

**Increasing Access to Quality Care for Temple Health's Patient Population and the
Residents of North Philadelphia**

by

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University of Pittsburgh, 2023

Abstract

In healthcare, access to care is a very important issue. The definition of healthcare access centers around the ability of a person to obtain healthcare services to prevent, diagnose, treat, and/or manage disease, illnesses, disorders, and other health related conditions. Access has become a major problem for low-income and rural communities. Temple University Health System also known as Temple Health, is located in North Philadelphia, Pennsylvania. North Philadelphia is home to a predominantly minority, low-socioeconomic community, Medicaid and Medicare payor mix. Increasing access to improve the quality of patient care for vulnerable populations is at the center of all Temple Health initiatives which has a significant impact on public health as a whole. My three residency projects center around the theme of increasing healthcare access for the North Philadelphia community. Through establishing a Federally Qualified Health Center (FQHC) Mobile Dental Program, investing in an Ambulatory Surgery Center, and the Chestnut Hill Hospital acquisition, Temple Health will continue its mission of providing quality care and increasing access to the patients and community of North Philadelphia.

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1.0 Federally Qualified Health Center (FQHC): Mobile Dental Clinic Program

How does the Federally Qualified Health Center (FQHC) look-alike that Temple University Health System (TUHS) is investing in, establish a beneficial dental program for the residents of North Philadelphia?

The purpose of establishing a mobile dental program as part of the FQHC look-alike, is to increase accessibility to affordable, comprehensive dental care to residents of the Medically Underserved Population (MUP) in North Philadelphia. Using a mobile dental clinic, dental care will be administered in an “at your door” fashion. The mobile unit will travel between the six clinic sites of the FQHC look-alike in order to serve the North Philadelphian patient population.

1.1 Introduction and Background

Oral health plays an important role in the overall health of children and adults. Poor oral health is associated with chronic diseases and illnesses, such as cardiovascular disease and low-birth weight. Problems with oral health can also affect a person’s self-esteem, school performance, attendance at work or school (Oral Health Basics). Adults and children from lower income areas and minority groups have an unmet need for dental treatment and report higher rates of poor oral health. For adults, the main oral health problems include: untreated cavities, gum disease, tooth loss, and oral cancer. Among children 5 to 19 years of age from low income families they are twice as likely to have cavities compared with children from higher income households (Children’s Oral Health).

By establishing FQHCs in areas that are designated as a Medically Underserved Population (MUP), there is increased access to medical, dental, and other health services that may not already typically exist in the community. The FQHC look-alike that Temple Health will help to establish, will be in the North Philadelphia area that will consist of six pre-existing clinics. Many patients in underserved populations experience barriers to dental care. These barriers may include cost, lack of insurance coverage, geographic location, or poor oral health literacy. By establishing a mobile dental clinic program, these barriers can be eliminated and increase access to oral care that can improve population health as a whole. Through a mobile dental clinic, the geographic barrier is diminished since the unit would be traveling between clinic sites that are more convenient for the residents of the community, thus increasing access to dental care. Mobile dental clinics also prove to be a great way to increase cultural competency, dental education, and overall health.

Aside from the convenient location of the FQHC clinics that will increase accessibility to medical care to North Philadelphians, is the affordable cost of FQHCs. FQHCs use a Medicaid Prospective Payment System (PPS) Base Rate which is a cost-based reimbursement that sets a pre-determined per visit amount for services by the FQHC. Rather than being paid fee-for-service (FFS), FQHCs receive a single, bundled rate for each patient visit which pays for all covered services and supplies during the visit (FQHC Look-alike General Orientation 220627). For a mobile dental clinic visit, the patient would be charged the PPS rate for their visit which has proven to be an effective form of cost-efficient management.

The mobile dental clinic care team would be comprised of part-time dentists, registered dental hygienists, and registered dental assistants/drivers. The driver and dental assistant position would be a dual position because that person would be required to drive the mobile dental clinic between the six clinic sites and also be responsible for setting up and taking down the mobile

dental clinic at the beginning and end of each day. They will also help to oversee the flow of patients and assist the dentists and hygienists as they see fit. Patients will be able to call into the clinic site where front desk staff will be able to schedule them for the day. Front desk clinic staff and the mobile dental clinic dental assistants will be in communication to ensure that patients are being seen in an effective manner. Again, the mobile dental clinic will provide routine check-ups, cleanings, fillings, and diagnostic care to pediatrics and adults. The cases that fall outside of the Mobile Dental Clinic's level of care, will be referred to Temple University's Kornberg School of Dentistry. The clinic would be in operation five days a week: Monday, Wednesday, Friday from 9a-5p and Tuesday and Thursday from 11a-7p. Since many patients may be working during normal business hours which prevents them from seeing medical providers, alternate hours on select days will allow for greater flexibility and access. Overall, the goal of the mobile dental program is to provide increased accessibility to preventative dental care at an affordable cost to further the FQHC look-alike's mission of providing comprehensive care to adults and children from North Philadelphia's vulnerable and underserved patient population.

1.1.2 Methods

In order to address how to establish an effective dental program as part of the FQHC look-alike, I collaborated with Dr. Steven Carson, the Senior Vice President of Population Health and outside consultants hired by Temple Health to oversee the establishment of the FQHC look-alike. The first step towards overcoming the problem was to construct a pro-forma to outline the startup costs for a mobile dental clinic. These costs included equipment, overhead, and salary costs.

To construct an accurate pro-forma, I conducted research to get an understanding of what is included on a mobile dental clinic while also seeking advice from Steve and the consultants.

Through my research and conversations, I learned it is possible to purchase either a refurbished or a brand-new unit. Even though the cost of a refurbished unit is less than a brand-new unit, a brand-new unit is a better investment in the long run because it is more durable and will only require minor repairs over a longer period of time. To get a better understanding of mobile dental units, I contacted approximately five mobile unit companies. The average cost of a new mobile unit was approximately \$150,000-\$200,000 and would take about five to six months to produce. The concern regarding a brand new mobile unit is the longer production time. The mobile unit would have to be in operation by July 1st, 2023 which is in time for the FQHC look-alike's rate setting year.

1.1.3 Results and Discussion

Through the research and conversations I conducted, I ultimately developed three pro-formas for this project. The first pro-forma outlined in Figure 1 outlines the expenses for the mobile dental clinic. The second and third pro-formas outlined in Figures 2 and 3 display the expenses for portable dental clinics from two different vendors. Portable Clinics were explored because a portable clinic would be able to get up and running by July 1st, 2023 which will be the beginning of the rate setting year. Even though the portable clinic option was not the original plan, it will still be very beneficial for the adults and children of the North Philadelphia community for a lower cost. The cost of a portable clinic would be approximately \$400,000 less than the cost of the mobile dental clinic and be up and running in half the time. Also, accessibility which is very important for the FQHC look-alike's dental program would not be compromised. The portable clinic would be set up in two of the FQHC look-alike clinic sites.

1.1.4 Recommendations

The benefits of this project, is that now there is a framework in place to be on the road to establishing a successful dental program as part of the FQHC Look-alike. Even though the original goal was to be establish a mobile dental clinic, establishing a portable dental clinic will still meet the purpose of the project. The purpose of this project was to establish a mobile dental program as part of the FQHC look-alike to increase accessibility to affordable, comprehensive dental care to residents of a Medically Underserved Population (MUP) in North Philadelphia. The portable dental clinic will be located in a clinic easily accessible to patients and since it will be established through the FQHC, dental care will be able to be given at an affordable cost. In the future, if possible, the option of a mobile dental clinic can still be pursued. By building off of the existing mobile dental clinic pro-forma, helped make the portable dental clinic a viable option.

1.1.5 Competency Development

The competencies that I have developed through my participation on this project are analytical thinking, communication, systems thinking, accountability, professionalism, self-development, financial skills, leadership, community orientation, organizational awareness, and strategic orientation. I learned how to effectively communicate with different stakeholders, which included consultants and Temple Health population health and finance leadership. I also was able to learn more about government funding protocols for FQHCs and the intricacies of dental programming overall.

2.0 Ambulatory Surgery Center (ASC) Planning

Ambulatory Surgery Centers (ASC) have become increasingly popular in the outpatient care setting. Temple Health is considering investing in a new ASC for its patient population because the clinical areas at Temple University Hospital-Main (TUH-Main) are experiencing space constraints that may have a negative effect on patient volumes and satisfaction. It may take a longer time than anticipated for patients to be seen by their doctors and patients have complained about difficulties navigating the TUH-Main Campus to find their appointments. The cost of a new ASC is approximately \$250 million dollars. In order to push the project forward the main concern is Temple Health will have to be able to generate a return on investment (ROI) on this costly investment in a timely manner. To generate an ROI on this project, there needs to be high enough patient volume demand in the service-lines that would move to the ASC setting. To determine if the current patient volumes are at a high enough level and can continue to grow in the ASC setting, a look into the space and other constraints of the TUH-Main service-lines will help to determine if a new ASC is the answer to better serving the patients.

The purpose of this project is to evaluate the feasibility of Temple Health investing in a \$250 million ASC. The desired outcome of this project is to determine if more space is needed for the clinical areas that are currently experiencing long appointment wait times and long lines. To determine if more space is needed, the patient volumes of the chosen service-lines would have to be able to have significantly increased volumes in the ASC setting. The growth potentials and constraints of the service-lines that will be getting a closer look are the following: Ophthalmology, Outpatient Pharmacy (Retail Pharmacy), Neurology, Neurosurgery, Sleep Disorders Center, Heart & Vascular Institute, Phlebotomy, Pain Management, Neurosciences, Radiology, Optical Shop,

Orthopaedic Surgery and Sports Medicine, Cancer Center Infusion Unit, Head and Neck Institute, Otolaryngology, Digestive Disease Center, Surgery, and Urology.

2.1 Introduction and Background

ASCs have become an increasingly popular trend in healthcare. Health care systems have been investing in ASCs because of their “demonstrated ability to improve quality and customer service while simultaneously reducing costs” (ASCs: A Positive Trend in Health Care). In the past, surgeries have been primarily performed in the inpatient setting which is often accompanied by longer hospital stays and recovery times. In the ASC setting, surgeries are same-day and their recovery times have significantly decreased due to the improved quality of care delivery. In a study that measured the quality of outpatient surgery in an ASC compared to a hospital-based facility (HBF), performance at the ASC surpassed that of the HBF. The cases that were studied consisted of four procedures: ventilation tube insertion, dental rehabilitation, adenotonsillectomy, and ventilation tube insertion/adenoidectomy. The results of the study showed that the “ASC had no unexpected safety events compared to the nine events at the HBF. Tonsil bleed rates were 0% at the ASC compared to 5.9% at the HBF” (Grisel and Arimand). In addition, “a total of 77% of ASC cases finished within the scheduled time compared to 38% at the HBF” (Grisel and Arjmand). In another study that compared perioperative time intervals for patients undergoing breast operations at an outpatient facility versus a hospital. The results of the study showed that there were “significantly shorter perioperative time intervals at the ASC with the perioperative, operating room entry to incision, and total facility time intervals significantly increased when breast cases were moved back to the hospital setting” (Trentman et al.).

Aside from the quality of care that occurs in the ASC setting, ASCs also provide care at a lower cost for patients, the government, and third party payors. Medicare pays significantly less for procedures performed in the ASC setting compared to those in hospitals. For example, Medicare pays hospitals \$1,671 for performing an outpatient cataract surgery while paying ASCs only \$964 for performing the same surgery (ASCs: A Positive Trend in Health Care). To determine reimbursements for procedures conducted in the ASC setting, the Center for Medicare & Medicaid Services (CMS) uses the Hospital Outpatient Prospective Payment System to reimburse physicians for surgeries performed at a hospital outpatient department (HOPD) and the Medicare Physician Fee Schedule for surgeries at an ASC (Nabi and Kaplan). If a number of surgeries shift from the HOPD to ASC setting, CMS could save up to \$2.3 billion annually on reimbursements. These savings are consistent for private insurers. For patient's the cost-savings for procedures in the ASC setting are also significant. In terms of coinsurance, patients pay less coinsurance for procedures performed in the ASC setting compared to those in the hospital setting, "a Medicare beneficiary could pay as much as \$496 in coinsurance for a cataract extraction procedure performed in a hospital outpatient department compared to a beneficiary copayment in the ASC would be only \$195" (ASCs: A Positive Trend in Health Care).

In addition to the increased quality of care and cost-savings that occur in the ASC setting, both physician and patient experience are also increased. In the hospital setting, physicians are oftentimes "faced with frustrations surrounding scheduling delays, limited operating room, slow operating room turnover times, and obtaining new equipment" (ASCs: A Positive Trend in Health Care). For patients, ASCs offer greater convenience since physicians from different specialties are in a centralized location, shorter wait times, and procedures are done in a timely manner. The negatives that surround ASCs are that they can be used only for outpatient procedures, have no

overnight facilities, complications and emergencies require transfers, and some patients do not qualify if they have a complicated medical issue or prior health problems that may increase risk (Ambulatory Surgery Centers: Pros and Cons). The benefits of ASCs seem to outweigh the negatives for all stakeholders involved. Since investing in ASCs comes at a high cost, it is best to consider if it is most feasible before proceeding with the investment.

2.1.2 Methods

In order to determine the growth potentials and constraints of each service-line, I conducted thorough conversations with each respective service-line administrator to gather data regarding each service-line. The reason for these conversations was to gain insight to supplement the data we already have. The numbers may say that a service-line has a certain percentage of growth based on patient volumes, but there may be other factors that are hindering said growth. Service-line administrators understand the ins and outs of the operations of each service-line, so they were able to give context to the problems that their respective service-line was experiencing. Once each conversation was conducted, each service-line was grouped into three categories: services not currently constrained by their footprint, services where space constraints exist along with other considerations, and services impacted by space constraints. I presented my findings to the Temple Faculty Physician (TFP) leadership to begin the conversation regarding the feasibility of the ASC along with an overall growth model constructed by Temple Health's Financial Operations and Business Intelligence team, to determine next steps.

2.1.3 Results and Discussion

The findings of the project can be seen in Figures 1-3. In Figure 1, the service-lines not currently constrained by their footprint are Ophthalmology, the Outpatient Pharmacy, Neurology and Neurosurgery EMG, the Sleep Disorders Center's Sleep Lab Procedural Space, and the Heart & Vascular Institute's Vascular service-line. The previous service-lines are not experiencing growth constraints due to space constraints, but instead their growth is impacted by limited physician availability, outdated examination rooms, or access issues. In Figure 2, the service-lines where space constraints exist along with other considerations are Phlebotomy's Central Lab, Pain Management's Procedural Space, Neuroscience's EEG, Stroke, Epilepsy Units, Radiology, Optical Shop, and Orthopaedic Surgery and Sports Medicine. These service-lines are experiencing long lines, long appointment wait times, or limited physician availability. In Figure 3, the service-lines impacted by space constraints are the Cancer Center's Infusion Unit and Clinical Space, Head & Neck Institute's Audiology Testing, Otolaryngology, Digestive Disease Center's GI Procedural Space, Surgery's General Surgery Clinic, and Urology's Procedural Space. These service-lines are experiencing long lines and long appointment wait times due to limited space and space constraints.

When looking at the service-lines in Figure 1, even though they are not impacted by space constraints, they are experiencing issues with access, limited physician availability, and outdated examination rooms. The service-lines, for example Ophthalmology, are having trouble finding providers and the other service-lines, such as Vascular, are experiencing limited physician availability, which isn't uncommon in the healthcare industry today. For the Sleep Disorders Center's Sleep Lab Procedural Space, insurance companies have been pushing for a shift to Home Sleep Tests (HSTs) and its older infrastructure may be impacting patient satisfaction.

Neurology/Neurosurgery EMG are making changes that can impact workflows. These results ultimately suggest that due to their current constraints, patient volumes could not be expected to grow even in a bigger space.

When looking at the service-lines in Figure 2, these services are experiencing space constraints along with other constraints as well. For example, the Phlebotomy Lab is experiencing space constraints but to fully increase patient volumes the number of FTEs and assays/tests need to increase. For Orthopaedic Surgery and Sports Medicine, they are not necessarily experiencing constraints due to space but they are experiencing issues with physician availability and referral inefficiencies. With these service-lines by increasing space, patient volumes may increase but other constraints exist that may hinder the anticipated growth.

When looking at the service-lines in Figure 3, these service-lines are experiencing space constraints that may be hindering their patient volumes from significant growth. The Head & Neck Institute's Audiology Testing, Urology's Procedural Space, Otolaryngology, and the Digestive Disease Center's GI Procedural Space are experiencing wait times that are about two months in time. This may cause patients to seek care at other facilities or even increase their Emergency Department usage. The space constraints among the service-lines in this category, can be directly related to hindered patient volume. If space is expanded for these service-lines, patient volumes can also be expected to increase.

The results of my research gave way to a consideration that was not in the forefront of my expectations. For a few service-lines such as Surgery's General Surgery Clinic, Digestive Disease Center's GI Procedural Space, Orthopaedic Surgery and Sports Medicine, Radiology, and Pain Management's Procedural Space, payors are a part of the conversation. For example, for the Orthopedics service-line payors are pushing for more procedures to be done in the ASC setting.

For many procedures, payors are offering reimbursements for procedures that are typically done in the inpatient setting to be moved to the outpatient setting because of the lower costs and potentially higher quality outcomes. The payors considerations should be highly considered because they may impact the patient population by causing patients to seek out procedures from other ASCs.

Overall, the results of this project indicate that in order to see a substantial ROI for an ASC investment, there are certain constraints that need to be tackled first to increase patient volumes and grow each respective service-line.

2.1.4 Recommendations

The benefits of completing this project are that problem areas within certain service-lines were identified. The service-lines that are working against constraints aside from space that may be hindering growth will be important to work through before pursuing an investment in an ASC further. The consideration that may become a focus of this investment, is the voice of the payor. Since payors are having a larger voice in where procedures are being conducted, it will be important to continue monitoring their decisions since they may ultimately have an impact on patient volumes. This project did address the intention of the Purpose Statement. The purpose of this project was to determine if an investment into an ASC would be feasible, and in this project, we determined that the project is feasible if the current constraints within the service-lines are resolved. Next steps would include continuing to resolve the issues within the service-lines that have been categorized as “not currently constrained by their footprint” and “space constraints exist along with other constraints”. As constraints are being resolved, it will be important to continue adjusting the growth model to determine the updated ROI of the project.

2.1.5 Competency Development

The competencies I have strengthened through completing this project are analytical thinking, communication, systems thinking, accountability, professionalism, self-development, financial skills, leadership, community orientation, organizational awareness, and strategic orientation. Through my conversations with Temple Health leaders and service-line administrators, I was able to learn: what exactly is important to health system financial and operational leaders on a day-to-day basis, what problems healthcare leaders are facing today and what steps need to be taken to resolve them, and the importance of considering the prospective all stakeholders which includes the patient, payor, physician, and health system, when making important decisions.

3.0 Chestnut Hill Hospital Patient Access/ Call Center Transition

Mergers and acquisitions have become increasingly common in the field of healthcare. Temple Health has recently acquired Chestnut Hill Hospital which is a 148 staffed-bed community-based inpatient and outpatient facility located in Northwest Philadelphia. During this acquisition, Chestnut Hill's operations need to be integrated into Temple Health's system. How does Temple's Patient Access/Call Center Teams ensure a successful Chestnut Hill Hospital transition?

On January 1st, 2023 Chestnut Hill Hospital officially began operating under Temple Health. On this day and several days prior to this date, appointments began converting from Chestnut Hill's original service area to a new Chestnut Hill service area, along with their Call Center which also transitioned to Temple Health's central scheduling. Members of Temple's Patient Access and Call Center teams along with preexisting Chestnut Hill staff would be responsible for scheduling appointments, conducting insurance verifications and pre-certifications, collections, and financial assistance. To facilitate a seamless transition, a taskforce was assembled to keep track of various transition items through status reports, work plans, and a day 1 operating model.

3.1 Introduction and Background

Mergers and acquisitions between health systems and hospitals have become an important part of the healthcare landscape. With the focus on healthcare reform, especially post Affordable

Care Act, mergers and acquisitions have increased greatly. Some reasons behind health system mergers and acquisitions are “to control interdependencies within the market, control costs, leverage debt, and negotiate better rates among health insurers” (Chesley). Temple Health has acquired Chestnut Hill Hospital under a partnership that includes Temple Health, Redeemer Health, and the Philadelphia College of Osteopathic Medicine. Temple Health serves as majority owner and responsible for management since they own 60% of the hospital. With this partnership, Chestnut Hill Hospital has been cleared of millions of dollars in debt.

Even though mergers and acquisitions benefit the health systems involved, they also serve a benefit to the community. Chestnut Hill Hospital is located in Northwest Philadelphia and is a 148 staffed-bed community-based inpatient and outpatient facility offering diagnostic and treatment services which includes emergency care, minimally invasive laparoscopic and robotic-assisted surgery, cardiology, gynecology, oncology, orthopedics, primary care practices, two Women’s Centers, and an off-site physical therapy center. Over the last three years, Chestnut Hill Hospital which was previously owned by Tower Health, was experiencing financial struggles. These financial struggles that Chestnut Hill experienced are not uncommon among hospitals and healthcare systems post Covid-19 pandemic. In 2022, “over half of the hospitals and health systems surveyed by Kaufman Hall are projected to operate in the red for the rest of this year, limiting access to care for patients and resulting in billions of dollars in losses for these organizations” (Schiavo). These financial struggles not only limit access to care for patients or cause healthcare organizations to experience losses, but they also can lead to hospital closures altogether. In 2020 there was a record 19 hospital closures which were mostly among rural and Medicare-dependent Hospitals. The repercussions of hospital closures can be very grave. Even though neighboring hospitals may become more efficient by increasing the speed of patient

treatments to serve the increased patient volumes, when hospitals close patients lose access to healthcare and there is a negative impact to the surrounding community. The surrounding community experiences a rise in unemployment rates since that hospital could have been a major employer and the neighboring hospitals that are increasing the speed of patient care can experience increases in patient mortality rates due to potential cuts in value-added care to meet the increased patient demand.

To ensure that mergers and acquisitions among health systems and hospitals are successful, it is important to focus on the cultures of the organizations. If two organizations combine and their organizational cultures are not considered, a culture clash can ensue. Research has said, “Organizational culture has been found to be the dominant factor in determining the success or failure of an M&A, and organizational culture has been directly linked to organizational performance and other operational outcomes” (Chesley). Through effective communication channels, cultural integration is possible. This project centers on the importance of communication with all stakeholders. Since there are multiple stakeholders involved in this acquisition that includes Temple Health, Tower Health, and Chestnut Hill Hospital, when focusing on Patient Access and the Call Center, it will be important for communication to be effective and streamlined.

3.2 Methods

The overall approach to addressing the problem of how to ensure communication is effective among the Patient Access and Call Center teams from Temple Health and Chestnut Hill during the transition, I tracked, updated, and edited the Patient Access/Call Center status reports and work plans following the Temple Health and Chestnut Hill Patient Access/Call Center

transition meetings. This allowed me to analyze and define which items were particularly important for a Patient Access/Call Center transition. These items played a crucial role in meeting the January 1st transition deadline and beyond.

3.3 Results and Discussion

In Table 1, the items that were most significant during the Patient Access/Call Center are outlined. The items that proved to be recurring fell within three categories which were: EPIC, Scheduling, and Pre-Registration/Insurance Verifications/Authorization. Under the EPIC category, the item that fell within this category was the Chestnut Hill Hospital EPIC training for all staff that will be working at the Chestnut Hill Hospital. This includes current Temple Health and Chestnut Hill Hospital staff. Under the Scheduling category the items were: phone tree details, policies and procedures, shared drive access, trainings, process review, and shadowing. Under the Pre-Registration/Insurance Verification/Authorization category the items were: EPIC training plans, EPIC work queue rule documentation, portal access, and resource validation.

The results of this project revealed the important items that required all stakeholders to be aligned with prior to the Jan. 1st go-live transition date, to ensure a successful transition. During this transition, these specific items were the focus of the transition and integrated taskforce meetings. The work plan and status reports included these items so that they were readily available to all team members.

3.4 Recommendations

This project was successful because the items that were necessary to complete a successful transition were identified. Since they were identified, they were able to be worked on jointly with the Temple Health and Chestnut Hill Hospital team members. The results of this project can be used for future mergers and acquisitions because they are crucial for a seamless transition of technology, people, processes, and data needs in regard to Patient Access and the Call Center. If these items are included within a status report, work plan, and day 1 operating model, efficiency and streamlined communication can be ensured between all team members and stakeholders.

3.5 Competency Development

The competencies that I have further strengthened by this project are communication, systems thinking, accountability, professionalism, self-development, human resources management, information technology management, performance measurement and process improvement, organizational awareness, and strategic orientation. Through this project I learned what a merger and acquisition looks like from the perspective of a health system. I also learned the importance of communication and culture when considering how a hospital integrates into a larger health system.

Appendix A Project 1 Attachments and Exhibits

Appendix A.1 Mobile Dental Clinic ProForma

Table 1

	FY1	FY2	FY3	FY4	FY5
Capital Costs					
Purchase of Mobile Unit	\$ 450,000				
Portable Computer & Software Management System	\$ 6,000				
Hand tools/Small Equipment	\$ 20,000				
Malpractice Insurance	\$ 13,500				
Electronic Dental Record Licensing (Wisdom)	\$ 42,400				
220 Plug-in	\$ 2,800				
Capital Totals	\$ 534,700				
Operating Costs					
Insurance & Maintenance for Mobile Vehicle	\$ 7,500	\$ 7,500	\$ 7,500	\$ 7,500	\$ 7,500
Dentist	\$ 284,000	\$ 284,000	\$ 284,000	\$ 284,000	\$ 284,000
Salary	\$ 227,200	\$ 227,200	\$ 227,200	\$ 227,200	\$ 227,200
Benefits	\$ 56,800	\$ 56,800	\$ 56,800	\$ 56,800	\$ 56,800
Registered Dental Hygienist (.5 FTE)	\$ 160,750	\$ 160,750	\$ 160,750	\$ 160,750	\$ 160,750
Salary	\$ 128,600	\$ 128,600	\$ 128,600	\$ 128,600	\$ 128,600
Benefits	\$ 32,150	\$ 32,150	\$ 32,150	\$ 32,150	\$ 32,150
Registered Dental Assistant	\$ 73,750	\$ 73,750	\$ 73,750	\$ 73,750	\$ 73,750
Salary	\$ 59,000	\$ 59,000	\$ 59,000	\$ 59,000	\$ 59,000
Benefits	\$ 14,750	\$ 14,750	\$ 14,750	\$ 14,750	\$ 14,750
Receptionist/Driver	\$ 48,000	\$ 48,000	\$ 48,000	\$ 48,000	\$ 48,000
Instruments & Disposable Supplies (per visit)	\$ 26,400	\$ 26,400	\$ 26,400	\$ 26,400	\$ 26,400
Office Supplies & Printing	\$ 3,600	\$ 3,600	\$ 3,600	\$ 3,600	\$ 3,600
Gasoline	\$ 9,600	\$ 9,600	\$ 9,600	\$ 9,600	\$ 9,600
Phone Service	\$ 2,400	\$ 2,400	\$ 2,400	\$ 2,400	\$ 2,400
Dental Equipment Repairs & Replacement	\$ 15,000	\$ 20,000	\$ 20,000	\$ 20,000	\$ 20,000
Computer Equipment costs	\$ 5,500	\$ 5,500	\$ 5,500	\$ 5,500	\$ 5,500
Electronic Dental Record Licensing	\$ 8,208	\$ 8,208	\$ 8,208	\$ 8,208	\$ 8,208
Overhead Costs (has to be a defined percentage)- 10% estimate	4.4%	4.4%	4.4%	4.4%	4.4%
Professional Licences	\$ -	\$ -	\$ -	\$ -	\$ -
Operating Totals	\$ 644,708	\$ 649,708	\$ 649,708	\$ 649,708	\$ 649,708
Grand Totals	\$ 1,179,408	\$ 649,708	\$ 649,708	\$ 649,708	\$ 649,708

Appendix A.2 Portable Dental Clinic ProForma- Vendor #1

Table 2

	FY1	FY2	FY3	FY4	FY5
Capital Costs					
Supreme Hydraulic Base Chair	\$ 5,144				
Doctor's Stool	\$ 929				
Assistant's Stool	\$ 1,141				
ProCart II, Self Contained Mobile Unit	\$ 10,682				
ProBrite LED 10 Light	\$ 2,272				
Chair Mount for Light	\$ 1,835				
Nomad Pro2	\$ 6,562				
KaVo IXS Size 1 Kit	\$ 6,516				
Autoclave (M11)	\$ 6,660				
KaVo IXS Size 2 Kit	\$ 7,210				
Hand tools/Small Equipment	\$ 20,000				
Malpractice Insurance	\$ 13,500				
Electronic Dental Record Licensing (Wisdom)	\$ 42,400				
Capital Totals	\$ 124,851				
Operating Costs					
Dentist	\$ 212,500	\$ 212,500	\$ 212,500	\$ 212,500	\$ 212,500
Salary	\$ 170,000	\$ 170,000	\$ 170,000	\$ 170,000	\$ 170,000
Benefits	\$ 42,500	\$ 42,500	\$ 42,500	\$ 42,500	\$ 42,500
Registered Dental Hygienist (.5 FTE)	\$ 160,750	\$ 160,750	\$ 160,750	\$ 160,750	\$ 160,750
Salary	\$ 128,600	\$ 128,600	\$ 128,600	\$ 128,600	\$ 128,600
Benefits	\$ 32,150	\$ 32,150	\$ 32,150	\$ 32,150	\$ 32,150
Registered Dental Assistant	\$ 56,250	\$ 56,250	\$ 56,250	\$ 56,250	\$ 56,250
Salary	\$ 45,000	\$ 45,000	\$ 45,000	\$ 45,000	\$ 45,000
Benefits	\$ 11,250	\$ 11,250	\$ 11,250	\$ 11,250	\$ 11,250
Receptionist	\$ 48,000	\$ 48,000	\$ 48,000	\$ 48,000	\$ 48,000
Instruments & Disposable Supplies (per visit)	\$ 26,400	\$ 26,400	\$ 26,400	\$ 26,400	\$ 26,400
Office Supplies & Printing	\$ 3,600	\$ 3,600	\$ 3,600	\$ 3,600	\$ 3,600
Dental Equipment Repairs & Replacement	\$ 15,000	\$ 20,000	\$ 20,000	\$ 20,000	\$ 20,000
Computer Equipment costs	\$ 5,500	\$ 5,500	\$ 5,500	\$ 5,500	\$ 5,500
Electronic Dental Record Licensing	\$ 8,208	\$ 8,208	\$ 8,208	\$ 8,208	\$ 8,208
Overhead Costs	4.4%	4.4%	4.4%	4.4%	4.4%
Professional Licences	\$ -	\$ -	\$ -	\$ -	\$ -
Operating Totals	\$ 536,208	\$ 541,208	\$ 541,208	\$ 541,208	\$ 541,208
Grand Totals	\$ 661,059	\$ 541,208	\$ 541,208	\$ 541,208	\$ 541,208

Appendix A.3 Portable Dental Clinic ProForma- Vendor #2

Table 3

	FY1	FY2	FY3	FY4	FY5
Capital Costs					
PROCART III MOBILE CONSOLE 110	\$ 11,842				
BASIC ALUMINIUM PAT CHR SCISSOR	\$ 4,743				
PROBRITE LED10 LIGHT KIT	\$ 2,518				
EZRAY AIR PORTABLE	\$ 8,542				
HD SENSOR SIZE 1.5	\$ 7,250				
CELEBRITY E-SERIES ASST STOOL	\$ 548				
CELEBRITY E-SERIES DRS STOOL	\$ 394				
Midmark M9® Steam Sterilizer 115V	\$ 8,133				
Hand tools/Small Equipment	\$ 20,000				
Malpractice Insurance	\$ 13,500				
Electronic Dental Record Licensing (Wisdom)	\$ 42,400				
Capital Totals	\$ 119,870				
Operating Costs					
Dentist	\$ 284,000	\$ 284,000	\$ 284,000	\$ 284,000	\$ 284,000
Salary	\$ 227,200	\$ 227,200	\$ 227,200	\$ 227,200	\$ 227,200
Benefits	\$ 56,800	\$ 56,800	\$ 56,800	\$ 56,800	\$ 56,800
Registered Dental Hygienist (.5 FTE)	\$ 160,750	\$ 160,750	\$ 160,750	\$ 160,750	\$ 160,750
Salary	\$ 128,600	\$ 128,600	\$ 128,600	\$ 128,600	\$ 128,600
Benefits	\$ 32,150	\$ 32,150	\$ 32,150	\$ 32,150	\$ 32,150
Registered Dental Assistant	\$ 73,750	\$ 73,750	\$ 73,750	\$ 73,750	\$ 73,750
Salary	\$ 59,000	\$ 59,000	\$ 59,000	\$ 59,000	\$ 59,000
Benefits	\$ 14,750	\$ 14,750	\$ 14,750	\$ 14,750	\$ 14,750
Receptionist	\$ 48,000	\$ 48,000	\$ 48,000	\$ 48,000	\$ 48,000
Instruments & Disposable Supplies (per visit)	\$ 26,400	\$ 26,400	\$ 26,400	\$ 26,400	\$ 26,400
Office Supplies & Printing	\$ 3,600	\$ 3,600	\$ 3,600	\$ 3,600	\$ 3,600
Dental Equipment Repairs & Replacement	\$ 15,000	\$ 20,000	\$ 20,000	\$ 20,000	\$ 20,000
Computer Equipment costs	\$ 5,500	\$ 5,500	\$ 5,500	\$ 5,500	\$ 5,500
Electronic Dental Record Licensing	\$ 8,208	\$ 8,208	\$ 8,208	\$ 8,208	\$ 8,208
Overhead Costs (has to be a defined percentage)- 10% estimate	4.4%	4.4%	4.4%	4.4%	4.4%
Professional Licences	\$ -	\$ -	\$ -	\$ -	\$ -
Operating Totals	\$ 563,500	\$ 568,500	\$ 568,500	\$ 568,500	\$ 568,500
Grand Totals	\$ 683,370	\$ 568,500	\$ 568,500	\$ 568,500	\$ 568,500

Appendix B Appendix B Project 2 Attachments and Exhibits

Appendix B.1 Services not Currently Constrained by their Footprint

Ophthalmology	• Difficulty finding providers • More space would allow for greater efficiency including Improved exam room layout
Outpatient Pharmacy (Retail Pharmacy)	• No current space constraints • Currently working on growth initiatives
Neurology, Neurosurgery (EMG)	• Ideally Neurology and Neurosurgery should be in the same space due to similar patient population, but since Neurosurgery is hospital based and Neurology is not, this is not possible • Neurology and Physical Medicine & Rehabilitation will be combining into one space which will have a significant impact on workflows (testing) but not decrease patient volumes
Sleep Disorders Center (Sleep Lab Procedural Space)	• Insurance has been pushing for a shift to Home Sleep Tests (HSTs) • Old infrastructure of Jones Hall can impact patient satisfaction
Heart & Vascular Institute (Vascular)	• Peripheral procedures can be done in the ASC setting • Growing population of patients but need to streamline screenings in the PCP setting to improve access • Limited physician availability

Figure 1

Appendix B.2 Space Constraints Exist Along with other Considerations

Phlebotomy (Central Lab)	•Collection area in Zone B-130 facing space constraints •Long lines and limited space makes keeping up with patient demands for registration and blood collection difficult •Patient volume is directly related to an increase in FTEs and assays/tests
Pain Management (Procedural Space)	•For reimbursement purposes, moving away from telehealth •In the future will need more space to accommodate in-person patient demand
Neurosciences (EEG, Stroke, Epilepsy)	•EMU Patients who come in for elective procedures have limited bed space due to ICU overflow
Radiology	•Many physicians are moving to pocket ultrasounds •TUH Main is reaching capacity for MRIs •Due to space constraints, appointment wait times are a month out •Ambulatory center in Northeastern does not have IR •Government is not paying for outpatient imaging in an in-hospital setting/free standing
Optical Shop	•Long lines
Orthopaedic Surgery and Sports Medicine (Orthopedics)	•Growth partially dependent on referral efficiencies •Losing 2 physicians •Payors are pushing for more procedures to be done in the ASC/outpatient setting

Figure 2

Appendix B.3 Services Impacted by Space Constraints

Cancer Center Infusion Unit & Clinical Space	• Current footprint has capacity for 5-10% additional growth in infusion treatment visit volume • Would need to consider adding hours of operation or expanding space • Physicians have been reluctant to forecast more volume that is currently built into FY 2023 budget • Forecasting growth beyond this would require identifying source of new demand
Head & Neck Institute (Audiology Testing)	• Due to limited space, patients are not able to receive an appointment until August • Currently have 2 booths for audiologists • An additional booth → 8 more linked patients and 14 more independent appointments
Otolaryngology	• Due to limited space, appointments are backed up until August • Newly hired surgeon only has space to complete telemedicine slots • An additional room → 14 more patients per day
Digestive Disease Center (GI Procedural Space)	• Due to space constraints, maximum appointment wait is 3 months • Due to site of service, payors are beginning to push back against routine GI procedures in the inpatient setting
Surgery (General Surgery Clinic)	• Newly recruited faculty • Need more exam room space • Physicians are currently sharing exams rooms, with more exam room space physicians can fill their own schedules and accommodate more new patients
Urology (Procedural Space)	• Approx. 2 month wait for appointments • May lose patients to ED due to long waits

Figure 3

Appendix C Project 3 Attachments and Exhibits

Appendix C.1 Items Crucial to Temple Health/Chestnut Hill Patient Access/Call Center Transition

Table 4

Category	Items
EPIC	- Confirm access to CHH EPIC for Temple Health employees - Confirm EPIC training requirements
Scheduling	- Determine appointment conversion and cutover plans - Confirm CHH and Tower Health phone tree details - Confirm policies and procedures for scheduling, cancellations, and rescheduling - Confirm shared drive access for Temple Health employees - Confirm scheduling protocols and training guides - Meet and shadow current CHH managers and staff
Pre-reg/IV/Auth	- Determine EPIC training plan for Temple Health staff - Confirm EPIC workqueue documentation - Confirm insurance verification portal access for Temple Health employees - Shadow CHH front-end staff - Confirm number of Temple Health FTEs to carry on operations at CHH

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