Disclosures

All speakers in this session have completed conflict of interest forms and none have any relevant financial relationships to disclose for themselves or any immediate family members.
Fundamentals of Leading a Health Center Oral Health Program

Lisa Kearney, DDS
Ethan Kerns, DDS
Kecia Leary, DDS, MS
Ernest Meshack-Hart, DDS, FAGD
An Nguyen, DDS, MPH
Allen Patterson, CGMA, CPA, FACMPE, MHA

Nick Pfannenstiel, DDS
Bob Russell, DDS, MPH
Tena Springer, RDH, MA
Ryan Tuscher, DDS
Scott Wolpin, DMD

Ask the Expert!
Who Are We?

National Network for Oral Health Access (NNOHA) envisions a future in which individuals and communities are aware of the importance of oral health to overall health, engage in recommended oral health practices, and receive affordable, high quality oral health services. Achieving this vision requires everyone to have access to care, regardless of income or geography.
History of NNOHA

- Founded in 1991 by a group of Health Center Dental Directors who identified a need for peer-to-peer networking, and valued collaborating with others with shared mission.

- From those humble beginnings, NNOHA’s membership has grown to represent the full diversity of safety-net oral health providers and has become a leader in strengthening and supporting the oral health safety-net.
NNOHA’s Mission

To improve the oral health of underserved populations and contribute to overall health through leadership, advocacy, and support to oral health providers in safety-net systems.
NNOHA Resources

- Website [www.nnoha.org](http://www.nnoha.org)
- Publications
- National Oral Health Learning Institute
- Webinars
- Listserv
- Promising Practices
- Speaker’s Bureau
- Individual consultation/referral
- Dashboard Quality Measures
- Annual Conference
NNOHA Operations Manual for Health Center Oral Health Programs

Chapters:

- Fundamentals
- Leadership
- Financials
- Risk Management
- Workforce and Staffing
- Quality

http://www.nnoha.org/resources/operations-manual/
National Oral Health Learning Institute (NOHLI)

- Year-long leadership training for clinical leaders in a safety net dental programs with <5 years of experience
- Online modules and webinars and in-person trainings (3x)
- The curriculum is based on NNOHA’s Operations Manual and Patient Centered Health Home Action Guide
- Next call for applications: NOHLI Cohort 7 (Summer of 2018)

http://www.nnoha.org/programs-initiatives/nohli/
About Today

1 pm - 4:45 pm Fundamentals
- Information needed for Community-Based Dental Program Leaders to effectively manage an excellent health center dental program
- Two concurrent tracks for four critical program areas; Track 1A Workforce and Staffing/Leadership and Track 1B Risk Management/Quality

Complete one this year and visit us next year for the other

4:45 pm - 5:30 pm Breakouts
- A chance to network with others, share what is working well, discover available resources
- There will be two 25 minute small group discussions on various topics relevant to health center dental directors

Pick two that are most interesting to you
## Today’s Schedule

<table>
<thead>
<tr>
<th>Time</th>
<th>Track 1A</th>
<th>Track 1B</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:00-1:10pm</td>
<td><strong>Welcome</strong>&lt;br&gt;(Ethan Kerns and Scott Wolpin)</td>
<td></td>
</tr>
<tr>
<td>1:10-2:00pm</td>
<td><strong>Fundamentals</strong>&lt;br&gt;(Bob Russell)</td>
<td></td>
</tr>
<tr>
<td>2:00-2:45pm</td>
<td><strong>Financials</strong>&lt;br&gt;(Kecia Leary, Allen Patterson)</td>
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</tr>
<tr>
<td>2:45-3:15pm</td>
<td><strong>Break</strong>&lt;br&gt;(Split into two groups in separate rooms)</td>
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</tr>
<tr>
<td>3:15-4:00pm</td>
<td><strong>Workforce and Staffing</strong>&lt;br&gt;(Ernest Meshack-Hart/Nick Pfannensteil)</td>
<td><strong>Risk Management</strong>&lt;br&gt;(Ethan Kerns/An Nguyen)</td>
</tr>
<tr>
<td>4:00-4:45pm</td>
<td><strong>Leadership</strong>&lt;br&gt;(Scott Wolpin/Tena Springer)</td>
<td><strong>Quality</strong>&lt;br&gt;(Ryan Tuscher/Lisa Kearney)</td>
</tr>
<tr>
<td>4:45-5:30pm</td>
<td><strong>Breakouts</strong>&lt;br&gt;(All)</td>
<td><strong>Breakouts</strong>&lt;br&gt;(All)</td>
</tr>
</tbody>
</table>
Breakout Discussion Topics

- Fee Schedule (PIN 2014-02)/Payer Mix - Bob Russell
- No Show Management - Tena Springer
- Governance, Scope of Project, FTCA Concerns - Jay Anderson
- Workforce/Staff Management and Recruitment - Ryan Tuscher
- Patient Scheduling and Extended Hours of Service - Ethan Kerns
- QA/QI - Kecia Leary
- Medical Dental Integration - An Nguyen
- Difficult Conversations with Staff - Lisa Kearney
- Privileging - Ernest Meshack-Hart
- The link between encounters and churning: Where is the danger zone? – Scott Wolpin
**Stop by the Coffee House to collaborate with colleagues and recharge on coffee, tea, and conversation!**

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Topic</th>
<th>Facilitator</th>
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</thead>
<tbody>
<tr>
<td><strong>Monday, November 13</strong></td>
<td>10:00-10:30am</td>
<td>Sexual Orientation/Gender Identity: Who, How, and When to Ask?</td>
<td>Scott Wolpin, DMD and Steve Geiermann, DDS</td>
</tr>
<tr>
<td></td>
<td>3:00-3:30pm</td>
<td>Students and Residents</td>
<td>Kecia Leary, DDS, MS, Ethan Kerns, DDS, and Wayne Cottam, DMD, MS</td>
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<tr>
<td><strong>Tuesday, November 14</strong></td>
<td>9:30-10:00am</td>
<td>Referrals</td>
<td>Mike Fox, DDS, MS</td>
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<tr>
<td></td>
<td>3:00-3:30pm</td>
<td>Nominal and Sliding Fees</td>
<td>Bob Russell, DDS, MPH, CPM</td>
</tr>
</tbody>
</table>
Can’t lose focus of the Fundamentals

HOW LONG HAS MR. DANVERS HAD THE SALIVA SUCTION IN HIS MOUTH?
Health Center Fundamentals

Bob Russell, DDS, MPH
Learning Objectives

- Discuss the characteristics of Health Center patient populations
- Recognize common terms used to reference Health Center oral health programs
- Describe how Health Centers are financed
- List of partners Health Centers collaborate with
- Learn where are Health Centers heading in the future
Health Centers

Public or private not-for-profit organizations that provide primary health services to populations with limited access to health care.

Health Centers were created to increase access to care among underserved and medically disenfranchised populations.
Examples of Health Centers

HRSA 330 grant-supported programs can be:

- Federally Qualified Health Centers (FQHCs)
- Outpatient health programs/facilities operated by tribal organizations
- Hospital- based
- Dental schools
- County public health departments

Sources: U.S. Department of Health and Human Services Health Resources and Services Administration, bphc.hrsa.gov and CDA May 2009
Federally Qualified Health Centers (FQHCs)

- Health care delivery organization must apply to be designated an FQHC by HRSA
- An FQHC can be reimbursed for Medicaid visits in a different manner than private practice—i.e. by encounter/visit
- FQHCs can apply for Federal Torts Claim Act malpractice protection
- Participate in federal student loan repayment programs
Health Center vs. FQHC

- Health Centers that also receive 330-HRSA grants are FQHCs.

- FQHC “look-alikes” do NOT receive 330-HRSA grant funding, for example, a county health department or a non-profit clinic, but can apply and also receive alternative Medicaid reimbursement such as the encounter based method.
Choptank Community Health Systems
Federalsburg, MD
Health Center Facts
2016 UDS

- Number Health Center programs receiving 330-grant funding: 1,367
- Number HC programs with dental programs: 1,029 or 75%
- Total users: 25,860,296
- Number medical users: 21,880,295
- Number dental users: 5,656,190
- Dental Users: 21.9% all FQHC patients
- Dental Users: 25.8% of all medical patients
Federally Qualified Health Centers (FQHCs)

Source: Centers for Medicare and Medicaid Services; U.S. Department of Health and Human Services; January 2014.

Note: Alaska and Hawaii not shown to scale
2016 Demographics:
Age & Ethnicity

- 0-17 30.9%
- 18-64 60.7%
- 65 & up 8.3%

- 62.3% identify as racial and/or ethnic minorities
  - Hispanic/Latino 35.4%
  - African-American 22.6%
Income Among HC Users as % of Poverty Level

- Over 200%: 8%
- 101-200%: 22%
- 100% and below: 70%
Common Chronic Conditions

- 21.8 million medical users (2016)
  - 4.3 million: Hypertension
  - 2.2 million: Diabetes
  - 1.2 million: Asthma
Scope of Service

- Each HC has a defined scope of service
  - should be based on assessment of the health care needs of the Health Center service population
- When a new service or a new site is added, a change in scope must be approved
Primary Care Focus

- Health Centers strive to provide community oriented primary care
- Focus on family medicine, pediatrics, general dentistry, pediatric dentistry
Public Health Focus

- Develop policies and plans that support health on individual and community level
- Emphasis is on health care that improves and maintains health
- Focus on prevention, screening, patient self-management of chronic conditions
Health Care Services Integration

- Strength of HC is multiple services available in one location
- Some only provide medical services
- Most provide medical, dental, behavioral and ancillary services (social workers, enabling services, community outreach etc.) at the same site
- Additional services:
  - optometry, pharmacy, lab, imaging, podiatry, WIC
Leadership Launch

Imagine your Health Center mirrors national data, and has capacity for only 1 in 4 medical patients to receive dental care.

How would you feel about this? How would you determine who should access dental care? Who else would need to be involved in this decision process?
HealthPoint Community Health Center
Seattle, WA
Dental Program Scope of Service

- **Phase I/Basic/Routine**
  - Level I- Emergency care
  - Level II- Diagnostic & preventive care
  - Level III- Expected care: Routine periodontal, restorative (including endodontics) and surgical care

- *If not available on site, Level I & II care must be available through contractual arrangement (1998 & later programs)*
Dental Program Scope of Service

- Phase II/Rehabilitative/Complex
  - Level IV- Recommended/Rehabilitative care: Complex periodontal, restorative (including endodontology) surgical care and prosthodontics. Other-than-routine specialty care.
Scope of Service

- Scope of service should be determined by the oral health needs of the HC population
- Most HC dental programs provide a majority of Phase I care services
- Many Phase II services have up-front fixed costs (i.e. prosthetic lab fees), which must be factored in the costs of delivering services
2016 Productivity

- 4,474 DDS FTEs across HCs
- 2,200 RDH FTEs across HCs
- 25 Dental Therapists FTEs across HCs

- 2,614 encounters/FTE DDS
- 1,231 encounters/FTE RDH
- 548 encounters/FTE DT
2016 Dental Productivity

- 14,420,355 visits
- 5,656,190 users
- 2.55 visits/user annually

Reasons for dental visits to CHC
- 211,463 had an emergency visit
- 421,216 had sealants
- 950,110 had extractions or other surgery
Health Center Financing

- Source of mystery & myth
  - “government pays”
  - “free care”
  - “unfair competition”

- The majority of HC revenues are derived from fees generated from patient care
- In 2016, Federal grants were on average, 18.7% of revenues
Health Center Revenue - 2016

- Medicaid: 44.4%
- Medicare: 6.6%
- Other public insurance: 1.2%
- Private insurance: 8.6%
- Self pay: 4.4%
- Federal grants: 19.8%
- State/local/private grants: 11%
- Other revenue: 4%
- Federal grants: 19.8%
- Medicare: 6.6%
Prospective Payment System (PPS)

- As FQHCs, Health Centers may be reimbursed for Medicaid visits on an encounter or capitation basis (instead of fee-for-service)
- The process for calculating the PPS rate is determined at the state level and can differ by state
- Rates differ based on scope of HC services, local cost of living, urban vs. rural, etc.
More PPS

- PPS base rate is readjusted yearly based on cost-of-living and whenever a new service is added to the Health Center’s scope of services

- Cost-based reimbursement system
  - For encounter based- rate is the actual cost of delivering services divided by the number of encounters.
  - For capitation, along with monthly rate, at the end of the budget year the difference between the cap rate and the actual cost is determined and reimbursed. This is called the “wrap around.”
Churning

- Churning - systematic, institutionalized practice of maximizing revenues by maximizing visits/encounters
- Each payer method has inherent flaws
  - Encounter based
  - FFS
  - Capitation
Examples of Churning

- Separation of exam & imaging procedures
- Separation of exam, imaging & P&F for children
- Lack of quadrant dentistry
- Separation of sealants
- Lack of definitive treatment of emergencies
Adverse “Churning” Outcomes

- Never finish treatment plans
- Return emergency visits
- Patient dissatisfaction
- Increased clinical risk
- Increased time burden for patients & caregivers
- Below standard of care
- Fraud
Churning I.D. via Quality System

- Chart audit
  - Separation of procedures

- Tracked service use measures
  - Low rates of treatment plan completion

- Patient satisfaction
  - Low because multiple visits
Sliding Scale

- The unique aspect of Health Centers
- Required to offer a sliding fee scale to patients between 100-200% of Federal Poverty Level (FPL)
- Base “nominal fee” that should not impede access to care
- Over 200% of FPL can pay full fee
- In 2016, 23.4% of HC patients were uninsured
Fiscal Sustainability

- Cost per encounter is fixed regardless of reimbursement source
- Sliding scale charges must be subsidized from other sources to balance budget
  - 330 grant
  - Other grants
  - Donations
- What in private practice is considered “profit,” in FQHCs is used to subsidize the sliding scale
2016 Cost Per Dental Visit

- $182.60/encounter nationally
- Medical visits cost $177.87 each
- Each program should know its costs
- Most basic financial data point needed to develop budget, allocate resources
- Needed to revise PPS rate
Leadership Launch

Do you have regular access to your dental program financial data (encounters, cost, payer mix)?

*If so, how do you use the information?*

*If not, how would you get this information?*
Erie Family Health Center
Chicago, IL
Licensure

- Mandatory process by which a governmental agency grants time-limited permission to an individual to engage in a given occupation

- Health Centers must comply with state license requirements for dental staff
Credentialing & Privileging

- Credentialing: assess and confirm qualifications
- Privileging: authorization to provide specific services
- Health Centers must perform both
- Usually Human Resources coordinates
Oversight

- Health Centers experience a level of oversight not always found in the private sector
  - HRSA/BPHC site visits- usually every five years
  - State inspections and Medicaid audits
  - Joint Commission (JC) accreditation visits
IOM Definition Quality- 2001

- “The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”

- Measurement
- Knowledge
Why Assess Quality?

- Section 330 of Public Health Service Act requires every Health Center to have a QI/QA program
- Federal Tort Claim Act deeming application process requires submission of Health Center QI/QA plan and QI/QA committee minutes
- Assures and improves the quality of health care delivery
- **NEW** UDS Sealant Measure: in 2016 48.7% of patients 6-9 years old with sealants on 1st molars
Leadership Launch

As part of your Dental Director duties, you have to direct your department efforts during Joint Commission (JC) accreditation and state Medicaid audits, as well as develop and implement quality improvement measures.

How do you get the rest of the dental team to buy into these efforts?
Penobscott Community Health Care
Bangor, ME
Academic Collaboration

- Dental assisting programs
- Dental hygiene programs
- Emerging new provider programs (dental therapy)
- Pre-doctoral rotations
- Post-graduate residencies
  - GPR
  - AEGD
  - Pediatric dentistry
Community Collaboration

As a part of the community, HCs partner with other agencies to facilitate access to health care and/or focus on specific conditions or populations

- WIC
- Head Start
- Title V (maternal & child health programs)
- County or state health departments
- School districts
- Other community-based organizations
More Collaboration

- Most Health Centers are members of state Primary Care Associations (PCAs)
  - PCAs provide training, specialized support, advocacy
  - Some have Dental Director peer networks and/or dedicated staff for oral health
- Organized dentistry can be a long-term local partner
The Future

- Health care reform- newly insured populations
  - Double Health Center capacity
- Meaningful Use/Technology adoption
- Health Home concept
  - Integration of health care disciplines
Workforce Innovation in Health Centers

- Unique characteristics of HC practice provide broad depth of training experience
- HCs train community members for employment
- Opportunities for dental programs to expand capacity
- Ideal locations to pilot innovations
Dental Teaching/Training Centers

- Dental assisting programs
- Dental hygiene programs
- New/emerging dental workforce models
- Pre-doctoral rotations
- Post-graduate residencies
  - GPR
  - AEGD
  - Pediatric dentistry
Practice Scope Innovations

- Expanded scope of practice for public health/Health Center dental hygienists
- Employment for dentist licensure by credential requirements
- Employer of an ADA Community Dental Health Practitioner
- One allowable practice site for the Minnesota Dental Therapist model
The “Triple Aim”

- Improved Health
- Improved Care
- Reduced Cost
Leadership Launch

Who are the external partners you currently work with to expand your Health Center dental workforce or scope of service?

OR

Who are the partners you could potentially work with to expand your Health Center dental workforce or scope of service?
Conclusion

- Health Centers provide health care to about 8.3% percent of the US population
- The Health Center population is overwhelmingly low-income, uninsured or publicly insured
- Health Center patients are disproportionately members of racial and ethnic minority groups
Oral Health

- Oral health is a vital component of Health Center care and demand for services exceeds capacity.
- Good oral health is important to the overall health of the people Health Centers serve.
- As a Health Center patient once testified: “How can I have good health when I have bad teeth?”
Thank you!

Bob Russell, DDS, MPH
State of Iowa Public Health Dental Director
515-281-4916
bob.russell@idph.iowa.gov
Health Center Financials

Kecia Leary, DDS, MS
University of Iowa, College of Dentistry

Allen Patterson, CPA, FNDNBM
Community Healthcare Center
The Dentist

Kecia Leary, DDS, MS
University of Iowa, College of Dentistry
The Accountant

Allen Patterson, CGMA, CPA, FACMPE, MHA, FNDNBM
(First Non-Dentist NNOHA Board Member)
Learning Objectives

- Become familiar with common HC *financial terms*
- Understand basic HC *financial tools*
- Develop a *financial strategy*
- Locate and utilize helpful resources
Federally funded health centers brace for financial loss

Jayne O'Donnell and Alicia McElhaney, USA TODAY 11:45 p.m. EST February 27, 2014

With resources stretched thin, clinics depend on government money

Federally funded health care centers, already straining to make ends meet, now are fighting to block a 70% cut in their funding next year.

The more than 9,000 health clinic centers, which serve 22 million mostly poor patients, were supposed to be big beneficiaries when an estimated 7 million more people were enrolled in health insurance under the Affordable Care Act. So while losing $3.5 billion a year in federal funding in October 2015 would be a steep reduction in support, it hadn't seemed as problematic when the law passed four years ago as it
Relevant Laws, Regulations and Guidance

- HRSA’s message
- Nominal fees and sliding fees
- Financial management and control policies
- Billing and collections
Types of Care

- **Mandated**
  - Prevention, Emergency, Risk Assessment

- **Expected**
  - Eliminate disease, Phase I

- **Optional**
  - Rehabilitative care

- **Execution through policies and procedures**
Section 330 Grant Funding

- Understanding the 330 grant
- Setting our HC fee schedule
- Nominal fees
- Sliding fees as an art and science
- Fees for patients above 200% FPL
- Income verification
Understanding Health Care Reimbursement Systems

- Fee For Service [FFS]
- Private Dental Insurance
- Capitation Reimbursement
- Managed Care
- Pay for Performance!!! Accountable Care Organizations
- Prospective Payment System [PPS]
- Alternative Payment Methodologies
FFS

- Patient centric services
- *Elimination of Disease* or *Completion of Phase One Treatment*
- Productivity goals - *Factors to consider related to affordability, access, quality and finance*
Nominal Fees and Sliding Fees

- **Nominal Fees**
  - <100% FPL

- **Sliding Fees**
  - 101%-200% FPL
Medicaid and the PPS

- The PPS system- **BIPA 2000** - Why and what does it mean?
- “A floor not a ceiling”
- The truth about PPS
- What to watch out for in the PPS world
The PPS as a System

- The PPS formula
- The Dental vs. the Medical PPS
- How to talk about the PPS
  - internally
  - externally
- External misconceptions about the PPS
- Understanding “wraparound”
- How Alternative Payment Methodologies [APMs] fit
PPS

- Assuring value for the visit
- Quadrant Dentistry:
  - “Not all quadrants are created equal”.
- Think: “Patient First”
- The Community Standard of Care
- The “Dark Side”
“Churning”

- *Let’s not make believe it is not out there*
  - *Don’t let it be your program.*
- What can be done about it?
  - *Policy and Protocol to the rescue*
- Document-Document-Document
- Don’t assume anything
- Lead through example
Capitation

- Prepaid Services
- Understanding the balance needed
- Patient needs vs. provider needs
- Treatment completion under a capitated system
- Transparency and equitable care
- Using policy and protocol to assure compliance
What Does Success Look Like?

Ask Yourself

“What will success look like?”

Back-map to a financial plan

Use financial tools to achieve the success.

Evaluation

Measure by looking at financial reports

See what the data accomplishes.
Understanding Capacity

- Understand the concept of capacity

- Establish clarity and strategy around productivity guidelines

Health Center dental programs cannot be everything for every patient.
Determining Scope of Service

**COMBINE:**

- Knowledge of patient need,
- Capacity of the organization

This determines the scope of service
The Approach

- Keep it simple
- Standardized tools and planning
- Standardization leads to predictability
- Recognize and eliminate variables
- Make it a shared journey
- Communicate with clarity and regularity
- Accurate, meaningful and timely data
Evaluating Dental Program Financial Performance

Tools that provide you with the meaningful, accurate and timely data with which to evaluate your success

- **Budget** -
  - *estimate or prediction*

- **Profit and Loss Statement** -
  - *actual report of finances as they are today*

- **Variance Report** -
  - *difference between budget and actual*

- **Reforecast** -
  - *new budget prediction based upon evaluation of the variance report*
Key Data to Evaluate Program Performance

- Number of visits
- Gross charges
- Total expenses (direct and indirect)
- Net revenue (including all sources of revenue)
- Expense/visit
- Revenue/visit
- Transactions (procedures by ADA code)
- Transactions/visit
- Aging report past 90 days
- Payer and patient mix
- No-show rate
- Emergency rate
- Number of unduplicated patients
- Number of new patients
- Percentage of completed treatments
- Percentage of children needing sealants who received sealants
- Number of FTE providers (dentists and dental hygienists)
Also have and use:

- Business plan *pro forma*
- Capacity report
- Aging report
- Program productivity report
- Individual provider productivity reports
The Business Plan

What the dental practice needs to accomplish:

- To be financially sustainable
- Maximize patient access
- Provide meaningful quality outcomes
The Business Plan (cont.)

- Numbers and types of patients to be seen
- Numbers, types and lengths of appointments
- Scope of service for the practice
- Staffing model
- Service delivery model
- Hours of operation
- Financial, productivity and quality goals to be met
- Optimal payer mix
- Evaluation plan
# Financial Projections

<table>
<thead>
<tr>
<th>Financial Projections</th>
<th>Projected Visits</th>
<th>Actual Visits</th>
<th>Difference</th>
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<tr>
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## Patient/Insurance mix:

<table>
<thead>
<tr>
<th>Patient/Insurance mix:</th>
<th>Yearly visits</th>
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<tbody>
<tr>
<td>Percent Medicaid</td>
<td>-</td>
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<tr>
<td>Percent Self Pay</td>
<td>-</td>
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<tr>
<td>Percent Commercial Insurance</td>
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<tr>
<td>Percent Other</td>
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<tr>
<td>Total</td>
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## Reimbursement Rate (per visit):

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<thead>
<tr>
<th>Reimbursement Rate (per visit):</th>
<th>Yearly Revenue</th>
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<td>Medicaid</td>
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<td>Self Pay</td>
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<td>Commercial Insurance</td>
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<td>Other</td>
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<tr>
<td>Total revenue</td>
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<td>Year One</td>
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<td>Projections</td>
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<td><strong>Gross Charges</strong></td>
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<td>Section 330 Revenue/Grants</td>
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<td>Commercial</td>
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<td><strong>Total Contractual Adjustments</strong></td>
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<tr>
<td><strong>Total Net Revenue</strong></td>
<td>$</td>
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## EXPENSES

### Direct Expenses:
- Salaries: $0
- Fringe Benefits: $0
- **Total Salaries**: $0

### Support Costs:
- Rent/Building Lease: $0
- Dental Supplies: $0
- Malpractice Insurance: $0
- Lab Fees: $0
- Education, Training, Conferences: $0
- Maintenance and repair: $0
- Dues: $0
- Bad Debt: $0
- Office Supplies: $0
- Depreciation: $0
- Printing, Postage: $0
- Software License and Fees: $0
- Utilities: $0
- Telephone: $0
- Laundry: $0
- **Total Support Costs**: $0

**Total Direct and Indirect Expenses**: $0

### Indirect Expenses:
- Administrative Allocation: $0

**Total Direct and Indirect Expenses**: $0

### Total Expenses Year Two: $0

**Net Income (Loss)**: $0
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<th>Jan-16</th>
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<th>Mar-16</th>
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## Variance Report

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<td>(752)</td>
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<td>Budget</td>
<td>Variance</td>
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<td>(160,594)</td>
<td>(33,634)</td>
<td>(126,960)</td>
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## ORAL HEALTH CENTER
### 2016 JUNE P&L REFORECAST BY MONTH

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<th>Mar-16</th>
<th>Apr-16</th>
<th>May-16</th>
<th>Jun-16</th>
<th>Jul-16</th>
<th>Aug-16</th>
<th>Sep-16</th>
<th>Oct-16</th>
<th>Nov-16</th>
<th>Dec-16</th>
<th>TOTAL</th>
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<td>(177,583)</td>
<td>(162,536)</td>
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<td>298,858</td>
<td>304,867</td>
<td>283,489</td>
<td>3,867,399</td>
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| NET INCOME | 2,043 | (60,709) | (14,840) | (5,657) | (54,271) | (27,160) | 52,451 | 7,919 | 4,110 | 38,509 | 24,580 | 33,148 | 122 |
Determining Potential Visit Capacity

• Basis
  • Number of FTE providers
  • Hours of operation
  • Number of chairs
  • Standard productivity benchmarks

• Benchmarks
  • Different for dentists vs. dental hygienists
  • Type of patients being seen by the providers

• The visit determines your quality and your quantity
  • No margin, no mission
Common Factors Impacting Provider Productivity

- No-shows and last-minute cancellations
- Scheduling issues--types of patients
- Insufficient support staff--dental assistants
- Lack of goals and accountability
- Individual provider issues
  - unmotivated, inexperienced, health problems, life issues, etc.
- Insufficient instruments, supplies
- Equipment issues--outdated, missing, broken
- Lack of EDR/EHR--not fully utilized
Determining Potential Visit Capacity (Dentists)

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<th></th>
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<th>X 1.7 Visits/FTE/Clinical Hour</th>
<th>X # of Clinical Hours</th>
<th>Potential Visit Capacity</th>
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<td>6.8</td>
<td>8</td>
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<td>Thurs.</td>
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<td>4</td>
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</table>
## Determining Potential Visit Capacity (Dentists)

<table>
<thead>
<tr>
<th>Day</th>
<th># of FTE Providers</th>
<th>X 2 Visits/FTE/Clinical Hour</th>
<th>X # of Clinical Hours</th>
<th>Potential Visit Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mon.</td>
<td>3</td>
<td>6</td>
<td>8</td>
<td>48</td>
</tr>
<tr>
<td>Tues.</td>
<td>4</td>
<td>8</td>
<td>8</td>
<td>64</td>
</tr>
<tr>
<td>Wed.</td>
<td>3</td>
<td>6</td>
<td>8</td>
<td>48</td>
</tr>
<tr>
<td>Thurs.</td>
<td>3</td>
<td>6</td>
<td>8</td>
<td>48</td>
</tr>
<tr>
<td>Fri.</td>
<td>3</td>
<td>6</td>
<td>4</td>
<td>24</td>
</tr>
</tbody>
</table>
Financial Production

- Production measured by gross charges or revenue.
  - If measured by gross charges, must know your collection rate.

- Each provider in the dental department should have individual production goals
  - They tie in with the dental department`s overall goals.

- Each member of the staff should know what it costs to see a patient (visits/expenses).
Setting Goals: Provider Productivity

- Use benchmarks
  - 1.7 visits/hour for dentists, 1.25 visits/hour for DH
  - 1 visit/hour for externs and new residents
- Benchmark x number of daily clinical time =
  - total number of visits/day/provider
  - Example: 1.7 x 8 hours = 14 visits
- Goal for procedures per visit: 2-5
  - for basic dental program serving a mix of adults and children
- Revenue goals need to be based on overall costs of running program.
Setting Goals: Provider Productivity

Example:
Total operating costs (Breakeven costs to cover from patient care) = $1,000,000
Total expected visits for the year = 7,820
Cost per visit = $1,000,000 ÷ 7,820 visits = $128 (this is also the revenue per visit goal to break even)

- Per Month: $1,000,000 ÷ 12 months = $83,333
- Per Day: $1,000,000 ÷ 230 days = $4,348
- Per Hour: $1,000,000 ÷ 1,840 hours = $543
- Per Minute: $1,000,000 ÷ 110,400 minutes = $9
- Per Visit: $128
# Individual Production Goals

<table>
<thead>
<tr>
<th>Provider</th>
<th>FTE</th>
<th>Gross Charges</th>
<th>Net Revenue (60%)</th>
<th>Annual Days Worked</th>
<th>Charges/Day</th>
<th>Revenue/Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. D</td>
<td>1.0</td>
<td>$541,667</td>
<td>$325,000</td>
<td>230</td>
<td>$2,355</td>
<td>$1,413</td>
</tr>
<tr>
<td>Dr. G</td>
<td>1.0</td>
<td>$541,667</td>
<td>$325,000</td>
<td>230</td>
<td>$2,355</td>
<td>$1,413</td>
</tr>
<tr>
<td><strong>Total Dentist</strong></td>
<td><strong>2.0</strong></td>
<td><strong>$1,083,333</strong></td>
<td><strong>$650,000</strong></td>
<td><strong>460</strong></td>
<td><strong>$4,710</strong></td>
<td><strong>$2,826</strong></td>
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<tr>
<td>RDH</td>
<td>1.0</td>
<td>$291,667</td>
<td>$175,000</td>
<td>230</td>
<td>$1,268</td>
<td>$761</td>
</tr>
<tr>
<td>RDH</td>
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<td>$291,667</td>
<td>$175,000</td>
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<td><strong>Total RDH</strong></td>
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<td><strong>$583,333</strong></td>
<td><strong>$350,000</strong></td>
<td><strong>460</strong></td>
<td><strong>$2,536</strong></td>
<td><strong>$1,522</strong></td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>$1,666,666</td>
<td>$1,000,000</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
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Payer Mix

- Huge impact on financial sustainability
- Big challenge to manage
- Determine the average revenue per visit
  - Per payer type
- Use the information to create a payer mix
  - Ensures financial sustainability
  - Preserves access for all patients.
Tweaking Payer Mix

- **Limited capacity**
  - Designate public health and/or medically indicated priority populations
  - Work to get them into the practice

- **Populations likely to have insurance coverage**
  - Pregnant women
  - Children

- **Goal**
  - Preserve as much access for uninsured patients as possible
  - Maintain financial sustainability

- **Financial sustainability**
  - Lays the groundwork for expansion
  - Increases access for all payer types

- **Use data and knowledge of the practice**
  - Informs decisions around patient and payer mix!
Impact of Payer Mix on Sustainability

Now (7,500 visits)
35% Medicaid (avg. revenue/visit = $100)
55% Self-Pay/SFS (avg. revenue/visit = $30)
10% Commercial (avg. revenue/visit = $125)

2,625 visits x $100 = $262,500
4,125 visits x $30 = $123,750
750 visits x $120 = $90,000
Total revenue = $476,250
Total expenses = $500,000
Operating loss = ($23,750)

Better (7,500 visits)
40% Medicaid (avg. revenue/visit = $100)
50% Self-Pay/SFS (avg. revenue/visit = $30)
10% Commercial (avg. revenue/visit = $125)

3,000 visits x $100 = $300,000
3,750 visits x $30 = $112,500
750 visits x $120 = $90,000
Total revenue = $502,500
Total expenses = $500,000
Operating surplus = $2,500
Our Major Strategic Tool: The Daily Schedule

- Scheduling is an art

- Supports maximum access
  - quality outcomes and financial sustainability

- Done improperly, all of these areas suffer
Steps to the Daily Schedule

- **First step:**
  Create a formal policy

- **Second step:**
  - Create a scheduling template with goals and designated access for priority populations

- **Third step:**
  - Make sure staff who schedule know how it needs to be done

- **Final step:**
  - Monitor how well things are working
  - Provide regular feedback to schedulers
Conclusion

Becoming knowledgeable about the financial aspects of your Health Center will help your program become more efficient, productive, and ultimately able to provide more care to the patients in the community.
Questions?

Kecia Leary, DDS, MS
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First Non-Dentist NNOHA Board Member
Community Healthcare Center
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(940) 397-2602
## Today’s Schedule

<table>
<thead>
<tr>
<th>Time</th>
<th>Track 1A</th>
<th>Track 1B</th>
</tr>
</thead>
</table>
| 1:00-1:10pm| **Welcome**
(Ethan Kerns and Scott Wolpin) |                                               |
| 1:10-2:00pm| **Fundamentals**
(Bob Russell) |                                               |
| 2:00-2:45pm| **Financials**
(Kecia Leary, Allen Patterson) |                                               |
| 2:45-3:15pm| **Break** *(Split into two groups in separate rooms)* |                                               |
| 3:15-4:00pm| **Workforce and Staffing**
(Ernest Meshack-Hart/Nick Pfannensteil) | **Risk Management**
(Ethan Kerns/An Nguyen) |
| 4:00-4:45pm| **Leadership**
(Scott Wolpin/Tena Springer) | **Quality** *(Ryan Tuscher/Lisa Kearney)* |
| 4:45-5:30pm| **Breakouts*** *(All)* | **Breakouts*** *(All)* |