Best Practices Manual

for Safety Net Dental Programs

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KEY PRACTICE DATA TO TRACK AND MONITOR; AND UNDERSTANDING WHAT THE DATA REVEALS:

1. ***Number of dental visits:*** The number of dental visits within a given reporting period is essential information for assessing cost/visit and revenue/visit; and for calculations regarding practice and provider productivity and service to the community.

2. ***Number of total unduplicated patients:*** Unduplicated patients refers to the number of "unique patients" cared for during the reporting period. (ie: multiple visits by the same patient would be counted as just one unduplicated patient.) This number gives a sense of how many patients are provided access to oral health services. The visit/unduplicated patient ratio is typically about 2.5 visits/patient. If it is less than 2.5, it may point to an issue of the clinic's limited ability to complete Phase 1 treatment plans. If it is much greater than 2.5, it could represent a practice of "unbundling services." It can also provide an indicator of how many community health center patients are receiving oral health services as compared with the percentage of patients receiving primary care services (medical, behavioral health, etc.).

3. ***Number of new dental patients:*** The number of new dental patients within a given reporting period gives a sense of how much access is available for new patients.

4. ***Number of emergency visits:*** The number of emergency visits in a given time period reflects how the practice defines and manages emergencies. This data reveals how many emergencies there were compared to the number of overall visits for the reporting period, and also by looking at revenue vs expenses it can be determined if emergencies are positively or negatively affecting the bottom line. For more information, please see the section on [managing emergencies](#).

5. ***Dental policies for no-shows, emergencies, scheduling, payment for dental care, and sliding fee scale:*** Best-in-practice dental clinics have policies governing all aspects of dental clinic operations. Equally important to having policies, they must be consistently enforced by all staff members. Consistent adherence to the policies is the only way to ensure that all patients are treated equally. Any exceptions show favoritism and are unfair. Scripting should be developed to help staff members explain these policies to patients clearly and with cultural sensitivity.

Review all dental clinic policies and look for strengths and potential weaknesses. Verify that all areas of dental care have been considered and included. If key policies are missing or seem to be limited, this should be addressed.

6. ***A dental department profit and loss statement:*** There is a lot of essential information on the P&L statement that is needed in order to complete a dental practice analysis. By comparing costs versus revenue, the financial sustainability (or lack thereof) of a practice is quickly ascertained.

The following key data can be revealed from the Dental Department Profit and Loss Statement:

- Gross Charges
  - o Benchmark: >$400K- $500K per dentist per year
- Net Revenue
  - o Revenue per visit
- Direct/Indirect Expenses
  - o Cost per visit
    - Benchmark: Per 2012 UDS summary the average cost per visit for FQHC dental clinics was $160/visit
- Sources of Income (including 330 grant funding)
- Gross charges vs. net revenue (Most federally qualified health centers (FQHC's) should have far greater gross charges than net revenue)
- Expense Details

When a dental clinic is part of a larger health center, there are rare occasions when dental expenses and revenue are not tracked separately from the overall health center. This needs to be the first thing to correct. Without clinic-specific financial information, you cannot monitor the dental department's sustainability nor appropriately gauge what needs to be done to achieve sustainability. Dental clinics that do not have dental department specific profit and loss statements should immediately meet with the health center's Chief Financial Officer (CFO) to discuss tracking this information separately going forward.

For guidance on understanding your profit and loss statement, see the sample profit and loss report. (**Please note that not all profit and loss statements look exactly the same. This sample is meant to show one example of a P&L and explain some of the key data points that should be able to be pulled from it.)

7. ***Current dental fee schedule:*** The fee schedule should be evaluated annually to ensure that charges are consistent with usual and customary fees for the practice's area (this is especially important for dental programs that are billing primarily on a fee-for-service basis). Often, safety net dental clinics have set their dental fees below what insurers are willing to pay for those services. For more information, please see the section on [developing a sliding fee discount schedule](#).

8. ***Number of Completed Phase 1 Treatments and Treatment Completion Rate:*** This will look at an important quality indicator recommended by the Health Resources and Service Administration (HRSA). Phase 1 treatment refers to the prevention and treatment of dental disease. The Phase 1 treatment completion rate can be used to infer how well the dental program is doing in relation to serving the needs of its patient base in a manner directed toward improved patient health outcomes. All safety net dental clinics should place a priority on the completion of Phase 1 treatment plans. Strategic planning should consider this quality indicator as a major goal. For more information, please see the section on [Phase 1 treatment plan completion.](#)

9. ***Aging Report:*** This report reveals how well the billing process is working within a dental practice. Broken out by payer, the aging report shows how much money is past due (by 30, 60, 90, or more days). This information can point to potential opportunities for improvement in both billing and dental operations. Insurers typically provide reimbursement within 60 days of the date of service, so any money in the "greater than 90 days" category is a red flag that there is a billing or collection problem. Experience teaches that this problem is most likely with uncollectible claims. These claims are usually uncollectible because of unpaid debts from uninsured self-pay patients or insurance claims that were denied. If there are large amounts outstanding, the practice needs to find out why these claims are going unpaid.

   Uncollectible claims can be reduced by:

   - Being more diligent about verifying patient's eligibility before providing services for insured patients
   - Understanding the rules, regulations, and covered services of each insurer
   - Collecting payment at the time of the visit for self-pay patients

   For more information on resolving large outstanding accounts receivable balances and verifying insurance eligibility, please see the [billing and collections](#) section.

10. ***Broken Appointment Rate***: This shows what percentage of dental patients are failing to keep their appointments. The percentage reveals the magnitude of the problem in a numerical manner. The overall impact on the practice can then be ascertained through discussion and a look at other practice trends such as double booking, low numbers of completed treatments and poor staff (and patient) satisfaction. For more information, please see the section [managing broken appointments](#).

11. ***Transaction Report:*** A transaction report (production report) shows the number of times that each procedure was provided by ADA code. It provides key information about services provided by the dental practice in the reporting period. This report reveals:

    - The scope of services that the practice is actually providing (percentage of diagnostic, preventive, restorative, specialty, oral surgical, rehabilitative, and emergency treatments.)
    - How many services are being provided at each visit? (total number of transactions/number of visits)
        - Services should not be unbundled. The community standard of care needs to be upheld.
            - An average of 2.5-3 ADA coded services/treatment visit
            - At the periodic or comprehensive exam visit, to avoid the unbundling of services, it is expected that the exam, cleaning, fluoride, and any needed radiographs would all be performed at the same visit.
            - All sealants needed (1, 2, 3, 4 or more) at sealant visit or as part of recall or comp exam visit.

12. ***Provider Productivity:*** Define daily productivity, financial, and outcome goals that need to be met; identify reports needed to evaluate dental program performance; track progress in meeting goals, and develop greater accountability through reports and sharing of results report regularly to dental staff.

    - Set provider productivity goals (number of visits/day and number of procedures/visit)
        - Develop and implement clinical protocols to standardize services provided, maximize revenue, guard against "unbundling," and foster the timely completion of Phase 1 treatment plans.

    - Productivity Benchmarks:

- 230 work days/year (or 1,600 work hours/year after holidays and vacations)
- Dentist:
  - 2,500-3,200 encounters/year/FTE dentist
  - 1.7 patients/hour or 13.6 patients per day per dentist2
  - Chairs/dentist (3:1 is ideal)
  - 1.5 Assistants/dentist (1 DA per chair is ideal)
- Dental Hygienist:
  - 1,300-1,600 encounters/year/FTE hygienist
  - 8-10 patients/day for hygienists

UNDERSTANDING THE PROFIT AND LOSS STATEMENT

REVENUE	
Gross Charges	
Self-Pay	$100,000
Medicaid	$500,000
Commercial Insurance	$70,000
Other	$--
Total Gross Charges	$670,000
Net Allowances & Write Offs	
Commercial Insurance	$20,361
Medicaid	$70,000
Self-pay	$75,000
Bad Debt	
Total Write-Offs	$165,361
Net Fee-for-Service Revenue	$504,639
Total Patient Revenue	
Other Income	
Grants and Contracts (list)	
State	$18,750
330 Grant	$50,000
Subtotal Other Income	$68,750
Total Operating Revenue	$573,389
EXPENSES	
Direct Expenses	
Personnel Related	
Salaries	$300,000
Fringe Benefits	$75,000
Malpractice Insurance	
Contracted Personnel	$50,000
Subtotal Personnel Costs	$425,000
Support Costs	
Dental Supplies	$50,000
Dental Lab Services	$10,000
Equipment	$5,302
Depreciation of Equipment	$5,367

Gross Charges can be used to document the value of the dental program to its patients and the community it serves. A large gap between gross charges and net revenue might be a signal to probe deeper into eligibility issues (ineligible services and/or ineligible patients).

Write-offs reflect the difference between what the practice charges and what insurers reimburse. Unusually large write-offs may warrant further investigation to determine the extent of the financial liability to the practice due to uninsured or underinsured patients. Large write-offs in this area signal the need to document how self-pay patients are managed by the practice.

330 Grant Allocation to dental = 11% average

Total Operating Revenue is the key figure used to calculate revenue per visit.

Direct Expenses are those costs associated with the provision of dental services and are usually broken out as salary vs. non-salary expenses (or, in this example, as personnel vs. support costs).

Continued Education	$1,527
Travel-Administrative	$1,775
Office Supplies	$2,500
Computer Supplies	$2,500
Janitorial Supplies	$1,000
Books $ Subscriptions	$500
Fees and Dues	$1,638
Recruitment Expenses	
Leasing and Contracts	
Data Processing	
Facility Repairs/Maintenance	$5,000
Equipment Maintenance	$3,241
Computer Service Contracts	$10,000
Payroll Processing	
Legal & Audit	
Consulting Services	
Insurance	
Printing	$2,500
Postage	$1,500
Marketing Expenses	
Fundraising Costs	
Miscellaneous Expenses	$2,500
Total Support Costs	$106,850
Total Direct Expenses	$531,850
Total Indirect Expenses	
Agency Allocation	$106,370
Total Indirect Expenses	$106,370
Total Expenses (direct & indirect.)	$638,220
Total Revenue	$573,389
Profit or Loss	($64,831)

These are the total direct costs for the dental program.

This is often charged to programs for shared services such as security, IT, marketing, billing, etc. and for the services of administrative leadership.

This is the key figure used to calculate cost per visit

This is the key figure used to calculate revenue per visit.

This is how much the dental program is losing overall for the reporting period.

SCHEDULING

Scheduling policies can improve the practice's efficiency and financial sustainability while simultaneously reducing chaos and increasing predictability within the practice. All practices should create a formal policy that defines the elements of the scheduling system that would include elements such as:

- Clinical protocols that define the services to be provided by visit type
- Appointment time length
- Number of appointments available in the daily schedule to meet practice goals for patient and payer mix.
- How far in advance appointments are scheduled

Because of the heavy demand for access to care in safety net dental practices, a common best practice is to schedule appointments out no further than 30-45 days. This helps by:

- Eliminating long waits for appointments
- Enabling providers to work patients into the schedule who are undergoing active treatment, which in turn helps increase the number of completed Phase 1 treatment plans
- Decreasing the likelihood of no-shows and cancellations

Another common best practice is to schedule appointments one at a time. After a visit is completed, patients can make appointments for a subsequent visit until their treatment plan is completed. Exception: patients who need a series of visits for procedures such as dentures, crowns or endodontics that are provided over multiple visits.

Only allowing designated and trained staff to make appointments will provide uniformity to scheduling and prohibit tampering with the schedule by others. It is a recommended best practice that providers should not schedule their own appointments. This will also allow the schedulers to have a sense of ownership over the schedule, and leadership will be able to hold them accountable for their ability to schedule appropriately and to keep the schedule full.

Design a scheduling template that manages patient and payer mix for maximum access, fosters the completion of Phase 1 treatment plans, and promotes financial sustainability. Elements to be considered in creating a scheduling template include:

- o The mission goals the practice has defined (i.e. treating more children, completing treatment plans, etc.).
- o Financial and productivity goals that the practice needs to achieve to maintain sustainability.

MANAGING BROKEN APPOINTMENTS

If not managed effectively, broken appointments negatively impact the productivity of the safety net dental practice, patient continuity of care, and financial sustainability.

Broken Appointments are defined as:
- Patients who are more than 10 minutes late for an appointment (number of minutes can be determined by the practice, but should be determined with consideration for patient care and effect on treatment of all patients)
- Patients who fail to cancel an appointment at least 24 hours in advance
- Patients who do not present for their scheduled appointment (no show)

Methods that can minimize Broken Appointments:
- Create and distribute a strong, no-tolerance Broken Appointment policy to establish accountability with the patient and staff. Post signs prominently within the practice explaining the no-show policy.
- Enforce the no-show policy consistently, despite angry patients or complaints to key health center leadership. In order for the policy to be effective, everyone affiliated with the practice must agree to support the policy.
- Provide scripts for staff to use for those patients who question the policy: One example 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 vital to the needs of our patients. We must preserve their use for patients who both need them and are able and willing to show up for their scheduled appointments."

Other strategies that can be used to decrease broken appointment rates are:
- Have patients sign contracts to commit to the broken appointment policy
- Provide reminder messages to patients 48 hours prior to appointments
  - Consider an automated reminder system that can call or text the patient in order to free up the front desk staff to work on more important tasks for the day. The calls can take place after business hours when patients are home from work. This system can also assist with appointment confirmations by requesting the patient confirm their appointment by responding to the text message.
- Flag patient charts of those who breach the policy and send letters reminding those patients of the policy they agreed to abide by.
- Explain policy as a part of new employee orientation and retrain staff on it once a year at a staff meeting.
- Schedule appointments no further out then 30-45 days
- Schedule one follow-up appointment at a time for patients

- Have emergency patients call back to schedule their follow up appointment a few days after the emergency visit
- New patients are always at high risk for being no-shows; consider strategies for reducing the potential impact of "new patient broken appointments" on the daily schedule by limiting the number of new patients appointment slots available each day)
- Do not schedule appointments for multiple family members on the same day unless these patients have a track record of reliability in showing up for their appointments. (Example: Three hour-long appointments were made for three different family members on the same day. If for any reason the family cannot make it to the office that day, instead of having just one hour-long opening in the schedule, you will have three, hour-long openings in the schedule. This reduces potential patient access to the clinic and jeopardizes financial sustainability goals)

Double-booking or triple-booking are common methods used to compensate for no-shows; however, these practices can create patient and staff dissatisfaction, disrupt clinic flow, and contribute to a general atmosphere of chaos in the practice. For those reasons, overbooking is not a recommended practice.

Track and monitor your broken appointment rate. Establish a starting point and seek to lower it. Ideal no-show rates are 15 percent or less.

CALCULATING YOUR BROKEN APPOINTMENT RATE:

- First you must determine the number of scheduled (planned) appointments for the reporting period.
  - Take the total number of patient visits
  - Add "no-show" appointments
  - Add last-minute cancellations
  - Subtract walk-ins/same day appointments.
- Then divide the sum of all no-shows and cancellations by the number of scheduled appointments for the reporting period.

MANAGING EMERGENCIES

Providing emergency care is a crucial part of the mission of most safety net dental clinics, but emergencies add to overall chaos, stress and unpredictability in the practice. These visits tend to reimburse poorly, and they can interfere with the care of regularly scheduled patients. The key is to develop a system and policy for managing emergencies that enables the practice to accommodate the needs of emergent patients while preserving the care of regularly scheduled patients, minimizing disruption to the practice, and maintaining financial sustainability. This will create an environment that promotes the completion of Phase 1 treatment plans and fosters both patient and staff satisfaction.

A well-defined emergency policy is critical to the flow of an efficient and effective dental practice. To develop an effective emergency policy:
- Define what constitutes a true emergency (pain, swelling, fever, trauma, etc.)
- Develop a triage form with a list of questions to ask patients that will assess the severity of their emergency. (include a copy of the triage form in the policy)
- Explain the daily protocol for emergencies and what happens if all the emergency slots are full. Also explain the protocol for after-hours emergencies.

Annual training should be provided for registration and reception staff to properly triage and schedule emergency. The triage form should help staff members to correctly determine true emergencies. Some clinics choose to designate someone on the clinical staff who is responsible for triaging emergencies.

Use data to determine the effect of emergencies upon each individual clinic by finding out how many emergencies the clinic typically sees per day, the amount of time that is taken out of the schedule to see emergency patients, and the types of emergencies that are seen. This will enable the practice to create an emergency policy that meets the data-determined demand for emergency care.

DETERMINING YOUR DAILY DEMAND FOR EMERGENCY CARE:

The daily demand for emergency care is the average number of emergency visits per clinic day during a reporting period.
- Divide the total number of emergency visits (CDT codes D0140 and D9110) by the total number of clinic days during a reporting period.

Create an emergency management system that meets the established level of need for legitimate emergency care, while also preserving regularly scheduled appointments for existing patients.

- Develop a strategy to efficiently accommodate emergency patients. Strategies can vary: (i.e. dedicating providers, chairs, or time slots in the daily schedule to care for true emergency patients).
- Emergency patients must be willing to come in for treatment at a time determined by the practice, not necessarily at a time that's convenient for them

If you find that your daily demand for emergency care exceeds your capacity to provide continuous quality care to your existing patients, you will need to make difficult decisions to prioritize the care you have the capacity to provide.

- Consider only seeing emergency patients who are patients of record of the overall health center
- Consider only seeing emergency patients who can prove that they live within their service area (as defined by the zip codes used in their application for FQHC status)

It is a best practice to track and monitor your emergency rate.

DETERMINING YOUR EMERGENCY RATE:

The emergency rate is the percentage of overall patient visits during a reporting period that were emergency visits.

- Divide the total number of emergency visits (CDT codes D0140 and D9110) by the total number of visits.
    - Note: To ensure accuracy, one of these codes must be applied at every emergency visit – including those when definitive care is provided (such as an extraction). A $0 dummy code could also be considered for billing purposes.

BILLING AND COLLECTIONS

According to HRSA, "sound billing and collections policies and their supporting operating procedures are critical to a health center's ability to carry out both the sliding fee discount program requirement and the requirement to maximize revenue from public and private third party payers." (HRSA PIN 2014-02)

Successful billing and collection practices are imperative to the financial sustainability of the safety net dental clinic. All safety net dental clinics should have a "Payment for Dental Care Policy" that will explain to the patient the necessity of them paying for their portion of their dental care. The policy should define all aspects of payment for dental care. Educate your patients about why payment is required at the time of the visit with scripting.

If your aging report shows a large amount of money in Accounts Receivable due past 90 days, the billing and collection process must be reviewed and streamlined.

- Bring together a multidisciplinary team with representatives from dental (eg, front desk, dental leadership) billing, finance and others who play a role in the billing process to meet on a regular basis—make this a formal Billing Performance Improvement Team
- Review the entire billing process, create a flow chart, and identify the staff person or position responsible for each step in the process
- Establish performance measures to monitor the success of the billing process

Providers should take care to update and prioritize all patients' treatment plans. That will enable reception staff to better prepare patients for their next appointment. With a prioritized treatment plan, receptionists will be able to explain to patients what they will be coming in for and what the out-of-pocket estimated expenses will be at their next visit.

When it comes to both private and public insurances, most reimbursement for oral health services is based upon the insurance plan's determined eligibility of the patient to receive those services. Practices that document eligibility appropriately can more precisely predict their financial outcomes by having a reasonable expectation of reimbursement for the services they provide. It is essential that dental practices thoroughly understand each payer or insurer (e.g. allowable services and reimbursement rates for each covered service).

- Practices should ensure that insurance tables within the dental/medical practice management system are updated and current.

- Verify the patient's eligibility for the specific services to be provided at every visit. Do this PRIOR to the visit.
- Patients should be educated on their coverage benefits and what co-payment is expected of them. (Of course, remind them that you only have "estimates" and it is always best for them to check directly with their insurance carrier or their HR department.)
- Prior authorizations should be obtained for all services that require them before the patient is scheduled an appointment to receive those services.

The practice has several options to deal with non-emergent patients who show up for appointments without the proper documentation to verify their insurance eligibility:
- Provide services anyway (understanding the risk that these services may go unreimbursed)
- Provide the minimum necessary services and postpone the remainder until coverage can be confirmed
- Offer the patient the option to be either rescheduled for a time when eligibility can be verified, or pay out of pocket for the visit.
- The key is to develop a formal policy for how these situations will be handled, to educate staff and patients accordingly, and to follow through consistently. The practice should continuously seek to know itself better so that policy and decisions be based upon conscious and informed decision making.

Consider the book, "Coding with Confidence: the 'Go To' Dental Insurance Guide," by Charles Blair, DDS. This book helps by thoroughly explaining what each CDT code means, thereby enabling clinics to reduce coding errors and increase legitimate reimbursement for their services.

Important Tips for Managing Self-pay Patients:
- Patients should receive thorough information regarding their financial responsibilities before they receive comprehensive services. The practice should have distinct policies for the provision of services provided to self-pay patients. These policies should be in the form of documents which are shared with staff and patients regularly so as to clearly delineate the responsibilities of all.
- It is extremely difficult to collect payment from self-pay patients after the time of the visit. It is not uncommon for a community dental practice to write off tens of thousands of dollars in uncollectible bad debt that is owed by self-pay patients each year. Therefore, it is imperative to have systems set up and processes that enable staff to collect fees and co-pays at the time of the visit.

An important key to receiving payment from sliding fee patients is to train reception staff and establish accountability from them for collecting payment at the time of the visit. To help ensure success with this:

- Provide staff with a script of what to say to patients when asking for payment and by developing staff performance evaluations and competency checklists that include self-pay collections.
- Begin monitoring accounts receivable due past 90 days from self-pay patients. Alert reception staff that this is a measure that will be used to evaluate their performance in collecting payments from patients.
- Set ceiling targets for the accounts receivable, monitor, provide feedback to staff and manage performance issues.

Refusal to Pay Policy: (Please see HRSA PIN: 2014-02)

Health centers are mandated to make "reasonable efforts" to secure payments from patients for services rendered. There may be instances when patients refuse to pay the amount they owe to the health center. To protect the financial viability of the dental clinic, the health center may elect to establish a "refusal to pay policy" as a last resort.

If the health center chooses to establish a refusal to pay policy, they must establish operating procedures that define:

- What constitutes "refusal to pay" and what individual circumstances are to be considered in making this determination.
- What collection efforts are taken when these situations occur.
    - Efforts could include: payment plans, grace periods, financial counseling, etc.
- What the consequences are for "refusal to pay" (such as discharging patient from the practice, or discontinuation of all "non-emergent" or elective treatment)

*All efforts to secure payment need to be documented prior to any action being taken.

DEVELOPING A SLIDING FEE DISCOUNT SCHEDULE

A sliding fee discount schedule (SFDS) allows patients who do not have private or public dental insurance or who are "underinsured" to receive care that they otherwise might not be able to afford. Having a SFDS is a HRSA regulation which applies to all 330 program grantees and look-alikes. For eligible patients, you must prepare and apply a schedule of discounts that is adjusted based on the patient's ability to pay. The patient's ability to pay will be determined by the federal government's poverty guidelines that are updated annually.

In order for your program to balance mission with financial sustainability, you must be both compassionate and strategic in developing your SFDS. The health center's governing board will need to give approval of the finalized schedule of discounts. They will ensure that the SFDS is patient centered, helps to improve access to care, and assures that no patient will be denied health care services due to an inability to pay. However, the discount schedules must be created with conscious and informed knowledge related to your practice's costs.

All patients who do not have insurance or are under-insured should be educated on the availability of the clinic's sliding fee discount schedule. It is a HRSA requirement that the availability of the SFDS be posted where all patients can see it.

To Formulate an Effective Sliding Fee Discount Schedule:

- Start with your full fee schedule:
    - Look at the usual and customary fees for your region to ensure that the full fees are in line with what other practitioners in the area are charging.
    - Compare the current fee schedule with reimbursement provided by each insurer that your clinic accepts. Ensure that the dental practice's fee schedule has charges that are equal to or greater than allowable fees by insurers.
- The practice should make conscious, data-driven decisions regarding the discounts offered to patients.
    - Calculate how low the practice can afford to set the discounts while still maintaining sustainability (factoring in 330 grant funding, if applicable).
- The discount schedule should be structured as such:
    - Nominal fee (a flat fee, and not a percentage of full fees) for individuals at or below 100% Federal Poverty Guidelines (FPG)
    - At least three discount pay classes above 100% and below 200% of the FPG tied to gradations in income levels

- Pay classes above 100% FPG should never pay less than pay classes below 100% FPG. Patients who qualify for the nominal fee should always receive the greatest discount.
    - Also per HRSA requirements, individuals and families with annual incomes above 200% of the FPL are not eligible for sliding fee discounts

Safety net dental clinics have individual discretion on how to structure their SFDS. Although there must be a minimum of at least three discount pay classes as described above, additional discount pay classes can be offered. Dental clinics also have the freedom to determine the types of discounts; this means the discount can a percentage of full fee or fixed, flat fee for each discount pay class. Also, the size/amount of each discount is to be determined by safety net dental clinics and their boards.

It is also possible to have multiple discounts schedules based on the services/mode of delivery. Lab costs should be paid by patients. Please keep in mind that all services within your approved scope of project, whether required or additional, must be provided on the SFDS. Also, the discounts must be applied uniformly across the patient population without regard to the patient's ability to pay.

Most of the information in this section is a reflection of the guidance in the HRSA PIN released September 22, 2014 entitled, "Sliding Fee Discount and Related Billing and Collections Program Requirements". (PIN 2014-02). Safety Net Solutions recommends directly consulting the HRSA PIN when developing your sliding fee schedule.

DOCUMENTATION OF SLIDING FEE DISCOUNT SCHEDULE ELIGIBILITY

In order to be eligible for this financial assistance, patients must provide proof of income to determine their eligibility for the sliding fee schedule discount. It is essential for the dental practice to create a formal process for documenting a patient's financial eligibility. Eligibility for the SFDS is based on a patient's annual income and family size, which is determined by the U.S. Department of Health and Human Services' (HHS) annual federal poverty guidelines. The eligibility determination process must be documented and its implementation periodically reviewed for compliance and effectiveness. It is also a best practice to renew/review patient eligibility for the SFDS at least once a year or upon the patient's next visit to the health center.

Strategies and Best Practices:

- Develop a formal policy defining the eligibility determination process for assessing income and household size.
  - The process must be conducted in an efficient, respectful, and culturally appropriate manner.
- Include the determination of eligibility in front desk job descriptions and performance evaluation tools.
- Only schedule non-emergent self-pay patient appointments AFTER the patient has completed the application process and the practice has verified proof of income to determine their discount.
- For non-emergent patients who show up for appointments without the proper documentation to verify their income, determine if your practice will:
  - Provide the minimum necessary services and postpone the remainder until coverage can be confirmed.
  - Offer the patient the option to be either rescheduled for a time when eligibility can be verified, or pay out of pocket with no discount for the visit.
  - The key is to develop a formal policy for how these situations will be handled, to educate staff and patients accordingly, and to follow through consistently.

If patients choose not to provide the information required for assessing income and family size even after being informed that they may qualify for it, then these patients are declining to be assessed. If the dental clinic has followed the SFDS eligibility determination policies and operating procedures and the patient declines to be considered for the SFDS, the patient may be considered ineligible for income based discounts.

PAYER MIX:

The payer mix identifies both challenges and opportunities related to access and financial viability. Practices that develop a strategic plan for sustainability based on predicted revenue from each payer source are the most successful. A strategic plan will determine the number and percentage of visits for each payer class that the practice can see and continue to meet its access and financial goals. By doing this, a practice can provide the maximum amount of care for the most needy patients without jeopardizing their viability.

DETERMINING YOUR OPTIMUM PAYER MIX:

- First you must determine your current payer mix:
  - o Divide the total number of patients with each payer type by the total number of all patients of the dental clinic. This will reveal what percentage each payer type is of the overall payer mix.
- Next determine the average revenue per visit for each payer type:
  - o Track a sample week or month of all collected revenue/reimbursement for each payer type.
  - o Then divide the total revenue by total the number of patients from each payer type during that sample time period to find your average revenue per visit for each payer type.
- Then determine your average daily cost of operation:
  - o Divide the total yearly expenses by the number of full workdays (most safety net dental clinics work around 230 workdays/year)
- Finally use the average revenue per payer type to determine the optimum payer mix that will ensure daily operating expenses will be met and therefore assure the financial sustainability of the dental clinic.

Best Practices & Strategies:
- Define & focus on "priority populations" such as: children, pregnant women, patients with diabetes, patients with cardiovascular disease, and patients with HIV/AIDS. There are excellent clinical reasons for prioritizing care to these populations, many of whom have coverage for dental care. Revenue from these patients can help offset the losses incurred by providing dental care to low-income uninsured patients. The way to do this is to use designated access/ through your scheduling template (For additional information, please see the scheduling section.)
- Identify every area within the health center where these priority patients are receiving medical care (Pediatrics, WIC, OBGYN, etc.) and develop formal referral mechanisms to direct priority patients without an established dental home to the dental clinic. These formal referral mechanisms should be bidirectional ensuring

that dental patients without an established medical home will also be referred to the health center.

- At consolidated all-staff meetings for the health center, the medical director should stress to all medical staff the importance of dental health for at-risk patients in need of regular dental care, such as patients with diabetes, patients who are HIV positive, patients with cardiovascular disease, perinatal women, and children.
- Design a formal early oral health intervention program in pediatrics/family practice as part of the well child visits. (caries risk assessments, anticipatory guidance, oral screenings, and referral to dental).
- Using designated access, develop a formal process for medical staff to make a direct referral to dental (and vice versa). (Reserve slots in the schedule for medical patient referrals.)
- Develop external referral relationships with departments and agencies serving priority populations (Such as: Head Starts, Boys & Girls' Clubs, YMCA, etc)

When needed, a practice can adjust the payer mix to ensure sustainability through designated access scheduling. The goal is to focus on the best sources of revenue in designated access to the point where it is needed, while creating an environment that provides equal care to all patients. By taking advantage of reimbursement opportunities, it enables the practice to provide more care to those patients who have very limited reimbursement potential by subsidizing their care with well reimbursed care.

QUALITY MANAGEMENT

It's a given that your safety net dental program places a high priority on high-quality oral health care which effectively prevents and manages dental disease. A good quality management system promotes oral health care that is quality driven, evidence-based, and that increases the likelihood of desired health outcomes. We consider the quality of care in the areas of structure (attributes of the settings in which care is provided), process (services actually provided to the patient) and outcomes (health status as a result of the preceding steps.)

Most dental clinics' quality management programs are based on the report by the Institute of Medicine (IOM). IOM urges providers to adopt a shared vision of six specific aims for improvement. These aims are built around the core need for health care to be:

- **Safe**: Avoiding injuries to patients from the care that is intended to help them.
- **Effective**: Providing services **based on scientific knowledge** to all who could benefit, and refraining from providing services to those not likely to benefit.
- **Efficient**: Avoiding waste, including waste of equipment, supplies, ideas, and energy.
- **Patient-centered**: Providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.
- **Timely**: Reducing waits and sometimes harmful delays for both those who receive and those who give care.
- **Equitable**: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

Effective quality improvement programs seek to continuously improve oral health care delivery systems. These programs should consider the service delivery process, quality of personnel and resources, sustainable business practices and desired optimal outcomes for patients that integrate prevention-focused care and disease management into the system.

Often, the goal of quality improvement initiatives is not to develop new treatments or methods but rather to encourage the adoption of proven prevention and treatment methodologies and to work with clinical providers to overcome the barriers to making those proven interventions a routine component of clinical practice.

- Is this the right care?

- For the right person?
- In the right way?
- At the right time?
- To achieve the desired outcome?

Best Practices and Strategies:

- First and foremost, clinics should create a formal documented policy defining all aspects of quality assurance and improvement program.
- Establish quality measures to be tracked and reported such as:
  - Phase 1 treatment completion rate within a 12 month period.
    - Tracking Phase 1 treatment completion is an excellent way to demonstrate the work being done to improve the overall oral health of the community. This quality outcome indicator is recognized by HRSA and is easy to track using a dummy code, Phase 1 treatment includes diagnosis and treatment planning, preventive services, emergency care, restorative treatment (including single unit crowns), non-surgical periodontal therapy and the simple extraction of hopeless teeth. (Please find additional information in the Phase 1 treatment completion section.)
  - Number of sealants provided for children
- Tracking and reporting these quality metrics demonstrates that the program is meeting community standards and pursuing excellence. Metrics around sealant placement and treatment plan completion are quickly gaining national attention.
- Create and document a prioritized treatment plan for every patient
  - Present patients with the expected cost for their next visit when it is scheduled.
  - Identify a process for identifying patients with uncompleted treatment needs and ensure they are not lost to follow-up
- Develop formal, documented clinical protocols (eg, new patients get full-mouth x-rays according to Medicaid regulations)
  - Examples: Protocols for children ages birth to three, emergency care protocols, guidance for when root canals are to be provided, under what conditions the clinic can provide extractions, who gets sealants, when are referrals made, what restorative materials are used, under what clinical conditions are partial dentures provided, what should be recorded in the record (almost everything) and what should not (subjective statements)

- Revise recall system to ensure that patients needing follow-up care are not lost to treatment
  - When the Phase I treatment plan is completed the patient is moved to recall status, which opens up a slot in the practice for a new patient.
- Develop a quality assurance review process to include:
  - A chart audit process that involves all providers.
    - Objective dental record peer reviews to examine and evaluate patient documentation against well-defined criteria. These reviews can be conducted by staff dentists (who will review charts other than their own) or be contracted with outside dental professionals.
  - Objective measures to demonstrate improved oral health outcomes (ex: the number of patients who have received completed phase 1 treatment plans within 12 months of their exam.
  - Subjective patient outcomes assessed via patient satisfaction surveys, which measure the patient's perception of the care experience and results of that care
- Develop a quality improvement process to identify problems, resolve issues, implement changes, monitor results, and to report progress.
  - Patient complaints and satisfaction surveys
  - Complaint resolution, action plans
  - Solicit patient feedback on the experience of care and resolving patient care incidents and issues

PHASE 1 TREATMENT PLAN COMPLETION

The tracking of completed treatment plans within a community health center is both a quality indicator and an important component for access to care for new patients. By tracking the completion of phase 1 treatment plans, you are in a sense monitoring the decrease in active dental disease in your patients. Monitoring this quality indicator encourages a collective team focus on treatment completion, which in turn helps to reduce the delivery of urgent, episodic, fragmented care and fosters continuous, coordinated care for your patients.

Although HRSA has defined four levels of care, only Levels 1, 2, and 3 are considered "Phase 1 Treatment." The four levels are:

- Level 1- Emergency
- Level 2- Primary (prevention)
- Level 3- Secondary (restorative)
- Level 4- Limited Rehabilitation (crowns, dentures, etc.)

Phase 1 Treatment is defined as: diagnostics, preventive services, and the treatment and elimination of dental disease (restorative services, minor periodontal services, extraction of hopeless teeth). Phase 1 treatments help patients achieve a baseline of normal disease-free, or disease-managed oral health.

Best Practices and Strategies:

- Begin tracking Phase 1 Treatment Completion
  - Create a dummy code in your EDR that will signify that Phase 1 treatment is complete.
    - Phase 1 treatment is considered complete when the patient has no active dental disease in their mouth; or when that disease is being actively managed.
    - Educate all dental providers/staff on the proper, consistent, accurate use of this code.
- Create and implement standardized clinical protocols defining the care to be delivered at each visit as an expectation of services rendered. These should be created with the intention of achieving the completion of Phase 1 treatment plans within a 12 month timeline.
- Optimize the timely completion of needed treatment through strategies such as:

- A plan in place to decrease broken appointments. (This is addressed in greater detail in the broken appointment section.)
- A defined emergency policy, the definition of a true emergency and a triage system in place for emergencies. (This is addressed in greater detail in the managing emergencies section.)
- Using designated access scheduling templates to balance the number of new patients coming into the practice with the number of patients who have completed Phase 1 Treatment plans.

FINDING YOUR TREATMENT COMPLETION RATE

- Divide the total number of completed treatment plans (tracked by a dummy code) by the sum of all periodic exams (D0120), oral exams for children under age 3 (D0145), and comprehensive exams (D0150) for a 12 month time period.

MEDICAL DENTAL INTEGRATION:

Good oral health is part of optimum overall health and well-being. Integration of oral health into primary care expands the potential for high risk individuals to have access to prevention focused care that halts and can even reverse dental disease, avoiding or reducing the need for expensive restorative treatment. Primary care providers can play an important role in improving each patient's oral health by educating and promoting self-care and utilizing therapies to reverse or prevent the progression of disease. Integration is oral health and primary care working within and as part of one another. It is the provision of dental services within primary care, and medical screening and basic systemic health counseling within dental care.

Medical/Dental Integration Best Practices:

- Consider designating priority populations for dental care within the health center such as children, pregnant women, diabetics, patients with HIV/AIDS and cardiovascular patients.
- Formally integrate medical and dental by developing a bidirectional referral system
  - Create a medical dental integration improvement team that meets on a regular basis to discuss the barriers to integration and brainstorm solutions to resolve barriers.
  - Educate medical and dental staff to make sure patients are receiving both medical and dental care within the system.
- Create designated slots in the dental schedule for referrals from primary care.
- Establish a warm handoff referral for priority populations such as children and perinatal women.
- Consider a formal early oral health intervention program in pediatrics/family practice as part of well-child visits (caries risk assessment, anticipatory guidance, screening and referrals to dental)
- Train and educate the primary care team to screen for disease and risk by doing exams and risk assessments on patients
  - Primary caregivers should educate patients on the nature of dental disease and self-care strategies
  - Primary caregivers should counsel patients and caregivers on the need to maintain optimum oral pH levels, Reduce levels of bad bacteria in the mouth and practice effective home care
  - Patients who are high risk or who have untreated dental disease should be referred to dental

- Incorporate screening for common health problems in the dental visits (i.e. high blood pressure and diabetes)
- The dental medical history should determine whether the patients has an ongoing medical home and ask about chronic and special conditions affected by dental disease (i.e. diabetes, heart disease, HIV/AIDS, pregnancy)
- Include in the medical health history questions in regards to the patient's oral health, if the patient has a dental home, and the date of their last dental visit.
- Develop educational materials for primary care givers to provide to patients educating them about the importance of oral health

STAFFING

A well-trained and committed workforce is required to manage the growing needs for dental services, and to enable the health center to fulfill its mission of providing excellent oral health care to its patients while improving the overall health of the community. Workforce issues can be a primary concern for health center oral health programs that are struggling with recruitment, retention, untrained or undertrained staff, determining proper salary and benefit packages, and high turnover rates. When the dental program is understaffed or does not have the right staff in place, the program will suffer and not be able to meet the demand in the community in an efficient and effective manner.

Staffing Best Practices:

Hiring Staff:

- Determine the type of provider you are seeking: MD, DO, DDS, DMD, mid-level, etc
  - If mid-level, are you seeking a nurse practitioner, physician assistant, or dental hygienist?
  - Board certification or board eligible required?
  - Do you want an experienced provider or new graduate?
  - Will you consider a foreign medical graduate (J-1 VISA)?
  - What educational requirements and/or certifications are required?
  - Are staff privileges at a local hospital required?
  - Does the provider need to speak a specific language?
  - Is prior urban or rural clinical experience required?
  - Are there any limitations in scope of practice for nurse practitioners, physician assistants, dental hygienists, or behavioral health providers because of state or payer restrictions?
  - Are there any licensing requirements/limitations for the provider?
  - What level of supervision dentist will be required for mid-level providers?
- Create a job description for each position in the dental program. Roles, goals, and responsibilities should be clearly defined for each position and shared with the employees. This will aide in accountability and productivity.
- Screen candidates- This includes preliminary interviews, checking references and credentials, and conducting the on-site interview visit.

Staffing Models:

- Dental assistants and hygienists should be used strategically in community dental practices. In some states, expanded-function dental hygienists and assistants can provide additional services that improve access, treatment protocols and

productivity. Because dental assistants and hygienists enhance the productivity of dentists, the key is to use personnel effectively to maximize their time.

- Develop a staffing model that maximizes efficiency and effectiveness in the dental program. For example, a ratio of 2.0 to 3.0 operatories per dentist will enable the program to function at peak efficiency. If expanded functions and EFDA restorative services are available in the clinic, 3.0 chairs should be available per dentist. In addition, a dental hygienist should have a separate, dedicated operatory.
- In order for the dental program to maximize productivity, there needs to be a sufficient amount of support staff. It is recommended to have 2.5 FTE Dental Assistants per FTE provider, or 1.0 FTE Dental Assistant per operatory.
- If understaffed, make your case by compiling the numbers. Run a test cycle using additional staff (for instance, if one provider is out for the day, have his or her support staff work with another provider). Prove that the additional staff will be productive and efficient and will enable you to provide high-quality care to the patients while not doing damage to the budget.

Recruiting Strategies:

- Create a one page announcement about the dental program and open position, post at local residency programs, dental school, and dental hygiene schools.
- Attend job fairs
- Advertise through national dental associations (National Network of Oral Health Access, American Dental Association, American Dental Hygiene Association, American Dental Assistants Association.)
- Advertise in state or local dental associations (primary care offices, state offices of rural health, and state dental association and dental societies)
- Advertise in professional journals
- Consider advertising on Craigslist, and other free classified advertisement websites
- Consider recruiting providers from the National Health Service Corp. loan repayment program
- Establishing a fair and competitive compensation arrangement for providers is essential to the continued growth and success of any community health center.
- Communicate the benefits of working in a community health center organization including fringe benefits such as dental, health and life insurance, paid time off, reimbursement for training and education etc.
- Offer an incentive plan for providers and staff when they meet or exceed their productivity and quality outcome goals.
- Investigate other recruiting sites (i.e. Craigslist)

Retention Strategies:

- Health center systems and policies should support staff with the tools and systems essential to providing a work environment that promotes and sustains quality of care, including high patient satisfaction. This includes human resources (well trained and adequate numbers of staff), facility and infrastructure, organizational culture, and technology, including electronic dental records.
- Management based collaboration, work structured to be meaningful and challenging, as well as a commitment to share information and ensure participation in decision making are key strategies for a stable and productive staff committed to the mission and future of the health center.
- A competitive compensation and benefit package that is kept current with the market and also supports long-term retention, and enhances productivity and quality. Appropriate incentive plans and deferred compensation plans which are compatible with fiscal resources, the health center mission and management philosophy, and are in accord with state and federal laws, should be explored as methods to maximize the retention of productive, high quality, and committed health professionals.
- Regularly scheduled staff meetings

Retention-building activities such as these should be ongoing. When a provider leaves your CHC, you should learn something from his/her departure. Some of the questions to consider are:
- What have been contributing factors to turnover among providers?
- What do providers perceive as the most important supports necessary to "succeed" in a clinical position within your organization?
- To what extent are those supports and other targeted support services such as mentoring, financial support and professional development made available?
- How can we improve our organization in order to retain providers?
- If you could change anything about the organization, what would that be?

LEADERSHIP AND TEAM BUILDING:

Throughout this Safety Net Solutions self-assessment, enhancement plan development process and implementation of the plan, the dental practice will undoubtedly undergo a significant amount of change. Certain aspects of change may come more easily than other aspects. Nonetheless, there are guiding principles that will make the changes come easier and more smoothly.

- A good leader must understand the environment of care under which they are working, and educate the department about that environment of care, as well as develop an action plan that will work for each unique environment.
- An excellent way to motivate staff is to keep them informed and educated about the practice. By meeting with staff regularly, developing accountability for their responsibilities and setting a positive example, leaders can more easily motivate staff toward goals.
- In order for the dental director to be an effective leader, he or she will need an adequate amount of administrative time for staff meetings, program evaluation, coaching and guidance.
- A dental director or manager must have the right skills to successfully lead a team. Not everyone makes a great leader, but that does not mean that person is not good at what they do. Leadership takes skill and experience. The right candidate can develop into a good leader with the right qualities. Essential elements for community health center leadership include:
  - The ability to secure trust, resolve conflict, get buy-in and commitment, create peer accountability, and attain results as a team.
  - Leadership by example; strong work ethic.
  - The ability to stimulate accountability
  - The ability to create a clear strategic plan based on their vision and then share it and inspire the team with it.
  - Excellent communication skills. Most problems stem from poor communication and lack of training.
  - The organization stills required to collect and monitor essential data relative to practice goals, and the diligence to review it with the team regularly.

PROGRAM EVALUATION

The cornerstone of Quality Improvement and Quality Assurance is evaluation data. For this reason, Safety Net Solutions recommends dental clinics track certain data on a regular basis in order to effectively monitor their program.

- Identify the key data to be gathered (Please see the section on [key practice data to track and monitor](#).)
    1. Data should be evaluated and tracked for individual providers and the dental department as a whole.
- Developing key indicators that measure productivity and performance for the clinic and the individual practitioners is only possible if the appropriate data elements are available in a timely manner and the accuracy of the data is tested and verified on a regular basis.
- Identify the reports that will need to be run to generate this data, who will be responsible for running these reports, when they will be run and how the results will be shared.
- Define daily productivity, financial, and outcome goals that need to be met; identify reports needed to evaluate dental program performance; track progress in meeting goals, and develop greater accountability through reports and sharing of results report regularly to dental staff.
- Set provider productivity goals (number of visits/day and number of procedures/visit)
    1. Develop and implement clinical protocols to standardize services provided, maximize revenue, guard against "unbundling," and foster the timely completion of phase 1 treatment plans.
- Productivity Benchmarks:
    1. 2,700 encounters/year with 1,100 patient base
    2. 230 work days/year (or 1,600 work hours/year after holidays and vacations)
    3. Dentist:
        - 2,500-3,200 encounters/year/FTE dentist
        - 1.7 patients/hour or 13.6 patients per day per dentist
        - 2 Chairs/dentist (3:1 is ideal)
        - 1.5 Assistants/dentist (1 DA per chair is ideal)
    4. Dental Hygienist:
        - 1,300-1,600 encounters/year/FTE hygienist
        - 8-10 patients/day for hygienists
- Dental program performance should also be regularly shared with staff to create a culture of accountability.

- The keys to creating a culture of accountability within the dental program are:
  1. Continuously monitor and analyze performance
  2. Provide regular feedback to staff
  3. Engage all staff in establishing goals and developing solutions to any issues
  4. Reward success and coach setbacks
  5. Always lead by example
  6. Ensure the work environment is fun, supportive, and encouraging

Dental program performance evaluation should be part of a formal continuous quality improvement focus.

Evaluating data should be done on an ongoing basis. By developing a variety of key indicators clinic managers will be able to measure and monitor various data, including:
- More accurate measurement of the impact of managerial decisions in a timely fashion
- Provision of feedback to employees regarding personal performance
- Generation of rationale for budgetary adjustments
- Provision of data for annual budget preparation and justification
- Identification of changes in production that require managerial intervention