# Dental Productivity: Finances and Access

## (Rambling Thoughts of an Old Dental Director)

HEALTH CENTER PARTNERS OF SOUTHERN CALIFORNIA

SAN DIEGO, CA

NOV 7TH 2019

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# Objectives

Gain an understand on the Dental Director level on improving clinical efficiencies

Understand why we must think population health as we fashion of dental programs

Learn how the future effect your clinical processes

# Written Vision Statement- What are you trying to achieve?

Quality

Access

Productivity

Growth

Improved population health

Preparing for future reimbursement changes

# A Case For Population Health Thinking

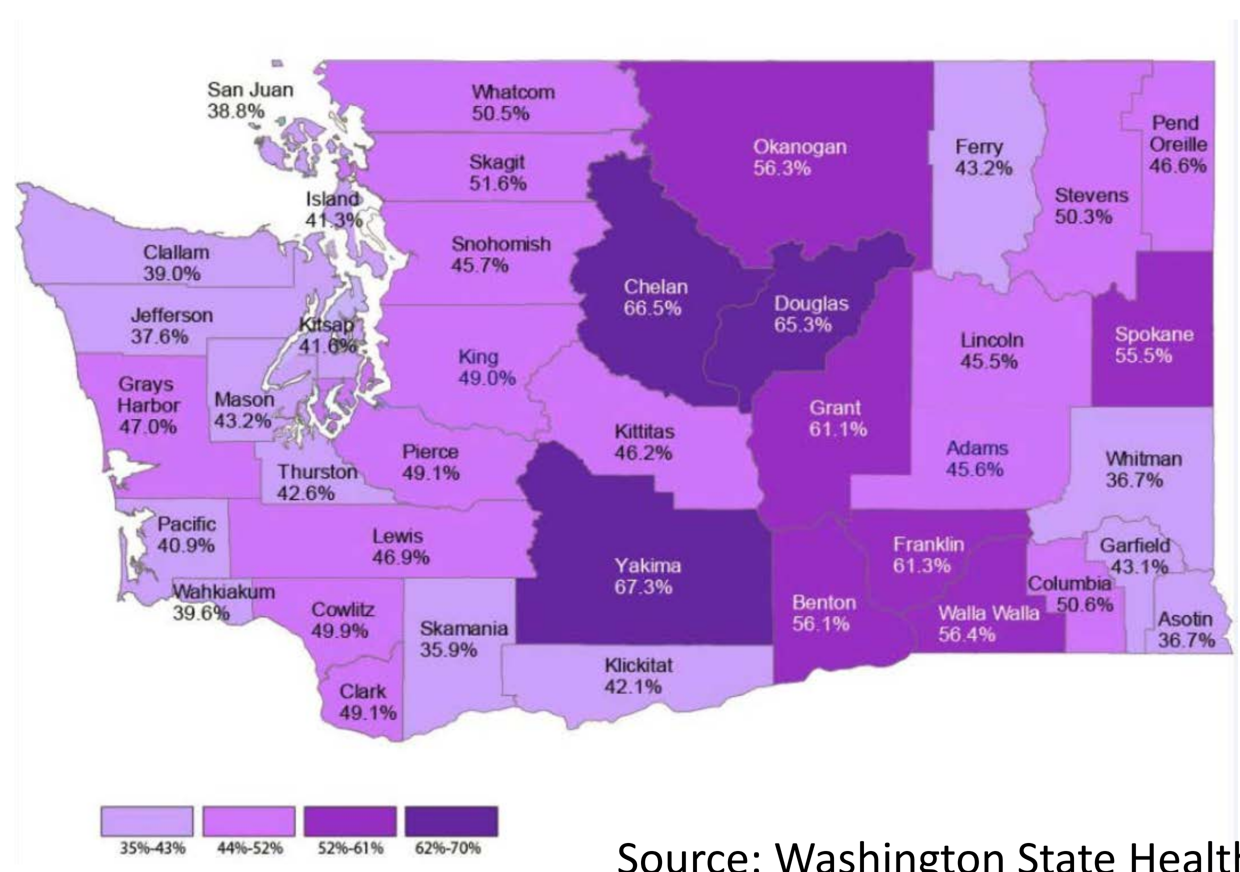
YAKIMA VALLEY- WASHINGTON

# Access Increase From 1986- 2016 in the Yakima Valley

- Community Health Clinics:
  - Operatories: 14 to 80: 570% increase
  - Dentists
    - General Dentists: 8 to 17 plus 5 residents:
    - Pediatric Dentists: 0-4 plus 6 residents
    - 350% increase

- Private Sector: pediatric dentists- 1 to 4; ABCD program

# Child Enrollees with at Least One Dental Service, by County, FY 2014




Source: Washington State Health Care Authority, Apple Health Dental Services Enrollment and Utilization Data

# Washington Smile Survey Results- Yakima Valley

1996 Smile Survey data

35% of 3-5 year olds had a hx of decay; 27% had untreated decay

64% of elementary school children had a hx of decay; 34% had untreated decay

2005 Smile Survey data

57% of 3-5 year olds had a hx of decay; 27% had untreated decay

76% of elementary school children had a hx of decay; 25% had untreated decay

# In Yakima CO- Dental Medicaid Spending for Children Has Increased 214% in only 4 years

| | ANNUAL PAYMENTS | | | | |
|---|---|---|---|---|---|
| | FY2008 | FY2009 | FY2010 | FY2011 | Increase in 4 years |
| | | | | | |
| **Yakima Co** | $10,746,099 | $14,888,755 | $18,421,782 | $23,047,869 | **2.14** |
| **WA State Total** | $105,447,755 | $131,936,368 | $160,155,956 | $203,957,595 | **1.93** |

**Total of 67 million dollars spent in Yakima County**

TOTAL DENTAL CLIENTS AND ANNUAL EXPENDITURES BY CLIENT COUNTY AND DATE OF SERVICE
FISCAL YEARS 2008-2011 DATES OF SERVICE - CLIENTS AGES 20 AND UNDER ONLY ^

# Summary of the Yakima Data

| | 1996 | 2000 | 2005 | 2010 | Healthy People 2020 Target |
|---|---|---|---|---|---|
| Untreated Decay 3- 5 Year Olds | 27% | | 23% | 13% ☺ | At or below 21% |
| Untreated Decay 3rd Graders | 34% | | 19.10% | 14.90% ☺ | At or below 25.9% |
| Needing Urgent Treatment | | | 21.50% | 12% ☺ | |
| Rampant Decay 3-5 Year olds | | | 15.30% | 17.20% ☹ | |
| Early Childhood Caries | | | 17.70% | 15.40% ☹ | |
| Caries Experience 3-5 Year olds | | | 45.10% | 40.30% ☹ | At or below 30% |
| Caries Experience 3rd Graders- mixed dentition | | | 59.70% | 57.90% ☹ | At or below 49% |
| Rampant decay 3rd Grader | | | 21.20% | 19.20% ☹ | |
| Medicaid Access- Children | 29.90% | 39.30% | | 67.3% ☺ | |
| Medicaid spending- children 0-20 | | $5,430,323 | | $18,421,782 | 339% increase ☹ |

# We Work In a Broken System

ONCE RECOGNIZED, YOU'LL HAVE A BETTER SENSE OF HOW TO DIRECT YOUR PROGRAM

# Children vs Adults

Take a realistic look at your patient populations- you can't do it all

Children are the key to population health

Children Medicaid is guaranteed by federal law

Must think and practice real prevention

# Managing Children Behavior

Behavior management techniques ( Dental Assistant driven)

Nitrous oxide

TVs over the operatory

Dressing up the clinic

Toys

# Making Pediatric Dentistry More Efficient

Treat the disease process and not just the end result of the disease (Medical vs surgical model)

Reevaluate the risk assessment process

Assess, treat and recall by risk

Make drill and fill the last choice and not the first for incipient lesions

# Managing Emergencies

Open for emergencies all day

Emergency hours

Can be good for encounters but not for financial success of the program

Definitive care: Is this your goal or is the patient just lucky

Follow-up calls

Triage or First Come/ First Served

Triage: Who does this and how are patients selected

# Emergency Triage Form (example)

SEE: YES or NO # ______________ (IN ORDER) WAIT: ________________

DENTAL EMERGENCY TRIAGE SLIP
Please fill out completely

DATE: ------------ TIME: -------------

1. PATIENT NAME: ______________________________________________
2. PATIENT DATE OF BIRTH: ______________________________________
3. HAVE YOU EVER BEEN SEEN HERE BEFORE? YES ____ NO____
4. HAS ANYONE IN YOUR FAMILY BEEN SEEN HERE BEFORE? YES ___ NO___
5. ARE YOU ENROLLED IN HEALTHY OPTIONS/COMMUNITY HEALTH PLAN? YES NO
6. METHOD OF PAYMENT: ___________________________________________________________
7. DO YOU HAVE NAY MEDICAL, HEART OR BLOOD PRESSURE CONDITIONS: YES ___ NO___

   IF YES, PLEASE EXPLAIN: _________________________________________________________
   ________________________________________________________________________________
   ________________________________________________________________________________
8. WHICH TOOTH HURTS? (Area in mouth)
   ________________________________________________________________________________
9. HOW LONG HAS THIS TOOTH BEEN HURTING? (days, months, years)
   ________________________________________________________________________________
10. WHEN DOES IT HURT? (morning, nights, all of the time) ____________________________________
11. ARE YOU SWOLLEN? YES ____ NO____
12. ARE YOU TAKING MEDICATION FOR THE PAIN? YES NO
    IF YES, WHAT MEDICATION? __________________________
    DOES IT HELP? YES ____ NO____
    HOW MUCH HAVE YOU TAKEN? ____________________________________________________

# Recare Vs Initial Exams

Recare critical for our patients' health

Recare critical for our program's financial health

Recare exams and follow-up appointments require less time so more appointments can be scheduled

The Recare process is critical for Treatment Plan Completion

# Recare Process

Post card file

EDR generated list

Appoint recare at the tx plan completion appointment verses calling patient when recare is due?

Start calling the month before the recare is due

DA and RDH staff can help call during down times

# Tracking Recare

EDR generated report:

Percent of patients making their recare appointment patients

Total # of patients needing Recare that month

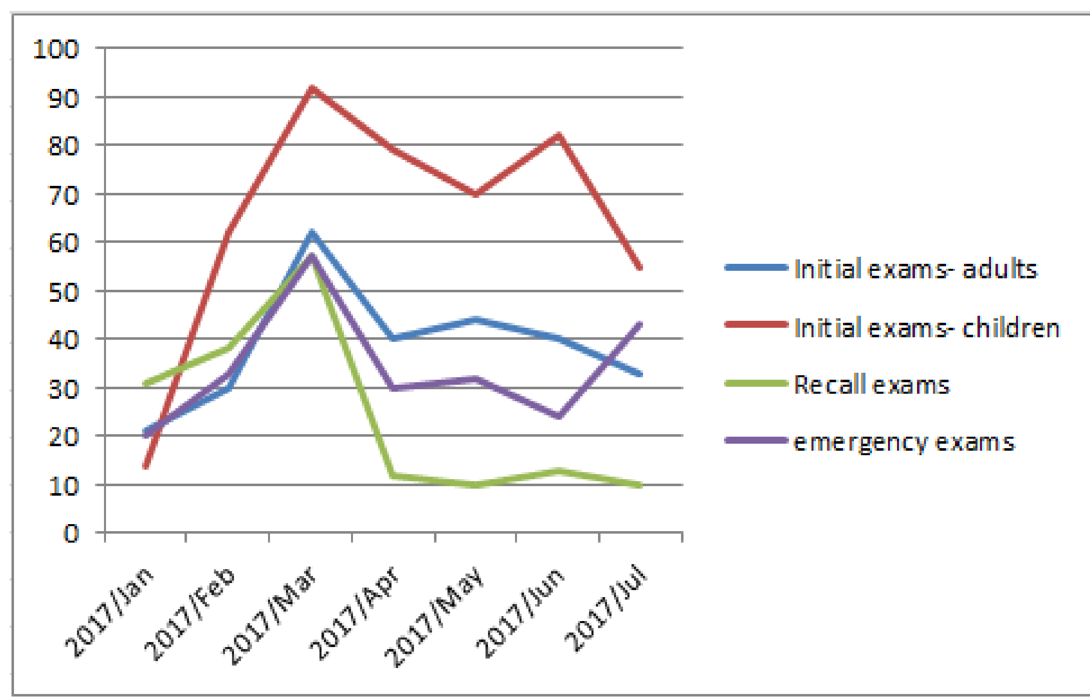
Simple data generated report:

Number of recare appoints in one month

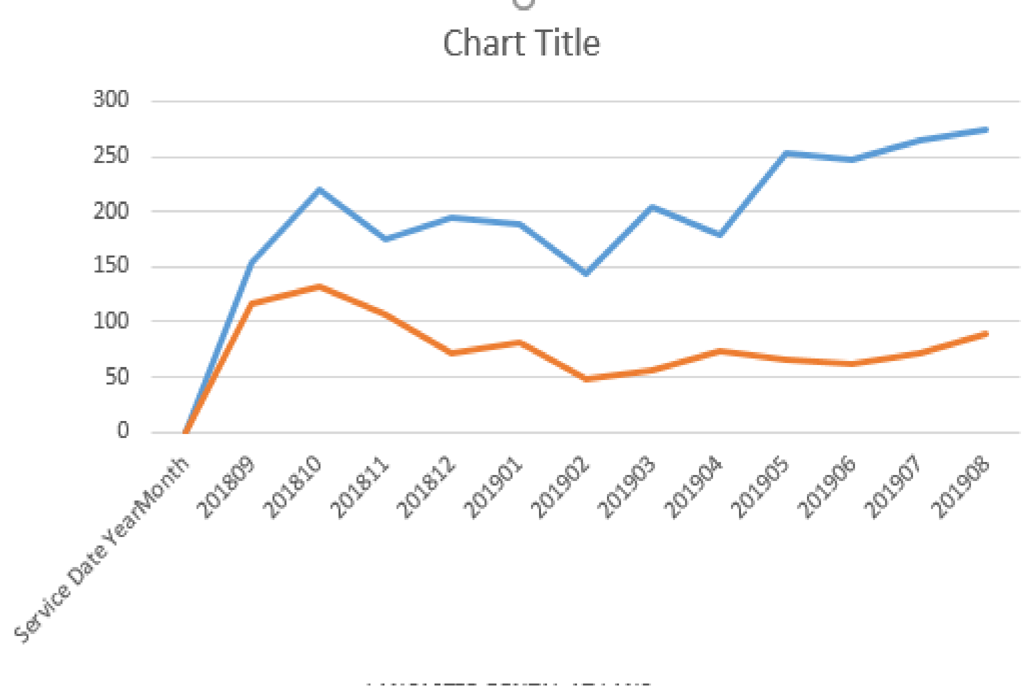
Total # of recare and initial exams 6 months earlier

# Recare vs Initial Exams

## NEW CLINIC




## ESTABLISHED CLINIC (BLUE- RECARE RED- INITIAL)



# School Programs

Incredible resource for child referrals

In-school clinics are typically very grant dependent

Generally have to follow school schedule for hours and days

Portable equipment and Headstarts exams

Prevention vs restorative?

Tele -dentistry possibilities

# Mobile Programs

Portable equipment vs mobile van

Sealants and prevention vs restorative care

Emergency services can be problematic

# Staff Training

Dental Assistant shortages

Contracting with DA Assisting Program

Internal training program:

- Hire DA trainer or Work with DA Assisting Program for the basic training
- Trainee assists DA
- DA assists trainee
- Trainee solos

# Expanded Functions

Registered Dental Assistant-

- Chart lesions, existing restorations and missing teeth
- application of sealants

Registered Dental Hygienist in Expanded Functions (RDHEF)

- Administer local anesthesia
- Place restorations

# RDHEF/ Dentist Schedule

Double book restorative care every hour

Select appropriate restorative patients

- Quadrants that can be done in 45 minutes are ideal
- No difficult behavioral issues
- No hx of broken appointments

Does not directly contribute to increased encounters

Does increase treatment Plan Completion

Does increase dentist and hygienist recruitment and retention

Does increase access capabilities

# What Does a Patient Centered Practice Mean?

Access to care

Integrated care (not just an integrated EHR)

End of Visit reports

Comfortable and pleasing patient environment

Continual care and expanded services

Acknowledgement that you value your patients (AIDET)

Treatment plans that take into account patient preferences

# Students and Productivity

Rotations can improve clinic productivity if scheduled correctly

Best used in a 3 operatory/ dentist staffed clinic

The 3rd column is the least productive so there is an opportunity for improvement

In 2 operatory/ dentist staffed clinic, students can improveTx Plan Completion rates but not production

# Residents and Productivity

Less supervision is needed over the long term so the supervising dentist can be more productive

Residents can improve productivity if there are dedicated residentoperatories

Can move to more operatories when open due to dentist vacations

You can start your own residency!

# Should You Hire a Pediatric Dentist- It Depends

**PRO**

Private pediatric dentists tend to keep our patients

Emulate private practice scheduling  model

May be better to contract with a pediatric dentist just to do GA cases

**Con**

Financial viability is questionable in a heath center

Tendency for general dentists to refer more children than needed

Schedule templates typically not robust enough

General Anesthesia: paid by the encounter

May be better to hire a general dentist trained to see young children

# On-Boarding of Staff (Dentist)

Corporate onboarding that is 4 days in length. Information on the organization in general, corporate polices and training on the EDR.

We also have the new dentist assigned to one of our Lead Dentists for at least 2-3 days: to review daily clinic operations, discuss treatment and patient care philosophy.

Clinic orientation: introduction to site dental staff and other departments

Chart audits: Week 1 to assure

6 month chart audit: evaluation

Participates in annual review process.

# Communications

Growth complicates communications

Consider a Lead Dentist position at each clinic

Dental Assistant Supervisors

Clinic Administrator/ Lead Dentist/ Dental Assistant Supervisor leadership team

Staff meetings: Clinic level, Org-wide level

# Department Leadership- Multi-clinics

Lead Dentist: Insures Dental Director's directives are followed at the clinic level

Dental Assistant Supervisor: Insures Clinic Administrator's directives are followed at the clinic level

Clinic Administrator: answers to the COO

Dental Director and COO meet on a regular basis to determine the direction of the dental program

Any unresolved issues between the Dental Director and the COO are handed by the CEO

# Strategic Scheduling by Time Units

## SCHEDULING EACH APPOINTMENT BY TIME

Starts with a prioritized Treatment Plan

Provider reviews next appointment and determines the time units needed

Information given to front desk for scheduling

Don’t start all appointment at beginning hour of the morning and afternoon

## GENERALIZED UNIT SCHEDULING

Starts with a prioritized Treatment Plan

Define simple restorative and complex restorative

Assign time units to each

Identify each operative appointment as simple or complex

Information given to front desk for scheduling

Don’t start all appointment at beginning hour of the morning and afternoon

# Scope of Services

| Service Type | Procedure Codes | % of Total |
|---|---|---|
| Diagnostic | D0100-D0999 (excluding D0140) | 30-40% |
| Preventive | D1000-D1999 | 25-35% |
| Restorative | D2000-D2999 | 18-25% |
| Endodontics | D3000-D3999 | 1-2% |
| Periodontics | D4000-D4999 | 2-5% |
| Removable Prosthodontics | D5000-D5899 | 1-3% |
| Fixed Prosthodontics | D6200-D6999 | <1% |
| Oral Surgery | D7000-D7999 | 5-10% |
| Emergency | D0140, D9110 | 2-6% |

Data from Safety Net Solutions- DentaQuest

# Levels of Services

Avoid high percentages of Diagnostic codes resulting from new patients- Indication of patient panels that are too large

Low Restorative codes indicate potential churning and lowTx Plan Completion scores

Monitor Removable and Fixed Prosth percentages that are too high or too low

Individual dentist percentages can differ but you should be aware of an agree with those differences

# Do you Allow Phase 4 Services?

CON

High need and demand for restorative services

Limited resources for delivering even basic care

More complicated financial arrangements required

Expensive supplies and equipment are needed

Increased Privileging issues

PRO

Patients need these services

One stop shopping for the patient

Not offering these services ca be detrimental to the pt's health

Dentists do not want to lose their skills

Dentists want to increase their skills

# Dentist Recruitment: Salaries

We are in competition with the private sector for dentists and not other CHCs

Set your eye on the private practice Associate Dentist salary benchmarks when establishing your salary matrix

Remember the ABCDs of CHC income: Medicaid %; PPS rate; Encounter #s

Determine what income/ productivity increases would be needed for a robust incentive (include increased staffing needs)

Can you shift to a 3 or 4 operatory/ dentist staffing model?

# Provider Retention

Open communication

Do not interfere with an individual dentist's ability to make clinical judgements

Involve the dentists in as many decisions as possible- especially those directly affecting their clinical practice

Pay them in relationship to their productivity

Involve them in chart audits

Sweat the small stuff!!!!

# Dental Director Success Formula

Quality is your prime responsibility

Understand your role with Operations and how that relationship must be finely tuned to insure high productivity and high quality

The Dental Director must set the example for the dentists. You must be the one who is a leader in clinical quality and if possible be the most productive dentist.

Be seen as the go-to person for all departments as they seek help in solving problems.

Prepare for program for the future- The times are clearly changing and the less prepared programs will struggle or fail.

# Finding Time To Be a Dental Director

You will never have enough time!!!!!!

Quality is your prime responsibility!!!!!

Work with your CEO to define essential duties to perform on an ongoing basis

Define annual goals and expectations with your CEO

Concentrate on your highest risks

# After-Hours Call

You must set up some type of after hours call process

The larger program you are, the formal that process should be

Check your medical after hours call process and to that process when possible

The EDR makes it easier to have dentists from multiple clinics to be on call

Know your state dental law and your state dental Board’s view on this issue

# Post-op Call list

**POST-TREATMENT COMPLICATIONS LOG**

**Complete a log entry for all surgical, endodontic and other patients the dentist desires to call back**

| | Patient name | chart # | Date of Procedure | Procedure | Date called | Patient condition |
|---|---|---|---|---|---|---|
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |
| 6 | | | | | | |
| 7 | | | | | | |
| 8 | | | | | | |
| 9 | | | | | | |
| 10 | | | | | | |

# What the Future May Look Like

## RISK BASED MANAGED CARE

# Managed Care

**Regular Managed Care**:

- Instead of the state Medicaid department paying you directly, funds are paid through a 3rd party administrator or a managed care plan.
- PPS rate still secured

**Risk Based Managed Care**

- Administrative cost- goes to the plan
- Set aside percent for specialty care
- You share upside and downside financial risk
- PPS rate still secured
- Managed care pm/pm is not included in the PPS formula
- Quality payments are not included in the PPS rate formula
- Profit or loss not included in the PPS rate formula

# Risk Based Managed Care Shakes Our World

We are at financial risk if we don't lower disease rates

- We will need to create real prevention strategies
- We will need to break down the walls of our dental clinics

We are at financial risk if we can't manage specialty referrals

- Will need increased in-house specialist or higher trained general dentists
- We will need to contract with private sector specialists

# Metrics

Educate yourself on the world of metrics

Dental Quality Alliance

Educate yourself on Value Based Reimbursement: the beginning of the change

Health centers will need to increase IT capabilities and add Business Intelligence expertize

Health centers will need to create sophisticated Operational and Quality dashboards dialed down to the provider

# Moving the Metric Dial

Components for moving metrics

- Data collecting capabilities
- Create specific metrics in your EDR
- Validation of the metric results
- Analysis of the metric results
- Creation of dashboards

Moving the dial

- Create a clinic leadership team: providers, operations, IT/ Business intelligence expertize; various medical/ behavioral health/ dental staff
- Analyze workflows
- Utilize the PDSA process and look for Best Practices in your system
- Adopt Best practices system wide

# Tele-dentistry

Equipment: Could be as simple as a laptop with a VPN connection; Portable chair and stool and a Nomad

Calibrated part-time dentist to do the non-synchronized exam

Goals:

- Find the high risk children not accessing dental and refer them in
- Keep healthy children healthy and out of the clinic

# Hygienists in Medical

Train as Community Dental Health Coordinator: motivational interviewing and case management

Oral assessment; fluoride varnish; health education and motivation; SDF; GI temporaries

Goals:

- Identify high risk children and case mange them into dental
- Stabilize urgent needs before they can access dental
- Keep health children healthy and out of the dental clinic

# Diagnose and Treat By Classification

**American Dental Association Caries Classification System.**

| | AMERICAN DENTAL ASSOCIATION CARIES CLASSIFICATION SYSTEM | | | |
|---|---|---|---|---|
| | Sound | Initial | Moderate | Advanced |
| **Clinical Presentation** | No clinically detectable lesion. Dental hard tissue appears normal in color, translucency, and gloss. | Earliest clinically detectable lesion compatible with mild demineralization. Lesion limited to enamel or to shallow demineralization of cementum/dentin. Mildest forms are detectable only after drying. When established and active, lesions may be white or brown and enamel has lost its normal gloss. | Visible signs of enamel breakdown or signs the dentin is moderately demineralized. | Enamel is fully cavitated and dentin is exposed. Dentin lesion is deeply/severely demineralized. |
| **Other Labels** | No surface change or adequately restored | Visually noncavitated | Established, early cavitated, shallow cavitation, microcavitation | Spread/disseminated, late cavitated, deep cavitation |
| **Infected Dentin** | None | Unlikely | Possible | Present |
| **Appearance of Occlusal Surfaces (Pit and Fissure)*†** | ICDAS 0 | ICDAS 1 ICDAS 2 | ICDAS 3 ICDAS 4 | ICDAS 5 ICDAS 6 |
| **Accessible Smooth Surfaces, Including Cervical and Root‡** | | | | |
| **Radiographic Presentation of the Approximal Surface§** | E0¶ or R0#<br>No radiolucency | E1¶ or RA1# E2¶ or RA2# D1¶ or RA3#<br>Radiolucency may extend to the dentinoenamel junction or outer one-third of the dentin. Note: radiographs are not reliable for mild occlusal lesions. | D2¶ or RB4#<br>Radiolucency extends into the middle one-third of the dentin | D3¶ or RC5#<br>Radiolucency extends into the inner one-third of the dentin |

* Photographs of extracted teeth illustrate examples of pit-and-fissure caries.
† The ICDAS notation system links the clinical visual appearance of occlusal caries lesions with the histologically determined degree of dentinal penetration using the evidence collated and published by the ICDAS Foundation over the last decade; ICDAS also has a menu of options, including 3 levels of caries lesion classification, radiographic scoring and an integrated, risk-based caries management system ICCMS. (Pitts NR, Ekstrand KR. International Caries Detection and Assessment System [ICDAS] and its International Caries Classification and Management System [ICCMS]: Methods for staging of the caries process and enabling dentists to manage caries. *Community Dent Oral Epidemiol* 2013;41(1):e41-e52. Pitts NR, Ismail AI, Martignon S, Ekstrand K, Douglas GAV, Longbottom C. ICCMS Guide for Practitioners and Educators. Available at: https://www.icdas.org/uploads/ICCMS-Guide_Full_Guide_US.pdf. Accessed April 13, 2015.)
‡ "Cervical and root" includes any smooth surface lesion above or below the anatomical crown that is accessible through direct visual/tactile examination.
§ Simulated radiographic images.
¶ E0-E2, D1-D3 notation system.[33]
\# R0, RA1-RA3, RB4, and RC5-RC6 ICCMS radiographic scoring system (RC6 – into pulp). (Pitts NR, Ismail AI, Martignon S, Ekstrand K, Douglas GAV, Longbottom C. ICCMS Guide for Practitioners and Educators. Available at: https://www.icdas.org/uploads/ICCMS-Guide_Full_Guide_US.pdf. Accessed April 13, 2015.)

Dentists will classify caries

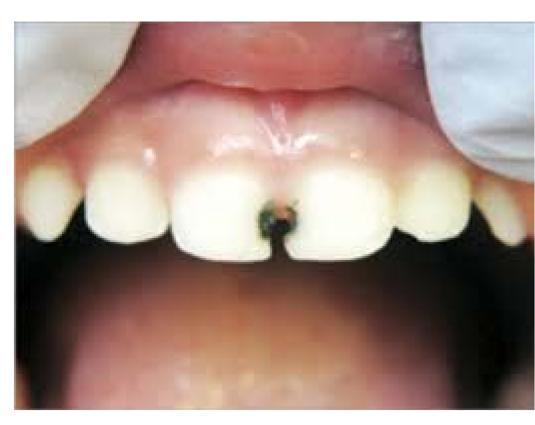
Protocols for SDF as the treatment of choice for Caries Classification 1-3

Protocols emphasizing SDF/ glass ionomers for Caries classification 4

Will need to better understand SDF's effect on interproximal decay

Will need to test out various esthetic fixes as needed

# Silver Diamine Fluoride- The Game Changer



Written Consent

Clinical protocols

Recall protocols

Marketing

Tracking

Limitations

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