“I don’t think we’re in Kansas anymore, Toto.”
I don’t think we are in medical anymore, Yadi
Guiding Principles

The dental schedule should be used to achieve three key strategic objectives:

- **Improved oral health status for patients**
  - don’t lose sight of your mission
  - do the little things right and the big things take care of themselves
- **Maximum access to care for patients**
  - empty chairs = empty pockets
- **Financial viability of the dental program**
  - ”no margin, no mission”
  - ”no cash, your oral health program will crash”
Keys to Maximizing Access Through Proper Scheduling

Match your provider skills to the patient needs – “don’t try to put a square peg in a round hole”
Keys to Maximizing Access Through Proper Scheduling

- Match your hours of operation to the needs of your community of patients
- Schedule appointment times to minimize no-shows
- Designate a daily “emergency dentist/overflow dentist” or build into schedule based on practice analysis
- Be consistent
Keys to Maximizing Access Through Proper Scheduling

• Avoid “double booking” as your strategy to reduce “no-shows”
• Match your physical resources to your community of patient needs
• Base the schedule on all staff working to the top of their license/ability
• Eliminate front desk distractions
• Don’t practice “there is never enough time to do it right but there is always time to do it over”
Keys to Maximizing Access Through Proper Scheduling

• Consider return appointments scheduled in operatory with provider input

• RECRUITMENT AND RETENTION ISSUE – “no dentist = no access”
Maximizing Access Will Maximize Outcomes: Completion of Phase 1 Treatments

- HRSA Definition of Phase 1 Treatment: diagnosis and treatment planning, preventive services, emergency treatment, restorative treatment, basic (non-surgical) periodontal therapy, basic oral surgery, non-surgical endodontic therapy and space maintenance and tooth eruption guidance for children
- The daily schedule is an important tool for maximizing the number of patients whose Phase 1 treatment needs are completed
Financial Viability

• Net revenue needs to be sufficient to meet total direct and indirect expenses

• Net revenue includes patient care revenue plus any ongoing, predictable grants (such as 330 grants for FQHCs)

• The daily schedule is an important tool for ensuring the generation of sufficient revenue to at least cover direct and indirect expenses (and ideally generate a surplus to grow your program)
Financial Viability

- Maintain scheduling priorities for patient populations designated as priorities
- Schedule certain procedures/patient populations on designated days
- Maintain a financially viable patient mix
- Monitor receivables breakdowns to identify billing issues early
Maximum Patient Access for Financial Viability

• As a safety net dental provider, your mission should be to provide access to all disadvantaged patients who have difficulty getting care but special populations can be designated as priorities (e.g., children, pregnant women)

• The schedule is how we preserve access for priority populations
Designated Access

• The daily schedule ensures access for all patients
• But a certain number of appointments are reserved for priority patients
• These appointments can’t be filled with other patient types until the day before
Defining Program Capacity

• Every dental program has a finite capacity
• Capacity depends on the number and type of staff, number of dental chairs and hours of operation
• Once we have defined our capacity, the schedule is the tool we use to maximize that capacity
• The schedule is also how we ensure that our capacity is utilized in a way that supports maximum access, outcomes and revenue
## Daily Visit Capacity, Dentists

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

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

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

Total weekly visit capacity = 273
Determining the Daily Revenue Goal

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

• For example:
  Total expenses = $950,000
  5 days per week x 46 weeks = 230 clinic days per year
  $950,000 ÷ 230 = daily net revenue goal of $4,131

• If you have built insurance tables into your EDR, the system should automatically calculate your adjusted net revenue (or expected net) for each day (gross production minus contractual adjustments = adjusted [or expected] net)
Building the Template

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

These elements are unique to each practice and must be factored into the creation of the schedule template.
Once Defined, Document the Entire Process

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

• How far out will appointments be scheduled?
• Only one appointment at a time (exception: procedures requiring more than one appointment to complete)
• Define how operatories will be used (how many per provider based on provider practice type)
• Define appointment lengths for various procedures (use RVUs and time studies to establish times) to maximize revenue based on patient cooperation and provider ability
• Indicate where in each appointment type the dentist is needed vs. dental assistant time – maximize use of auxiliaries
The Scheduling Policy (cont.)

• Start and end times for appointments each day – stagger staff to minimize loss of production
• Who is authorized to schedule appointments
• Providers should always be working to the top of their license (e.g., dentists being dentists, hygienists being hygienists)
• If expanded function dental assistants are available, they should also be working to the top of their ability
• Indicate what types of appointments can be double-booked
Schedule Busters

- Patients who cancel at the last minute
- Patients who don’t show up or show up late
- Double- or triple-booked patients who all show up unexpectedly
- Too many emergencies/walk-ins worked into the daily schedule
- Too many new patients in the daily schedule
- Too many patients altogether in the daily schedule
- Logjams at check-in or out
- Providers who fall behind (or the entire practice falls behind)
- Not enough support staff (assistants and reception/registration)
Schedule Busters

• Patients put in wrong appointment slots (eg, hygiene patient in dentist’s column; single restoration put in crown prep slot; multiple filling appointment put in short-procedure slot)
• Appointments that are too short (or too long)
• Lack of instruments/staff to keep up with sterilization
• Technology issues (computers slow, freeze up, bounce staff out, breakdowns, etc.)
• Providers and assistants bogged down with paperwork (referrals, pre-treatment authorizations, prior authorization requests, etc.)
Case Study: Scheduling for Survival and Beyond

Dr. Travis Shearer
Dental Director, Southern Missouri Community Health Center
I grew up in the mountains of Colorado. In my family we were mostly coal miners and cattle ranchers.
Life was much simpler. Hard work was the norm and that was one of the first lessons I learned growing up. Communication with the outside world was very limited.
Many students in my high school went to the coal mines after graduation. I went to college. I received a scholarship from the National Health Service Corps and completed my DDS from the University of Nebraska in 1994.
The early days of Southern Missouri Community Health Center (SMCHC) were pretty simple too.

In the spring of 2001, community members of Howell and Oregon counties came together to discuss access to care in their region. One of the foremost issues was access to dental care for children in the area.

The efforts of these community members resulted in Southern Missouri Community Health Center, which opened in February 2003.
Our first needs assessment indicated an immediate, overwhelming need for both adults and children. We had our work cut out for us.
SMCHC’s first home was in a strip mall

The dental clinic operated with two dentists with a total of six operatories

Limited capacity and providers made it necessary to immediately define our focus and target population
We focused on restoring health vs. high end dentistry

Our target population was children and pregnant women

We accepted referrals from SMCHC medical clinic for adults with diabetes and/or special circumstances

We worked closely with our pediatrician at SMCHC medical clinic
In 2006 we opened this new facility.
The new facility has four dentists’ offices and twelve operatories.

We started to recruit new dentists.
Our recruitment efforts were successful, and after several years of being open we were starting to control the flow of patients---somewhat.
We had 3 dentists, then 4. We were seeing a lot of patients---until 2014.
In 2014 one SMCHC provider decided to retire from dentistry. A second provider decided to go into private practice.

Suddenly, we had more patients than the remaining dentists could care for.

Safety Net Solutions and Expert Advisor Dr. Bruce Wilcox conducted an assessment of our dental program previous to these providers leaving. Dr. Wilcox reviewed our systems and helped us identify what we were doing right and where changes could be made.
What We Were Doing Right

• Focus on completion of treatment plans.
• Continued financial viability.
• Peer review utilized not only to ensure quality but for provider growth and comraderie.
• Investment in continuing education for providers and dental assistants.
Dr. Wilcox’s Recommendations

• Overcome resistance to change.
• Recognize scheduling practices that were effective and productive with several providers but were less so with a reduced staff.
• Revise scheduling practices to optimize provider time and efficiency.
Current Model - “Keep it Simple”

4 columns, 1 dental assistant per column for experienced providers like myself.

3 columns, 1 dental assistant per column for newer providers.

Dental assistants do not have assigned rooms.

Dental assistants rotate doing operative.
Schedules are built to the strengths of providers and assistants. Attempts are made to maximize skill level of dentists and dental assistants.

Myself—children 0-8 years old

Provider 2—patients over 8 years old

Provider 3—patients 15 years and older
Scheduling Template
Column 1 - most time consuming, difficult procedures
Column 2 - this column is used for multitude of purposes - flexible
Column 3 - recall
Column 4 - recall

Front Office
1 person at check-in
1 person at check-out
 Individuals help each other, especially at the top and bottom of each hour
<table>
<thead>
<tr>
<th>Time</th>
<th>Doctor 1</th>
<th>Doctor 1</th>
<th>Doctor 1</th>
<th>Doctor 1</th>
<th>Doctor 2</th>
<th>Doctor 2</th>
<th>Doctor 2</th>
<th>Doctor 3</th>
<th>Doctor 3</th>
<th>Doctor 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>8am</td>
<td>Production</td>
<td>Prod/Emer</td>
<td>Recall</td>
<td>Recall</td>
<td>Production</td>
<td>Prod/Emer</td>
<td>Recall</td>
<td>Production</td>
<td>Prod/Emer</td>
<td>Recall</td>
</tr>
<tr>
<td>9am</td>
<td>Production</td>
<td>Prod/Emer</td>
<td>Recall</td>
<td>Recall</td>
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<tr>
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<td>Recall</td>
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<td>Prod/Emer</td>
<td>Recall</td>
</tr>
<tr>
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<td>Production</td>
<td>Prod/Emer</td>
<td>Recall</td>
</tr>
<tr>
<td>Noon</td>
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<td>LUNCH</td>
<td>LUNCH</td>
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<td>LUNCH</td>
</tr>
<tr>
<td>1pm</td>
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<td>Prod/Emer</td>
<td>Recall</td>
<td>Recall</td>
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<td>Prod/Emer</td>
<td>Recall</td>
<td>Production</td>
<td>Prod/Emer</td>
<td>Recall</td>
</tr>
<tr>
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<td>Prod/Emer</td>
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<td>Recall</td>
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<td>Prod/Emer</td>
<td>Recall</td>
<td>Production</td>
<td>Prod/Emer</td>
<td>Recall</td>
</tr>
<tr>
<td>3pm</td>
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<td>Prod/Emer</td>
<td>Recall</td>
</tr>
<tr>
<td>4pm</td>
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<td>Recall</td>
<td>Production</td>
<td>Prod/Emer</td>
<td>Recall</td>
</tr>
</tbody>
</table>
Are we back? We’re getting there and scheduling was a big part of the solution
## Then vs. Now

<table>
<thead>
<tr>
<th>Baseline</th>
<th>Now</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 FTE Providers</td>
<td>2 FTE Providers</td>
</tr>
<tr>
<td>9,812 visits</td>
<td>7,455 visits</td>
</tr>
<tr>
<td>4,420 unduplicated patients</td>
<td>5,168 unduplicated patients</td>
</tr>
<tr>
<td>Bottom line (excess of revenue over expenses) = $76,600</td>
<td>Bottom line (excess of revenue over expenses) = $377,740</td>
</tr>
</tbody>
</table>
Problems and Hopeful Solutions

- Bottlenecks at front desk during top and bottom of each hour
- Currently expanding registration to help with scanning documents including HIPPA and inputting information
- No Show rate—currently 11%—if a patient no shows we offer to do more for the patient in the chair
- Continue to call all patients
- Looking at robo call system