Maximum Access with Minimum Risk
Planning for Effective Dental Growth and Expansion

Our mission is to improve the oral health of all.

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Program Manager-Teen Pregnancy Prevention, Multnomah County Health Department, 1999-2003

Senior Health Educator, Southwest Washington Health District, 1991-1999
Today We Are Going to Discuss:

- The planning framework for both new starts and expansions
- The key decisions that need to be made in starting or expanding a dental program
- The common pitfalls of starting a health center dental program and how to avoid them
- The metrics needed to evaluate dental program performance
- The importance of using data to make informed decisions related to dental operations
Project Plan: The Big Picture

• Environmental Assessment
• Market Analysis
• Program Structure (eg, fixed vs. mobile/portable vs. hub-and-spokes, number of operatories, days/hours of operation, etc.)
• Staffing Model(s)
• Facility Needs
• Equipment Needs
Environmental Assessment/Market Analysis

- Who do we want to serve (who needs us)?
- Who do we need to serve (focus populations)?
- What’s the size of the target market?
- What are the sociodemographics of the target market?
- What is the demand for dental care by the target market?
- What other dental programs are serving the target market?
- If you build it, will they come?
Environmental Assessment (cont.)

• Define the Reimbursement Environment

✓ Who is covered by the state Medicaid program?
✓ What services are covered and for whom?
✓ What does the Medicaid fee schedule look like? Will we be reimbursed fee-for-service or by encounter? If encounter, what is our rate likely to be?
✓ How many members of the target population are uninsured? Are they potentially insurable or completely uninsurable? What is their income status?
✓ Who are the other primary insurers, who do they cover and what services do they cover?
✓ Are there agencies in the area with special grants to pay for oral health services for their clients?
Program Structure: Fixed Dental Clinic

- Location, Location, Location!
- Number of Operatories
- Staffing
- Hours of Operation
- Clinic Design/Build-Out
- Equipment Decisions
- Integration with Primary/Behavioral Care
Program Structure: Mobile/Portable

- Portable equipment vs. mobile dental van
- Who are we going to serve?
- What services are we going to provide (preventive vs. comprehensive)
- How many days per week?
- How many weeks per year?
- What is the staffing plan?
- Equipment decisions
- Hub-and-spokes?
Staffing Considerations

- Number and type of staff
- Salary ranges
- State Practice Act
- Staffing models play a key role in program success
- Match staff to program needs
- Hire for attitude first, then skill
- Reward success
Staff Benchmarks

- At least 1.5 assistants per FTE dentist (2 is better)
- 1 FTE reception/registration clerk per 5,000 visits
- At least two operatories per FTE dentist MINIMUM
- Potential to use three operatories if dentist has a dedicated EFDA as well as a dedicated assistant
- Staff dentist with 2 assistants and 2 operatories = 14 visits/8 hour day
- Staff dentist with 1 assistant and 1 EFDA and 2-3 operatories = at least 20 visits/day
- Staff dentist with 1 assistant and 1 operatory = 8 visits/8 hour day
Determining Staffing Models

1. Identify programmatic resources (number of operatories, hours of operation and number/type of service sites (eg, fixed clinics, mobile/portable or hub-and-spokes)
2. Review your state Practice Act to identify the types of dental staff and their scope of practice
4. Develop daily visit capacity for each provider
5. Consider whether you have the potential to add students or residents to the staffing mix
6. Establish a median salary for each staff type (dentists, hygienists, assistants, EFDAs, reception/registration, practice manager)
7. Staff, when possible, to the bi-lingual needs of your patients
Facility Needs

- Build/renovate?
- Lease/own?
- Number of square feet needed?
- Sufficient parking for staff and patients?
- Access to public transportation?
- Clinic design/plans
- Construction/renovation costs, potential contractors, timeline
Equipment Needs

• What equipment is needed?
• Who are the potential equipment vendors?
• What are the projected equipment costs (clinical and non-clinical)?
• Don’t forget instruments and handpieces
Creating the Project Plan

• Designate the project team to carry out the expansion plan (need a leader with sufficient organizational clout to remove barriers)

• Create an implementation plan with action steps, responsible persons and due dates

• Develop a formal reporting process to get regular progress updates from the project team
## Sample Project Plan (Excerpt)

<table>
<thead>
<tr>
<th>Area</th>
<th>Action Step</th>
<th>Due Date</th>
<th>Responsible Person(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dental Equipment</strong></td>
<td>Determine which dental equipment vendor you want to work with by comparing competitors' price, value, and services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sign contract with your dental vendor for purchase and installation of all needed equipment (purchased and donated)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inventory donated equipment (Dental vendor could do this)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Have your dental vendor inspect donated equipment--anything in need of repair or not usable?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Finalize list of dental equipment to be purchased</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Involve the dental vendor during clinic build-out--they will tell you when they should do walk-throughs</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Move donated equipment to clinic site</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dental vendor to install donated and purchased equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Office Equipment/Furnishings</strong></td>
<td>Order computers, monitors and Ergo arms</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Order phones</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Order printers, faxes, copier</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Develop list of needed furniture</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Determine best vendor and purchase</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Install computers and printers</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Install phones, faxes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Install copier</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Install office furniture</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dental Supplies/Instruments</strong></td>
<td>Create list of needed dental supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Create list of needed instruments/handpieces</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Negotiate best prices with vendors (such as Schein and Patterson)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Set up inventory management system for supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Order supplies and stock clinic for start-up</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Order instruments and handpieces</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The Clinical Plan

• Focus Populations
• Scope of Service
• Quality Management
• Integration with Primary Care/Behavioral Health
Identifying Focus Populations

• **It is essential to understand and define the dental clinic’s capacity to bring new patients into the practice, and to actively manage that capacity**

  – Dental capacity is typically 1/5 of medical capacity. This makes it incumbent upon us to prioritize who receives dental treatment
  – When we try to deliver care to everyone in need, we often end up delivering urgent, episodic and fragmented care
Identifying Priority Populations

• As an FQHC, you are NOT allowed to discriminate against patients based on insurance status or ability to pay
• However, you ARE permitted to define focus populations who would have priority access to care
• There are excellent clinical reasons for identifying children and pregnant women as priority populations
• Other priority populations might include patients with diabetes, heart disease or HIV/AIDS referred from primary care
• Access to ALL patients is preserved, but focus populations have priority access to care
HRSA Scope of Service

REQUIRED SERVICES

• Dental Screenings for Children
• Preventive Services
• Emergency Services

EXPECTED SERVICES

• Restorative Treatment
• Basic Endodontic Services (if able to provide)
• Non-Surgical Periodontal Care
• Basic Oral Surgery
• Space Maintenance

Phase 1 Tx
HRSA Scope of Service (cont.)

OPTIONAL SERVICES

- Removable Prosthetic Services (Full and Partial Dentures)
- Fixed Prosthetic Services (Bridges and Crowns)
- Oral Surgery Services (Elective or Complicated)
- Periodontal Surgery
- Orthodontics
Define *Your Proposed Scope of Service*

- Decisions about scope of service can have a tremendous impact on dental program sustainability.
- Complex, costly and time-consuming services such as dentures and root canals may or may not fit financially—important to run the numbers and make an informed decision.
- You are not required to provide them, but if you don’t, are there other places your patients can go to receive this care?
- Not providing them could create a retention issue with your dentists—they won’t want their skills to get rusty.
Define Scope of Service (cont.)

• Also, if you have students or residents, will they need to provide these services to fulfill their clinical training requirements?

• All in-scope services fall under the Sliding Fee Discount Schedule PIN, which means a nominal fee and at least three discount categories.

• Keeping these services out of scope may be the answer.

• Out-of-scope services will not be covered by FTCA, so you will need to purchase malpractice tail insurance (relatively inexpensive).
Quality Management

• Quality Assurance (what is the process for assuring quality of care?)

• Assessing the Patient Experience of Care (how will this be done? How will the results be used to improve care?)

• Quality Outcome Measures (what measures will we track? How will they be tracked? How will they be shared? How will they be used to improve processes?)
Integration of Oral Health Into Primary Care

Components

- Identification of focus population(s)
- Staff training (primary care providers and dental professionals)
- Caries Risk Assessment
- EMR/EDR Interfaces/Information Sharing
- Oral Health Screenings in Medical
- Health Screenings in Dental
- Patient/Caregiver Educational Materials
- Preventive Therapies
- Referral Process (medical to dental and vice versa)
- Case Management
- Warm-Handoffs
- Designated Access Appointments
- Oral Health Services in Primary Care
The Business Plan: Road Map to Success

• What the dental practice needs to accomplish to be financially sustainable, maximize patient access and provide meaningful quality outcomes
• Visit projections (based on staffing and hours/days of operation)
• Revenue projections (for each payer type)
• Expense projections (start-up/expansion costs plus direct/indirect expenses)
• Creation of the pro forma
• Fee schedule/sliding fee scale
• Definition of program goals
• Process for evaluating program success
• Leadership and accountability
Benchmarks

- 2,500-3,200 encounters/year/FTE dentist
- 1,400-1,800 encounters/year/FTE hygienist
- 1,100-1,200 unduplicated patients per FTE general dentist
- 1.7 patients/hour or 14 patients per 8-hour day per general dentist
- 1.2 patients/hour or 8-10 patients per 8-hour day for hygienists
- Gross Charges = >$400K- $500K per FTE dentist per year
## Interactive Budget Planning Tool

www.dentaquestinstitute.org/learn/online-learning-center/resource-library

### Financial Projections

<table>
<thead>
<tr>
<th>Financial Projections</th>
<th>Projected Visits</th>
<th>Actual Visits</th>
<th>Difference</th>
<th>* See the worksheet labeled &quot;Calculating Project Visits&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient/Insurance mix:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent Medicaid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent Self Pay</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent Commercial Insurance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td><strong>Reimbursement Rate (per visit):</strong></td>
<td>Yearly Revenue</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid</td>
<td>$</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self Pay</td>
<td>$</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commercial Insurance</td>
<td>$</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td><strong>Total Projected Revenue</strong></td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
</tr>
</tbody>
</table>

### Fiscal Year Projection Tool

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Projection Tool</th>
</tr>
</thead>
</table>

### Profit & Loss - Budget Variance

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Profit &amp; Loss - Budget Variance</th>
</tr>
</thead>
</table>

### Net Income or (Loss)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Profit &amp; Loss - Budget Variance</th>
</tr>
</thead>
</table>

### Gross Charges

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Profit &amp; Loss - Budget Variance</th>
</tr>
</thead>
</table>

### Revenue:

- **Section 330 Revenue/Grants**: $-
- **Medicaid**: $-
- **Self Pay**: $-
- **Commercial Insurance**: $-
- **Other**: $-
- **Total Revenue**: $-

### Direct Expenses:

- **Salaries**: $-
- **Benefits**: $-
- **Total Salaries**: $-
- **Support Costs**:
  - **Rent**: $-
  - **Lab Fees**: $-
  - **Education, Training, Conferences**: $-
  - **Maintenance and repair**: $-
  - **Dues**: $-
  - **Bad Debt**: $-
  - **Office Supplies**: $-
  - **Depreciation**: $-
  - **Printing, Postage**: $-
  - **Laundry**: $-
  - **Cleaning**: $-
- **Total Support Costs**: $-
- **Total Direct Expenses**: $-

### Indirect Expenses:

- **Administrative costs**: $-
- **Total Direct and Indirect Expenses**: $-

### Net Income or (Loss)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Profit &amp; Loss - Budget Variance</th>
</tr>
</thead>
</table>

* See the worksheet labeled "Calculating Project Visits"
Interactive Tool for Calculating Visits
www.dentaquestinstitute.org/learn/online-learning-center/resource-library

<table>
<thead>
<tr>
<th></th>
<th>FTE</th>
<th>Clinic Days Per Year</th>
<th>Clinic Hours Per Day</th>
<th>Total Provider Hours</th>
<th>Visits Per Hour*</th>
<th>Total Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Visits</td>
<td></td>
<td></td>
<td></td>
<td>0</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Hygiene Visits</td>
<td></td>
<td></td>
<td></td>
<td>0</td>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>

TOTAL VISITS 0

1. Enter in the number of Full Time Equivalent Dentists in Cell B2 and same for Hygienists in Cell B3
2. Enter the total number of days the clinic operates per year in cell C2 and C3. Note: 230 clinic days is a benchmark for clinics that operate 5 days per week to factor in weekends
3. Enter the number of hours per day the clinic is open minus the lunch hour in cell's D2 and D3
4. Cell E2 will automatically calculate the total dental provider hours for the year
5. Cell E3 will automatically calculate the total hygiene hours for the year
6. Enter the average number of visits per hour for dentists in Cell F2 Note: 1.5 - 1.7 visits per hour is the national average for Community Health Center Dentists. This may be higher
7. Enter the average number of visits per hour for hygienists in Cell F3. Note 1.0-1.2 visits per hour is the national average for Community Health Center Hygienists
8. The total potential yearly visits for dentists will automatically calculate in Cell G2
9. The total potential yearly visits for hygienists will automatically calculate in Cell G3
10. The total number of projected visits per year will automatically calculate in Cell G4. This is the projected visit number to enter in Cell D2 of the Financial Tool Spreadsheet
Fee Schedule/Sliding Fee Discount Scale (SFDS)

- Fees should be set at prevailing rates and reviewed annually.
- ALL dental services within the HRSA-approved scope must be on the SFDS (including nominal fees).
- A nominal fee only (or no fee) for patients at or below 100% FPG—does not have to be the same as medical.
- Nominal fee must be a fixed fee (not a percentage).
- A minimum of three discount categories for patients between 101% and 200% of FPG.
The Dental Pro Forma

Revenue

- Projected number of visits/year
- Payer mix (identify all payers and the percentage each needs to contribute for sustainability)—be realistic in your assessment of whether you can attain the percentages
  - Medicaid
  - Self-pay/sliding fee scale (break out nominal fee vs. other SFS/SP)
  - Commercial
  - Other (CHIP, Ryan White, other contracts)
  - Grants (eg, 330 awards, expansion grants, other)
- Determine the projected average reimbursement per visit for each payer type
The Dental Pro Forma (cont.)

Expenses

- Capital expenses (clinical and non-clinical equipment and furniture)
- Construction costs (build-out, architect’s fees, license and permit fees, etc.)
- Dental technology costs (electronic dental record/practice management system, digital radiography)
- Staffing plan (clinical, administrative and support staff)
- Salary expenses (don’t forget to include fringe benefits)
- Non-salary expenses (direct costs AND indirect costs)
Example, Pro Forma

- Federally qualified community health center looking to add a new four-chair dental program
- Clinic will operate 230 days/year
- Hours of operation in Year 1 = M-F, 8-5; Year 2 = M-F 8-5, plus Sat. 9-3 and one evening 5-8
- Year 1 Staffing: 1 FTE dentist/clinical director, 0.2 FTE staff dentist, 2 FTE dental assistants, 1 FTE hygienist, 1 FTE reception/registration clerk, 1 FTE clinic manager
- Year 2 Staffing: 1 FTE dentist/clinical director, 0.4 FTE staff dentist, 2.5 FTE dental assistants, 1.2 FTE hygienist, 2 FTE reception/registration clerks, 1 FTE clinic manager
- Number of visits in Year 1 = 5,520; number of visits in Year 2 = 6,624
## Example

<table>
<thead>
<tr>
<th>REVENUE</th>
<th>Year 1</th>
<th>5520 visits</th>
<th>Year 2</th>
<th>6624 visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Pay/SFS (15%)</td>
<td>$49,680</td>
<td>$60/visit</td>
<td>$59,640</td>
<td>$60/visit</td>
</tr>
<tr>
<td>Medicaid (65%)</td>
<td>$538,200</td>
<td>$150/visit</td>
<td>$645,900</td>
<td>$150/visit</td>
</tr>
<tr>
<td>Commercial Insurance (5%)</td>
<td>$51,060</td>
<td>$185/visit</td>
<td>$61,235</td>
<td>$185/visit</td>
</tr>
<tr>
<td>Nominal fee patients (10%)</td>
<td>$16,560</td>
<td>$30/visit</td>
<td>$19,860</td>
<td>$30/visit</td>
</tr>
<tr>
<td></td>
<td>$655,500</td>
<td></td>
<td>$786,635</td>
<td></td>
</tr>
<tr>
<td>Grant Revenue</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Federal Expansion</td>
<td>$350,000</td>
<td></td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Foundations</td>
<td>$600,000</td>
<td></td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>330 Allocation</td>
<td>$0</td>
<td></td>
<td>$100,000</td>
<td></td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td>$1,605,500</td>
<td></td>
<td>$886,635</td>
<td></td>
</tr>
</tbody>
</table>
**Example (cont.)**

**EXPENSES**

**Build-Out**

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Construction</td>
<td>$400,000</td>
</tr>
<tr>
<td>Clinical Equipment</td>
<td>$363,006</td>
</tr>
<tr>
<td>Office equipment/supplies</td>
<td>$41,700</td>
</tr>
</tbody>
</table>

**Total build-out expenses**

$804,706

**Direct Expenses**

**Personnel Related**

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries</td>
<td>$345,280</td>
</tr>
<tr>
<td>Fringe Benefits (25%)</td>
<td>$86,320</td>
</tr>
<tr>
<td>Malpractice Insurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**Subtotal Personnel Costs**

$431,600

$560,300
### Support costs

<table>
<thead>
<tr>
<th>Category</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Supplies</td>
<td>$55,200</td>
<td>$10/visit</td>
<td>$66,240</td>
<td>$10/visit</td>
</tr>
<tr>
<td>Dental Lab Services</td>
<td>$22,500</td>
<td></td>
<td>$26,250</td>
<td></td>
</tr>
<tr>
<td>Equipment Repair/Maintenance</td>
<td>$9,500</td>
<td></td>
<td>$10,000</td>
<td></td>
</tr>
<tr>
<td>Housekeeping</td>
<td>$7,500</td>
<td></td>
<td>$8,000</td>
<td></td>
</tr>
<tr>
<td>Conference/Travel</td>
<td>$2,000</td>
<td></td>
<td>$3,000</td>
<td></td>
</tr>
<tr>
<td>Office Supplies</td>
<td>$3,000</td>
<td></td>
<td>$4,000</td>
<td></td>
</tr>
<tr>
<td>Books &amp; Subscriptions</td>
<td>$1,000</td>
<td></td>
<td>$1,000</td>
<td></td>
</tr>
<tr>
<td>Fees &amp; Dues</td>
<td>$3,500</td>
<td></td>
<td>$4,000</td>
<td></td>
</tr>
<tr>
<td>Recruitment Expenses</td>
<td>$3,000</td>
<td></td>
<td>$4,000</td>
<td></td>
</tr>
<tr>
<td>Computer--licenses fees, maintenance agreements</td>
<td>$12,000</td>
<td></td>
<td>$15,000</td>
<td></td>
</tr>
<tr>
<td>Insurance</td>
<td>$10,000</td>
<td></td>
<td>$10,000</td>
<td></td>
</tr>
<tr>
<td>Printing</td>
<td>$2,000</td>
<td></td>
<td>$3,000</td>
<td></td>
</tr>
<tr>
<td>Postage</td>
<td>$2,000</td>
<td></td>
<td>$3,000</td>
<td></td>
</tr>
<tr>
<td><strong>Total Support Costs</strong></td>
<td><strong>$133,200</strong></td>
<td></td>
<td><strong>$157,490</strong></td>
<td></td>
</tr>
</tbody>
</table>
### Example (cont.)

**Building-Related Costs**

<table>
<thead>
<tr>
<th></th>
<th>Direct Costs</th>
<th>Indirect Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintenance</td>
<td>$6,000</td>
<td>$6,500</td>
</tr>
<tr>
<td>Rent/Mortgage</td>
<td>$30,000</td>
<td>$30,000</td>
</tr>
<tr>
<td>Utilities</td>
<td>$12,000</td>
<td>$15,000</td>
</tr>
<tr>
<td>Telephone/Internet</td>
<td>$6,000</td>
<td>$6,500</td>
</tr>
<tr>
<td><strong>Total Building Costs</strong></td>
<td><strong>$54,000</strong></td>
<td><strong>$58,000</strong></td>
</tr>
</tbody>
</table>

**Total Direct Expenses**

<table>
<thead>
<tr>
<th></th>
<th>Direct Costs</th>
<th>Indirect Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$618,800</td>
<td>$775,790</td>
</tr>
</tbody>
</table>

**Indirect Expenses**

<table>
<thead>
<tr>
<th></th>
<th>Direct Costs</th>
<th>Indirect Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Support &amp; Admin Allocation (12% of direct expenses)</td>
<td>$74,256</td>
<td>$93,095</td>
</tr>
<tr>
<td>Build-Out expenses</td>
<td>$804,706</td>
<td>$ -</td>
</tr>
<tr>
<td><strong>TOTAL EXPENSES</strong></td>
<td><strong>$1,497,762</strong></td>
<td><strong>$868,885</strong></td>
</tr>
<tr>
<td><strong>TOTAL REVENUE</strong></td>
<td><strong>$1,605,500</strong></td>
<td><strong>$886,635</strong></td>
</tr>
<tr>
<td>Excess revenue over expenses</td>
<td>$107,738</td>
<td>$17,750</td>
</tr>
</tbody>
</table>
Setting Goals

• **Access**
  --Total number of visits
  --Number of unduplicated patients
  --Number of new patients

• **Provider Productivity**
  --Visits/day
  --Procedures/visit
  --Expected net revenue/day

• **Quality Outcomes**
  --Percentage of completed Phase I treatments
  --Percentage of high- and moderate-risk children ages 6-9 who received at least one sealant

• **Financial Outcomes**
  --Gross charges
  --Net revenue
  --Bottom line
Key Metrics to Measure:

- Gross Charges
- Net Revenue
- Expenses
- Bottom Line
- Number of visits
- Revenue per visit
- Cost per visit
- # of Unduplicated Patients
- # of New Patients
- # of Procedures
- Broken Appointment Rate
- Emergency Rate
- Payer Mix Percentages
- Scope of Service
- # FTE Providers
- A/R past 90 days
- Phase I Treatment Completion Rate
- # of children receiving sealants (esp. moderate- to high-risk children aged 6-9)
- # of sealants applied
Evaluation of Dental Program Performance

1. Define the goals that need to be met (access, finance, productivity and outcomes)
2. Identify the reports needed to generate data related to these goals
3. Determine who will be responsible for running these reports, when they will be run and how the results will be tracked and reported
4. Use data to make informed decisions about dental program operations
5. Dental program performance evaluation should be part of a formal continuous quality improvement focus
6. Dental program performance should also be regularly shared with dental staff to create a culture of accountability
Common Barriers to Success

- Dental program too small to be financially sustainable (e.g., 2-operatory dental clinic)—minimum is three operatories.
- Be cautious with mobile van programs—high overhead raises risk.
- Dental program overrun by patients with little or no ability to pay for care (e.g., low-income, uninsured adults).
- For programs relying heavily on grants to provide operating support, loss of grant funding is a constant threat.
- Lack of program goals to define success (financial, productivity, access, outcomes).
- Failure to continuously monitor dental program performance.
Common Barriers to Success (cont.)

- Lack of accountability within the dental program (staff and patients)
- Leadership issues (reporting structure, training/experience, administrative time, clarity around vision/goals, clinical and administrative leadership needed)
- Lack of infrastructure for billing excellence (staff resources, processes, policies, EDR/EHR system configuration)
- Scheduling issues
- Lack of sufficient support staff (assistants and front desk)
- Practice overrun with emergencies
- Practice bringing in more new patients than capacity allows
Top Priorities for Dental Success

1. **Data**: Accurate, Meaningful, Timely
2. Understand your **Capacity**
3. Use the Dental **Schedule Strategically**
4. Have a Policy for **Everything**
5. Actively **Manage** Broken Appointments
6. **Manage** Emergencies Effectively
7. Define Clinical **Scope of Service** and Protocols
Top Priorities for Dental Success

8. *Document* Patient Eligibility
9. Develop *Billing Excellence*
10. *Manage* Self-Pay Patients Effectively
11. *Maximize* Productivity Through Productivity *Goals*
12. *Manage Payer Mix* Through Focus on Priority Populations
13. *Set Goals*; Financial, Productivity, Access, Quality and Outcomes
14. Create a Culture of *Accountability*
15. Implement a *Continuous Quality Improvement* System
Case Study: The Wallace Medical Concern
Portland, Oregon
About Us
About Us
Our Journey With Dental
Challenges and Successes
No Need to Go It Alone!

Many resources to help those contemplating a dental start-up or expansion, including:

- National Network for Oral Health Access (www.nnoha.org)
- Safety Net Dental Clinic Manual (www.dentalclinicmanual.com)
- HRSA Technical Assistance
- Safety Net Solutions (consultants) (www.dentaquestinstitute.org/safetynetsolutions)
- Qualis Health (www.qualishealth.org)
How to Start a Dental Clinic

If you are looking to start a clinic from scratch, there are many resources available to help. Here is a list of resources that have been helpful for other organizations.

NNOHA Resources:
- Sample Dental Budget
- Health Center Oral Health Start-Up Tool Kit
- Needs Assessment of Health Centers without Dental Programs

Other Resources:
- For the Henry Schein document “Essentials of Dental Clinic Planning & Operations Manual”
Welcome to Safety Net Dental Clinic Manual, which is designed to help safety net dental clinic staff with all aspects of clinic development and ongoing operations.

- **Chapter 1: Partnerships & Planning**
- **Chapter 2: Facility Design & Staffing**
- **Chapter 3: Finances**
- **Chapter 4: Clinic Operations**
- **Chapter 5: Quality Improvement**
- **Chapter 6: Program Sustainability**

- The manual is a comprehensive guide, organized in chapters.
- There are many links and downloads to additional resources.
- It is updated on a quarterly basis with the assistance of the steering committee.
- It is not available in print.
Oral Health: An Essential Component of Primary Care

White Paper

June 2015
www.dentaquestinstitute.org
Click on Safety Net Solutions
DentaQuest Institute’s Safety Net Solutions program works with safety net dental programs because we believe in their mission of providing high-quality clinical care to underserved populations. Through customized technical assistance, Safety Net Solutions guides programs through the practice improvement process to assist them in achieving their goals in areas such as increased access, strengthened financial viability, and improved quality outcomes.

Our philosophy is to work collaboratively with administrators, dental directors, and program staff to develop strategies that are realistic and achievable. We also encourage collaboration among safety net clinics through our online learning center, a place where safety net dental providers can ‘meet’ to connect, learn, and discuss solutions.

Click on the items in the left-hand menu to learn more. You can also click this PDF link to read an exciting summary about our program.
Click on HRSA Oral Health Service Expansion Grant Resources
Questions/Discussion
Partnering to Strengthen and Preserve the Oral Health Safety Net