The Three C’s

WILLIAM DONIGAN DDS MPH
"The 3 C's of Life: Choices, Chances, Changes.
You must make a choice to take a chance or your life will never change."

ZIG ZIGLAR
There are 6.8 BILLION people on the planet.

4 BILLION of them use a mobile phone.

Only 3.5 BILLION of them use a toothbrush.
Always remember!!!!!!!

- Two Rules for Public Health Dentistry
- Rule #1
- NO MARGIN
- NO MISSION!
- Rule #2
- Never forget rule #1
HRSA – Comprehensive Primary Oral Health Care

HRSA adopted the following definition of comprehensive primary oral health care that has appeared in policy and program guidance since 1997:
COMPREHENSIVE PRIMARY ORAL HEALTH SERVICES

DEFINED AS PERSONAL ORAL HEALTH CARE, DELIVERED IN THE CONTEXT OF FAMILY, CULTURE, AND COMMUNITY, THAT INCLUDES ALL BUT THE MOST SPECIALIZED ORAL HEALTH NEEDS OF THE INDIVIDUALS BEING SERVED.
RANGE OF SERVICES

SHOULD INCLUDE PREVENTIVE CARE AND EDUCATION, OUTREACH, EMERGENCY SERVICES, BASIC RESTORATIVE SERVICES, AND (BASIC) PERIODONTAL SERVICES.
MAY INCLUDE BASIC REHABILITATIVE SERVICES THAT REPLACE MISSING TEETH TO ENABLE THE INDIVIDUAL TO EAT, BENEFIT FROM ENHANCED SELF-ESTEEM, AND HAVE INCREASED EMPLOYMENT ACCEPTABILITY.
Vulnerable populations

HRSA - Vulnerable populations include the economically disadvantaged, racial and ethnic minorities, the uninsured, low-income children, the elderly, the homeless, those with human immunodeficiency virus (HIV), and those with other chronic health conditions, including severe mental illness.

Pregnant Women?
Increasing access to care

- Increasing Access to Care Health centers deliver care to the Nation’s most vulnerable populations, and now, more than ever, the Nation’s veterans.

- More than 24 million people – 1 of 13 nationwide – rely on a HRSA-funded health center for affordable, accessible primary health care, including:
  - One in three people living in poverty nationwide
  - One in ten children nationwide and nearly four in ten children living in poverty nationwide
  - More than 8.4 million patients in rural health centers, across approximately 4,000 sites nationwide
  - More than 305,000 veterans – a 5.6 percent increase from 2014 – which is expected to increase in 2016 as more health centers participate in the Veterans Access, Choice, and Accountability Act (“Veterans Choice Act”)
Patients need to take some responsibility for their own care!

Education!

Education!

Education!

Education!!!!!!!!!!!!!!!!!!
Patients have the responsibility for:

- Providing accurate and complete information about medical complaints, past illnesses, hospitalizations, medications, pain, and other matters relating to their health.
- Following the treatment plan recommended by those responsible for their care.
- Their actions if they refuse treatment or do not follow the healthcare team's instructions.
- Seeing that their bills are paid as promptly as possible; following hospital rules and regulations.
- Being considerate of the rights of other patients and hospital personnel.
- Seeking information, and in the event they have questions, asking them.
The difference between Medical and Dental

- What is the room an MD uses in a Health Center called?
  - Exam room
- What is the room a DDS uses in a Health Center called?
  - Operatory

Would you like your heart operation scheduled for 15 minutes?
Surgery

Surgery (from the Greek: χειρουργική cheiourgikē (composed of χείρ, "hand", and ἔργον, "work"), via Latin: chirurgiae, meaning "hand work") is an ancient medical specialty that uses operative manual and instrumental techniques on a patient to investigate and/or treat a pathological condition such as disease or injury, or to help improve bodily function or appearance.

Surgery is a technology consisting of a physical intervention on tissues.

As a general rule, a procedure is considered surgical when it involves cutting of a patient's tissues or closure of a previously sustained wound. Other procedures may be considered surgery if they involve "common" surgical procedure or settings, such as use of a sterile environment, anaesthesia, antiseptic conditions, typical surgical instruments, and suturing or stapling.
We must remember that everyone wants to:

1. Improve Access - Every infant and child is worthy of the opportunity to benefit from contemporary knowledge and measures that will improve his or her oral health, overall health, and health trajectory.

2. Improve oral health outcomes - Oral health is the window to the entire body.
Balance?

Medicaid Patients, Commercial Insurance Patients

Equals Sustainability

Uninsured Patients
Everyone wants to be sustainable:

BUT HOW DO WE ACCOMPLISH IT?

1. Increase the number of patients we see
2. More children (Payer Mix) - Early evaluation and education is the key to preventing the acquisition and development of oral disease. To break the unfortunate chain of events associated with Early Childhood Caries, we must reach children at an earlier age.
Opportunities

Visiting the Dentist and the Physician

Have a Physician Visit and no Dentist Visit

- 60.3%
- 30.4%
- 34.2%
- 36.9%
- 46.2%

Have a Dentist Visit and no Physician Visit

- 24.8%
- 14.0%
- 10.6%
- 9.6%
- 7.3%
- 2.0%
- 8.8%

Productivity

- National Benchmarks
- Encounters
- RVU’s
- Transactions
- Dollars produced
## Benchmarks

### Dentists
- 2,500-3,200 encounters/year/FTE dentist
- 1.7 patients/hour or 13.6 patients per day
- 2 Chairs/dentist (3:1 is ideal)
- 1.5 Assistants/dentist (1 DA per chair is ideal)
- Gross Charges = $400K - $500K/FTE dentist/year

### Hygienists
- 1,300-1,600 encounters/year/FTE hygienist
- 8-10 patients per day
Procedures/visits:

- A minimum average of 2.5 CDT coded services/visit
- Recare visit standard protocol: the periodic exam, cleaning, fluoride, and any needed radiographs would all be performed at the same visit.
- All sealants needed (1, 2, 3 or 4) at sealant visit
# Productivity

## Table One: Visits/Hour Capacity Goals for General and Pediatric Dentists

<table>
<thead>
<tr>
<th>Variables</th>
<th>Number of Operatories</th>
<th>1 Operatory (Not Recommend)</th>
<th>2 Operatories</th>
<th>3 Operatories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Dental Assistants</td>
<td>1 DA</td>
<td>1.5 DA</td>
<td>2 DA</td>
<td>1 DA</td>
</tr>
<tr>
<td>Provider Type</td>
<td>General Dentist</td>
<td>1.2</td>
<td>1.4</td>
<td>1.5</td>
</tr>
<tr>
<td></td>
<td>Pediatric Dentist</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>
Table Two: Visits/8 hour day Goals for General and Pediatric Dentists

<table>
<thead>
<tr>
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</tr>
<tr>
<td></td>
<td>1 DA</td>
<td>1.5 DA</td>
<td>2 DA</td>
<td>2.5 DA</td>
</tr>
<tr>
<td>Provider Type</td>
<td>General Dentist</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>14</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Pediatric Dentist</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>15</td>
<td>17</td>
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</table>


## Table Three: Encounters per Year and Patient Pool size

<table>
<thead>
<tr>
<th>Variables</th>
<th>Number of Operatories</th>
<th>1 Operatory (Not Recommend)</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of Dental Assistants</td>
<td>1 DA</td>
<td>1.5 DA</td>
<td>2 DA</td>
</tr>
<tr>
<td>General</td>
<td>2300</td>
<td>2530</td>
<td>2760</td>
<td>2530</td>
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<tr>
<td>General Dentist Patient Pool</td>
<td>920</td>
<td>1012</td>
<td>1104</td>
<td>1012</td>
</tr>
<tr>
<td>Reception/FTE Dentist *</td>
<td>0.46</td>
<td>0.51</td>
<td>0.55</td>
<td>0.51</td>
</tr>
<tr>
<td>Pediatric</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>3220</td>
</tr>
<tr>
<td>Pediatric Dentist Patient Pool</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>1288</td>
</tr>
<tr>
<td>Reception/FTE Dentist *</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>0.64</td>
</tr>
</tbody>
</table>

* Minimum reception staffing should never be below 1 FTE. Rate is 0.20 to 0.23 Reception FTE per 1000 annual encounters.
<table>
<thead>
<tr>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gross Charges</strong></td>
</tr>
<tr>
<td><strong>Net Revenue</strong></td>
</tr>
<tr>
<td><strong>Expenses</strong></td>
</tr>
<tr>
<td><strong>Number of visits</strong></td>
</tr>
<tr>
<td><strong>Revenue per visit</strong></td>
</tr>
<tr>
<td><strong>Cost per visit</strong></td>
</tr>
<tr>
<td><strong># of Unduplicated Patients</strong></td>
</tr>
<tr>
<td><strong># of New Patients</strong></td>
</tr>
<tr>
<td><strong># of Transactions</strong></td>
</tr>
<tr>
<td><strong>Broken Appointment Rate</strong></td>
</tr>
<tr>
<td><strong>Emergency Rate</strong></td>
</tr>
<tr>
<td><strong>Payer Mix Percentages</strong></td>
</tr>
<tr>
<td><strong>Scope of Service</strong></td>
</tr>
<tr>
<td><strong># FTE Providers</strong></td>
</tr>
<tr>
<td><strong># FTE Billing Staff</strong></td>
</tr>
<tr>
<td><strong>A/R past 90 days</strong></td>
</tr>
<tr>
<td><strong>Treatment Completion Rate</strong></td>
</tr>
<tr>
<td><strong># of children receiving sealants (under 21)</strong></td>
</tr>
<tr>
<td><strong># of sealants applied</strong></td>
</tr>
<tr>
<td><strong>% Children seen receiving a preventive service</strong></td>
</tr>
</tbody>
</table>
No-shows

- 1100 **Good** patients produce ~2700 encounters
- **Good** Patients. What is a **GOOD** patient?
- 48 hour confirmation calls
  - Robo calls, why they can be bad
- 24 hour call backs
- We need a **strong** policy
Our Policy

- Strike One – Shame on you!
- Strike Two – Letter to Dental Director
- Strike Three – No comprehensive care for one year
Dear [Name],

Missed an appointment.

I am reaching out to apologize for missing the first two appointments and the flu the 1st time. I don't drive and have to depend on others to give me a ride. The 2nd time my friend did not show up and I tried to get another one but could not.

I am sorry if I made anyone else miss the chance to be seen.

I really need to be seen and get a cleaning done and I apologize for any inconvenience and hope to get another chance please. I do understand that if I miss anymore that it will result in me being dismissed.

Thank you,
Geoffrey Koster
#704-685-6391

[Handwritten note on the right page]

I understand that if I miss another appointment I will be dismissed for a year.

Thanks, Sharmayar

Sharmayar Kollison

[Handwritten note on the left page]
Questions?
Billing and Collections

- D9110 & D0140
- Unbundling & Chumming
  - Definition - the practice of submitting bills piecemeal or in a fragmented fashion to maximize the reimbursement for various tests or procedures that are required, pursuant to Medicare and Medicaid guidelines, to be billed together and therefore at a reduced cost.
- Denials
  - When are they resubmitted? Or are they?
- Billing FTE’s how many? How many is enough?
- Credentialing
  - Who is doing it?
Why are codes changed

- Dentistry is changing
- New codes added
- Old codes deleted or removed
- Codes are (supposed to be) responsive to provider concerns
- Codes are responsive to insurance concerns
Changes

2005
- 39 new codes
- 47 revised codes
- 3 deleted codes

2007-2008
- 23 New codes
- 33 revised codes
- 3 deleted codes

2014
- 29 new & 4 deleted

The 2017 version of the CDTCODE incorporates a significant number of procedure code changes with 11 new procedure code entries, 37 revised procedure code entries and one deleted code entry. The 2017 CDTCODE also includes new subcategory and revised subcategory changes.

D0414, D0600, D1575, D6081, D6085

D4346 – Scaling in the presence of generalized moderate or severe gingival inflammation – full mouth after oral evaluation

D9311 Consultation with Medical health care professional concerning medical issues that may affect patients planned dental treatment

D9991, D9992, D9993, D9994

D9630
Dental case management – addressing appointment compliance barriers

Individualized efforts to assist a patient to maintain scheduled appointments by solving transportation challenges or other barriers
Dental case management – care coordination

Assisting in patient’s decisions regarding the coordination of oral health services across multiple providers, provider types, specialty areas of treatment, health care settings, health care organizations and payment systems. This is the additional time and resources expended to provide experience or expertise beyond that possessed by the patient.
Dental case management – motivational interviewing

Patient centered personalized counseling using methods such as motivational interviewing to identify and modify behaviors interfering with positive oral health outcomes. This is a separate service from traditional nutritional or tobacco counseling.
Dental case management - patient education to improve oral health literacy

- Individual customized communication of information to assist the patient in making appropriate health decisions designed to improve oral health literacy, explained in a manner acknowledging economic circumstance and different cultural beliefs, values, attitudes, traditions and language preferences, and adopting information and services to these differences, which requires the expenditure of time and resource beyond that of an oral evaluation or case presentation.
Why is it important to use these codes? We can’t bill for them!!!!

- CMS will be looking at the number of times these are billed
- CDHC Community Dental Health Coordinator
- We do all of this anyway! And therefore need to submit it!
- Encounters?
- Billable in the future will help with administrative costs
Scheduling

- 13-14 patients daily is the expectation so how many do we book and how? Are all appointments 60 minutes in length?
- Need to know no-show rate
  - 5/10
- Walk-ins & emergencies
  - Clinic capacity
    - Emergency capacity
  - When, how and what is to be done?
EDR & Chart Notes

- Treatment plans
  - Must be done, Dentrix green chair
- Scheduling
  - What does effective scheduling look like, what makes it effective?
  - 30, 45, 60 minutes which is best?
  - Why ten minute increments (13 days - Levin)
- Autonotes
  - For all types of procedures
- Signing charts
  - Within 48 hours
Medical/Dental Integration

- The separation of the mouth from the body has been built into the cultures of medicine and dentistry for generations by separate training programs, professional identities, payment structures, and delivery systems. As a consequence, collaboration between medicine and dentistry rarely occurs.

- Referrals from primary care providers to medical specialists have standard protocols for requesting either a procedure, the answer to a question, or the transfer of care with expectations for a consultation report after the patient is seen.

- No such standards exist for communication between medical providers and dentists.
Referrals and Integration

- Questions on medical health history
  - Medical versus dental
  - Medical to dental and back again
- Navigators
  - CHOP
- School programs
  - DAP
Treatment Value

- Scripting
- If I had a dollar ..................
- Many patients think that dental services should be free and do not understand the true value of the services they are receiving.
Emergencies

- What is an emergency?
- Telephone triage
  - STATE LAW
- Low reimbursement
- Delays comprehensive care and Phase I completion
Dental Emergency Triage Form

Patient Name: ____________________________ Date: ____________________________
Parent’s Name: ____________________________ Appointment Date: ____________________________

**Please answer the Following Questions:**

1. On a scale of 1-10 how bad is the pain:
2. How would you describe the pain? Is it sharp, throbbing or dull?
3. Is the pain constant or off and on?
4. How long have you had the pain? Hours, days, weeks etc.?
5. Where is the pain? Tooth or gums?
6. If the pain is in the tooth is it broken or did you lose a filling?
7. If the pain is in the gums is swelling, bleeding or pus present?
8. Is there swelling?
9. Do you have a fever?
10. Have you taken any medications?
   If yes, please list the medication.
11. Was the problem caused by an accident?

**Quick Decision Guide**

**Emergent Symptoms: See Today**
- Pain is sharp or throbbing
- Pain is persistent
- Pain not relieved by medication
- Bleeding
- Swelling
- Fever
- Pain is 7 or above
- Trauma

**Non-Emergent: Schedule an Appointment**
- Pain is dull or minimal
- Pain is off and on
- Pain is relieved by medication
- No bleeding
- No swelling
- No fever
- Pain is < 6
- No trauma
Fees

- NDAS (National Dental Advisory Service)
- 70-80%
- Why?
  1) The dental program will be portrayed as being less productive than it really is.
  2) The site may not be as competitive as it should be with other 330 sites applying for expansion grants.
  3) Having fees set at local market rates enables the site to claim the full value of services provided to the community, which is important to public and private funders and other key stakeholders.
  4) Higher fees will allow the site to collect more funds from commercial insurers.
Staff accountability and Buy In

- The entire dental staff including the reception staff responsible for dental scheduling needs to understand the current situation.
- The entire dental staff needs to know what it costs to run the dental program, why and how broken appointments affect sustainability.
- The entire dental staff needs to know where the opportunities lie and what the goals for the program are going to be.
- The entire dental staff needs to know & understand that participation in the departmental improvement initiative is not optional.
- The entire dental staff needs to know that their individual and collective performance will be measured and reported.
Continuous Quality Improvement means Quality Improvement plus Quality Assurance.

Quality Improvement:
- TXCO
- UDS Sealant measure
- No shows
- Other PDSAs - arrival time vs. seating time vs treatment

Quality Assurance:
- Peer review
- Annual assessment of staff
LOVE YOUR **PATIENTS**
AND TREAT THEM
WITH LOVING CARE...
Questions?
FOR YOU WILL
ONLY KNOW
THEIR VALUE
WHEN YOU SEE
THEIR EMPTY CHAIR...

Edha24
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