Comparing fee-for-service and capitation revenue models in dental practice: Part 2

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WHEN I RECEIVED MY FIRST BOTTLE of Saforide 38% silver diamine fluoride (SDF), I let it sit on my desk for six months while I thought about what to do with it. Still, during this time, I continued to do the same things, such as hospital dentistry, sedations, and quadrant restorations.

Since my waiting list for hospital dentistry cases was approaching six months and I was seeing abscesses occurring during the wait period, I decided to apply Saforide[1] (figure 1) to lesions on the pending OR cases. My office currently uses the comparable 38% SDF Advantage Arrest by Elevate Oral Care.

WHAT HAPPENED WHEN I APPLIED SAFORIDE

What I saw was astonishing! The abscesses stopped. The pain from active decay stopped. When we finally got into the hospital OR, it was clear that all lesions had become arrested, and that tertiary dentin was forming beneath arrested lesions (figure 2).

Figure 1: Saforide 38% silver diamine fluoride manufactured by Morita. Image courtesy of Morita.

Finally, a tool was available to treat high-needs dental patients by stopping all decay in the mouth at once. Amazingly, this approach was also very inexpensive. A caries lesion could be treated with 38% SDF for about $1. ~~The World Health Organization (WHO) recently added SDF to its list of essential medicines that should be available in every country.~~

I began to treat all patients who had active decay using SDF at the initial exam appointment. A code to recognize this treatment was adopted by the American Dental Association in 2016—D1354. Another code, D1355, was created to consider SDF as a preventive agent.

The arrest of active caries does not eliminate the need for various forms of restorative care determined by the extent of damage caused by caries, and by patient preferences. In some cases where the primary tooth exfoliates, parents and patients have selected no further treatment. In other cases, various materials and methods have been chosen.

Read part 1 of my FFS and capitation series at dentaleconomics.com/FFS-capitation.

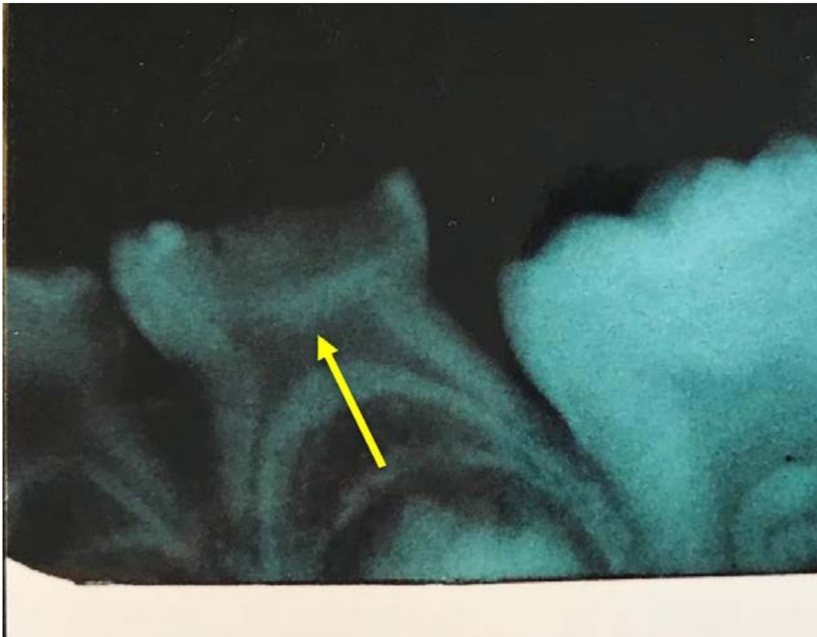
SOME NEGATIVES OF USING SDF

Side effects of treatment with SDF are a lesion color change to dark black and surface texture change from soft to hard. While this may not be a problem in a posterior occlusal groove, in the anterior region, the placement of a tooth-colored restoration will often be necessary for cosmetic reasons.

Figure 3 demonstrates the dark arrested caries after SDF application, followed by the placement of GIC strip crowns, with excellent esthetic results. Due to desensitization by SDF, this step can often be accomplished without local anesthesia. Interestingly, this color change may be used as a caries detector, as well as a treatment intended to arrest the lesion.

SAME TIME SPENT ON MORE PATIENTS

Another finding revealed from early intervention of all active lesions with SDF was



Figures 2-8 courtesy of Shoreview Dental

Figure 2: Radiograph shows tertiary dentin formation after treatment of caries lesion with 38% SDF.

Figure 3: Images showing caries lesions after treatment with 38% SDF (left) followed by those same lesions after a GIC strip crown is applied (center), and the patient and parent smiling.

a reduction in the number of after-hours emergency calls my practice received. Our patient base has grown dramatically between 2008 and 2023, and at the same time our after-hours emergency calls have dropped by 90%.

My need to take cases to the hospital for general anesthesia has plummeted.[3] During a typical treatment day in the hospital, I could see, at the most, four patients. This reduction in hospital cases opened my schedule to see many more patients in the office (figure 4).

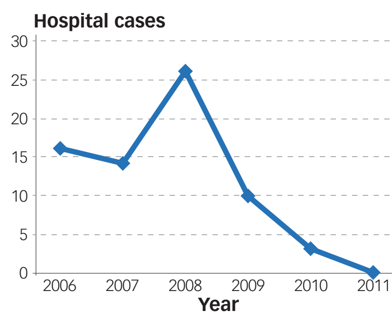


Figure 4: Trend in declining hospital cases over six years at Shoreview Dental after initiating use of 38% SDF.[4]

In a capitation reimbursement business model, the incentive is to have a large group of patients with few costly restorative needs whose oral health can be maintained. By adopting the combination of patient assignment with capitation, together with the low-cost treatment with SDF, I was able to open space in my schedule and accept a higher number of assigned patients. Our capitation assignment patient population has grown from 2,000 in 2008 to 5,000-plus today.

An example of this is comparing my daily patient schedules from 2008 and 2023 (figures 5 and 6). Over time, our fee-for-service practice component has grown and our capitation patient assignment has doubled. Many patients who began as assigned members chose to remain in the practice when their insurance changed to a fee-for-service model. This has required us to expand our office space and add clinical and support staff.

The fact that revenue is coming from multiple sources strengthens our business and improves overall profitability. We recently did an evaluation of the revenue, costs, and profitability in both the capitation and fee-for-service sides of our combined practice.

We found that both models were equivalent from a straight business perspective. This was evident during the pandemic when our office was essentially closed, but our large assignment population of healthy patients without active disease proved to be a vital asset.

See what the schedule for the fee-for-service side of our practice looks like in Figure 7, and what the schedule for the capitation/Medicaid side of our office looks like in Figure 8.

A patient who enters our combined fee-for-service/capitation practice will see no difference between the two sides of the practice. The patient reception areas and clinical treatment rooms are identical. Our clinical staff are cross-trained to provide care in either the fee-for-service or capitation environment.

There's nothing intrinsically good or bad about fee-for-service or capitation reimbursement models in dentistry. They can coexist in a practice that understands the fundamentals and incentives involved. When a dental practice is committed to ethically serving patients, they will encounter

a wide range of clinical problems to solve and economic systems to support the appropriate interventions.

As a business owner, it's also important to ensure that appropriate profitability is achieved through this process to protect the interests of the clinical and support staff, and to update the clinic infrastructure.[4] My experiences at Shoreview Dental during the past 20 years have exceeded my expectations in service to our community and as a successful business financially. DE

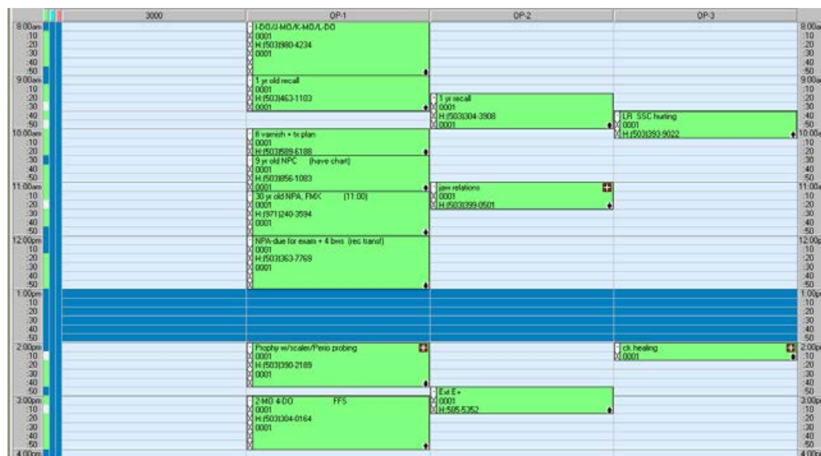


Figure 5: Dr. Duffin's patient schedule from Shoreview Dental for one day in 2008 showing 13 patients treated using traditional restorative dentistry. This schedule comes from EasyDental software.

Figure 6: Dr. Duffin's patient schedule from Shoreview Dental LLC for one day in 2023 showing 23 patients treated using 38% SDF. Patient through-put has nearly doubled since using SDF. This schedule comes from Dentrix software.

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During his 40 years of practice as a general dentist, **Steven Duffin, DDS,** owner of Shoreview Dental, dental director for NoDK, worked in a rural solo practice with one employee, grew a large group practice with more than 20 locations, served as dental director and CEO of a large managed care DSO, and last, served as a primary investigator in large dental public health research programs.

Figure 7: Shoreview Dental fee-for-service treatment room.

Figure 8: Shoreview Dental capitation treatment room.