Digging Deeper: Preparing for a HRSA Operational Site Visit

Our mission is to improve the oral health of all.
Pre-Test Questionnaire

Please take a few minutes before we begin by completing the Pre-Test Questionnaire

www.surveymonkey.com/r/FS5MBCL
Today’s Agenda

1:00-2:00 p.m.  Part 1, What is an Operational Site Visit?
2:00-3:00 p.m.  Part 2, What is Evaluated?
3:00-3:15 p.m.  Break
3:15-4:00 p.m.  Part 3, Fees/Sliding Fee Scale Discounts
4:00-4:50 p.m.  Part 4, Activity: You’re the Reviewer!
4:50-5:00 p.m.  Wrap-Up
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safety net solutions
NNOHA
DentaQuest Institute
Today We Are Going to Discuss:

- The rationale and format of an Operational Site Visit
- The 19 HRSA program guidelines and how they apply to dental
- The “win-win” of preparing dental for an OSV
- A deeper dive into the Sliding Fee Schedule Discount
- A case study where you will get a chance to be a surveyor!
Part 1: What is an Operational Site Visit?
But First, a Poll!
Your poll will show here

1. Install the app from pollev.com/app
2. Make sure you are in Slide Show mode

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Friend or Foe?
When Can You Expect an OSV?

• Generally during the first 10 to 14 months of a newly funded/designated health center’s project/designation period

• At least once per project/designation period or at least once every 3 years

• Typically, OSVs will take place 18 months into a 3-year project/designation period for most health centers
The OSV Purpose

• Evaluate HC performance in meeting 19 program guidelines
• Understand what makes the health center unique
• Learn about the HC’s successes, challenges and future plans
• Assess overall HC financial and operational performance
• Identify opportunities for improvement and/or technical assistance
• Discover best practices that can be shared with other HCs
• Gather the information necessary to formulate a report to HRSA
Preparing for the OSV

- Typically receive notice of visit 3 months before
- Inform key staff and Board members
- Review the 19 Program Guidelines
- Review the HRSA Site Visit Guide
- Gather/review documents to determine compliance—each reviewer will send the health center a list of required documents
- Contact your Project Officer with any questions related to the site visit
- Participate in the Planning Call—key health center staff, reviewers, Project Officer
The OSV Process

- Takes place over three days
- Entrance conference—Senior Management/Board
- Tour of the site(s)
- Document review
- Individual Key Staff Interviews
- Board of Directors Meeting
- Pre-Exit Conference with CEO
- Exit conference—Senior Management/Board
- Site visit report to HRSA
- Final report from HRSA to health center
OSV Logistics

- Generally, there are three members on the site visit team, who are members of BPHC’s Expert Roster.

- Each member is assigned a particular area of the review (administration/governance, fiscal, or clinical) based on their program expertise.

- When possible, the health center’s Project Officer and/or other BPHC staff will attend the site visit.

- The health center’s Project Officer works and communicates with the consultant site visit team and serves as the health center’s primary point of contact for all questions and areas related to this program.
The OSV is an Opportunity, not a Threat

• Survey team members have great depth of experience in running or providing services to health centers

• Surveyors are often peers (CEO/CFO/Key Leaders) of other CHCs

• They’ve done other OSVs and can share best practices gathered from other health centers

• Consider this an opportunity to get some free technical assistance

• This is also a wonderful opportunity to tell your story!
The Surveyor’s Perspective

- Have been on the receiving end of two OSVs
- Have been a reviewer on a dozen OSVs
- In my experience, the focus has primarily been on Medical
What Do Reviewers Look At in Dental?

- Credentialing and Privileging
- Peer Review
- Quality Indicators, Now and in the Future
- Minutes from Staff Meetings—”Very Informative”
- Sterilization/Infection Control
- Prescribing Patterns (esp. with Emergency Patients)
What Do Reviewers Look At in Dental?

• Tracking Process for Referrals
• Policies and Procedures- Nitrous Oxide
• MOU/MOA– Community Specialists– Does the oral surgeon offer discounted fees?
What Else?

• As a surveyor, I like it when someone takes us around and introduces us to the dental staff

• Have Chief Dental Officer and Chief Medical Officer give site tour together—talk about integration efforts

• What is the staffing plan for dental?

• Do people look happy to be there?

• Dental *should* be part of the OSV—”You’re an important part of the health center!”
Other Thoughts

• HRSA is trying to be helpful with OSVs

• The OSV is your time to brag—we want to hear who you are and what you’re doing for your patients and the community

• HRSA Project Officers are supposed to attend OSVs but sometimes aren’t able to

• Health centers should invite their Primary Care Associations to attend the exit interview

• If the health center’s Board isn’t involved in the OSV, that’s a red flag to surveyors
Part 2: What is Evaluated?
19 Guidelines in Four Sections

• SECTION 1: Needs Assessment
• SECTION 2: Services
• SECTION 3: Management and Finance
• SECTION 4: Governance
Section I, Guideline 1: Needs Assessment

Requirement:

Health center demonstrates and documents the needs of its target population, updating its service area, when appropriate.
Needs Assessment

• Health center performs periodic needs assessments.

• Assessments document the needs of its target population in order to inform and improve its delivery of appropriate services.
Needs Assessment

A health center needs assessment typically includes, but is not limited to, data addressing:

- Population to Primary Care Physician FTE ratio (dentist)
- Percent of population at or below 200% of poverty
- Percent of uninsured population (use post ACA data)
- Proximity to providers who accept Medicaid and/or uninsured patients
- Health indicators, such as diabetes, hypertension, low birthweight, and/or immunization rates
What does this mean to Dental?

- Identify the target populations to be served (same as medical?)
- What is the rationale for identifying these populations (such as children and pregnant women)?
- What is the level of need among your target populations? How was this need determined?
  - Do the zip codes of your dental patients match those of your service unit?
  - Are the majority of your dental patients users of the health center medical services?
- Use data and cite your sources
Some Great Sources for Data!

- American FactFinder (US. Census Bureau) [http://factfinder.census.gov](http://factfinder.census.gov)
- Centers for Disease Control
  - [http://www.cdc.gov/OralHealth/state_programs](http://www.cdc.gov/OralHealth/state_programs)
- Health Data Tools and Statistics [https://phpartners.org/health_stats.html](https://phpartners.org/health_stats.html)
- Local, County and State Departments Public Health, Oral Health Division
  - Comparison data and mapping
Section II, Guideline 2: Required and Additional Services

Requirement:

- Health center provides all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established written arrangements and referrals

- Health centers requesting funding to serve homeless individuals and their families must provide substance abuse services among their required services
Required and Additional Services

• Ensures the health center is directly providing or has written arrangements and referrals in place to provide a comprehensive array of required and as necessary, additional primary and preventive services that meet the needs of the populations it serves.

• All services in the health center’s scope of project must be reasonably accessible and available on a sliding fee scale to health center patients.

• In scope referral arrangements must be formally documented in a written agreement (MOA, MOU, etc.) that at a minimum describes the manner by which the referral will be made and managed and the process for referring patients back to the health center for appropriate follow-up care.
<table>
<thead>
<tr>
<th>5A Service</th>
<th>Service Descriptor</th>
<th>Statute Reference</th>
<th>Regulation Reference</th>
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</thead>
<tbody>
<tr>
<td>Preventive Dental</td>
<td>Preventive dental services prevent diseases of the oral cavity and related structures. At a minimum, these services include all of the following: basic dental screenings and recommendations for preventive intervention; oral hygiene instruction and related oral health education (e.g., prevention of oral trauma and oral cancer); oral prophylaxis, as necessary; and topical application of fluorides (e.g., fluoride varnishes) and the prescription of fluorides for systemic use when not available in the water supply. Services may include application of sealants, and diagnostic screening for caries and periodontal disease through the use of dental x-rays.</td>
<td>Section 330(b)(1)(A) “(i) Basic Health Services:... (i) Preventive Health Services, including...(hh) preventive dental services”</td>
<td>42 CFR, Part 51c.102(h) “Primary Health Services means...(6) Preventive dental services provided by a licensed dentist or other qualified personnel, including (i) oral hygiene instruction; (ii) oral prophylaxis, as necessary; and (iii) topical application of fluorides, and the prescription of fluorides for systemic use when not available in the community water supply.”</td>
</tr>
<tr>
<td>Pharmaceutical Services</td>
<td>Pharmaceutical services provide access to prescribed medications. These services may include a broad spectrum of functions ranging from the dispensing and tracking of medications to pharmacist-delivered patient care services (e.g., disease state management, medication reconciliation, therapeutic monitoring, wellness promotion, and disease prevention).</td>
<td>Section 330(b)(1)(A) “(i) Basic Health Services:... (V) pharmaceutical services as may be appropriate for particular centers”</td>
<td>42 CFR, Part 51c.102(j) “Supplemental health services means health services which are not included as primary health services and which are: ... (9) Pharmaceutical services, including the provision of prescription drugs;”</td>
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</table>
**ADDITIONAL SERVICES**

<table>
<thead>
<tr>
<th>Additional Dental Services</th>
<th>Not described</th>
<th>42 CFR, Part 51c.102(j) “...(6) Dental services other than those provided as primary health services”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional dental services are basic services at a general practice level to diagnose and treat disease, injury, or impairment in teeth and associated structures of the oral cavity and include any diagnostic x-rays or imaging.</td>
<td>Not described</td>
<td>42 CFR, Part 51c.102(j) “...(6) Dental services other than those provided as primary health services”</td>
</tr>
<tr>
<td>These services may include: fillings and single unit crowns; non-surgical-endodontics, extractions, periodontal therapies, bridges or dentures.</td>
<td>Not described</td>
<td>42 CFR, Part 51c.102(j) “...(6) Dental services other than those provided as primary health services”</td>
</tr>
<tr>
<td>Complex dental services (e.g., oral surgery, surgical endodontics, orthodontics) are considered specialty services.</td>
<td>Not described</td>
<td>42 CFR, Part 51c.102(j) “...(6) Dental services other than those provided as primary health services”</td>
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</tbody>
</table>
What Does This Mean to Dental?

• Is your scope of service reasonable, in alignment with the standard of care within your community and timely?

• Where do you refer patients for services that you don’t deliver? Be ready with lists and other documentation.

• What written agreement is in place with these providers? Be able to demonstrate and discuss the fees and discounts your patients receive from these referral providers.

• How do you track referrals to make sure the patient got the necessary care? Did you get written feedback? Document!
What Does This Mean? (cont.)

• Does the health center provide staff training on cultural competence to all staff? Is this part of new staff orientation?

• Do you have educational materials and patient information that reflect the primary language(s) your patients speak?

• Be able to describe the interpreter services available for your non-English-speaking patients?
Section II, Guideline 3: Clinical Staffing

Requirement:

Health center maintains a core staff as necessary to carry out all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established arrangements and referrals. Staff must be appropriately licensed, credentialed and privileged.
Staffing Requirement

- Staff composition and numbers must support the health center’s Health Care Plan including required and additional services.

- Staffing should be culturally and linguistically appropriate for the population being served and as noted in the health center’s needs assessment.
What Does This Mean for Dental?

- All providers’ licensure on file and up to date—make copies and have a folder ready in case you are asked to show this.
- Are providers credentialed and privileged for the services they are providing? Is there documentation of this? (privileging form). Be able to show your policy and processes related to this area.
- Do you have up-to-date job descriptions for each dental staff member ready to show?
- Does your staff have copies of their job descriptions?
What Does This Mean? (Cont.)

- Is there a formal dental orientation for new staff? Be prepared to show your policy and checklist.
- Are you fully staffed as to budgeted positions? Do you have vacancies? How are you recruiting?
- Do you maintain employee files in the dental area? Are they locked and secure?
- Do you have staff members on contract? If so, do you have copies of their current contracts on file and readily available?
- Are all contracted staff or volunteer providers credentialed and privileged?
Section II, Guideline 4: Accessibility

Requirement:

The required primary health services of the health center must be available and accessible in the service area promptly, as appropriate, and in a manner which assures continuity of service to the patient population.
Accessible Hours of Operation/ Locations

• The **times/hours** that services are provided are **appropriate to ensure access** for the health center’s patient population.

• The **locations** at which services are provided must be **accessible** to the patient population.

• **Appropriate consideration is taken into account in determining site/service locations and hours of operation for health centers serving special populations.** *(migrants)*
What Does This Mean for Dental?

• Are you open at times that assure accessibility and meet the needs of your patients? (evening, early morning or Saturday hours)

• Do you offer services at locations that assure accessibility and meet the needs of your patients?

• Can individuals in your defined service area get to your dental program readily? If not, do you bring portable/mobile services to them?

• Are there other strategies to increase access in play or meet unmet need/demand for care?
Section II, Guideline 5: After-Hours Coverage

Requirement:

*Health center provides professional coverage for medical emergencies during hours when the center is closed*
After Hours Coverage

- After hours coverage includes the provision, through clearly defined arrangements, for access of health center patients to professional coverage for emergencies after the center's regularly scheduled hours.

- Specific arrangements for after-hours coverage (such as in a rural area) may vary by community. However, all health centers must have some type of clear arrangement(s) for after hours coverage.
After Hours Coverage

• The coverage system should ensure telephone access to a covering clinician (not necessarily a health center clinician), who can exercise independent professional judgment in assessing a health center patient's need for emergency care and who can refer patients to appropriate locations for such care, including emergency rooms, when warranted.
What Does This Mean for Dental?

How do you address patients who call after hours?

- Is there a message about emergency coverage on the dental department phone? Is there reference to dental emergencies on the overall HC after hours message?
- Is the message in the language(s) your patients speak?
- Is there written information on what to do after hours in all relevant languages? When is this shared with the patient?
Section II, Guideline 6: Hospital Admitting Privileges and Continuum of Care

Requirement:

Health center physicians have admitting privileges at one or more referral hospitals, or other such arrangement to ensure continuity of care. In cases where hospital arrangements (including admitting privileges and membership) are not possible, health center must firmly establish arrangements for hospitalization, discharge planning, and patient tracking.
Hospital Admitting Privileges and Continuum of Care

• All health centers must either have admitting privileges for their physicians at one or more referral hospitals, or some other arrangements that ensure continuity of care.

• In cases where hospital admitting privileges and membership are not possible, the health center must have firmly established arrangements for patient hospitalization, discharge planning, and tracking.
What Does This Mean for Dental?

- Generally does not apply to dental
- If your health center treats dental patients in a hospital operating room, this very well could apply.
Section II, Guideline 8: Quality Improvement / Assurance Plan

Requirement:

*Health center has an ongoing Quality Improvement/Quality Assurance (QI/QA) program that includes clinical services and management, and that maintains the confidentiality of patient records*
Quality Improvement / Assurance Plan

The QI/QA program must include:

• A clinical director whose focus of responsibility is to support the quality improvement/assurance program and the provision of high quality patient care

• Periodic assessment of the appropriateness of the utilization of services and the quality of services provided or proposed to be provided to individuals served by the health center
What Does it Mean for Dental?

- If you still have paper charts in dental, are they secured when staff is not present?
- Is the dental director responsible for QI/QA or is it delegated?
- Do you have a process for periodic chart reviews? If so, who does them and how often? How are the results shared and used?
- Is there a formal process to follow up on deficiencies noted during these reviews? Are formal action plans developed and documented? Is regular re-evaluation part of your overall QI/QA process?
What Does it Mean for Dental? (cont.)

- Do your records have standardized content and organization?
- Is patient information handled in a way that is HIPAA compliant?
- Is there a process within your health center (including dental) to report/track incidents/adverse outcomes?
- What happens with these reports? How is follow-up documented?
- Is the dental program tracking clinical outcome measures? Where are they reported? How are the results used? Be ready with data!
Section III, Management and Finance, Guideline 9: Key Management Staff

Requirement:

Health center maintains a fully staffed health center management team as appropriate for the size and needs of the center. Prior approval by HRSA of a change in the Project Director/Executive Director/CEO position is required.
What Does it Mean for Dental?

• Is there a dental director? Is this person an active member of the Health Center executive leadership team?

• Does the dental director have regularly scheduled time for administrative duties?

• What is the cost per patient encounter in dental? How does that compare with the average cost per dental encounter nationally (from UDS data)? If it is higher, be prepared to explain why.
Section III, Guideline 10, Contractual/Affiliation Agreements

Requirement:

*Health center exercises appropriate oversight and authority over all contracted services, including assuring that any sub-recipient(s) meets Health Center Program requirements*
Contractual/Affiliation Agreements

• The health center has the appropriate amount of oversight and the ability to maintain its independence and compliance for all contracted services and affiliation agreements.

• All contractual arrangements must comply with Federal procurement standards set forth in 45 CFR Part 74 (including conflict of interest standards).
What Does it Mean for Dental?

• If the dental program utilizes contracted services, they must meet health center requirements.

• Affiliation agreements or contracts must not:
  ▪ Threaten the health center’s integrity
  ▪ Compromise compliance with any other Program Requirements
  ▪ Limit the health center’s autonomy
Section III, Guideline 11: Collaborative Relationships

Requirement:

Health center makes effort to establish and maintain collaborative relationships with other health care providers, including other health centers, in the service area of the center. The health center secures letter(s) of support from existing health centers (section 330 grantees and FQHC Look-Alikes) in the service area or provides an explanation for why such letter(s) of support cannot be obtained.
What Does it Mean for Dental?

- Are there any collaborations in place between the dental program and other community organizations, such as hospital ERs, Public Health Departments, private dentists in the community, other health and human service organizations, public schools, WIC, and/or Head Start?

- When do you cross the line between a collaboration agreed to “with a gentle person’s agreement” to the need for a contractual relationship?

- Be prepared to talk about them—show data and storyboards
Section III, Guideline 12: Financial Management and Control

Requirement:

Health center maintains accounting and internal control systems appropriate to the size and complexity of the organization reflecting Generally Accepted Accounting Principles (GAAP) and separates functions appropriate to organizational size to safeguard assets and maintain financial stability.

Health center assures an annual independent financial audit is performed in accordance with federal audit requirements, including submission of a corrective action plan addressing all findings, questioned costs, reportable conditions, and material weaknesses cited in the Audit Report.
Financial Management and Control Policies

• The health center has appropriate measures in place to protect its assets and adheres to Federal accounting requirements, including:

  ▪ Accounting and internal control systems that are appropriate to the size and complexity of the organization and reflect Generally Accepted Accounting Principles (GAAP).

  ▪ Policies and processes that safeguard the organization’s assets.
Financial Management and Control Policies

• A complete audit submission, which must include:
  ▪ The auditor’s report (including the auditor’s opinion, financial statements, auditor’s notes and required communications from the auditor).
  ▪ Any management letter issued by the auditor, or a statement signed by an authorized representative of the health center that no management letter was issued.

Note: If any material weaknesses are identified in the audit, these must be addressed by the health center.
What Does it Mean for Dental?

- Is there a separate cost center for dental? Is it site specific?
- Does the dental director receive billing info monthly?
- Does the dental director review and share provider productivity reports?
- Does the dental director receive an aging report for dental broken out by payer source?
- Does the dental director know what the current payer mix is in dental?
What Does it Mean for Dental? (cont.)

- Does the dental program regularly review its financial viability and develop ways to respond to negative variances?
- Does the dental director know the break even number for visits and payer mix?
- Are gross charges and net revenue tracked and reported by payer type?
- Are your fees reflective of those charged by private practitioners in the area?
Section III, Guideline 13, Billing and Collections

Requirement:
Health center has systems in place to maximize collections and reimbursement for its costs in providing health services, including written billing, credit and collection policies and procedures.
Billing and Collections

• Health centers must have documented billing and collection policies and procedures in place to maximize reimbursement.

• Health centers must bill Medicare, Medicaid, CHIP, and other applicable public or private third party payers.
What Does it Mean for Dental?

- Are there written policies for billing, credit and collections?
- Are dental codes updated annually?
- **Who is responsible for dental billing?** How is it done? Through a dental or medical practice management system?
  - If done through medical, how are charges entered? Via HL7 interface or do they have to be entered manually?
  - If entered manually, by whom and when? Who checks to make sure procedures were completely and accurately entered? Who checks to make sure all charges went across the interface?
- Do you know your collection rate? What happens to Accounts Receivable after 90 days?
What Does it Mean for Dental? (cont.)

- How are claims submitted to public and private payers?
- Are patients asked to pay at the time of the visit? What percentage do? Is this tracked and reported anywhere? What is the follow-up with patients who have outstanding balances?
- What is the process for managing denied claims? Are they reviewed in a timely manner? By whom? If inappropriate coding or billing patterns are noted, are procedures adjusted accordingly?
Section III, Guideline 14, Budget

Requirement:

Health center has developed a budget that reflects the costs of operations, expenses, and revenues (including the federal grant) necessary to accomplish the service delivery plan, including the number of patients to be served.
Budget

• A complete and clear budget should include: SF-424A, budget justification, Form 2 Staffing Profile, and Form 3 Income Analysis.

• The budget should describe/reflect:
  ▪ How total budget is aligned and consistent with the service delivery plan and patients to be served.
  ▪ How reimbursement will be maximized from 3rd party payers.
  ▪ How the proportion of requested Federal grant funds is appropriate given other sources of income.
What Does it Mean for Dental?

- Is there an annual operating budget for dental?
- Did the dental director provide primary input into the development of the budget?
- Is the dental director responsible for the dental budget?
- Does the dental director meet regularly with the CFO to discuss and better understand how the dental budget fits into the overall health center budget?
Section III, Guideline 15, Program Data Reporting Systems

Requirement:

Health center has systems which accurately collect and organize data for program reporting and which support management decision-making
Program Data Reporting Systems

• The health center has systems, including Management Information Systems (MIS), in place that accurately collect and produce data to support health center oversight and direction.

• The health center submits accurate and timely reports, as required, such as UDS.

• The health center provides a complete Health Care and Business Plan with its annual application to demonstrate performance improvement.
What Does it Mean for Dental?

- Does dental have an electronic dental record system?
- Is it integrated seamlessly with the EMR?
- Does the dental program have specific metrics that will be used to evaluate program success?
- Does dental leadership have ready access to reports that will show performance in meeting/exceeding program metrics?
- Does dental leadership use dashboards to track and report success in meeting performance metrics?
What Does it Mean for Dental? (cont.)

- Is there a process for regularly sharing dental program performance with administrative leadership and dental staff?
- Does dental leadership use data to make informed decisions about changes in dental program operations?
Section III, Guideline 16, Scope of Project

Requirement:

*Health center maintains its funded scope of project (sites, services, service area, target population, and providers), including any increases based on recent grant awards*
Scope of Project

• The section 330 approved Scope of Project stipulates what the total grant-related project budget supports (including program income and other non-section 330 funds).
  ▪ Five core elements: Services, Sites, Providers, Target Population, Service Area
  ▪ Changes in scope may affect eligibility and coverage
  ▪ Significant changes in scope must be approved by HRSA/BPHC

• Health centers must maintain their approved and funded scope of project in terms of number of patients served, visits, services available, providers, and/or sites.
What Does it Mean for Dental?

- What is the current visit capacity of dental?
- What percentage of that capacity has been reached?
- If capacity has been reached, what strategies are being considered to expand capacity, such as more providers, more operatories, more hours of operation, and/or more sites.
- If currently planning dental expansion, has a pro forma been completed detailing additional expenses, additional revenue and visit projections?
Section IV, Governance, Guideline 17, Board Authority

Requirement:

Health center governing board maintains appropriate authority to oversee the operations of the center
Board Authority

The Health Center Board of Directors:

• Meets monthly.

• Reviews and approves the annual health center (renewal) application and budget.

• Conducts an annual review of the CEO’s performance (with clear authority to select a new CEO and/or dismiss the current CEO if needed).
Board Authority

The Health Center Board:

• Reviews and approves the services to be provided and the health center’s hours of operation.

• Measures and evaluates the health center’s progress in meeting annual and long term clinical and financial goals.

• Engages in strategic and/or long term planning for the health center.
Board Authority

The Health Center Board:

• Reviews the health center’s mission and bylaws as necessary on a periodic basis.

• Receives appropriate information that enables it to evaluate health center patient satisfaction, organizational assets, and performance.

• Establishes the general policies, which must include, but are not limited to: personnel, health care, fiscal, and quality assurance/improvement policies for the organization.
What Does it Mean for Dental?

- Be prepared to share performance data for dental regularly with the Board (offer to do this if you’re not already!)
- Any scope of service changes in dental should be approved by the Board
- Any scope of project changes in dental should be approved by the Board
- All significant dental policies should be reviewed by the Board
Section IV, Guideline 18, Board Composition

Requirement:

The health center governing board is composed of individuals, a majority of whom are being served by the center and, this majority as a group, represent the individuals being served by the center in terms of demographic factors such as race, ethnicity, and sex.
Board Composition

- A majority (at least 51%) of the board members receive services (i.e., are patients) at the health center.

- As a group, the “patient/consumer” board members must reasonably represent the individuals who are served by the health center in terms of race, ethnicity, and sex.

Note: There is no established ratio for board members to population served.
Board Composition

• Health centers that receive part of their section 330 funding to serve special populations and are not eligible for a waiver—the board includes representation from/for these special populations group(s), as appropriate, such as an advocate for the homeless, the director of a Migrant Head Start program, and/or a formerly homeless individual.

• The board has between 9 and 25 members.

• The size of the board is appropriate for the complexity of the organization and the diversity of the community served.
Board Composition

• The board includes a member (or members) with expertise in any of the following:
  ▪ Community affairs
  ▪ Local government
  ▪ Finance and banking
  ▪ Legal affairs
  ▪ Trade union and other commercial and industrial concerns
  ▪ Community social service agencies

• No more than 50% of the non-consumer board members may derive more than 10% of their annual income from the health care industry.
What Does it Mean for Dental?

• How many Board members access dental care in the health center?

• Can you recommend any dental patients for the Board?

• For the 49% of non-patient Board members, are there any private practice dentists in the community that are (or might be) champions for health center dentistry?

Such dentists should offer to serve on board committees, such as finance or clinical...to gain familiarity with the health center and to let the current board get to know them.
Section IV, Guideline 19, Conflict of Interest

Requirement:

Health center bylaws or written corporate board approved policy include provisions that prohibit conflict of interest by board members, employees, consultants, and those who furnish goods or services to the health center.
Conflict of Interest Policy

- The bylaws or other policy documents include a conflict of interest provision(s).
- No current board member(s) is an employee of the health center or an immediate family member of an employee.
- The CEO/Program Director does not participate as a voting member of the board.
Conflict of Interest Policy

• The health center’s conflict of interest policy must address such issues as:
  - disclosure of business and personal relationships, including nepotism, that create an actual or potential conflict of interest;
  - extent to which a board member can participate in board decisions where the member has a personal or financial interest;
  - using board members to provide services to the center;
  - board member expense reimbursement policies;
  - acceptance of gifts and gratuities;
  - personal political activities of board members; and
  - statement of consequences for violating the conflict policy.
Conflict of Interest Policy

When section 330 grantees procure supplies and other expendable property, equipment, real property, and other services, the health center's conflict of interest policy must also address the following:

• The health center grantee must have written standards of conduct governing the performance of its employees engaged in the award and administration of contracts.

• No health center employee, board member, or agent may participate in the selection, award, or administration of a contract supported by Federal funds if a real or apparent conflict of interest would be involved. Such a conflict would arise when a health center employee, board member or agent, or any member of his or her immediate family, his or her partner, or an organization which employs or is about to employ any of the parties indicated herein, has a financial or other interest in the firm selected for an award.

• The board members, employees, and agents of the health center grantee shall neither solicit nor accept gratuities, favors, or anything of monetary value from contractors, or parties to subagreements. However, recipients may set standards for situations in which the financial interest is not substantial or the gift is an unsolicited item of nominal value.

• The standards of conduct must provide for disciplinary actions to be applied for violations of such standards by board members, employers, or agents of the health center grantee.
What Does it Mean for Dental?

• Always do the right thing for your patients and for the health center!
STRETCH BREAK!!!!
Part 3: Taking a Closer Look
Sliding Fee Discount Program-Requirements

• The health center must operate in a manner such that no patient shall be denied service due to an individual’s inability to pay.

• The health center must prepare a schedule of fees or payments for the provision of its services consistent with locally prevailing rates or charges and designed to cover its reasonable costs of operation.

• The health center must prepare a corresponding schedule of discounts (sliding fee discount schedule) to be applied to the payment of such fees or payments, by which discounts are adjusted on the basis of the patient's ability to pay.

• The health center must establish systems for SFDS eligibility determination.
Sliding Fee Discount Program - Requirements

- The health center’s schedule of discounts must provide for a full discount to individuals and families with annual incomes at or below those set forth in the most recent Federal Poverty Guidelines (FPG) [100% of the FPG], except that nominal charges for service may be collected from such individuals and families where imposition of such fees is consistent with project goals.

- No discounts will be given to individuals and families with annual incomes greater than twice those set forth in such Guidelines [200% of the FPG].
Sliding Fee Discount—Demonstrating Compliance

• Must be applied to all required and additional services within HRSA approved scope of project
• Must have board-approved policies that apply uniformly to all patients and address the following areas:
  • Assessment of all patients for sliding fee discount eligibility based only on income and family size (in accordance with the FPG)
  • Definitions of, and requirements for, verifying income and family size
  • The manner in which the health center’s sliding fee discount schedule(s) will be structured to ensure that patient charges are adjusted based on ability to pay
  • Nominal charge(s) must be nominal from the patient’s perspective and not reflect the actual cost of the service being provided
Demonstrating Compliance (cont.)

• Have SFDSs based on services (e.g., having separate SFDSs for medical and dental services) or service delivery methods (e.g., having separate SFDSs for services provided directly by the health center and for services provided via formal written contract).

• Have procedures for and records of assessing/re-assessing patients for income and family size (unless the patient declines/refuses to be assessed) consistent with board-approved policies.

• Have mechanisms for informing patients of the availability of sliding fee discounts (e.g., using materials in language(s) and literacy levels appropriate for the patient population).
Demonstrating Compliance (cont.)

• Regularly evaluate sliding fee discount program to ensure its effectiveness in reducing financial barriers to care and changes made as needed

• For services provided directly by the health center, have records that show it provides sliding fee discounts in accordance with its established SFDS(s)

• The health center’s SFDS(s) has incorporated the most recent FPG
For services provided via contractual agreements (Form 5A: Services Provided, Column II), the health center’s contracts/agreements contain provisions for sliding fee discounts as follows:

- A full discount is provided for individuals and families with annual incomes at or below 100% of the current FPG, unless a health center elects to have a nominal charge.

- Partial discounts are provided for individuals and families with incomes above 100% and at or below 200% of the current FPG that adjust in accordance with income (for example, three (3) to five (5) discount pay classes based on gradations in income levels above 100% and at or below 200% of the FPG)

- No discounts are provided to individuals and families with annual incomes above 200% of the current FPG.
Demonstrating Compliance (cont.)

For services provided via formal referral arrangements (Form 5A: Services Provided, Column III), the health center has ensured that:

- The referral provider either offers sliding fee discounts as described in the prior slide or offers greater discounts to patients such that patients at or below 200% of the FPG receive a greater discount for these services than if the health center’s SFDS was applied to the referral provider’s fee schedule

- Patients at or below 100% of the FPG receive no charge or only a nominal charge for these services
Demonstrating Compliance

• Show that patients, including those at or below 100% of the FPG, are accessing health center services, regardless of discount pay class (e.g., patient utilization data shows that patients at all income levels are accessing health center services)

• Subject to potential legal and contractual restrictions, health center patients with third-party coverage who are also eligible for sliding fee discounts are provided with any applicable sliding fee discounts
Related Considerations

The health center has latitude with regard to:

✓ Providing alternative mechanisms for determining SFDS eligibility (eg, self-declaration, streamlined eligibility renewal)

✓ Identifying as ineligible for SFDS individuals who refuse to provide income and family size

✓ Establishing multiple SFDSs (eg, separate SFDSs for medical services and dental services, including different nominal fees)

✓ Determining whether to establish a nominal charge for patients at/below 100% FPG (vs. waiving fees) and whether to establish different nominal charges for different services
Related Considerations (cont.)

More health center latitude re:

• What income range to establish for each discount pay class

• What method to use for discounting fees (e.g., percentage of fee, fixed/flat fee per discount pay class)

• For in-scope services provided through formal referral arrangements (Form 5A: Services Provided, Column III), the health center determines whether to enter into formal referral agreements with organizations that may also provide discounts to patients with incomes above 200% of the FPG
Insured Patients Who Are Also Eligible for SFDS

- Income and family size make many insured individuals eligible for sliding fee discounts.
- Important to know your state laws and various insurance plan rules—sometimes not allowed to give insured patients’ discounts on their co-payment responsibilities.
- Generally if allowed, the insurance is billed at their normal rate, and the patient’s co-pay portion is discounted based on their sliding fee scale percentage.
Laboratory Charges

• The costs for items done outside the health centers (eg, 3rd party lab charges) can be charged to the patient

• The professional services associated with services that include lab charges are subject to all sliding fee discount conditions

• Nominal fees can be charged to the patient for each visit where lab fees have also been incurred and charged

• Payment options and lab or separate service costs must be discussed up front prior to the initiation of services and referenced in written documentation (eg, a treatment planned signed by the patient)
## Sample Fee Schedule with Labs

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Full Fee</th>
<th>Lab</th>
<th>Slide A--Patients at/below 100% FPG--Patient pays $35 per visit</th>
<th>Slide B--101-125%, Patient pays 30% of fee</th>
<th>Slide C--126-150%, Patient pays 40% of fee</th>
<th>Slide D--151-175%, Patient pays 50% of fee</th>
<th>Slide E--176-200%, Patient pays 60% of fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1110</td>
<td>Prophylaxis, Adult</td>
<td>$130.00</td>
<td>0</td>
<td>$35.00</td>
<td>$39.00</td>
<td>$52.00</td>
<td>$65.00</td>
<td>$78.00</td>
</tr>
<tr>
<td>D2391</td>
<td>One surface posterior composite filling</td>
<td>$220.00</td>
<td>0</td>
<td>$35.00</td>
<td>$66.00</td>
<td>$88.00</td>
<td>$110.00</td>
<td>$132.00</td>
</tr>
<tr>
<td>D2751</td>
<td>crown - porcelain fused to predominantly base metal</td>
<td>$1,263.00</td>
<td>75.00</td>
<td>$35.00</td>
<td>$378.90</td>
<td>$505.20</td>
<td>$631.50</td>
<td>$757.80</td>
</tr>
<tr>
<td>D2752</td>
<td>crown - porcelain fused to noble metal</td>
<td>$1,294.00</td>
<td>90.00</td>
<td>$35.00</td>
<td>$388.20</td>
<td>$517.60</td>
<td>$647.00</td>
<td>$776.40</td>
</tr>
<tr>
<td>D2790</td>
<td>crown - full cast high noble metal</td>
<td>$1,402.00</td>
<td>99.00</td>
<td>$35.00</td>
<td>$420.60</td>
<td>$560.80</td>
<td>$701.00</td>
<td>$841.20</td>
</tr>
</tbody>
</table>
Sliding Fee Discounts—Are You Ready?

- Is there signage about the availability of discounts for eligible patients? In appropriate languages?

- Are dental fees consistent with locally prevailing rates and designed to cover the reasonable costs of operations? Can you explain how you determined your fees? When were they last updated? Did your Board review and approve them?

- Do patients at or below 100% pay no fees or only a nominal fee? What is your nominal fee? How do you know your nominal fee is not a barrier to care? (tip: look at payer mix to determine the percentage of uninsured patients at/below 100% FPG)

- Do you have a minimum of three discounts for patients between 101% and 200% based on family size and income?
Fees/SFDS—Are You Ready? (Cont.)

- Are patients above 200% of FPL charged full fees?
- Are new patients evaluated during registration to determine their eligibility for the sliding fee scale? Do you require patients to provide proof of income?
- What happens if a patient refuses (or is unable) to provide proof of income?
- Do you have Board-approved policies defining all aspects of the SFDS program?
Sliding Fee Discounts—Are You Ready?

• What discounts do your patients get from contracted or referred providers? Do they comply with HRSA guidelines? Do you have supporting documentation?

• Are you using the most current Federal Poverty Guidelines?
Setting Fees--Requirements

• The health center must prepare a schedule of fees for the provision of its services consistent with locally prevailing rates or charges and designed to cover its reasonable costs of operation.

• The health center must assure that any fees or payments required by the center for health care services will be reduced or waived in order to assure that no patient will be denied such services due to an individual’s inability to pay for such services.
Fees, Billing and Collections—Demonstrating Compliance

• The health center has a fee schedule for services that are within the HRSA-approved scope of project and that are typically billed for in the local health care market.

• The health center uses data on locally prevailing rates and actual health center costs to develop and update its fee schedule.
Fees, Billing and Collections—Demonstrating Compliance

The health center has policies and procedures for billing and collections that address:

• Educating patients on insurance and, if applicable, related third-party coverage options available to them

• Billing Medicare, Medicaid, CHIP, and other public and private assistance programs or insurance in a timely manner, as applicable

• Requesting applicable payments from patients, while ensuring that no patient is denied service based on inability to pay

• If applicable, incorporating additional elements such as payment plans, grace periods, and prompt payment incentives
Fees, Billing and Collections—Demonstrating Compliance

• The health center has billing records that show claims are submitted in a timely and accurate manner to the third party payer sources with which it participates (Medicaid, CHIP, Medicare, and other public and private insurance) in order to collect reimbursement for its costs in providing health services consistent with the terms of such contracts and other arrangements.

• The health center has billing records or other forms of documentation that demonstrate that patients are charged in accordance with its fee schedule and, if applicable, the sliding fee discount schedule and makes reasonable efforts to collect amounts owed from patients.
Fees, Billing and Collections—Demonstrating Compliance

• The health center utilizes board-approved policies and operating procedures that address the waiving or reducing of amounts owed by patients due to a patient’s inability to pay.

• If a health center provides supplies or equipment that are related to, but not included in the service itself (e.g., eyeglasses, prescription drugs, including those purchased under discount programs, dentures) and charges patients for these items, the health center informs patients of such charges (“out of pocket costs”) prior to the time of service.
Fees, Billing and Collections—Demonstrating Compliance

- If a health center elects to limit or deny services based on a patient’s refusal to pay, the health center has a board-approved policy that distinguishes between refusal to pay and inability to pay.
Fees, Billing and Collections—Related Considerations

• The health center can determine whether to charge a single fee for related services, medically-related supplies, and/or equipment. Examples include, but are not limited to, charging a single fee for a well-child visit and the immunizations provided during that visit or combining all prenatal care visits and labs into a single fee.

• The health center can determine whether to participate in a specific insurance plan based on its patient population and the costs and benefits of such participation.

• If a health center elects to provide its patients access to supplies or equipment (eg, eyeglasses, prescription drugs, dentures), the health center determines how to charge its patients for such supplies or equipment (eg, flat discounts, at cost, sliding fee discounts).
Fees, Billing and Collections—Related Considerations

• If a health center has a funding source (other than a Health Center Program award) that subsidizes or covers all or part of the fees for certain services for specific patients (in accordance with the terms and conditions of such funding sources), the health center may charge such fees to that funding source (e.g., Ryan White Part C grant) rather than to the patient.
Billing and Collections—Are You Ready?

- Are there written policies for billing, credit and collections?

- Are dental codes updated annually using the latest CDT code book?

- How is billing done? Through the medical practice management system? Through the dental PMS? If done through medical, how do charges get into the medical system? Via HL7 interface or do they have to be entered manually? If entered manually, by whom and when? Who checks to make sure procedures were completely and accurately entered?
Billing and Collections—Are You Ready?

- How are claims submitted to Medicaid and 3rd party insurers?
- Who is responsible for dental billing? Are they trained in dental billing?
- Are patients asked to pay at the time of the visit? What percentage do? Is this tracked and reported anywhere? What is the follow-up with patients who have outstanding balances?
- What is the process for managing denied claims? Does anyone review and report reasons for dental denials?
Actions to Consider

• Review all intended or provided dental services, performing a cost analysis on each and making informed decisions about scope, nominal fee, and sliding fees in dental

• Decisions should not be made on guess work, instinct or intuition but should be made using timely, meaningful and accurate data to inform those decisions
Case Study

- An FQHC in Pennsylvania was concerned that it was “losing its shirt” providing molar root canals, crowns and dentures to nominal fee patients

- They were strongly considering dropping all such “high-end” services

- We analyzed the data related to those services for a three-month period
The Results

• Total of 110 patients received specialty services (average of 37 per month)
• Over half of patients had Medicaid, 3% had commercial and 45% were uninsured
• 39 patients had root canals. Total revenue = $6,995. Average revenue per patient $243
• 52 patients got dentures. Total revenue = $22,995. Average revenue per patient was $460
• 19 patients got crowns. Crown revenue = $5,814. Average revenue per patient was $323.
• Average net revenue per visit for all specialty services = $325.50
• Average cost per patient = $117
The Takeaways

• Shows the importance of using data to make informed decisions!
• Watch the number of specialty services being provided
• Monitor the payer mix for specialty services
• Monitor what’s being collected for each service
• Calculate revenue per visit vs. cost per visit
• THEN decide what to do based on what the data is telling you
Potential Strategies

• Use designated access scheduling to restrict the number of specialty cases that can be started in a given period

• If you do this, create objective criteria to determine who gets these appointments (can’t be only given to insured patients!!!!)

• Can also consider taking specialty services out of scope (requires formal approval from HRSA and the creation of a “firewall” between in-scope and out-of-scope services)
Key Cost-Related Data to Help Determine Scope of Service

- Cost per visit (expenses divided by number of visits)
- Lab, supplies, time and costs for each procedure
- Reports on services provided by ADA code (transaction report)
- Calculation of RVUs for all services divided by expenses (determines the cost for each RVU provided)
Your poll will show here

1. Install the app from pollev.com/app
2. Make sure you are in Slide Show mode

Still not working? Get help at pollev.com/app/help
or
Open poll in your web browser
Your poll will show here

1. Install the app from pollev.com/app
2. Make sure you are in Slide Show mode

Still not working? Get help at pollev.com/app/help
or
Open poll in your web browser
Questions/Discussion
Part 4: Your Turn to be the Reviewers!
Part 4: Your Turn to be the Reviewers!

• Each table has a packet with the description of the health center’s dental program

• Based on the 19 HRSA Program Guidelines and what you’ve heard today, work as a group to identify the key issues that the reviewer found

• If you were the dental leadership of this program, how would you resolve these issues?

• Take 20 minutes to list the issues and solutions

• We will then “debrief” for 15 minutes and then wrap up
The Health Center

• A federally qualified health center in Anywhere, US

• The health center has five clinical sites providing primary care to 35,000 unduplicated patients

• Two of these sites also have dental clinics under the same roof that combined provide an average of 10,000 dental visits per year to 5,000 unduplicated patients

• Each dental clinic has six operatories, all of which are equipped to provide comprehensive general dentistry
Staffing Model

Jones Street Clinic (Main Clinic)
3 FTE dentists (one is the Dental Director)
1 FTE hygienist
3 FTE dental assistants
2 FTE reception/registration staff
0.5 FTE practice manager

Smith Street Clinic
1 FTE dentist
1 FTE hygienist
2 FTE dental assistants
1 FTE reception/registration staff
0.5 FTE practice manager

Dental billing is done by the Central Billing Department
Hours of Operation

• Both clinics are open Monday through Friday, 8 a.m. to 5 p.m.

• Both clinics close down for lunch between 12 and 1 p.m. each day
Scope of Service

The health center provides all required and additional services in its HRSA-approved scope:

- Preventive care
- Emergency care
- Restorative care
- Non-surgical periodontal care
- Simple and surgical extractions
- Single-unit crowns
- Plus full and partial dentures
- Patients needing root canals, advanced periodontal care, orthodontics or complex oral surgery are referred out
Patients

- Dental patients are a mix of adults and children
- The payer mix in dental is 60% Medicaid, 30% uninsured and 10% commercial dental insurance
- The health center is located in a refugee resettlement community and serves a high percentage of non-English speaking patients
- There are a few interpreters on staff in the health center, but in the dental clinics, all signage and voice mail messages are in English only
Staffing

- The Dental Director works four 9-hour days and has the first hour of each day blocked out for “Administrative time”
- The Dental Director works only at the main clinic and rarely visits the other dental clinic
- The dental Practice Manager’s office is in the main clinic and she, too, rarely visits the other dental clinic
- Both clinics come together once a month for a one-hour joint staff meeting. There are no minutes taken of these meetings
Staffing (cont.)

- There is no formal orientation to the dental department for new providers or staff
- There is a policies and procedures manual in the Dental Director’s office, but it has not been reviewed in several years
- The practice manager keeps all personnel records in an unlocked file cabinet in her office. She does lock her office door when she leaves the building for the day
Fees and Discounts

• No one has any idea when dental fees were last reviewed or how they were set

• The nominal fee for dental patients at or below 100% of federal poverty guidelines is $10 (the same as it is in primary care)

• There are two other discount levels for patients between 101% and 200% of federal poverty
Quality

- There is no process in place in dental to periodically review patient charts
- The health center has begun tracking the new HRSA sealant measure but does not track any other outcome measures in dental
- There is no formal process in place to ensure licensed staff are competent to provide the services they are providing
- Credentialing is done “by another department,” and dental program leadership does not review
Financial Management

• The dental leadership team does not regularly receive a profit and loss statement for the dental program (although they have requested one several times)

• Therefore, they do not know the average cost per visit for dental

• Therefore, they do not know the average revenue per visit for dental

• The dental leadership team does not receive an Aging Report for dental to evaluate billing/collections

• Even though the dental department uses an Electronic Dental Record system, no one in program leadership knows how to run reports
The Operational Site Visit

• The health center was scheduled for a HRSA Operational Site Visit

• The site visit team consisted of an administrative reviewer, a clinical reviewer and a financial reviewer

• The health center’s HRSA project officer attended the site visit

• As part of the site visit, the team looked closely at the dental program, including a tour of both clinics and interviews with dental leadership and staff

• They also reviewed some patient charts, personnel files and the department’s Policies and Procedures Manual
Findings From the Operational Site Visit

- The site visit team identified a number of compliance issues within the dental department.
- These issues were presented to health center leadership at the exit interview and included in the final written report sent to the health center by HRSA.
- The health center was instructed to correct each of these issues and report back to their HRSA project officer detailing how the issues were addressed.
Findings From the Operational Site Visit

• The intent of the site visit was not punitive—rather, this was an opportunity to review the health center, ensure compliance with key guidelines and identify ways to improve overall health center operations.

• However, sanctions would be applied if the health center failed to address and resolve these issues in a timely manner.

• These sanctions could include the withholding of grant payments to the health center until the issues were resolved.
What Were Your Findings?
What Were the Issues?

Staffing

1. Ratio of dental assistants to dentists was 1:1 in both clinics—the minimum required to maximize provider productivity (and thus patient access) is 1.5:1

2. Lack of dental leadership oversight at the second clinic

3. Distribution of dentists—too many in the main clinic for six operatories and too few at the second clinic

4. Structure of dental director’s administrative time (one hour per day) is not sufficient to get any meaningful work done
What Were the Issues?

Staffing (cont.)

5. While the dental staff met as a group monthly, no minutes were taken to document what was discussed or to share with staff who were not present at the meeting

6. There was no formal orientation process to dental for new staff

7. The Policies and Procedures manual was outdated and not being used to guide day-to-day program operations

8. The personnel folders were not secured at all times
How Were the Staffing Issues Resolved?

• Moved one FTE dentist from the main clinic to the second clinic, which left two FTE dentists and three FTE assistants at the main clinic

• Added one more FTE assistant at the second clinic

• As a result, each clinic now has two FTE dentists and three FTE assistants—better structured to improve provider productivity
How Were the Staffing Issues Resolved?

- To improve oversight of the second dental clinic, the dental director now sees patients there one day per week, and the practice manager also spends one day per week there.
- The dental director now has one half-day per week (4 hours at a time) for administrative time rather than one hour per day. This allows more time to complete tasks.
- Minutes are now taken at monthly staff meetings and shared with all dental staff.
How Were the Staffing Issues Resolved?

• A formal orientation process was developed for new dental staff that was documented in the Policy and Procedures manual, including a checklist for each new staff member that was completed and placed in their personnel folder as documentation that orientation was completed.

• The Policies and Procedures manual is being reviewed and updated, and a process for its regular use is being developed.

• The practice manager now locks the file cabinet with personnel folders at all times.
What Were the Issues?

Accessibility

1. The lack of evening or early morning hours makes it difficult for patients who work to access dental care without taking time off from their jobs

2. The lack of any weekend hours also makes it difficult for patients who work to access dental care without taking time off from their jobs

3. Signage, patient education materials and voice mail messages were not in patients’ primary language(s)
How Were the Accessibility Issues Resolved?

- Clinic hours were shifted for each clinic, as follows:
  Monday, 9 a.m. to 6 p.m.
  Tuesday and Friday, 7 a.m. to 4 p.m.
  Wednesday and Thursday, 8 a.m. to 5 p.m.

- The health center is assessing patient demand for Saturday appointments—if the demand is there, Saturday hours will be piloted

- All signage and voice mail messages are now available in the primary language(s) spoken by the patient population, and patient materials are being translated into primary language(s)
What Were the Issues?

Scope of Service

1. The dental department referred patients out for specialty care but did not have formal referral agreements with the specialists.

2. The dental department did not have a process in place to track and document whether patients received the care for which they were referred.
How Were the Scope of Service Issues Resolved?

• The health center implemented formal referral agreements with the specialists to whom they were sending patients.

• The health center implemented a process to track referrals and document in the patient’s chart when the patient received the care. They regularly run reports to identify referred patients with outstanding treatment needs, and a dental case manager follows up with referred patients whose care has not been received to remove any barriers.
What Were the Issues?

Fees and Discounts

• The health center was unable to document when dental fees were last reviewed and updated

• Fees were determined to be below the 40th percentile rather than at prevailing rates for the health center’s area

• Having the same nominal fee for primary care and dental is not a best practice

• There were only two discount categories in addition to the nominal fee (there must be a minimum of three)
How Were the Fees and Discount Issues Resolved?

• The health center obtained a fee report to determine prevailing rates for their service area and adjusted fees accordingly.

• They raised their nominal fee for patients at/below 100% of federal poverty to $20 for dental, with plans to raise it again in a year to $30.

• They created a third discount category for patients between 101% and 200% of federal poverty.

• They submitted all proposed changes to the health center Board for formal approval.
What Were the Issues?

Quality

• There was no process in place in dental to periodically review patient charts

• While the health center tracks the HRSA sealant measure, they did not track any other measures in dental that demonstrate improved outcomes for patients

• There was no formal process in place to ensure licensed staff are competent to provide the services they are providing

• Dental leadership did not have a process to ensure licensed staff were properly credentialed and that credentialing is kept up to date
How Were the Quality Issues Resolved?

• The dental program began a quarterly program of peer chart reviews using a standard audit tool.

• A formal process was developed that included action plans for issues identified through the chart reviews with follow-up to ensure that issues were resolved.

• The results of the quarterly chart reviews are now presented to the health center’s Quality Improvement Committee.
How Were the Quality Issues Resolved?

• A formal process was developed for privileging all new licensed staff that included a checklist that is now completed by the dental director for each new provider and included in their personnel folder.

• Even though primary credentialing is done by Human Resources, dental leadership now takes responsibility for ensuring that all licensed staff are properly credentialed, including an annual review of all licensed staff on their date of hire.
How Were the Quality Issues Resolved?

• The dental program identified Phase I Treatment Completion as another quality outcome measure that would be tracked.

• All of these changes are documented in the new Quality Management Policy, which has been added to the updated Policies and Procedures manual.
What Were the Issues?

Financial Management

• Dental leadership had not established performance goals for the dental program, nor were they formally tracking program performance

• Dental leadership did not have access to all the reports they needed to evaluate dental program performance (e.g., profit and loss statements, aging reports)

• Dental leadership was not aware of reports they could generate themselves from the dental record system that would provide performance data
How Were the Financial Management Issues Resolved?

- Dental leadership established performance goals for dental to measure and evaluate access, quality, finance and productivity

- The Finance Department began sending dental leadership a monthly Profit and Loss statement and Aging Report

- Dental leadership received additional training in their dental record system to identify the standard reports they could run to obtain specific dental performance data

- Dental leadership began using a Dental Dashboard to track and monitor dental performance data and make informed decisions about changes to dental operations
What Were Some Important Results of the Operational Site Visit?

Improved Operations

• Increased oversight of second dental clinic
• Staffing changes to improve provider productivity
• More effective use of Dental Director’s administrative time
• Structured orientation process for new staff
• Revitalization of the Policies and Procedures manual
What Were Some Important Results of the Operational Site Visit?

Improved Access for Patients

- More variable hours of operation
- Improved provider productivity means more available appointments
- Important messaging now in patients’ primary language(s)
- Better oversight of referrals ensures patients get access to the specialty care they need
What Were Some Important Results of the Operational Site Visit?

Improved Assurance/Documentation of Quality of Care

• Formal process to periodically review patient charts
• Added another metric to measure patient outcomes of care provided
• Better control of privileging and credentialing
What Were Some Important Results of the Operational Site Visit?

Better Understanding of Dental Program Performance

• Identification of dental program performance goals
• Identification of reports needed to get performance data
• Use of a Dental Dashboard to track and monitor data
• Dental leadership began using performance data to make informed decisions about needed changes in dental program operations
Questions/Comments?

Thank You!!!!!

Please take a few moments before you leave to complete the post-evaluation using this link:

www.surveymonkey.com/r/FHTBKNF