



Environmental Drift in Health Center Dental Practice Management

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ABSTRACT Federally qualified health centers, FQHCs, face a number of challenges providing low-cost health services and meeting their primary mission of being available to all users regardless of their ability to pay. In effect, health centers must provide services that border on free to minimal revenue-generating potential. This is especially challenging for health centers providing dental services that are often more costly on a case-by-case visit encounter than primary care services. .

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Community health centers face many challenges attempting to provide health services to low-income populations. As a major consideration in successful practice management, a health center dental clinic must manage the inflow of new patients entering the dental practice. While it is customary to allow “open access” and simply treat all potential patients as they walk into the clinic, a successful practice must monitor and manage new patient activities. This includes such practice parameters as dental service time allocation; revenue generation ratios of uninsured to insured patients; the ratio of emergency walk-ins versus comprehensive regular care seekers; after-hours and extended-office hours coverage; and patient flow.

A health center dental clinic that simply allows a passive open access policy without

management is playing a game of dice and faces the risk of poor performance due to environmental changes. This can threaten the longevity of the dental program.

According to guidelines established by the Health Resources and Services Administration, HRSA, Bureau of Primary Health Care, health centers are to provide broad and comprehensive health services to their service areas regardless of ability to pay, yet maximize all revenues from all sources.¹ This includes the provision of dental services.² In addition, health centers must be able to monitor internal and external changes that may impact their ability to continue operations. This entails the ability to predict changes within the environment that impact future revenue streams and take appropriate action in advance of such changes. This drift in environmental factors can present a

serious challenge to health centers, and, unless accounted for, can doom a well-meaning program to financial failure.

Environmental drift signifies that conditions change over time. Communities as vital entities in motion, also face constant and often predictable changes over time. Such drift can sometimes occur rapidly in factors such as demographic makeup, employment, resources, and health care demand. A health center's project scope and the initial population needs assessment may not reflect the reality of health service demand, future trends, and projected revenue streams once the health center is up and running. Unless the assessment of the community is thorough, accurate, ongoing, and taken from reliable sources, the real operating conditions faced by the health center when compared to the projected scope of practice may not be or remain realistic.

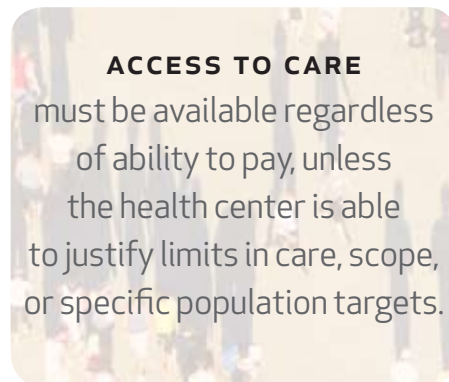
"It is a HRSA Bureau of Primary Health Care program expectation that health centers establish comprehensive primary oral health care as an integral component of primary health care services provided when resources are available to support such a program. Access to services defined within that scope must be made available to all health center users regardless of ability to pay."³

Access to care must be available regardless of ability to pay, unless the health center is able to justify limits in care, scope, or specific population targets. For example, a health center may limit service to special needs populations or children only.

An example of an environmental drift that could be used to justify a scope of service change or targeted subgroup would be a sudden loss of a large portion of Medicaid covered services, or the number of enrolled or eligible population determined

to exist based on previous needs assessment of the service area has changed.

A state may exclude from coverage certain federal classified elective additions to Medicaid, such as the provision of dental services to all adults over age 20. Such a change would have a devastating impact on a health center with an open access policy for all age groups. A health center may change the scope of practice to target primarily children and exclude adult patients. This decision can be based on the demographic need to target specific population subgroups that sustain the ability of the health center to continue operations.



"Health centers must be able to justify why services and/or populations are excluded from the scope of practice, if the scope of services is limited and/or less than comprehensive."^{4,5}

The key principle is to justify necessary subgroup targeting based on an acceptable standard according to federal rules and quality oversight. Justification can consist of extreme financial difficulty based on unusual shifts in environmental changes or population. To support justification, a health center must collect appropriate data to prove their case. Such data must include changes in demographics of the health

center's target community and a needs analysis that can project proportions of potential payer types and resources. This information should include general age, gender, race, disabilities, special needs, and ethnic-cultural makeup.

Population health needs data can demonstrate and support the health center's access policy and the general mix of patients seen. By combining the population financial profile and demographic data with the health center's financial bottom-line indicators, the health center can manage patient access by matching clinic access patterns with the combined profile data. The data helps the health center dental clinic avoid appearing arbitrarily selective or cherry-picking practices. HRSA Bureau of Primary Health Care expects initial and ongoing regular community assessments in order to evaluate needs, resources, and program service potential.

"The primary oral health care plan is an integral component of the overall primary health care plan, based upon what is feasible, taking into consideration the program's projected revenue, other resources, and grant support."⁶

The primary elements of a health center community needs analysis should include project plans, prevention service mix, organization of care, and staffing requirements. A breakout example of a community needs analyst includes the following elements:

1. Estimates of the number of users (specify critical mass of dental patients for the program);
2. Description of existing providers and resources in the community as well as an assessment of unmet needs;
3. Predominant characteristics of service population such as race, gender, age, ethnicity, primary language, income, etc.;
4. Oral health status, prevention, and treatment needs of the population;

5. Barriers to access/availability to comprehensive oral health care services; and

6. Description of needs and treatment of special populations (e.g., HIV, homeless, migrants).

“Since oral health care needs in underserved communities are extensive and cannot be fully addressed by any one organization, it is important that programs actively solicit collaboration and linkages with dentists, dental schools, dental societies, and other health care providers in the community.”⁷

An example of a type of environmental drift that negatively impacts a health center’s ability to serve those most in need and remain financially viable is a community facing a sharp rise in overall unemployment and a subsequent rise in uninsured and indigent clients. While the number of Medicaid patients in this community may still be substantial, the immediate crisis of increasing demand by rising uninsured patients begin to outnumber and crowd out other revenue generating patients.

If the health center dental program maintains an open access policy, the dental clinic will soon find the majority of patients seeking entrance into the practice are uninsured and unable to pay for services resulting in a fiscal crisis. However, in this scenario, there are still viable Medicaid enrolled clients and other revenue generating care seekers within the community. Yet, the demand for services is highest among the growing population of indigent and uninsured clients. Better management of all resources including service appointments could improve the health center’s viability in these situations.

Unrestricted open access during negative community demographic and environmental changes result in health center dental programs facing declin-

ing revenue streams, rising costs, and rapid depletion of federal grant funds. It is important that the health center’s administrative leadership determine the underlying reason for the negative cash flow and accommodate for this trend. It should not be assumed that a health center’s federal grant will cover all costs if severe negative cash flow situations arise. While federal grant funds assist a health center to cover some of its operational costs providing services to low-income and indigent populations, the average federal grant only provides an average of 22 percent of the center’s total operational budget.⁸

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A health center cannot sustain itself depending on grant dollars alone. National data reflect that Medicaid revenues represent 37 percent or more of a health center’s revenue stream and for a health center-based dental program, Medicaid is the largest single payment source.^{9,10}

The health center’s budgetary goal should be to anticipate a future impact on program viability and develop an intervention to stop potential negative cash flow if deemed necessary. However, this effort must be consistent with the health center’s mission and overall federal guidelines for health center programs. The National Association of

Community Health Centers recommends the following for health centers when evaluating budgetary constraints:¹¹

- Health center administrators should strive to know and understand current costs and patient utilization patterns in as much detail as possible. This is necessary in order to know whether participation at different rates of reimbursement and all associated financial risks is prudent.

- Be sure the scope of required services is clearly defined in order to determine whether payment will be adequate.

- Do not assume risk for services that cannot be controlled directly by the health center, a member of the health center network, or managed care organization working on behalf of the health center.

A method to help further control financial losses within the health center dental program would be to adjust the ratios of dental chairtime slots or the dental service mix available to the target population. Such decisions can be based on shifting demographic data and patient categories such as age, type of service, payer source, and the percentage the practice can absorb and remain viable.

The focus of a health center is to be available to all potential users within the community at competitive prices and standards of care available with other health service providers within the community. Health centers provide affordable good care standards at less costly rates to the underserved low-income users. To accomplish this, demographic changes and population profile data can be used to solicit other funding resources from local charities, state, regional, and national grants targeting specific need-based groups. A health center dental director and health center program administrator should first seek these types of revenue enhancers rather than resorting to limiting patient services or exclusions.

As an example, a certain health center after a fiscal analysis requires average monthly revenue proportions of 40 percent Medicaid, 30 percent sliding fee services, 10 percent insured, and 20 percent uncompensated care write-offs for minimum program viability. If the environmental assessment closely matches this proportion of revenue generators needed for minimum program viability, chairtime appointment slots can be set up to target these payer categories.


Targeted restrictions in scheduling must closely match the population needs profile and be assigned by call-ins and appointments. Chair appointment control methods work best when a practice utilizes electronic scheduling and integrated billing software, along with close monitoring by the health center's financial team. Once available patient type categories/ratio slots are filled, all others are placed on standby or next day fill-in with the exception of emergencies.

Emergency care should never be restricted by this methodology. Emergency access is limited only by the clinic's excess volume limitations per day based on the number of providers available, no-shows, and unscheduled chair capacity. Indigent emergency care is applied against the 20 percent uncompensated care proportion if uninsured and uncollectible. The FQHC federal grant authorized under Health Service Act, Section 330, should be used to assist the health center cover these revenue losses.

This type of chair management system or targeted scheduling works best with a minimum of three dental chairs per full-time equivalent dentist. One chair is unscheduled for emergencies and walk-ins while two chairs utilize a targeted scheduling system. The key in addressing environmental drift in health centers is to manage all practice resources, sched-

uled appointment time, and patient flow consistent with mission objectives and financial limitations. Such decisions must be based on data that justifies exclusions and service limitations.

It must be emphasized that targeted scheduling is not justification for churning, or shortening patient visits, or the amount of treatment performed. Effective and quality quadrant dentistry within the full field of anesthesia is the preferred standard of care. Selective targeted scheduling simply serves as a method for establishing appointment priorities by targeting all available payer categories within the service area.



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A health center dental program must be realistic in terms of resources and ability to meet the needs of their service population. Decisions must not be limited to expensive idealistic treatment outcomes or fiscal bottom-line concerns alone. A balanced perspective must be developed with focus on community and individual patient care needs, fiscal, and mission objectives consistent with federal FQHC policy guidelines.

Federal grants that support some portion of FQHC operations are limited. They are fixed at specific rates over several years without guarantees in adjustments. Administrative decisions within health

centers must be supported by good, data-driven evidence. While decisions to reduce programmatic services can be made, health centers should strive to use negative trend data to support the need for additional resources. A case should be made that if new resources were available how these resources would increase the health center's ability to meet the service population's needs.

This kind of planning is further illustrated in BPHC regulations, "Health centers are required to maximize revenue from all sources of income to meet the needs of the patient population served. Health centers are required to assure that services shall be available to the service population without regard to method of payment or health status. At the same time, health centers are expected to maximize revenue from third-party payers and from patients to the extent they are able to pay."^{12,13}

Health centers should develop a financial plan for oral health delivery. The program should operate and be tracked as a cost center for analysis of cash flow, revenue generation, program costs, and utilization. The data should reflect the degree to which the budget and financial plan assures appropriate utilization of resources, meets service objectives, and projects a likelihood that the program will remain viable.

Principle Elements of a Financial Plan Should:

- Link the budget with the goals and objectives specified in the oral health program plan and overall health center plan.
- Identify specific cost such as salaries, equipment, supplies, rent, etc.
- Provide a budget forecast for future years which demonstrates increasing potential for program success.
- Apply federal grant resources to all cost centers within the health

center's budget to offset low-revenue generating services.

Health center dental clinics are in effect hybrid-managed care programs that primarily benefit from health maintenance and prevention-based activities more than time intensive and costly restorative or repair services unlike most private practices. Revenue generation in these centers is not proportional to the full cost of providing care or based on the expense or complexity of services. This forces restrictions on what health centers can do when facing overwhelming demand and limited resources. ■■■■

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