Implementing the Plan for Success

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Learning Objectives for Today

- Learn strategies for managing emergencies, broken appointments and the demand for care
- Learn strategies for maximizing access and provider productivity
- Understand the essentials of effective revenue cycle management

Our Top 10 Priorities for Success

1. Determine Actual Program Capacity (and Manage to Your Capacity)
2. Set Realistic and Achievable Program Goals
3. Develop a Sound Plan for Sustainability
4. Maximize Productivity
5. Maximize Access
6. Minimize Chaos/Unpredictability
7. Maximize Revenue
8. Measure Performance
9. Embrace Continuous Quality Improvement
10. Get Buy-In and Accountability

4 and #5: Maximize Productivity and Access

Best Practices for Improving Productivity and Access

Decrease	Broken Appointments
Improve	Scheduling
Hire	More Dental Assistants (if necessary to meet benchmark)
Share	Goals and Provide Feedback
Consider	An Incentive Program
Resolve	Instruments, Supplies, Equipment Barriers
Train	Staff on EDR

Broken Appointments: Our #1 Problem

- Lost productivity
- Lost revenue
- Wasted chair time
- Diminished access
- Incomplete treatment
- Chaos/unpredictability
- Staff/provider frustration
- Patient frustration

Broken Appointment Best Practices

- A strong policy
- Consistent enforcement
- Scripting
- Same-day only
- Alerts
- Track

Minimizing the Risk of Broken Appointments

- Multiple reminder calls
- Patrol the schedule
- Multiple touchpoints
- Two-way confirmation system
- Strategies for patients you couldn’t reach

Minimizing the Risk of Broken Appointments

- Limit new patients
- Emergency patient F/U
- Multiple family members
- Limit how far out to schedule

Late Patients

- Patients who show up more than a few minutes late for their scheduled appointment
- >5 minutes late is a problem
- How to manage needs to be decided and part of policy
- Decision to see or reschedule needs to be made in collaboration with clinical team
- If meaningful care can still be provided without disrupting the practice, that should be done

Tracking/Quantifying Broken Appointments

- Patients who failed to show
- Patients who called <24 hours' notice
- Count even if appointment slot was filled with another patient
- Numerator: all patients who broke appointments for the reporting period
- Denominator: all patients who were scheduled for the reporting period

15%

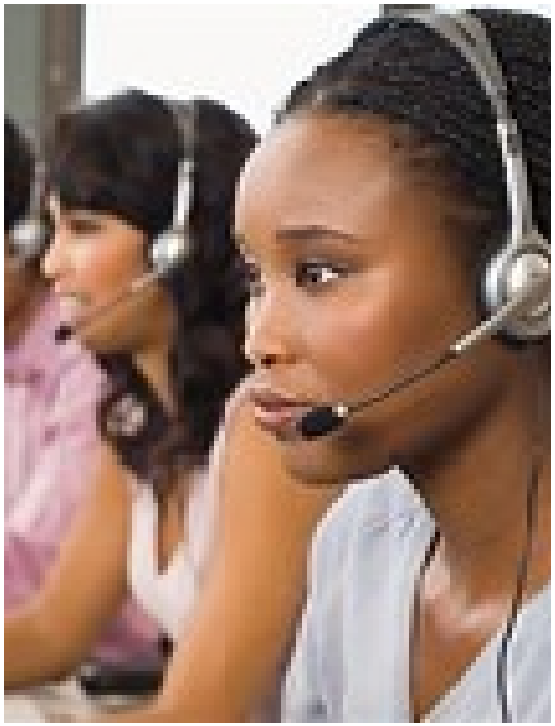

BHAG
BIG HAIRY AUDACIOUS GOAL - WE GOT THIS
memegenerator.net

So, What About Scheduling?

- One of the biggest contributors to dental program success or failure
- Huge strategic tool
- Often given least amount of thought
- Dental schedulers: friend or foe?
- We need to be ALL over that schedule!

What Are We Trying to Accomplish?

- Fill schedule!
- Yes, BUT also:
  - ✓ Patients who are likely to show up
  - ✓ Right patients in the right slot
  - ✓ Appropriate balance of new and existing patients
  - ✓ Right amount of time each patient needs



The Dental Schedule….

Maximizes access

Maximizes outcomes

Maximizes revenue

Common Scheduling Pitfalls

Scheduling out too far	Multiple appointments	Too many new patients	Appointment lengths
Misuse of provider time	Double-booking	Unused time	Schedulers

How Far Out to Schedule?

- Generally, <4 weeks (6 max.)
- Even hygiene
- Maintains patient engagement
- Completes treatment faster
- Reduces broken appointments
- Schedule recall out 6 months only for faithful, established patients
- Need effective recall system
- Pressure to go beyond 4 weeks may signal too many new patients

Giving Out Multiple Appointments

Only for procedures (eg, dentures, RCTs) requiring multiple visits to complete

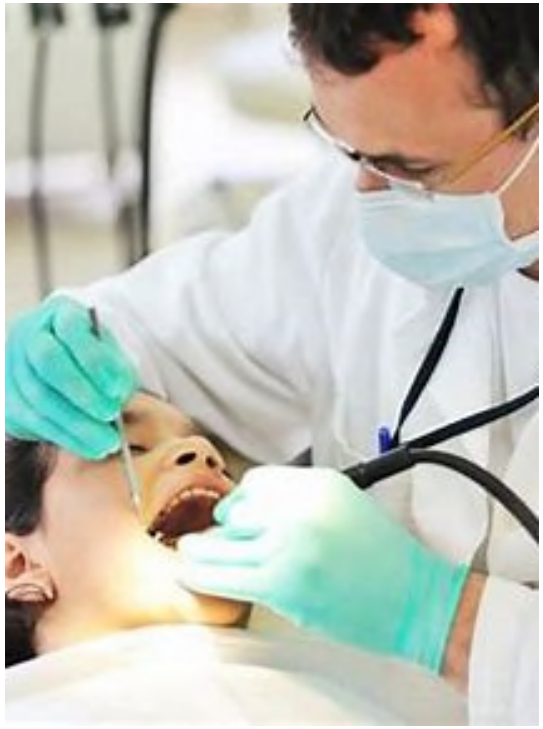
Pressure to schedule multiples to ensure patients get the follow-up care they need signals too many new patients

Too Many New Patients

- New patients constitute bulk of calls to call centers
- When someone calls the call center, they typically get an appointment
- If too many new patients is a problem, look here!
- May need to template designated access to new patients to control number
- Provide talking points for call center staff to explain situation to callers looking to get in as new patients
- Monitor the schedule to ensure call center staff are complying with restricted access and not putting new patients in elsewhere

How Many New Patients is Too Many?

- Depends (new vs. existing practice)
- Signs:
  - Difficult to find follow-up appointments for existing patients (long waits in between appointments)
  - Scope of Service reveals high percentage of diagnostic services and low percentage of treatment
  - Low percentage of completed Phase I treatments



New Adult Patient Exam (Dentist)	# of Min
Seat/place bib and glasses	2
x-rays	20
Review medical HX/take vitals	4
Chart existing	4
Exam/oral cancer screen	15
Treatment plan/chart	10
Unseat/escort/turnover room	5
Total time required	**60**

New Adult Patient (RDH)	# of Min
Seat/place bib and glasses	2
Review medical HX/take vitals	4
Perio charting	5
Prophy/OHI	20
Unseat/escort/turnover room	5
Document	5
Total time required	**41**

New Child (4-14)	# of Min
Seat/place bib and glasses	2
x-rays	15
Review medical HX	3
Chart existing	4
Prophy (D1120)/OHI	10
D1206	5
D0150	10
Unseat/escort/turnover room	5
Document	6
Total time required	**60**

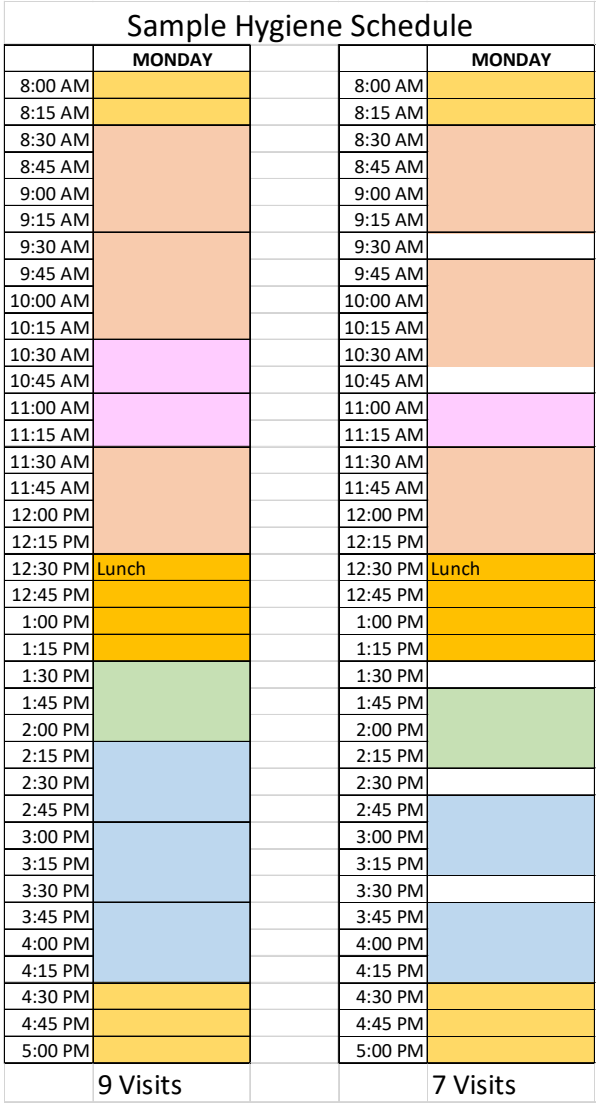
Appointment Lengths

- Too long, too short—both are problematic
- Too short means limited time for providers to complete meaningful work—frustrating for both staff and patients
- Too long means a precious resource (provider time) is being wasted
- Striving for “just right”—enough time to do the work required but no more
- Identify all work in the visit and time required (RVUs help with the actual dental services)
- 10-minute increments if possible

Misuse of Provider Time

- Dentists being dentists, hygienists being hygienists
- Everyone works to the top of their license
- Diligence to make sure appointments are being scheduled appropriately

Unused Time: A Sneaky Thief



75 minutes of lost access!

To Double-Book, or Not to Double-Book: That is the Question

- Workaround for problem of patients not showing for scheduled appointments
- Feast or famine!
- Judicious double-booking okay
- Widespread double-booking not okay
- Tackle the root issue—BAs

Schedulers

- Should be part of dental team
- Should be well-trained and supported
- Should be held closely monitored and held accountable
- They are the ones who can make or break dental program success!

What About Call Centers?

- Hire dedicated dental call center staff if possible (ideally people with prior dental experience)
- Provide training to all call center staff on difference between medical and dental appointments
- Simplify appointments
- Use designated access to control the schedule
- Monitor and provide immediate feedback on errors
- Train all new staff

Sample Template, Dentist, 2 Assistants

	Op 1	Op 2	
8:00-8:15	Simple Treatment		
8:15-8:30	45 minutes		
8:30-8:45		Complex Treatment	
8:45-9:00		60 min	
9:00-9:15			
9:15-9:30	Simple Treatment		
9:30-9:45	45 minutes	Turnover	
9:45-10:00		Simple Treatment	
10:00-10:15	Turnover	45 minutes	
10:15-10:30	Simple Treatment		
10:30-10:45	45 minutes	Turnover	
10:45-11:00		Simple Treatment	
11:00-11:15	Turnover	45 minutes	
11:15-11:30	Simple Treatment		
11:30-11:45	45 minutes	Turnover	
11:45-12:00		Short Visit	
12:00-12:15	Turnover		
12:15-12:30		Turnover	
12:30-12:45			Lunch
12:45-1:00	Simple Treatment		
1:00-1:15	45 minutes		
1:15-1:30		Simple Treatment	
1:30-1:45	Turnover	45 minutes	
1:45-2:00	Complex Treatment		
2:00-2:15	60 min	Turnover	
2:15-2:30			
2:30-2:45		Complex Treatment	
2:45-3:00	Turnover	60 min	
3:00-3:15	Simple Treatment		
3:15-3:30	45 minutes		
3:30-3:45		Turnover	
3:45-4:00		Simple Treatment	
4:00-4:15		45 minutes	
4:15-4:30	Short Visit		
4:30-4:45		Turnover	
4:45-5:00	Turnover		

Key:			
Simple Treatment 45 minutes	45 for care; single or simple restorations, extractions, emergency visit with definitive care, etc.		
Complex Treatment 60 minutes	60 for care; multiple or complex restorations, extractions, etc.		
Short Visit	30-minute (exams, ER, interim denture, post-op visit, post-op visit, crown delivery, etc.		
Turnover	15 minutes for room cleaning, turnover		

More of a conventional, pre-pandemic scheduling (note this doesn't include some judicious double-booking)

Sample Template, Dentist, 2 Assistants

	Op 1	Op 2	
8:00-8:15	treatment		Double-book
8:15-8:30	45 minutes		
8:30-8:45		Treatment	
8:45-9:00	Turnover	60 min	
9:00-9:15			
9:15-9:30	treatment		
9:30-9:45	45 minutes	Turnover	
9:45-10:00		treatment	
10:00-10:15	Turnover	45 minutes	
10:15-10:30	Treatment		
10:30-10:45	45 minutes	Turnover	
10:45-11:00		treatment	
11:00-11:15	Turnover	45 minutes	
11:15-11:30	Treatment		
11:30-11:45	45 minutes	Turnover	Double-book
11:45-12:00		Short Visit	
12:00-12:15	Turnover		
12:15-12:30		Turnover	
12:30-12:45			Lunch
12:45-1:00	treatment		Double-book
1:00-1:15	45 minutes		
1:15-1:30		treatment	
1:30-1:45		45 minutes	
1:45-2:00	Treatment		
2:00-2:15	60 min		
2:15-2:30			
2:30-2:45		treatment	
2:45-3:00	Turnover	45 minutes	Double-book
3:00-3:15	Short Visit		
3:15-3:30		Turnover	
3:30-3:45	Turnover		
3:45-4:00			

This schedule shows a shorter day and some careful double-booking

Sample Template, Dentist, 2 Assistants, 85%

	Op 1	Op 2	
8:00-8:15	treatment		
8:15-8:30	60 minutes		
8:30-8:45			
8:45-9:00		treatment	
9:00-9:15	Turnover	60 minutes	
9:15-9:30			
9:30-9:45	treatment		
9:45-10:00	60 minutes	Turnover	
10:00-10:15			
10:15-10:30		treatment	
10:30-10:45	Turnover	60 minutes	
10:45-11:00			
11:00-11:15	Short Visit		
11:15-11:30		Turnover	
11:30-11:45	Turnover	Short Visit	
11:45-12:00			
12:00-12:15		Turnover	
12:15-12:30			Lunch
12:30-12:45	treatment		
12:45-1:00	60 minutes		
1:00-1:15			
1:15-1:30		treatment	
1:30-1:45	Turnover	60 minutes	
1:45-2:00			
2:00-2:15	treatment		
2:15-2:30	60 minutes	Turnover	
2:30-2:45			
2:45-3:00		treatment	
3:00-3:15	Turnover	60 minutes	
3:15-3:30			
3:30-3:45	treatment		
3:45-4:00	60 minutes	Turnover	
4:00-4:15		Short Visit	
4:15-4:30			
4:30-4:45	Turnover	Turnover	
4:45-5:00			

Key:			
Treatment 60 minutes	60 for care		
Short Visit	30-minute (exams, ER, interim denture, post-op visit, etc.)		
Turnover	15 minutes for room cleaning, turnover		

Fewer appointments but longer and more overlap—gives providers flexibility to determine where they are needed and when

Sample Template, Dentist (85% Pre-Pandemic Productivity), 1 Assistant

	Op 1	Op 2	
8:00-8:15	treatment		
8:15-8:30	60 minutes		
8:30-8:45			
8:45-9:00			
9:00-9:15	Turnover	Hygiene check	
9:15-9:30		treatment	
9:30-9:45		60 minutes	
9:45-10:00			
10:00-10:15			
10:15-10:30	Hygiene check	Turnover	
10:30-10:45	60 minutes		
10:45-11:00			
11:00-11:15			
11:15-11:30	Turnover		
11:30-11:45		Short Visit	
11:45-12:00			
12:00-12:15		Turnover	Dentist 1 Lunch
12:15-12:30			
12:30-12:45	60 minutes		
12:45-1:00			
1:00-1:15			
1:15-1:30	Turnover	Hygiene check	
1:30-1:45		60 minutes	
1:45-2:00			
2:00-2:15			
2:15-2:30		Turnover	
2:30-2:45	Hygiene check		
2:45-3:00	60 minutes		
3:00-3:15			
3:15-3:30			
3:30-3:45	Turnover		
3:45-4:00		Hygiene check	
4:00-4:15		60 minutes	
4:15-4:30			
4:30-4:45			
4:45-5:00		Turnover	

Key:			
Treatment 60 minutes	60 for care		
Short Visit	30-minute (exams, ER, interim denture, post-op visit, etc.)		
Turnover	15 minutes for room cleaning, turnover		

Lack of sufficient dental assistants means 4 fewer visits/day for a dentist

Sample Template, Hygienist, One Op (unassisted)

	Op 1	
8:00-8:15	Hygiene, Adult	
8:15-8:30	60 min	
8:30-8:45		
8:45-9:00		
9:00-9:15	Turnover	
9:15-9:30	Hygiene, Adult	
9:30-9:45	60 min	
9:45-10:00		
10:00-10:15		
10:15-10:30	Turnover	
10:30-11:00	Hygiene, Adult	
11:00-11:15	60 min	
11:15-11:30		
11:30-11:45		
11:45-12:00	Room Turnover	
12:00-12:15		RDH Lunch
12:15-12:30		
12:30-12:45	Hygiene, Adult	
12:45-1:00	60 min	
1:00-1:15		
1:15-1:30		
1:30-1:45	Room Turnover	
1:45-2:00	Hygiene, Adult	
2:00-2:15	60 min	
2:15-2:30		
2:30-2:45		
2:45-3:00	Room Turnover	
3:00-3:15	Hygiene, child	
3:15-3:30	>13	
3:30-3:45		
3:45-4:00	Room Turnover	
4:00-4:15	Hygiene, child	
4:15-4:30	<13	
4:30-4:45	Turnover	
4:45-5:00		

Key:			
Child Hygiene <13	30 minutes		
Adult Hygiene	60 minutes		
Child Hygiene >13	45 minutes		
Turnover	15 minutes to clean and prep operatory		

If the dental practice is comprised of mostly adults, longer appointments = fewer encounters

Designated Access

- The daily schedule ensures access for all patients
- But a *certain number* of appointments are reserved for focus populations
- These reserved appointments can't be filled with other patient types until the day before
- Designated access also protects slots for patients in the midst of specialty services requiring multiple visits such as dentures

Important Takeaways

- Pre-Pandemic productivity may not be possible—however, many health centers have returned to near pre-pandemic productivity
- Make sure you have enough dental assistants to maximize productivity
- Schedules need to be strategic but also realistic and achievable
- Don’t set encounter goals to hit “budget” if those goals are not achievable
- Focus on ensuring no open slots in the schedule (ratchet down on BAs)
- Designated access can help with payer mix
- Make sure you get paid for EVERY visit possible (watch billing and collections like a hawk!)

6: Minimize Chaos and Unpredictability

Contributing Factors

- Broken Appointments
- Overdemand
- Overscheduling
- Emergencies
- Insufficient Staffing

Overdemand for Care

What's the Problem?

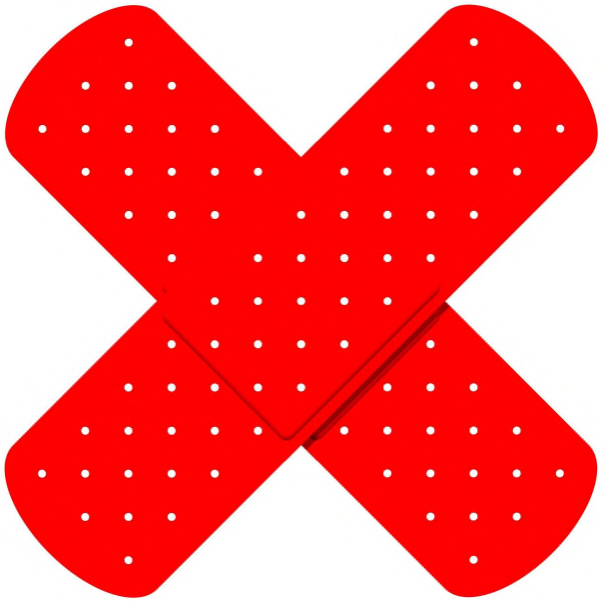
- Finite capacity
- Usually way less than medical
- Few other access points to affordable care

Common Pitfalls

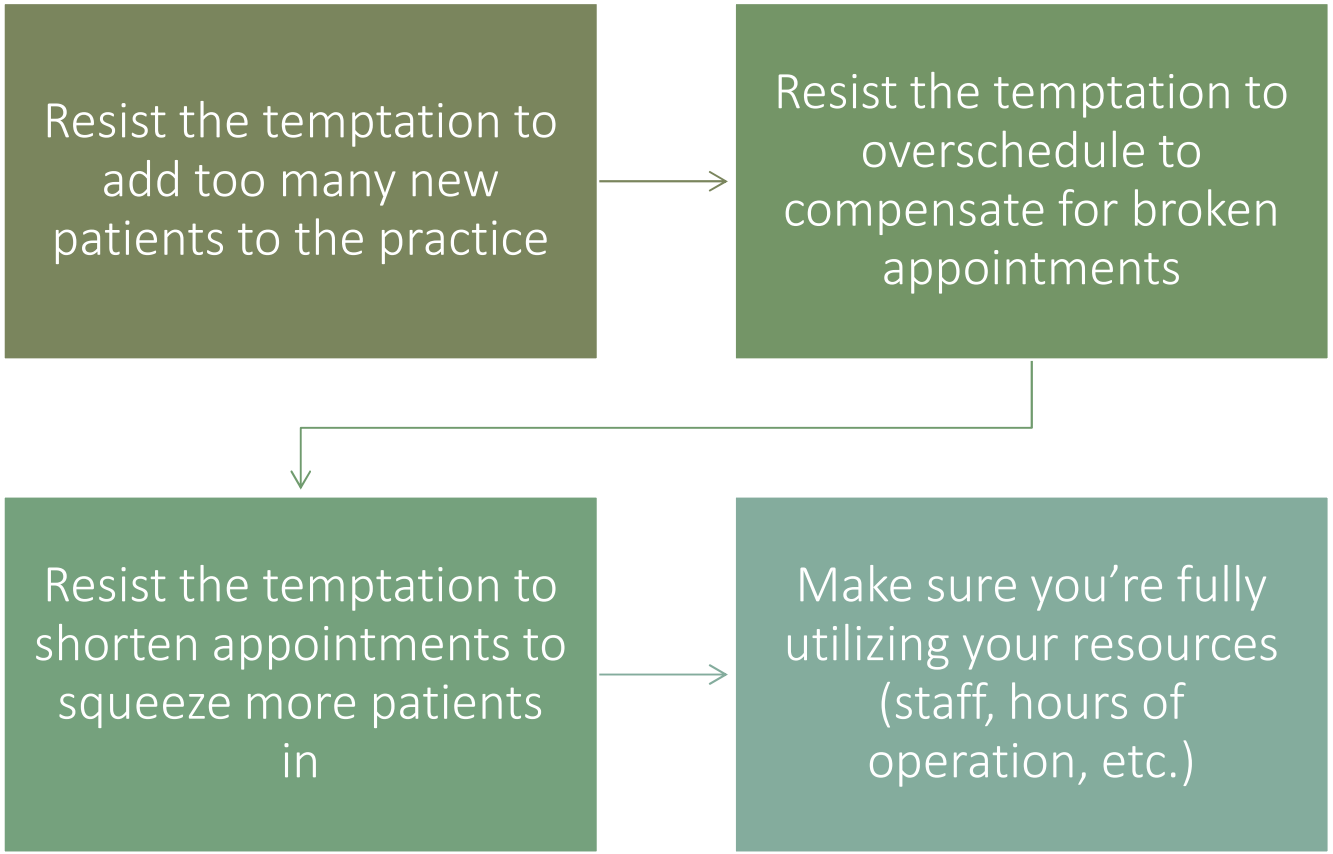
- Bring in more and more new patients
- Shorter appointments = more patients, right?
- Overschedule (they won't all show up!)

What Happens?

- Schedule becomes clogged
- Long waits for appointments
- Diagnosing but not treating
- Unhappy patients
- Unhappy staff



Managing to Capacity



What to Do?

- Define potential capacity based on current structure
- Manage to your potential capacity
- Track completed treatments
- Maximize efficiency to prevent wasted capacity
- Change structure (more operatories, more staff, more hours, more dental sites) to increase capacity

Why Manage Emergencies?

- Dental ER or Dental Home?
- Unpredictability
- Extra Work
- Reimbursement
- Disruption
- Patient/Staff Satisfaction

Quantify Demand

- Average Per Day
- Reality vs. Perception
- Tracking

Have A System In Place

- Where do emergencies fit?
- Who will provide care?
- What care will be provided?
- Morning huddle

Beware of Walk-ins

Definitive vs. Palliative Care

- Definitive whenever possible
- Time
- Impact on BAs
- Patient/provider satisfactio

#7: Maximize Revenue

If You're in Charge of Dental

- Control
- Predictability
- Self-Reliance

Major Impacts on Dental Revenue

- Payer mix—HUGE impact
- Provider productivity (encounters and services)
- Fees/discounts
- Collections (third-party and patient payments)

Impact of Payer Mix on Sustainability

8,000 visits	8,000 visits
35% Medicaid =2,800 visits x $125 = $350,000	40% Medicaid =3,200 visits x $125 = $400,000
55% Self-Pay/SFS =4,400 visits x $30 = $132,000	50% Self-Pay/SFS =4,000 visits x $30 = $120,000
10% Commercial =800 visits x $125 = $100,000	10% Commercial=800 visits x $125 = $100,000
Total revenue = $582,000	Total revenue = $620,000
Total expenses = $600,000	Total expenses = $600,000
Operating loss = ($18,000)	Operating surplus = $20,000

Impact of Productivity on Sustainability

6,000 visits	8,000 visits
40% Medicaid =2,400 visits x $125 = $300,000	40% Medicaid =3,200 visits x $125 = $400,000
50% Self-Pay/SFS =3,000 visits x $30 = $90,000	50% Self-Pay/SFS =4,000 visits x $30 = $120,000
10% Commercial =600 visits x $125 = $75,000	10% Commercial=800 visits x $125 = $100,000
Total revenue = $465,000	Total revenue = $620,000
Total expenses = $600,000	Total expenses = $600,000
Operating loss = ($135,000)	Operating surplus = $20,000

Impact of Fees and Discounts

- Potential missed opportunities with FFS reimbursement
- Need to make sure charges aren't less than third-party payers would pay
- Full fees should be set at "prevailing rates"
- Discounts make dental as affordable as possible

Are We Collecting What We're Owed?

- Net patient revenue as percentage of gross charges
- Accounts receivable
  - Past 90 days
  - % of total A/R
- Claims management issues (esp. denials)
- Collections at time of service

Impact of Collections

- Can be HUGE!
- Demoralizing for dental staff
- Frustrating for all

BILLING AND COLLECTIONS

Why do we leave money on the table?

- Non-covered services
- Non-covered patients
- Failure to submit clean claims
- Flaws in billing process
- Don’t collect from patients

Key Factors Impacting Billing/Collections

- Management of self-pay/SFDS patients
- Eligibility process
- Documentation
- Check-in/check-out
- Prior authorization process
- Revenue cycle processes
- Scripting
- Fees/SFDS
- Ongoing evaluation of performance

Billing and Collections Best Practices

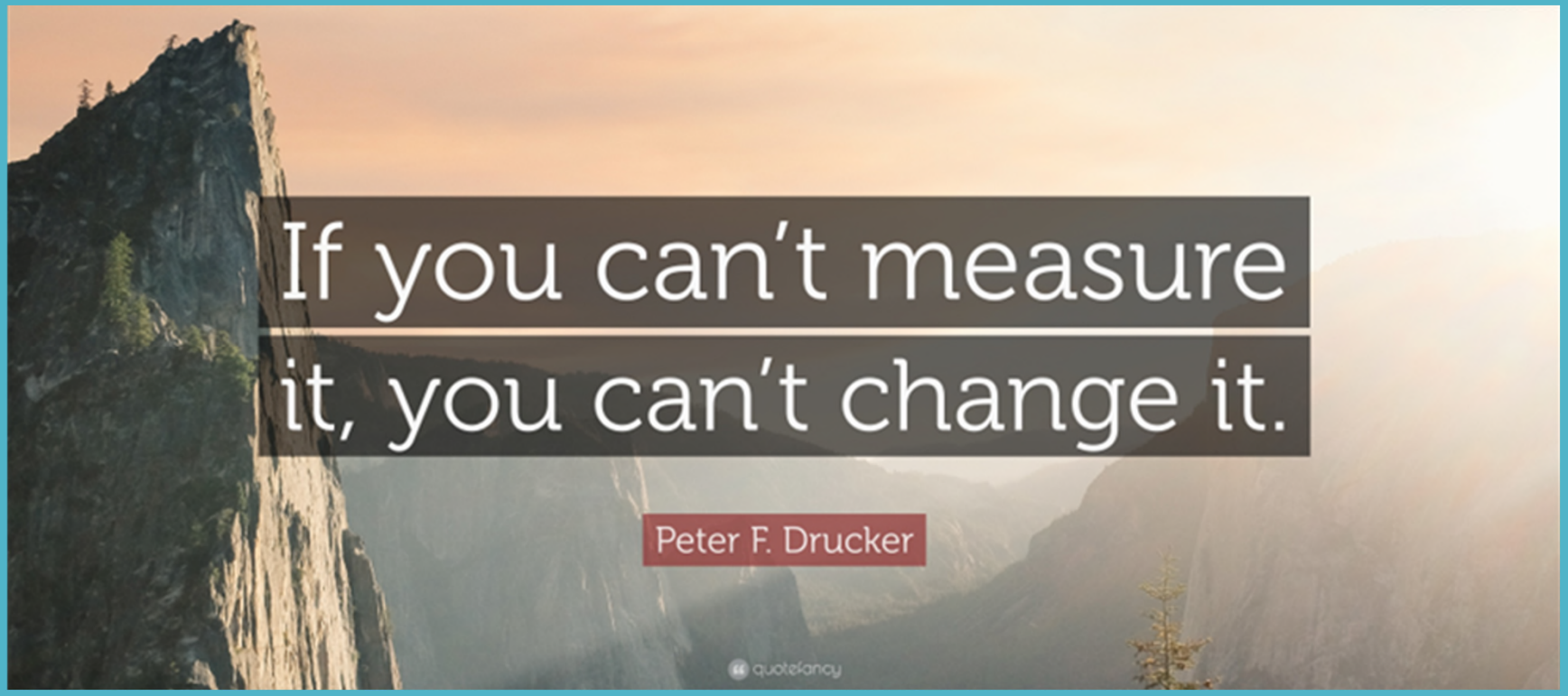
- Closely monitor A/R past 90 days
- Implement scripting for front desk staff
- Make sure providers formulate and sequence treatment plans
- Maintain insurance tables in EDR
- Faithfully document eligibility

Billing/Collections Best Practices

- Communicate clearly and accurately with patients
- Schedule appointments WHEN prior approvals have been received
- Stay abreast of dental codes
- Know each insurer's rules/regulations/covered services
- Review daily encounters for accuracy/completeness

Set Goals for Billing and Collections

- Decrease the amount of money in A/R past 90 days
- Decrease the number of denied claims
- Decrease bad debt (increase collections from patients at the time of the visit)
- Increase net patient revenue



#8:
Measure Dental Performance

Operating a Dental Practice Without Data is Like Driving a Car Without a Dashboard

Why Does Data Matter?

- Allows us to monitor our performance
- Allows for good business decisions
- Early warning system when trouble brews
- Baseline data to guide improvement efforts
- Communicating with staff about program performance

Success Metrics

- Gross Charges
- Net Revenue
- Expenses
- Number of visits
- Revenue per visit
- Cost per visit
- A/R past 90 days
- # of Unduplicated Patients
- # of New Patients
- # of Procedures
- Scope of Service (types of procedures)
- % of Phase I Treatment Plans Completed
- % of children ages 6-9 at moderate or high-risk receiving sealants (UDS)
- Broken Appointment Rate
- Emergency Rate
- Payer/Patient Mix Percentages

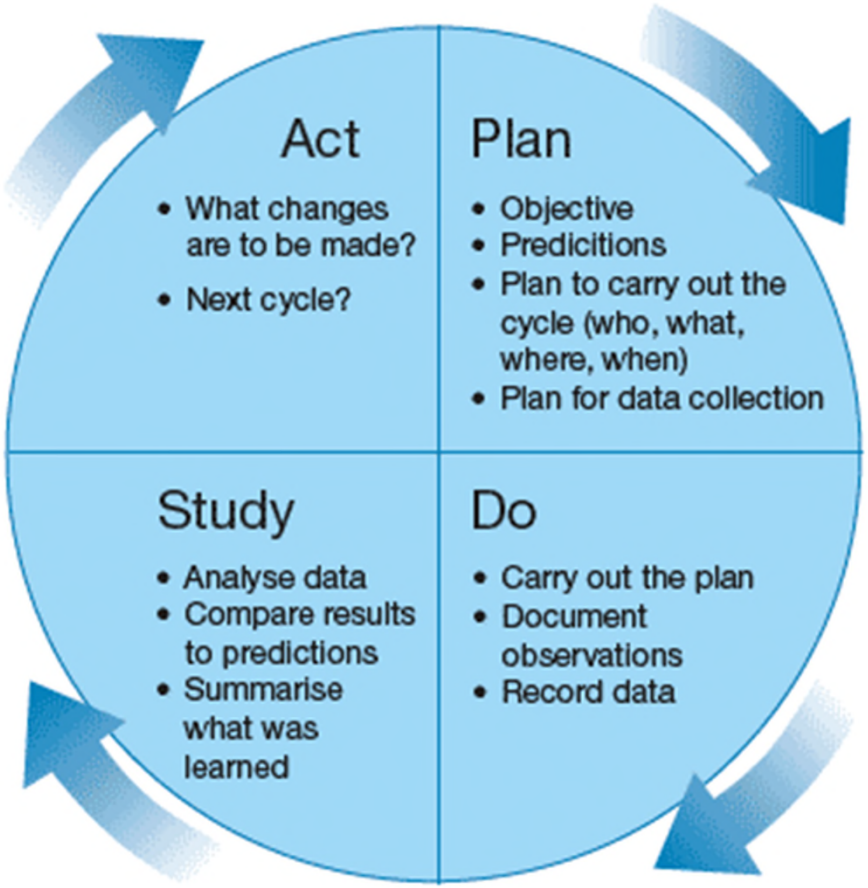
Evaluating Program Performance

- Which reports?
- How often?
- Who will run them?
- How will data be collated?
- How will it be shared?
- How will it be USED?

Dashboards

- Simple to Sophisticated
- Excel Spreadsheet to Power BI
- NNOHA has a great dashboard
- Some integrated EHR/EDR systems have built-in dashboard functionality
- Many vendors sell reporting software
- Decide what to use and start tracking!

#9 Embrace Continuous Quality Improvement

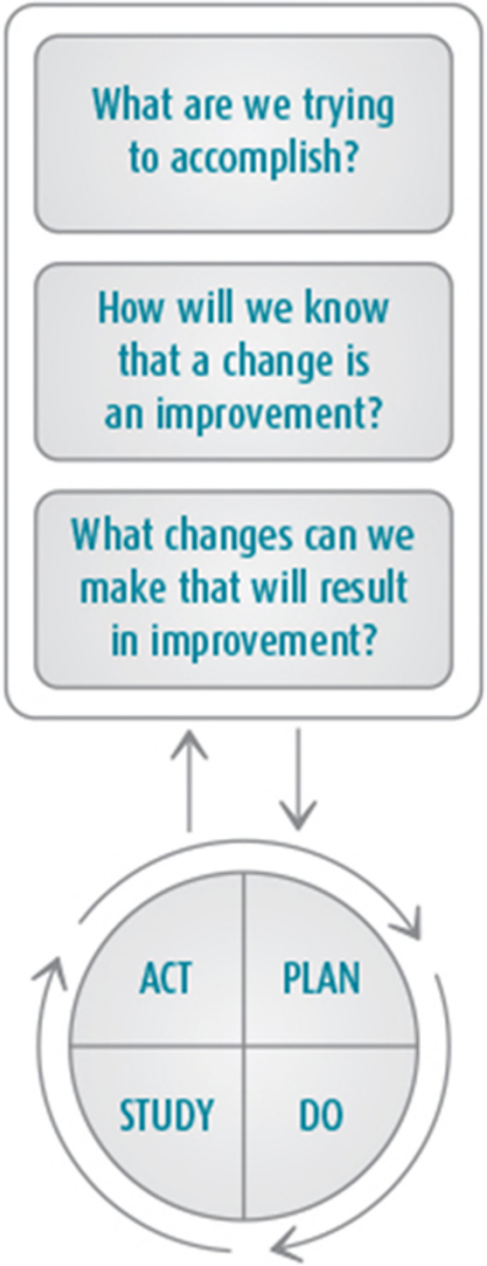


Quality Assurance vs. Quality Improvement

Quality Assurance	Quality Improvement
Delegated to a few	Embraced by all as everyone's job
Focus on individuals, outliers	Focus on processes
Work toward endpoints	Has no endpoints (continuous)
Ensures minimum standard is met	Assumes/desires maximum potential
Retrospective, detection	Proactive, preventive
Function/provider focused	Customer/population focused

Source: NNOHA Operations Manual, Chapter 6
Resources | Operations Manual (nnoha.org)

The Model for Improvement



https://www.ihs.gov/office-of-quality/ipc/models-for-improving-care/model-for-improvement/

The Fundamentals of QI

- Establish a culture of quality
- Determine potential areas of improvement
- Collect and analyze data
- Communicate your results
- Commit to ongoing evaluation
- Spread your successes

Source: NNOHA Operations Manual, Chapter 6
Resources | Operations Manual (nnoha.org)

#10 Get Buy-In and Accountability

Foster Accountability

- Be an active listener
- Talk with, not at staff
- Foster open and direct two-way communication
- Confront and resolve issues
- Be clear about performance expectations
- Don’t ignore poor performance
- Recognize high performers

Team Communication

- Morning huddles (involve entire dental staff)
- Regular (monthly) staff meetings—block out the patient schedule, not over lunch (eg, 4-5 p.m., 1-2 p.m.)
- Create a formal agenda and include review of dental program performance
- Allow staff to suggest topics to be covered at next staff meeting
- Promote staff feedback and discussion
- Take and share meeting minutes with staff who couldn’t attend

Build Teamwork

- Involve staff in the development of program goals
- Regularly share progress in meeting goals with staff
- Involve staff in problem-solving barriers to program success
- Smart people want to be heard!

Reward Success

- Incentives/bonuses are effective in rewarding/motivating providers
- Be strategic (what behavior do you want to reward?)
- Beware unintended consequences
- Please consider rewarding all staff (fosters teamwork and shared accountability)
- Getting to at least break-even should be the threshold

Incentive Models—Pros & Cons

Pros:

- Providers highly motivated to be productive

Cons:

- Providers might be tempted to overtreat
- Providers might try to cherry-pick patients

- Monitor to assure quality of care
- Need equitable scheduling process and controls on who schedules appointments
- Monitor completed treatment plans, patient outcomes and patient satisfaction

Incentive Models—Making it Work

- Hard wire the cost of commissions/bonuses into dental budget (define potential bonus pool)
- Define the goals that need to be met (individual and overall practice goals)
- Not just visits and not just revenue—should be a mix of goals: visits, net revenue, number of procedures, quality goals (eg, % of completed treatments, patient satisfaction scores, compliance with documentation)

Creating a Culture of Accountability and Buy-In

- Have a PLAN for success
- Monitor and analyze dental program performance
- Provide regular feedback to staff
- Get everyone at the table and engage them in establishing solutions and goals
- Reward success, coach setbacks
- Lead by example
- Make it fun!

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Questions/Discussion