	Chief Operating Officer, Benefits Division, Western Dental, Orange, CA
John Neale, D.D.S., M.P.H.	Oral Health Consultant; Retired, Indian Health Services, Farmington, NM
Kathy Phipps, R.D.H., Dr.P.H.	Oral Health Surveillance Consultant, Morro Bay, CA
Robert Russell, D.D.S., M.P.H.	Public Health Dental Director, Iowa Department of Public Health, Des Moines, IA
Mark Siegal, D.D.S., M.P.H.	Chief, Bureau of Oral Health Services, Ohio Department of Health
Tu Tran, D.D.S.	Chief Dentist, Operations, Kool Smiles, Atlanta GA
John Yamamoto, D.D.S., M.P.H.	Director, UCLA Venice Dental Center, Venice, CA

Appendix B: Valuable Resources for Community Dental Programs

Association of State and Territorial Dental Directors (ASTDD)	www.astdd.org/index.php?template=main.html
Best Practice Approaches	www.astdd.org/index.php?template=bestpractices.html
Health Resources and Services Administration (HRSA)	
Medicaid Primer	www.hrsa.gov/medicaidprimer
Oral Health Information Center	www.ask.hrsa.gov/OralHealth.cfm
Mobile-Portable Dental Clinic Manual	www.mobile-portabledentalmanual.com
National Maternal and Child Health Oral Health Resource Center	www.mchoralhealth.org
Ohio Dental Safety Net Information Center	www.ohiodentalclinics.com/index.html
Public Health Foundation	www.phf.org
Rural Assistance Center	www.raconline.org
Safety Net Dental Clinic Manual	dentalclinicmanual.com

California
HealthCare
Foundation

1438 Webster Street, Suite 400
Oakland, CA 94612
tel: 510.238.1040
fax: 510.238.1388
www.chcf.org