OF THE CALIFORNIA DENTAL ASSOCIATION

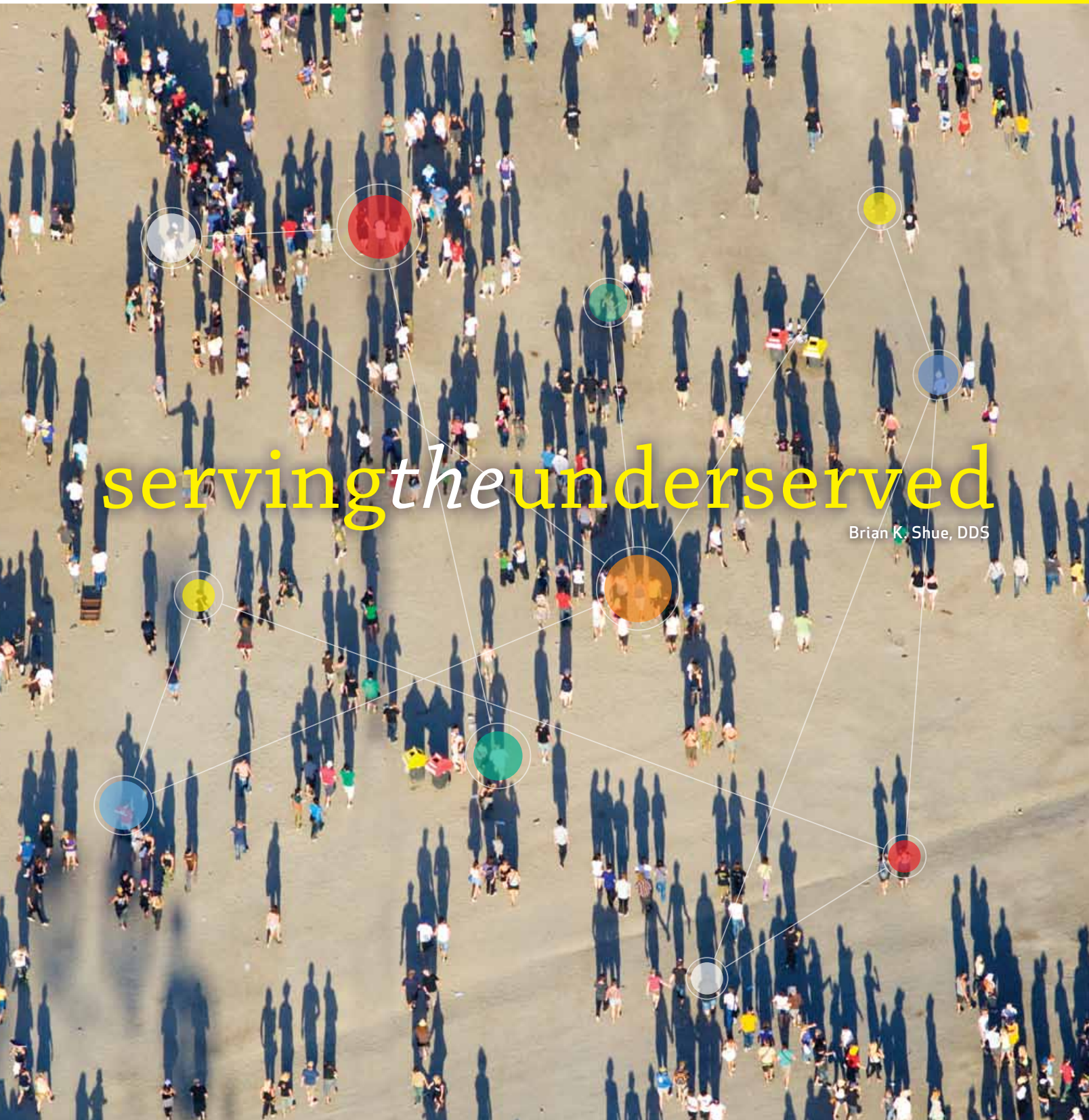
Journal

MAY 2009

Health Centers

Financing CHCs

Issues Facing CHCs



serving *the* underserved

Brian K. Shue, DDS

OF THE CALIFORNIA DENTAL ASSOCIATION
Journal
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DEPARTMENTS

FEATURES

CDA JOURNAL, VOL 37, Nº5

Judgment

BY RUCHI NIJJAR, DDS

There's more to dental procedures than just picking up the handpiece and drilling.

Our profession is more than a skill. It is science. It is art.

Food Network's prime time show *Unwrapped* gives us an inside look into the mechanics of producing foods like candy, chips, and other confections. We see the assembly line. The large metal machines – melt, mold, and pack. The machine endlessly repeats the motion without direction. The plastic wrap goes on that confection without a wrinkle.

It makes me think. The machines can perform their duties without direction. But who created the machines? Who directs the packaging protocol? Who assesses the quality of the confection?

Ace of Cakes, another prime time Food Network show, demonstrates how a unique bakery in Baltimore named Charm City Cakes, brings a customer's passions alive with their cake creations. They mold fondant into real-life replicas of pianos, people, and other personifications. It is a big-picture, vision-fueled, super-skilled operation — much like a dental practice.

Both TV programs show products that serve the same need: to delight, to sweeten, and to feed. But they used different processes to get there. One is assembly line mass production; the other is science-based art. One requires pushing the button; the other requires judgment.

According to the California Health Foundation, about 40 percent of California dentists are providers for DentiCal. This number decreases every year. Twenty-six percent of kindergarten-bound children have untreated decay, as reported by the California Smile Survey in 2005. In California, 6.5 million people are low income or disadvantaged. Most qualify for Medicaid. A significant 3.5 million of these people are children. However, only 700,000 of these children are covered by the California SCHIP program, Healthy Families. There is an unmet need for oral services for the underserved.

Special interests see a gap in the need for services and their delivery. The Legislature is driven by this unmet need to seek solutions. Hygiene uses delivery of care for the underserved as justification for entry into independent practice. The registered dental hygienist in alternative practice is the first step into that territory.

Special interests introduced legislation for a limited license allowing the graduates of one Mexican dental school to practice in California. Although the thrust was unsuccessful, the legislation showed the driver to meet the unmet needs of the undeserved.

Most recently, dental health aide therapists work in remote villages in Alaska, performing dental procedures including extractions, palliative treatment, and prevention counseling. In Minnesota, an oral health provider, OHP, is being established. A workgroup is developing the curriculum as we speak. The Legislature originally proposed an "advanced dental hygiene practitioner, ADHP.

Last year's May issue of the ADA's *Your Dental Advocate* reported that the Minnesota Dental Association and two dental students from the University of Minnesota (who were previously licensed, practicing dental hygienists) testified before the Minnesota Legislature, "I can't now imagine trying to make a final diagnosis and an adequate dental treatment plan without the education I'm getting in dental school." The former hygienists asserted: Creating an ADHP would not solve the access problem. It would expose patients to risk.

The 2008 CDA House of Delegates discussed the subject of the midlevel provider. In most settings, these providers provide care directed and/or dictated by a supervising doctor on whom liability for those activities rests. Other states, such as Minnesota, have been driven to implement this model to address the discrepancy of enough workforce to treat the underserved. The midlevel provider changes the prototype of the workforce model. Is this model relevant to the delivery of care in California?

It is the culture of the house, and perhaps dentists in general, to study

the many textures and implications of a problem before offering solutions. So we will study the options for alternative providers and how they may fit into the delivery of care. We will study the current workforce needs in California. We will study how to deliver the finest care with finite resources. The path of open-ended research could lead us in any-which direction. Yet, we want to be prepared to address all options the Legislature may propose with factual data.

The challenge will lay in our timing. As we debate the issue, study the statistics, and analyze the forks in the road, the world will continue to spin. It could pass us up easily.

My brother, a biomedical engineering major in college, constantly reminds me that one day a robot will be able to perform dental procedures on patients. He cites the robots already performing mitral valve repair surgeries. I get his point. We cannot begin to visualize or imagine tomorrow's technology possibilities. But the concept of a nondentist "robot" performing irreversible procedures on my patients frightens me.

There's more to dental procedures than just picking up the handpiece and drilling. However, are the procedures we perform the result of habitual exercises? Is the everyday rheostat or hand instrument dentistry the motivating element of our day? What keeps us excited about our Monday mornings? It's the patients.

We listen. Patients must feel comfortable with the doctor to whom they tell their stories. We ask questions about their medical history, their symptoms, their daily life habits, and other factors impacting their overall health. We examine. Dentists collect objective data to effectively assess and diagnose the patient's oral condition. We use our education and experience to effectively explain the situation. We outline a plan. Isn't that the tough part? Understanding the type of procedures necessary and identifying the appropriate sequence and priority?

It is the mind of a dentist that the patient trusts. It is the diagnosis of a dentist that the patient seeks so that he can have faith that the procedure will resolve their oral health care needs. Our patients' oral health care is not a series of robotic tasks strung together and performed assembly line style. The picture is not complete without the judgment of a dentist. ■■■■

Address comments, letters, and questions to the editor to kerry.carney@cda.org.

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Continued Competency

I feel I must respond to the guest column in the January issue ("Yet Another Test," Page 5) regarding continued competency examinations by Dr. Felsenfeld.

Continued competence presupposes the premise that experienced dentists need to be constantly updated and graded on the materials, techniques, and procedures that are regularly being introduced into dentistry. It, therefore, also postulates that dentists who have graduated and have been licensed some years ago are somehow inferior academically and clinically to those dentists more recently graduated and licensed. I have found that both these premises are flawed.

Competency is more a result of integrity, ethics, and morals than improper training or knowledge. A cursory examination of the State Dental Board's actions is quite revealing in this regard. There appears to be no statistical relationship to years of practice and clinically unacceptable dentistry. State Board sanctions are actually skewed to the more recent graduates, those who have the benefit of just learning and being tested on the same methods and techniques that continued competency would address. So how are we to assume that continued competency will alleviate the presumed incompetence of dentists?

As a former member of the peer-review committee of my local component, I saw many instances where dentists knew what was right but somehow veered off course. Some of these cases were inadvertent and quickly remedied. Other dentists insisted they were doing the right thing and, even in the face of an impartial jury of their peers, refused to admit wrongdoing. The majority of this latter group apparently simply chose to ignore their training. Again, as in the cases disciplined by the State Board, there did not appear to be a statistical relationship in regard to length of practice.

In all of these cases, were these dentists required to take a competency test I am sure they would all pass. But take them out of the spotlight of a testing situation and they would quickly revert to delivering poor dentistry. Please note I am not talking about "ivory tower" dentistry, but rather clinically acceptable dentistry that restores health and adheres to the first principle of medicine: DO NO HARM.

Competency is more a result of integrity, ethics, and morals than improper training or knowledge.

Can the principles of integrity, morals, and ethics really be taught? What changes some dentist's perception of right and wrong when thrust into the real world? We all know the pressures brought upon recent graduates. The tremendous debt of dental school, the establishment of a practice, and the need to fulfill dreams and expectations seem to overshadow some dentists' training. For some, this becomes a burden that appears to require a short-term solution that turns into a pattern of practice.

To compare us to our physician brothers is ludicrous. Studying outcomes in medicine is akin to closing the proverbial barn door after the cows have left. The same moral and ethical dilemmas we face as dentists also confront physicians. We no longer are a cottage industry in which we can treat our patients void of any peer review.

The issue of flying an airplane and the training and continued re-examination required to maintain a license to fly is quite true. However, with all these precautions there are still private pilots who commit what is euphemistically called pilot error: Poor judgment resulting in tragic results.

I am frankly appalled at the notion of third-party involvement in the demand of training and competency of dentists. It is bad enough some of these organizations dictate our fees. It is bad enough they diagnose our cases and demand lesser treatment so as to save money. Is it not bad enough they direct clients to dentists of their choosing rather than allowing their clients to seek the dentists the patients choose? To now cower to this kind of possible third-party pressure of our training is beyond understanding. It is not out of our control to resist this kind of meddling in our profession. Just because physicians have succumbed to this type of extortion does not mean we have to do the same. It is the role of the CDA and us as dentists to stand up, individually and as a group, and withstand this assault on our profession.

This is not meant as an indictment of any individual. Rather, it is an attempt to look at the issue of continued competency through a different prism. If continued competency training becomes an institution in our profession, it is my opinion that, with the foregoing in mind, our patients will not be better served. Those of us who oppose continued competency testing do so not from fear of peer assessment nor are we cowed by presumed guilt. It will only open a Pandora's box that will be impossible to close and will not result in better dentistry for our patients.

RUSSELL ANDERS, DDS
Camino, Calif.

Reader Begs to Differ With Editorial

Dr. Kerry Carney's March editorial ("When Good Ideas Go Bad," Page 145) describing problem-based learning in dentistry as a good idea gone bad didn't resonate with me as true.

I graduated from USCSD's PBL program in 2000. It was a pilot project then and we shared school space with the traditional class, so there was a lot of interaction. While I admit it was always a challenge, often frustrating, and some-

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times we weren't sure what was going on, for me, it was even still far superior to my "traditional" schooling from an earlier health care professional career and to my subsequent traditional dental residency training program. In fact, if it wasn't for PBL, I don't think I would have ever made it through dental school. I barely made it through my residency, as mind-numbingly didactic and boring as it was.

There are more objective measures, too. My PBL group had among the highest National Board parts I and II scores compared to the traditional class, and we all passed the California licensing exams the first time around — in a year when a startlingly high percentage of our traditional classmates had to retake the test. Most of us went on to pursue specialty training.

Finally, whenever I run into my traditional dental classmates, they invariably remark how much they hated dental school and would have loved to be in the PBL program. Seems to me, then, didactic dental training may actually be the better example of a good idea gone bad?

BRIAN A. KELLEHER, DDS
Angels Camp, Calif.

Reader Agrees With Editorial

As a retired life member, I loyally read the *Journal*. I will admit, as do many of my friends, that we first turn to the last page to read Bob Horseman's article. Dr. Jack Conley did a great thing in asking Bob to write these articles.

After reading Dr. Bob's article I turn to the editor's column, scan it for content and determine if I should read further. Does that sound familiar? Your article in the March *Journal* ("When Good Ideas Go Bad," Page 145) caught my eye, mainly the PBL comments.

I have been involved in dental journalism for a long time (now it's over) and was privileged to co-edit our USC 100-year history book (1897-1997), and it was a task, but fun. Turned out to be 518 pages. All departments were asked to contribute and we edited and placed photos. I was given an article on PBL for the book. I must say, I read it of course, but understand it, I did not.

Some on the committee tried to explain it to me but to no avail. I spoke to the dean at the time and he said "Bill, I will send you a paper which will explain it all to you." He did send it, but it was the same content as the article that was to go in the book, so I was no better off. I then asked one of my committee members to proof it as I would not be a good one for that job. We did print the article and I still do not understand it. One of the specialists on PBL called me and said I should go down to the school and sit in and learn about it. For some reason I did not go and retired shortly after that.

So, I am in agreement with you that PBL is a good idea gone bad; real bad in my view. However, there is always the probability that I am convinced that the manner in which I was taught was the preferred manner.

In conclusion, thanks for your effort and I know it takes a lot of work. I wish you success in this endeavor. Maybe we will meet soon.

REGARDS,
WILLIAM E. DAHLBERG, DDS
Shadow Hills, Calif.

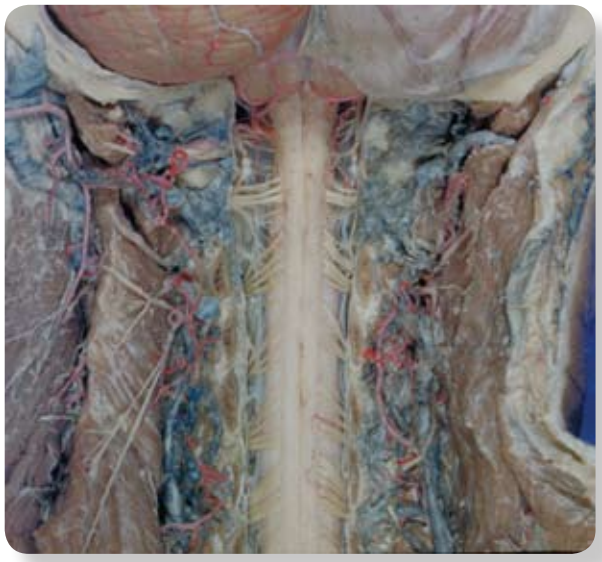


Photo: William Gruber

By removing the rear arches of the neck (cervical) vertebra and the fibrous covering (dura) over the spinal cord one sees the cervical spinal cord and its nerves. The blood vessels nourishing the cord and vertebral column and the origin of the cord from the brain are clearly shown.

Anatomical Image Library Created

W. PAUL BROWN, DDS

In the spring of 1998, Eric Herbranson, DDS, and I, both Bay Area endodontists, joined forces with the original intention of developing a library of very high resolution, digital anatomical models of real teeth to be used in research and teaching in dentistry. The project began within the Division of Anatomy at Stanford University.

At that time, a group of NASA computer scientists had formed the Stanford/NASA Biocomputational Centre and their task was to create surgical simulation programs for the NASA Mars trip. These simulations included programs for head and neck surgical planning. Our goals fit well into this program, and consequently NASA offered us their 3-D interactive

CONTINUES ON 309

Identafi 3000

Trimira, LLC, recently introduced the first of its kind device that aids dentists and doctors in detecting oral cancer. Identafi 3000 is a cancer-screening device intended to detect the early signs of oral cancers. The Identafi 3000 consists of a three-wavelength optical illumination and visualization system that is housed in a compact unit. The device is cordless and handheld, specifically designed for dentists, periodontists, oral surgeons, otolaryngologists, and primary care physicians. Providing the ability to identify biochemical and morphological changes in the cells of the mouth, throat, tongue, and tonsils, the Identafi 3000 is unlike any detection tool used by dental and health professionals alike. For more information go to trimira.net.

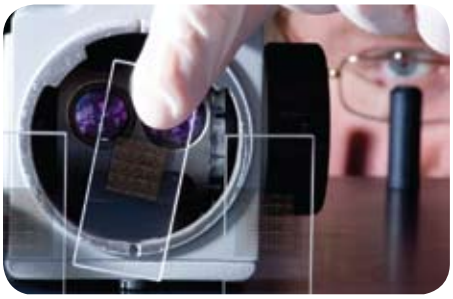
ADA/Kellogg Executive Management Program Offered

Applications are being accepted for the 2009 session of the ADA/Kellogg Executive Management Program, an executive-level series that ranges from learning about business strategy, marketing, finance, and organizational leadership to economics, accounting, quantitative methods, and information systems.

The registration deadline is May 31. The 17-day program, taught by Kellogg professors, will be held at Northwestern University's Chicago campus, near ADA headquarters, and consists of three sessions separated by seven-week intervals. The dates for the 2009 sessions are July 9-14, Sept. 10-15, and Nov. 6-10.

"The ADA/Kellogg Executive Management Program provides dentists with a curriculum that is both intellectually demanding and, at the same time, very stimulating," said John S. Findley, DDS, ADA president. "It expands their business and management expertise, and enhances their ability to manage more effectively in a dynamic environment."

For more information and application materials, go to ada.org/goto/kellogg or contact Connie Paslaski at paslaskic@ada.org or 312.440.3451.



Dental Treatment Advances Possible With Genetic Discovery

Researchers have identified Ctip2, a gene that controls the production of tooth enamel, thus bringing forth a new concept in preventing caries, restoration, and even the production of replacement teeth.

Ctip2 is a "transcription factor," already known to be multifunctional in the development of skin and the nervous system as well as immune response and now tooth development.

"It's not unusual for a gene to have multiple functions, but before this we didn't know what regulated the production of tooth enamel," said Chrissa Kioussi, an assistant professor in the College of Pharmacy at Oregon State University. "This is the first transcription factor ever found to control the formation and maturation of ameloblasts, which are the cells that secrete enamel."

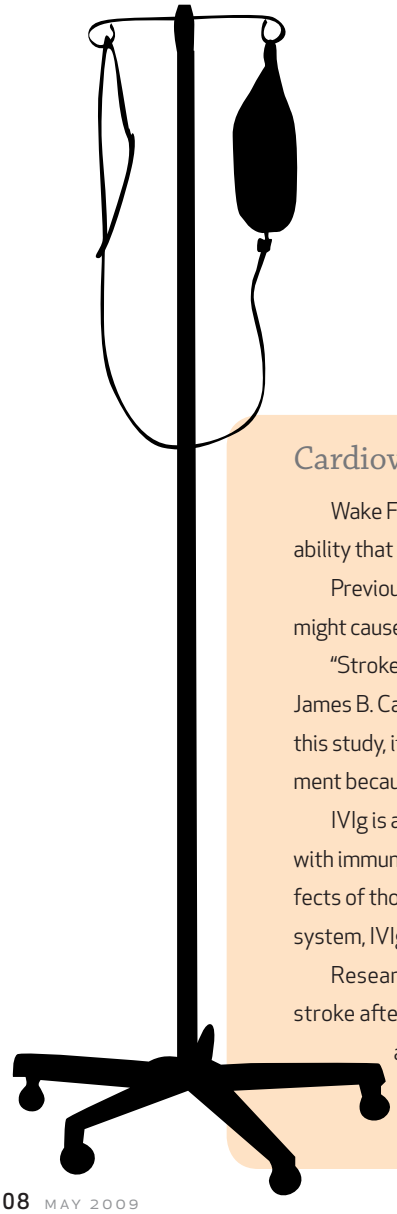
Using a laboratory mouse model, the gene was knocked out and its protein was missing. In cases like this, these mice lack basic biological systems and cannot live after birth but allow scientists to study what is present and what is not. These mice had undeveloped teeth ready to erupt, but lacked a proper enamel coating and never would have been functional.

"Enamel is one of the hardest coatings found in nature, it evolved to give carnivores the tough and long-lasting teeth they needed to survive," said Kioussi.

Kioussi said it may be possible to use tooth stem cells to stimulate the growth of new enamel. Some research groups already are having success growing the inner portions of teeth in laboratory animal experiments; but those teeth have no hard coatings — the scientists lacked the genetic material that makes enamel.

"A lot of work would still be needed to bring this to human applications, but it should work," Kioussi said. "It could be really cool, a whole new approach to dental health."

The findings were published in the *Proceedings of the National Academy of Science*.



Cardiovascular Risk Factors May Compromise Safety of IV Treatment

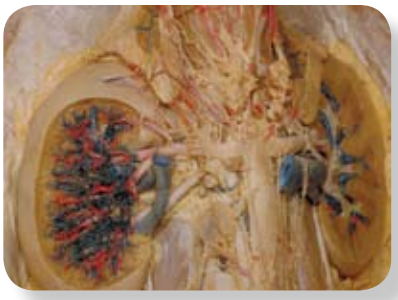
Wake Forest School of Medicine has identified the presence of cardiovascular risk factors as a sign of the probability that older, hospitalized patients taking intravenous immunoglobulin, IVIg, will suffer a heart attack or stroke.

Previous to this study, which was published in the *Journal of Neurology*, it was known that administering IVIg might cause heart attack or stroke; however, it was not known for certain when those serious side effects would occur.

"Stroke or heart attack has always been considered a fairly rare complication, but it's a catastrophic one," said James B. Caress, MD, an associate professor of neurology and the study's lead researcher, in a press release. Before this study, it was difficult for doctors to counsel patients about their risk for stroke or heart attack from IVIg treatment because previous reports could not identify which patients were at the highest risk, he said.

IVIg is a medicine made from human blood components and used to treat patients with multiple sclerosis and with immunodeficiences, for example. In individuals with autoimmune disease, IVIg can stem the detrimental effects of those antibodies. In people with advanced cancer, where the tumor or chemotherapy damages the immune system, IVIg boosts the immune system to fend off infections.

Researchers in the recent study reviewed the medical records of 19 patients who suffered a heart attack or stroke after having IVIg administered. The team also reviewed the records of 38 patients who were the same age as the 19 patients in the study but who also received IVIg treatment but did not have a heart attack or stroke. The patients, who had an average age of 71, received treatment between August 1998 and May 2004.



By injecting the arteries and veins with red and blue material, Bassett demonstrates their distribution in these dissected kidneys. The image provides a detailed view of the lymphatic drainage of the region.

Our long-term mission is to create the first "clickable" human, something akin to Google Earth for the human body.

LIBRARY, CONTINUED FROM 307

surgical simulation software platform to use for developing the library.

At this point, giving the group the name "eHuman," we were joined by Bruce Fogel, DDS, an endodontist, and Terry Kessler, DDS, a general dentist. After two years of researching, experimenting, and going through the painful process of learning how to write an NIH grant application, eHuman received its first grant from National Institutes of Dental and Craniofacial Research.

Since then, the scope of eHuman's educational research project has greatly expanded. It has since received 10 NIH grants for $4.7 million and has a staff of 22 people creating content for medical and dental education. The digital anatomical programs that have been developed are now used worldwide. In the United States, they are used by 80 percent of all dental schools and many medical schools. eHuman currently is developing a server-based haptic-enabled dental simulator to completely replace the typodonts and mannequins used in preclinical dental school skill laboratories.

Of enormous importance in the development of our long-term goals was the fortuitous discovery, in its anatomy lab, of shelves and shelves of dusty boxes. These boxes contained booklets of View-Master sets of discs of anatomical dissections called the Bassett Collection. Next door to our lab was the office of Emeritus Professor Robert Chase, MD, an anatomist and a former head and neck surgeon. Chase, an enthusiastic educator and the curator of this collection, introduced us to the spectacular contents and its colorful history.

The quality of the dissection and the quality of the images were simply astounding. Just as remarkable was the fact that this collection, although very well known by anatomists, was not widely used. Some of the images had been licensed for textbook use and a few schools use it with the View-Master in its original form.

The history of the collection is worthy of repetition. Beginning in 1948, Bassett, as associate professor of anatomy at Stanford, known for his meticulous dissections, invited William Gruber, the developer of the View-Master stereoscope, to photograph his work. For 17 years, Gruber traveled back and forth between his home in Washington state and Stanford where, using a two camera set-up, he would photograph the dissections in stereo.

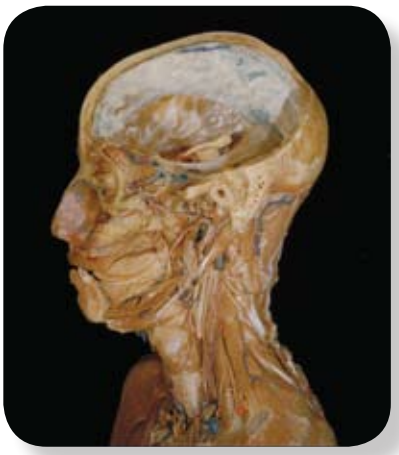
In 1962, Bassett published *A Stereoscopic Atlas of Human Anatomy*, with 1,547 color stereo views of dissections of every region of the human body. They were compiled on 221 View-Master reels tucked inside the back cover of the hardbound volumes. The original photographs, taken on Kodak's highest resolution film, are now archived in the Lane Library of Stanford's Medical School.

The atlas was an immediate success and the images became an important source for medical and dental students. Even the University of the Pacific had an Atlas until it was stolen. Despite its success and importance, the atlas eventually went out of production. Bassett died in 1966.

The raw images and annotations in their analog traditional form while spectacular are difficult to use, consequently five people from our research group have worked full time on the collection for more than a year and transformed it into an interactive, Web-based experience. The digitized images now have Bassett's annotations attached to the images with Chase's voice reading the annotation with correct pronunciations.

The new computerized format, with a quiz built on every page, is appropriate for all students studying anatomy on any level of complexity, including dental and medical students, nurses, physical therapists, and chiropractors.

While cadavers are still used by most anatomy departments, the eHuman Bassett program will immeasurably augment anatomy education. Think "Body Worlds," the traveling exhibit of preserved human bodies viewed by millions, but much larger, with more detail and geared toward providing an encyclopedic volume of information about the anatomy of the human body.



Photos: William Gruber

This classical dissection image shows structures in the neck, oral cavity, and cranium. When viewed in stereo, it gives anatomy students an understanding of anatomical structure relationships.

Our long-term mission is to create the first "clickable" human, something akin to Google Earth for the human body. The annotated Bassett Collection online, an important component of the mission, is available now for the global medical, health care, educational, and consumer communities. A demonstration of the Bassett programs can be seen on www.eHuman.com. An Internet connection and standard browser is all that is required to access this information. An iPhone version will be available through the Apple stores later this year.

Author / W. Paul Brown, DDS, is a consulting associate professor, Stanford University, Department of Surgery, Stanford, Calif.

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Research Grant Awarded to NYU College of Dentistry

New York University College of Dentistry has received a five-year $1.9 million NIH grant for its AIDS research team, which is studying HIV's ability to survive in the body and cause disease.

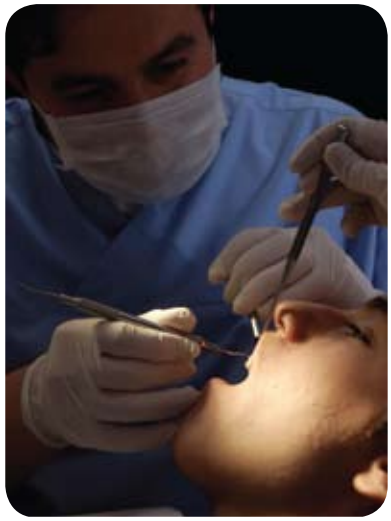
The grant was awarded by the National Institute of Allergy and Infectious Disease to the research team to continue its study of a new mode of HIV replication that involves cooperation between viruses.

In a process called integration, HIV inserts its DNA into the DNA of the cells it infects. This process is considered inefficient, likely to fail, and can result in an aborted virus replication cycle. As such, up to 99 percent of HIV DNA is found in an unintegrated form; and while the profusion of unintegrated DNA has long been known, its biological implications have not been easily evident.

David N. Levy, PhD, an assistant professor of Basic Science and Craniofacial Biology and research team leader, discovered the method in study he conducted previously with the help of a one-year pilot grant from the Center for AIDS Research at the NYU's School of Medicine.

Levy and his team, in a July 2008 article in *Retrovirology*, documented that unintegrated viruses can reproduce when assisted or "complemented" by viruses that successfully integrate with the DNA of infected cells. Levy is of the opinion that this newfound cooperation among HIV viruses aids in HIV's ability to dodge immune response and its persistence in the body.

"HIV rapidly mutates and evolves during infection, which prevents the immune system from successfully stopping virus replication," Levy said in the article, adding, "and we have shown that these cooperative interactions speed up the evolution of the virus by increasing the amount of genetic exchange between viruses through a process called recombination.



Dental Benefits Figure More Prominently in Benefit Packages

Dental benefits are now being ranked higher as an essential part of a benefit package by employers, according to the National Association of Dental Plans' *2008 Group Purchaser Behavior Study*.

An estimated 62 percent view dental coverage as essential to their benefits packages, a nine-point percentage jump from just four years ago. Employers with 250 to 999 employees reported the largest increase since 2005, with 55 to 71 percent.

"Clearly one reason for the dramatic increase in employers' views about the value of dental benefits is growing awareness of the connection between oral and overall health," said Evelyn F. Ireland, CAE, NADP executive director. "NADP's 2007 Consumer Survey and other published reports show that dental benefits have a positive impact on individuals' attitudes and behaviors regarding both their dental and overall health."

A nonprofit trade association, NADP represents dental PPOs and HMOs, dental indemnity products and discount dental plans.

Employers cite dental health on medical health as the most important reason for considering a change in dental carriers. Employers offering dental benefits should consider a variety of strategies to keep dental in their benefits portfolio. According to the NADP survey:

- 15 percent are likely to transition to voluntary dental benefits (employee-paid)
- 28 percent are likely to increase the premium paid by employees

This study presents the results of a survey of more than 1,900 employers in the United States last July regarding their attitudes and behaviors toward dental benefits. This recent report, which also offers insight into what drives employer loyalty, the features and benefits employers are looking for in a dental plan, the sales channels used by various-sized employer groups, builds on a similar study conducted four years ago of key findings and trends.

The NADP *2008 Group Purchaser Behavior Study* is available online in the NADP Mall with detailed data tables. For more information, contact Jerry Berggren, director of research and information, (972) 458-6998.

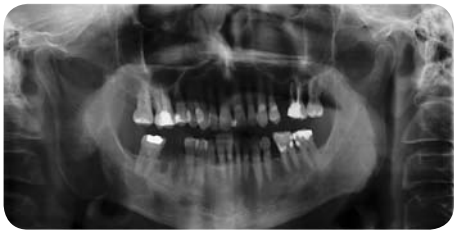
Higher New Bone Regeneration May Be Due to Composite

A factor in dental implant success is in the quality and volume of bone in the recipient and bone regeneration is a well-established solution to the problem of the scarce amount of bone. Recently, a study has found that a composite mix demonstrates complete bone regeneration of critical-size bone defects, according to a study in an issue of the *Journal of Oral Implantology*.

In the article, researchers demonstrated complete bone regeneration of critical-size bone defects using a composite alloplastic graft of beta-tricalcium phosphate (β-TCP) in a calcium sulfate (CS) matrix without a membrane barrier. Tricalcium phosphate, TCP, considered biocompatible and bioactive, is an alloplastic ceramic material showing potential as a bone graft substitute. However, while TCP cements have a slower resorption rate than bone, they are fairly dense. By adding a faster resorbing material, pores may be created, ensuring new bone tissue growing into the defect.

CS may fill that need. The study found that when CS mixed with other bone graft materials, osteogenesis was accelerated. Calcification is increased and the needed quantity of new bone is achieved in a shorter period of time.

To see the full text of the article, go to allenpress.com/pdf/orim35.1_10.1563-2-F1548-1336-35.1.pdf.



Oxford Handbook of Clinical Dentistry, Fourth Edition

The Oxford Handbook of Clinical Dentistry covers clinical dentistry in a concise format. This fourth edition extensively revises cavity classification, diagnosis, resin composites, endodontic, implants, and more. It offers the latest developments in pediatric dentistry and new material on caries risk assessment. New color and text design assist the reader with identifying oral medicine lesions, illustrating pathology and interpreting restorative techniques. The handbook also offers key elements of clinical practice and has been completely updated to include useful Web sites as well as Web-based learning. For more information go to www.researchandmarkets.com.

UPCOMING MEETINGS

2009	
May 14-17	*CDA Presents The Art and Science of Dentistry*, Anaheim, 800-CDA-SMILE (232-7645), cda.org.
Sept. 11-13	*CDA Presents The Art and Science of Dentistry*, San Francisco, 800-CDA-SMILE (232-7645), cda.org.
Sept. 30-Oct.-4	American Dental Association 150th Annual Session, Honolulu, Hawaii, ada.org.
Nov. 8-14	United States Dental Tennis Association fall meeting, Scottsdale, Ariz., dentaltennis.org.
2010	
April 11-17	United States Dental Tennis Association, Amelia Island Plantation, Fla., www.dentaltennis.org.
April 26-28	National Oral Health Conference, St. Louis, Mo., nationaloralhealthconference.com.
May 13-16	*CDA Presents the Art and Science of Dentistry*, Anaheim, 800-CDA-SMILE (232-7645), cda.org.
Sept. 24-26	*CDA Presents the Art and Science of Dentistry*, San Francisco, 800-CDA-SMILE (232-7645), cda.org.
Nov. 7-13	United States Dental Tennis Association, Grand Wailea, Hawaii, www.dentaltennis.org.

To have an event included on this list of nonprofit association continuing education meetings, please send the information to Upcoming Meetings, CDA Journal, 1201 K St., 16th Floor, Sacramento, CA 95814 or fax the information to 916-554-5962.

Clarification

The biography for Fred Fendler, DDS, that appeared on page 259 of the April 2009 issue of the *Journal of the California Dental Association*, should have been "Fred Fendler, DDS, is a full-time assistant professor, Department of Dental Practice, Arthur A. Dugoni School of Dentistry. Prior to his appointment, he maintained a general dentistry practice for 20 years in San Francisco."

CDA JOURNAL, VOL 37, Nº5

The Community Health Center Dental Clinic

BRIAN K. SHUE, DDS

With this issue of the *Journal*, we seek to demystify the community health center dental practice in order to develop the foundation for increased cooperation and collaboration between private practice and health center dental providers. Many of these articles have been written by ADA and CDA member dentists who are long-time employees of community health center dental programs. We hope that the information shared from this issue will lead to positive outcomes for patients and the profession.

GUEST EDITOR

Brian K. Shue, DDS, is the dental director at Clinicas de Salud del Pueblo Inc. in Imperial County, Calif., and an associate editor for the *Journal of the California Dental Association*.

So what exactly is a health center? You probably drive by one on the way to work or you know a dentist who works for one. What does this dentist do that is different than what you do? And how exactly does a community health center provide dental care?

A community health center, CHC, is one type of a "safety net" clinic. The California Primary Care Association defines safety net clinics as the not-for-profit CHCs, county health departments, public hospitals, and other health care providers who share a common mission to provide care without regard of the patient's ability to pay.[1]

According to The Health Resources and Services Administration, HRSA, of the U.S. Department of Health and Human Services, the types of health centers include grant-supported federally qualified health centers, FQHCs, FQHC look-alikes, outpatient health programs/facilities operated by tribal organizations, hospital-based, dental school, community public health department, or others.[2]

The term "community health center" has been replaced with the more appropriate (and legal) term "health center," although the care provided at both is the same. You will find the authors of the articles in this *Journal* issue use the two terms interchangeably.

This issue brings together the many facets of providing dental care in the community health center environment, with most emphasis on

the federally qualified health center.

A community health center dental clinic in appearance is no different than a private practice. You will find all the comforts in a CHC as you would find in private dental office; from basic things like issues of *Highlights* and other magazines in the waiting room, to the latest composite materials and light curing units in the operatories. In fact, CHCs are audited and evaluated in quality assurance, patient safety, and patient care outcomes by federal, state, and local entities more frequently and consistently than private practices. Dr. Huong Le and I, both dental directors of FQHCs, discuss the basics of how dental care is provided.

A common misunderstanding about health centers is the federal government pays all the expenses of a health center through grants indirectly from the taxpayer. This is not so. In fact, Section 330 grants provide funding that is typically a small percentage of the total cost of the operations of a health center. Employees of a health center do not work for the federal government. In this issue, Dr. Irene Hilton, clinical dentist at two FQHCs, examines the finances and funding of the CHC dental clinic.

How does a health center manage its patient care with challenges not seen in the private sector? A patient in pain from a broken tooth or a tooth infection will go to a health center and receive treatment to relieve pain and suffering without having to pay a dime. This isn't possible nor expected of the dentist in the private dental office, but it is expected of the health center. Dr. Bob Russell, dental director at the Iowa Department of Public Health, presents the changing environment of managing the health center dental practice.

Dr. Jane Grover, immediate past first vice-president of the American Dental Association and current ADA consultant on health centers, examines the challenges a community health clinic and dental director overcome in managing a health center dental clinic, sometimes in between patient care.

A special mention goes to Colleen Lampron, executive director of National Network for Oral Health Access, for her tremendous help in making this issue happen, and for all the authors of this *Journal* issue, who authenticated all of our articles.

Health centers have an inherent mission to provide care to all, regardless of the barriers to health care that exist. It is reassuring to see this mission accomplished, one patient at a time. ■■■■

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CDA JOURNAL, VOL 37, Nº5

The Framework for Patient Care at California Community Health Center Dental Clinics

BRIAN K. SHUE, DDS, AND HUONG LE, DDS

ABSTRACT Community health centers in the United States improve access to dental care for underserved populations and individuals who live in underserved areas. The not-for- profit health centers provide care to patients regardless of their ability to pay and must follow extensive federal and state regulations. There are 245 California health center sites that provide dental care. This article reviews the framework for patient care at the California community health center dental clinic.

AUTHORS

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Huong Le, DDS, is the dental director at Asian Health Services Community Health Center in Oakland.

For more than 40 years, community health centers in the United States have provided comprehensive health care to underserved populations and patients in underserved areas regardless of their ability to pay.

Authorizing legislation has officially changed the term "community health center" to the accepted term "health center."[1] The Health Resources and Services Administration, HRSA, of the U.S. Department of Health and Human Services recognizes the health center (HC) as an all-encompassing designation that includes the following: federally qualified health centers, FQHC, FQHC look-alikes, outpatient health program/facility operated by tribal organizations, hospital-based or dental school-based programs, community public health departments or others[2] (**TABLE 1**).

All of these listed entities are known as "safety net providers" because they provide health care to underserved patients regardless of their ability to pay.

FQHCs are not-for-profit organizations that receive grant funding under the Health Care Program, Section 330 of the Public Health Service Act.[3] FQHCs are community health centers, migrant health centers, health care for the homeless programs and public housing primary care programs.[2]

HRSA states that health centers provide services to the medically underserved or to a special medically underserved group of migrant and seasonal agricultural workers, the homeless, and residents of public housing.[3] The California Primary Care Association describes additional users of health centers as those with language or cultural barriers, those with fear of repercussions on immigration status, and those who are

TABLE 1

Glossary of Key Terms

CHC	Community health center, also now simply referred by federal regulations as "health center."
Health Center	All-encompassing term. Means an "entity that serves a population that is medically underserved, or a special medically underserved population comprised of migratory and seasonal agricultural workers, the homeless, and residents of public housing, by providing, either through the staff and supporting resources of the center or through contracts or cooperative arrangements" — HRSA. A health center can have any of the following in its organizational system: community health center, migrant health center, health care for the homeless, school-based, or public housing primary care.
Safety Net Provider	All community health centers, local county health departments, public hospitals and other health care providers who provide health services to the underserved populations, regardless of their ability to pay.
FQHC	Federally qualified health center, a not-for-profit health center organization with one or more clinic sites and receives Section 330 federal grant support under the U.S. Public Health Service Act to provide health services to underserved populations. Uses a sliding fee for eligible patients. There are 376 FQHC sites in California, as of 2005.
FQHC Look-Alike	A health center that meets all requirements to be a FQHC but does not receive any Section 330 federal grant support. There are 71 FQHC look-alike sites in California, as of 2005.
330	Federally qualified health centers that receive federal grant funding under the Health Center Program, Section 330 of the Public Health Service Act. There are 110 Section 330 grantee organizations in California, as of 2007.
Sliding Fee	FQHCs and FQHC look-alikes provide access to services without regard for a person's ability to pay and provide a sliding fee discount. This discount is based on the patient's ability to pay, using the patient's annual income and family size according to the most recent U.S. Department of Health & Human Services Federal Poverty Guidelines — HRSA.
UDS	Uniform Data System. Federal system tracks a core set of information appropriate for reviewing the operation and performance of health centers, including patient demographics, services provided, staffing, clinical indicators, utilization rates, costs, and revenues. UDS data are collected at the grantee, state, and national levels.
Medi-Cal	California calls its Medicaid program Medi-Cal. It provides health coverage for low-income people and people with disabilities and is funded by federal and state monies.
CMSP	The county medical services program provides health coverage for low-income, indigent adults in 34 primarily rural California counties, managed by the CMSP Governing Board administered by Anthem Blue Cross Life & Health Insurance Company. CMSP is not Medi-Cal.
HPSA	A health professional shortage area is a geographic area, population group, or medical facility that has been designated by the Secretary of the Department of Health and Human Services as having a shortage of health professionals and is assigned a score based on the level of need.

not able to use traditional health services.[4]

HCs in the United States provide comprehensive and culturally competent services to the uninsured and a growing minority population, and are a valuable asset in reducing emergency room admissions, according to the National Association of Community Health Centers.[5] In fact, HCs have been reported to be one of the federal government's most successful programs by the Office of Management and Budget.[6] There are many agencies and support organizations for the HC (TABLE 2).

Residents in California face many challenges (TABLE 3). Because of the increasing cost of health insurance, HCs will continue to be an important model to serve California's uninsured.[7] California has 6.5 million uninsured residents, which is almost one in every five residents, and is 15 percent of the uninsured population in the United States, the largest total of any state.[8]

To meet the needs of the high number

TABLE 2

Agencies and Support Organizations for the HC

HRSA/BPHC — Health Resources and Services Administration
HRSA, an agency of the U.S. Department of Health and Human Services, is the primary federal agency for improving access to health care services for people who are uninsured, isolated, or medically vulnerable. It is made up of six bureaus, including the Bureau of Primary Health Care, BPHC. HRSA provides leadership and financial support to health care providers in every state and U.S. territory. HRSA grantees provide health care to uninsured people, people living with HIV/AIDS, and pregnant women, mothers, and children. They train health professionals and improve systems of care in rural communities. — hrsa.gov and bphc.hrsa.gov. Accessed March 3, 2009.

DHCS — Department of Health Care Services
DHCS is a department within the California Health and Human Services Agency. DHCS' mission is to preserve and improve the health status of all Californians. DHCS works closely with health care professionals, county governments and health plans to provide a health care safety net for California's low-income and persons with disabilities. — dhcs.ca.gov. Accessed March 3, 2009.

CPCA — California Primary Care Association
Membership organization of more than 645 community clinics and health centers, CCHC, sites and regional consortia. CPCA is charged with the mission of strengthening its member CCHCs and networks through advocacy, education, and services in order to improve the health status of their communities. Through its work with member organizations, CPCA accomplishes its mission, vision, and core values by promoting and advocating for equal access to high quality health care for all Californians. — cpca.org. Accessed March 3, 2009.

NACHC — National Association of Community Health Centers
The only national organization dedicated exclusively to expanding health care access for America's medically underserved through the community-based health center model. Works with a network of state health center and primary care organizations to serve health centers in a variety of ways. — nachc.org. Accessed March 3, 2009.

NNOHA — National Network for Oral Health Access
NNOHA is a nationwide network of dental providers who care for patients in migrant, homeless, and community health centers. These providers understand that oral disease can affect a person's speech, appearance, health, and quality of life and that inadequate access to oral health services is a significant problem for low-income individuals. The members of NNOHA are committed to improving the overall health of the country's underserved individuals through increased access to oral health services. The NNOHA Web site is a collection of information, contacts, and resources for current and prospective members. — nnoha.org. Accessed March 3, 2009.

CHCF — California HealthCare Foundation
The California HealthCare Foundation is an independent philanthropy committed to improving the way health care is delivered and financed in California. By promoting innovations in care and broader access to information, our goal is to ensure that all Californians can get the care they need, when they need it, at a price they can afford. — chcf.org. Accessed March 3, 2009.

of uninsured residents, 323 new California HC clinic sites opened their doors from 1995 to 2005, an increase of 68.6 percent, and all California HCs took care of over 3.6 million patients in more than 11 million patient encounter visits in both rural and urban communities in 2005.[4] As of 2007, there are 110 Section 330 FQHC corporations or organizations in California.[9]

The mission of the HCs make them a valuable part of addressing access to dental care.[10] California has 8.5 million poor, elderly, and disabled patients eligible for the state Medicaid dental program, known as the Denti-Cal program.[11] HCs are well-prepared to take care of Denti-Cal patients. However, it is noted that only 26 percent of those eligible for Denti-Cal seek dental care and, furthermore, less than 2 percent of this group receive dental care at California HCs.[12]

HCs that provide direct dental care are able to provide comprehensive services for its patients similar to what is available to patients in the private sector. The latest data shows that out of the 857 total licensed community clinic sites, only 245 California HC sites provide direct dental care, just 29 percent of the sites.[12]

For the purposes of this article, the term CHC will be used as it is the specific type of health center that will be discussed (TABLE 1).

This article will focus on the framework of providing dental care to the underserved at the not-for-profit community health centers in California and will cover the following subjects: licensure and basic services, the CHC dental clinic, administration, dental director, staff dentist, patient care on types of coverage and scope of service, and quality assurance.

Licensure and Basic Services

HCs provide comprehensive health care to many different types of people and areas of need (TABLE 4). The California Department of Public Health, CDPH, defines the community clinic as "a clinic operated by a tax-exempt nonprofit corporation that is supported and maintained in whole or in part by donations, bequests, gifts, grants, government funds or contributions that may be in the

form of money, goods, or services. In a community clinic, any charges to the patient shall be based on the patients ability to pay, utilizing a sliding scale," pursuant to Section 1204 (a)(1)(A) of the Health and Safety (H&S) Code."[13]

A CHC must also satisfy the following requirements set by HRSA: be located in or serve a high-need community, be governed by a community board, provide comprehensive primary health care services as well as support services, provide services to all residents regardless of ability to pay, establish a sliding fee schedule based on income, and meet other performance requirements.[2,5]

All CHCs must also completely follow California code of regulations called Title 22, which provide detailed instructions divided in the following categories: license, basic services, drug distribution, administration, and physical plant.[14]

All applicable laws and regulations of California, including that of the California Dental Board, apply to the private dental office also apply to the CHC. Yet, to ensure the appropriateness of care and the safety of the patient population served, HRSA, Title 22 and other regulations require compliance through routine CHC inspections and audits from the federal, state, and local levels that are not always found in the private sector. This oversight starts with a CDPH licensing and certification officer inspection in order to receive licensure to operate.

For 2008-2009, the CDPH basic licensing fee for a CHC is $600 annually per each site.[15] Other individual licenses are required for the dentist and licensed personnel, just as with a private dental office.

As per Title 22, the CHC must provide written documents available for review on basic services. In order to ensure comprehensive care, general requirements state all patients of record will have diagnostic, therapeutic, radiological, laboratory, and other services provided at the clinic or have a system of referrals to other providers. The clinics must have a licensed professional to supervise the provision of each service, written care policies and reference materials, and proper equipment to provide services.

The basic policies and procedures for a CHC required by Title 22 include the type of clinic and scope of services to be provided to its patients, patient care, education of the patients, plans for follow-up, referrals, handling emergencies, available emergency consultation, nursing procedures if provided, infection control, treatment of minors or those under guardianship, and opportunities for counseling.

If CHCs provide dental services, it falls under the auspices of the medical department. The CHC must have a licensed physician appointed as the professional director, known as the medical director, who is responsible for all services provided. In cases where no medical services are given, then the professional director is the dentist. The medical director oversees policies and standards, quality, protocols, peer review, credentialing and assigning clinical privileges, and ensuring at least one member of the staff has hospital privileges.[14]

TABLE 3

Facts of Life in California

- 794 health center clinic sites *(2005 CPCA data)*
- 110 overall Section 330 grantees — grantee can have one or more component(s)
  - 93 Section 330 grantees with a "CHC component
  - 26 Section 330 grantees with a "Migrant Health Center" component
  - 25 Section 330 grantees with a "Health Care for the Homeless" component
  - 7 Section 330 grantees with a "School-based" component
  - 7 Section 330 grantees with a "Public Housing Primary Care" component — *2007 UDS data*
- 6.5 million are uninsured (1 in 5 Californians)
- 3.6 million patients receive care at HCs with more than 11 million encounters
- Nearly two-thirds of clinic patients (62 percent) have incomes below the federal poverty line; 83 percent live below 200 percent of poverty
- Ranks 47th out of 50 states in total Medi-Cal (Medicaid) spending per beneficiaries and spends the least on beneficiaries among the 10 most populous states
- California health centers still only received $199 (federal dollars) per uninsured patient served, which is significantly less than the national average of $309 per uninsured patient and less than other states with large uninsured populations such as New Mexico ($362) and Texas ($247). California's huge uninsured community continues to make the case for 330 funding increases.

The average total annual cost of care:

- for Medi-Cal patients at HCs: $455
- for Medi-Cal patients at office-based medical providers: $657
- HCs reduced Medicaid spending by 30 percent

- Health centers overall economic impact of more than $3.15 billion in 2005: directly injecting almost $1.6 billion into their local economies and supporting more than 26,500 jobs (13,953 full-time jobs directly and indirectly supporting another 12,254 full-time jobs through their operating expenditures).

Source: California Primary Care Association.

TABLE 4

Patient Profile of the California Health Center

- 70 percent are from ethnic communities
- 49 percent report English as the secondary language
- 35 percent are children under 19 years of age, as of 2004
- About 70 percent of adult women
- 4 percent are seniors

Source: California Primary Care Association.

The CHC Dental Clinic

California regulations establish basic physical requirements for the dental clinic. It requires the clinic to operate in a clean and completely functional environment. The requirements listed in Title 22 do not differ greatly from basic expectations for a private facility or dental office. Thus, there is usually no general difference in appearance and function of a CHC dental clinic compared to any other dental office. For example, proper standard precautions and infection control regulations set by the California Dental Board must be followed in both types of offices.

There are some additional requirements set by Title 22 for patient safety. For example, all autoclaved bags should be marked with expiration dates. Other examples of differences include such basic CHC requirements as having flashlights maintained and ready for use at any time, a minimum requirement that all equipment must be tested and calibrated annually with documentation available, and quarterly bacteriological analysis of water at the clinic to ensure patient safety.

Some CHCs use mobile vans to reach out to their patients: Urban CHCs have utilized mobile clinics to go to school sites to provide the needed medical or dental care, and rural clinics have used mobile vans to deliver care at migrant camps, remote locations or school programs. Dental mobile vans can be completely self-contained with one or two fully functional, albeit smaller, operatories, a waiting area, a restroom for staff and patients, and a sterilizing area. Vans can be a recreational vehicle, platform, or on a trailer bed that needs to be pulled to each location. The California Dental Practice Act now allows mobile dental clinics to be licensed and owned by the CHC instead of the dentist.

Although most of the mobile clinics are limited to school-based Head Start programs, several of these clinics reach out to the special populations such as migrants, homeless, and patients with HIV/AIDS. The mobile clinic operations have proven to be quite challenging and could be a financial drain for health centers. These challenges include the logistics to bringing the van and staff to remote locations, transient patients, need for specialized staffing like the mobile van driver, and the costs of maintenance and repair. Of special concern is the cost of fuel, especially when gasoline had sold at more than $4 per gallon in 2008. Since RVs get less than 5 miles per gallon, it can be quite costly to fill a 75-gallon tank. Additionally, vans equipped with gas-powered generators (or diesel) to run the operatories will steadily draw (or drain) fuel from the tank unless the van is plugged into an electrical grid.

THE CALIFORNIA Dental Practice Act now allows mobile dental clinics to be licensed and owned by the CHC instead of the dentist.

Administration

Title 22 mandates the CHC must have a governing body, known as a board of directors. As the full legal governing body, the board has full responsibility for clinic operations and compliance with regulations. Such duties, as set by HRSA, include holding monthly meetings, approval of the health center's grant application and budget, selection of services to be provided and the health center's hours of operations, and establishment of general policies for the health center.[2]

The volunteer board, which should be at least nine members but no more than 25, is composed both professionals and patients. A key stipulation to make sure the CHC is meeting the needs of the patients it serves is the requirement that more than 50 percent of the board must be patients who actually utilize the services provided by the CHC.[2] Board members customarily have different professions by day; they can be attorneys, farm workers, stay-at-home parents, or community leaders — all of whom share a commitment to leading a not-for-profit organization. They should be "selected for their expertise in community affairs, local government, finance and banking, legal affairs, trade unions, and other commercial and industrial concerns, or social service agencies within the community."[2]

In order to oversee the day-to-day operations of a CHC, Title 22 and HRSA holds the board to be responsible for hiring an administrator or executive director, ED.[2,14] The ED manages the daily functions of the clinic, or clinics if there are multiple sites, and oversees the performance of health care given to the patients with medical and dental directors. The ED and is responsible to lead the CHC and work with the board. The board sets the qualifications needed for the job, sets the parameters, and monitors the

TABLE 5

California Health Center Staffing and Utilization State Summary for California, 2007, From a Total of 110 Grantees

PERSONNEL BY MAJOR SERVICE CATEGORY	Full-Time Employees (a)	Encounters (b)	Patients (c)	FTEs as Percent of Group	FTEs as Percent of Total	Encounters as Percent of Group	Encounters as Percent of Total	Encounters per FTE
Total physicians (all categories)	1,074.03	4,377,273		20.6%	6.7%	63.6%	45.1%	4,076
Nurse practitioners	333.76	1,116,545		6.4%	2.1%	16.2%	11.5%	3,345
Physician assistants	275.57	1,014,778		5.3%	1.7%	14.7%	10.5%	3,682
Certified nurse midwives	50.27	128,357		1.0%	0.3%	1.9%	1.3%	2,553
Total midlevel practitioners	659.60	2,259,680		12.6%	4.1%	32.8%	23.3%	3,426
Nurses	615.99	248,431		11.8%	3.8%	3.6%	2.6%	403
15. Total medical care services (not including physicians)	**5,222.71**	**6,885,384**	**2,023,266**	**100.0%**	**32.3%**	**100.0%**	**70.9%**	**2,930**
Dentists	309.75	988,471		31.1%	1.9%	96.5%	10.2%	3,191
Dental hygienists	29.21	36,031		2.9%	0.2%	3.5%	0.4%	1,234
Dental assistants, aides, and technicians	656.90			66.0%	4.1%			
Total dental services (lines 16 - 18)	**995.86**	**1,024,502**	**362,375**	**100.0%**	**6.2%**	**100.0%**	**10.6%**	**3,022**

Source: HRSA Uniform Data System for California, 2007.

performance of the ED. An ED can have a college degree or postgraduate degree, but a medical degree is not required.

Dental Director

If dental services are provided, the CHC appoints a licensed dentist as the dental director to oversee the dental program under the leadership of the medical director.[14] The typical dental director/dentist performs dental care for the patients in addition to administrative work. In fact, a significant portion of the dental director's time is allocated to provide direct patient care, often 90 percent or more, leaving the remainder of the usual 40-hour workweek devoted to administration duties. The dental director must be efficient in balancing duties. The dental director can often be found in the middle of performing dental services when asked to address an immediate concern of the dental clinic because administration of the clinic must occur every hour the clinic is open, whether it is during administrative time or not.

Typically, the dental director performs all dental scopes of services provided at the clinic. The dental director supervises the staff dentists working at the clinic and ensures all follow policies and regulations for the clinic. Just as with the medical director, the dental director is responsible to maintaining quality of care provided at the CHC.

The dental director's administrative duties are numerous. The responsibilities include overseeing the day-to-day operations of the clinic, monitoring

daily patient flow, reviewing and making budgetary decisions, maintaining clinic compliance with regulations, writing and reviewing office policy manuals, overseeing patient care quality, and management of staff.[12] The dental director can be part of the executive management team responsible for working with the ED for the overall performance and success of the clinic, which requires attendance at various meetings.

Staff Dentist

CHCs typically recruit dentists who are interested in working at the community level with a strong commitment to public service.[12] It is difficult to recruit for CHC dentists in California.[4,12] The No. 1 factor for a dentist to stay employed with a CHC is the desire to take care of the underserved community or an "altruistic motivation."[16] There are 309.8 full-time equivalent dentists working at the 110 Section 330 grantee HCs in California[9] (**TABLE 5**).

The average salary of a dental director is $133,000; the average salary of a staff dentist is $107,000, according to an independent salary survey conducted on 75 primary care dentists in Alaska, Arizona, California, Nevada, and/or the Pacific Territories of the United States in 2007.[17] Another smaller survey in 2008 reported the average staff dentist is paid $52 to $62 per hour, or a full-time average of $118,560 per year.[12] As a frame of reference, the American Dental Association reports the average earnings for a general dentist who owned his/her office is more than $198,000, as of 2005.[12]

The CHCs commonly give significant benefits to full-time employees, such as vacation leave, sick leave, multiple paid holidays, continuing education allowance, professional liability coverage, disability and life insurance, matching benefits to a 403(b) self-funded retirement plan, and full medical, dental, and vision insurance.

One source for finding dentists is by offering the National Health Service Corps, NHSC, loan repayment program. By using Health Professions Shortage Area (HPSA) scores, areas of greater need or underrepresentation can offer medical or dental school loan repayment up to $50,000 based on a minimum two-year employment commitment at the CHC.[18] The loan repayment is above and beyond the staff dentist's salary. More than 78 percent of NHSC clinicians continue to work in underserved communities after their commitment ends.[18]

THE NO. 1 FACTOR
for a dentist to stay employed with a CHC is the desire to take care of the underserved community or an "altruistic motivation."[16]

Other personnel at the CHC dental clinic include a clinic or office manager, dental hygienists, registered or unregistered dental assistants, front desk personnel, and other administrative employees related to processing or billing for services who often oversee billing for both dental and medical services. Few dental hygienists are employed at California's 110 FQHCs, only 29.2 full-time equivalent dental hygienists, compared to 309.8 full-time equivalent dentists. Assistant personnel total 656.9 full-time equivalent employees, or slightly more than two per each full-time dentist[9] (**TABLE 5**).

Patient Care: Possible Types of Coverage

CHC dental clinics provide care to patients who have more complex dental needs, poor compliance, and more medically compromising conditions than those seen at the private practice.[12] The patient population at community clinics sometimes dictate the scope of services provided.[11] Some clinics have a high percentage of Medicaid (Medi-Cal) and some have more patients on a sliding fee scale. Some do not participate in any commercial private insurance plans and there are those who sign up with several.

There are three major types of reimbursement at the dental CHC site:

1. *Medi-Cal Dental Program.* The California Medi-Cal Dental program is different than the Denti-Cal program in private practices. Private practices are required to send treatment authorization requests or preauthorizations to Denti-Cal whereas the HCs are not. The Medi-Cal Dental program for HC dental clinics is administered through Medi-Cal and reimbursement is based on encounters or direct patient visits instead of by procedure. However, HCs must follow the same Denti-Cal treatment guidelines as the private practices and document such rationale for treatment in the patient record, which is audited. It is the responsibility of the dental director to make sure the guidelines are clearly understood and followed by the HC staff.

Each state individually determines the scope of Medicaid dental services for adults since it is a benefit that is not required by the federal government.[19] This is one of the reasons why the adult Medi-Cal dental coverage in California has often been at risk of being eliminated during state budget negotiations in Sacramento.

2. *County Medical Services Program.* The community clinic's relationship

with the county public health department can also have an impact on its capacity. Some California county health departments offer dental services, however, most don't. The counties can refer their eligible patients to the CHCs to receive care through county medical services program, CMSP, a special program for a county's own indigent residents. This program was started in 1983 when the State of California transferred the responsibility of taking care of this group of patients to the counties. CMSP is not a Denti-Cal program but the services provided are often similar, although they can differ per county. The scope of services of CMSP program is decided by a governing board instead of the state's Department of Health Care Services.[20]

3. *Sliding Fee.* HCs are a great opportunity to provide dental care to the lower socioeconomic population because HRSA requires care to be provided regardless of the patient's ability to pay. CHCs offer a sliding discount based on family size and income. This significant discount of UCR fees is given to individuals and families with annual income is at or below the federal poverty guidelines and for those with incomes between 100 percent and 200 percent of poverty.[2]

It should be emphasized that patients do not subjectively tell the HCs their ability to pay, but their documented income level (copies of tax returns) and family size set by standard HC policies will objectively dictate their ability to pay. Patients who seek emergency services and treatment to relieve pain are not turned away if they cannot pay.

HCs also provide services at direct fee-for-service. Private insurance plans make up a small part of the patient population at the CHC.

TABLE 6

California Health Center Data

	1995 data	2005 data	% increase
Number of HC clinic sites	471	794	68.6%
Number of FQHC sites	148	376	154.1%
Number of FQHC look-alike sites	66	71	7.6%
Total patients	2,200,156	3,645,740	65.7%
Total encounters	6,869,492	11,286,312	64.3%

Source: California Office of Statewide Health Planning and Development, compiled by California Primary Care Association.

Patient Care: Scope of Service

The Bureau of Primary Health Care that directly oversees FQHCs under HRSA mandates that preventive and emergency dental care and dental screening for all children are to be made available to all patients if the center has a dental clinic. If the center does not have a dental program on site, the center is required to make arrangements for referrals to a private practice or other clinics through a contractual agreement.[3]

No two CHC dental clinics are alike. Some clinics are so inundated with patients and can only provide emergency care and possibly prevention. Others, with different infrastructure or populations, can provide a wider scope of dental care ranging from prevention, comprehensive services from amalgams, composites, root canal therapy and periodontal procedures to reconstructive services such as crown and bridge, and even implant services and cosmetics. That is why those who have worked in a community clinic say, "If you've seen ONE community health center, you've seen ONE community health center."

The type of treatment and scope of service provided for patients at a community health center dental clinic should not be any different from that of the private sector. CHC patients are encouraged to become regular patients with comprehensive exams and follow-up treatment. The concept of having a "dental/medical home" is the goal of all community clinics. CHC dental clinics provide dental care to all ages. Children under the age of 5 are encouraged and welcome, and often children as young as 1 year old are seen with important anticipatory guidance.

The training and the mix of providers at the centers also dictate the types of care provided. Most CHC dental clinics employ general dentists, who, in order to successfully take care of the patients' needs, must have much experience in providing extractions and root canals.[12] There are a few who are able to recruit specialists to join their staff. These centers, of course, will be able to provide more specialty services to their patients.

The 2000 General Surgeon's Report clearly illustrated the very grim picture of oral health status of the low socioeconomic patient population, which is the core group of patients that community clinics serve.[21] It comes as no surprise to any that the needs of the community often exceed the capacity of the health center.[12] It is not uncommon to see that a new clinic reaches its capacity shortly after it opens. A long wait for an appointment, three months or longer, is not unusual. The familiar saying for those who have worked at CHCs for a long time is that for every new expansion, the clinic

TABLE 7

Former President George W. Bush's First Health Center Initiative, Improvement in California

California's underserved benefited from former President George W. Bush's 2002 multiyear initiative for the Federal Consolidated Health Centers Program under Section 330. For the first five years of the Program in California:

- 79 new health center sites have been established.
- 49 health centers have substantially expanded their capacity to serve more patients.
- Seven health centers have expanded and improved their mental health and substance abuse programs.
- 23 health centers have expanded and improved their dental programs.

Source[4]: California Primary Care Association.

usually outgrows the new site even before it moves in. California's HCs continue to grow in numbers of sites, patients seen, and number of patient visits (TABLE 6).

As some clinic patients may be receiving dental care for the first time in their lives, patient education on prevention is an important aspect of the community clinic operation. The staff of a CHC is trained on providing oral hygiene instruction as well as the etiology of the periodontal disease, its treatment and prevention. As with patients in the private sector, oral disease prevention is often a difficult concept for CHC patients. Due to financial reasons, many may opt for no treatment, a common reality that sometimes frustrates many clinic providers. Every treatment has to be explained to patients very clearly to ensure the patients are making the right, well-informed decisions.

Since most dental clinics are co-located with a medical component, there is usually some integration between dental and medical care of the patients. For example, if a medical component is participating in a health disparities collaborative to improve the health of vulnerable populations, the dental clinic will also participate in the national collaborative and track information on a selected oral health measure.[5] One example is in the diabetes health disparity collaborative.

The HC health care plan or strategic plan usually reflects the aspect of integration of medical and dental care.[19] Pediatric referrals are an example. If it is one of the objectives of the health care plan to refer pediatric patients to the dentist for an examination by age 1, the patients will be more than likely to be seen in dental at an earlier age than if the health care plan does not address oral health care.

An additional integration example of the health care plan is a prenatal program. CHC patients who are pregnant are routinely referred to dental for a periodontal check up and treatment when the staff understands the relationship between periodontal disease and preterm, low birthweight.

Quality Assurance

Regardless of whether the dental services are provided on site or off site, CHCs are required to have a quality assurance program that follows extensive federal requirements on clinical care standards as a way to monitor the quality of care provided to their patients.[6]

Quality assurance starts out at the time of hiring. Providers must go through intensive background and reference checks. This is a very important aspect for CHCs because of the deeming process for Federal Tort Claims Act, FTCA, credentialing, which provides the professional liability for the providers. Most CHCs also purchase additional wraparound malpractice insurance for its dentists, physicians, and other clinical providers. The providers and clinical staffs have to be privileged and credentialed annually to continue practicing at the centers. This process includes, but is not limited to, reviewing dental licenses, DEA licensing, and CPR renewals.

Quality assurance also minimally includes a periodic chart audit system and peer-review process to review the appropriateness of services as well as quality.[2] The audit and peer review as well as the frequency are set by the dental director or the quality assurance/compliance officer of the health center. The audit can also be done by all providers working at the clinics. Some clinics choose to hire an outside consultant, usually someone who is familiar with community health center setting or a local dentist of a dental society who is familiar with the peer-review process. Either way, it is to be a regular part of the clinic operations and a requirement for federal grant application.

In the quality assurance protocol, an improvement or correction plan has to be included, should a deficiency be discovered. A patient satisfaction survey is another tool the clinics use to gauge their progress and performance. All the quality assurance activities and findings are reported to the executive management/leadership team and board of directors.

Finally, all of the health centers are required to go through HRSA performance reviews, done by the Office of Performance Review, OPR. During a performance review, the CHCs have to select an outcome measure that it wants to monitor and report periodically to the OPR.[22] For example, common measures selected for reviews include "treatment completion rate" or "caries rates among pediatric patients." Data collection is a necessary part of the life of a health center to evaluate results in providing care to the underserved.

Conclusion

Health center dental clinics undeniably improve access to care by providing services to patients who do not normally seek dental care in the private sector. The Office of the Surgeon General in 2003 reported, "No one should suffer from oral diseases or conditions that can be effectively prevented and treated. No schoolchild should suffer the stigma of craniofacial birth defects nor be found unable to concentrate because of the pain of untreated oral infections. No rural inhabitant, no homebound adult, no inner city dweller should experience poor oral health because of barriers to access to care and shortages of resources and personnel," according to the National Call to Action to Promote Oral Health.[23]

Yet, even with an increase in access available to Californians in need, a common problem expressed by a recent survey of stated that CHCs still believe they do not have the capacity to meet all the dental needs of this underserved population.[12]

There is good news. Former President George W. Bush made CHCs the centerpiece for his health care plan.[8] Under Bush, with bipartisan support from the Congress, federal funding for CHCs doubled and 1,297 health center clinic sites have been created or expanded over the past eight years in the United States.[24]

California greatly benefited from the Bush's Health Center Initiative (**TABLE 7**). HCs and their support organizations hope this expansion of health centers and dental clinics will continue under President Barack Obama as he and the Congress shape a universal health care proposal. More oral health access expansion grants from HRSA are necessary to continue to provide health centers with funding to improve access to care.

Finally, a board member of the National Network for Oral Health Access, a membership organization of community health center providers, staff and advocates, once said, "We can't afford not to do it right (create a CHC) the first time since we don't have a second chance to do it over" because the waiting list is too long and we can't accommodate the needs. ■■■■

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The Funding of Community Health Center Dental Programs in California

IRENE V. HILTON, DDS, MPH

ABSTRACT The financing of dental services in community health centers, CHCs, is a mystery to most dentists in private practice, and this lack of knowledge has resulted in misconceptions that hamper mutual support. This review seeks to explain and demystify how CHC dental clinics remain financially viable. The mechanisms of financing dental care in CHCs are described including types of revenues received, financing constraints unique to CHCs and how services to indigent patients are funded.

AUTHOR

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Perhaps no aspect of the community health center, CHC, dental practice engenders more questions than financing. There are many myths, assumptions, and opinions about how CHC dental clinics are funded, where their operating income derives from, and how patients are charged for services. There is a common misconception that CHC dental clinics see patients "for free," that CHCs are "in competition" with private practice dentists, and that the clinics somehow have an unfair advantage because "they are funded by the government."

Community Health Center History

To begin to understand CHC dental clinic financing, a brief history is needed. Many of the regulations that govern CHC finances are contained within the federal legislation that created and continues to fund CHCs.

Community health centers were first developed and funded in the mid-60s as part of President Lyndon Johnson's war on poverty.[1,2] Section 330 of the Public Health Service Act consolidated and defined the characteristics of CHCs.[3] From that point onward, CHCs that receive federal funding have also been known by the short hand of "330s"or "330 CHCs" to differentiate them from other nonprofit clinics that may also exist in a given community.

From an initial group of two demonstration sites, the number of CHCs has grown to 1,067 organizations across the United States and its territories, many with multiple clinic locations, providing medical services to 16 million individuals in 2007.[4] Of 1,067 grantee organiza-

tions, 742 (70 percent) also deliver dental services serving 2.8 million individuals.[4]

The federal government has simplified the terminology so that all programs that have received funding in the past (330 CHCs, migrant health centers, health care for the homeless grantees, health services for the residents of public housing grantees, etc.) will be referred to as "health centers," although the term CHC will be used in this article.

Funding Considerations

Two historically codified aspects within the CHC statutes are: 1) A CHC must not deny services to any member of its patient population due to their inability to pay; and 2) the CHC is obligated to offer a sliding fee scale for services to patients with incomes between zero to 200 percent of the federal poverty level, FPL. The 2008 Federal Poverty Level is $10,400 for a single person, therefore 200 percent of the FPL is $20,800.[5]

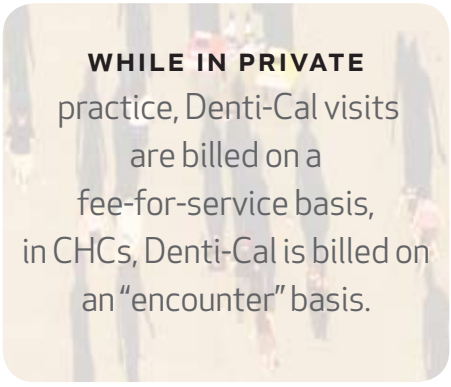
CHCs are nonprofit organizations. However, in the end, the health center as a whole must be financially viable or it would not able to pay employees or procure supplies to deliver care. As a part of the health center, the dental clinic is under the same constraints. Like a private practice, a dental clinic must be self-sustaining over the long term, or it will not survive.

CHC dental program expenditures are the same as in any private practice, including salaries, supplies, utilities, laboratory costs, and capital equipment. Additionally, the dental program may be assigned its proportionate share of administrative overhead for the entire health center.

Revenues

There are a few important differences in the types of revenue received by private practices and CHCs. CHC dental clinics receive traditional reimbursement sources such as third-party payer revenues from insurance plans and patient fees. Unlike private practice, a CHC dental program can/should be assigned revenue that is a percentage of the total health center 330 grant, usually based on the percentage of total health center operating costs that the dental program utilizes. A dental program can also have additional funding sources such as private grants and donations.

Another key difference is that CHCs are reimbursed for Denti-Cal visits in a different manner than in private practice. In California, the Medicaid program is called Medi-Cal for medical services and Denti-Cal for dental services. While in private practice, Denti-Cal visits are billed on a fee-for-service basis, in CHCs, Denti-Cal is billed on an "encounter" basis.



When CHCs were initially developed, services to Medicaid beneficiaries in CHCs were reimbursed in a fee-for-service manner. This was changed in 1989 when Congress created the Federally Qualified Health Center, FQHC, provision of the Medicaid program. Under this provision, CHCs could be reimbursed their average cost of providing a visit as determined by each state Medicaid program.[6] This was called the "cost-based" reimbursement system.

When this change in reimbursement occurred, each CHC had to apply to be designated as an FQHC and to determine the initial per encounter reimbursement rate for the health center. Variables that influenced the individual FQHC reimbursement rate were the cost of providing services in a rural versus urban community, the total scope of services the health center provides and the local variations in the cost of living. FQHC rates could increase yearly based on the federal cost of living adjustments.

In 2001, newer legislation modified the terminology and methodology for determining the per visit reimbursement, now called the "Prospective Payment System," with medical and dental services in California CHCs are still reimbursed on a per encounter basis.

Sliding Scale

Returning to the original purpose of the 330 Public Health Service Act, which was to increase access to health care for individuals with income and/or geographic barriers, what makes health centers unique is that CHCs utilize what in private practice would be considered the "profit," to subsidize the sliding scale for services offered to indigent patients without resources to pay the full fee.

Health center patients without an existing third-party payer source would be routed to the health center's eligibility department, to ascertain if the client might be eligible for some type of third-party payer program. Clients will be assisted in applying for benefits. If a client does not quality for any third-party payer program, then their income level is verified and used to assign their individual/family sliding scale discount. In most health centers, clients can only qualify for a sliding scale discount if their income is between zero and 200

percent of the FPL. Clients above that level pay the regular full fee for services.

The development of the sliding scale fees for dental services is both an art and a science. Although the sliding scale may be described as 100 percent (or full discount), 75 percent, 50 percent and 25 percent based on income, those clients at 100 percent full discount are usually expected to pay a nominal fee that should not impede access but yet contributes to the viability of the dental clinic. Some services such as prosthodontics may never be discounted to a nominal fee even for those at 100 percent sliding scale because these services generate upfront costs for the dental clinic through laboratory charges.

A practical example can illustrate this process. Assume that a private practice and a CHC dental clinic have the same fee schedule and the same 65 percent overhead. If in a private practice the fee for a particular procedure is $100 with an overhead of 65 percent, then the dentist (if reimbursed fully) will have a $35 profit. In a CHC dental practice, an individual with a 100 percent sliding scale discount may be charged $25 for the same procedure. The dental clinic must still subsidize the remaining $40 from some other revenue stream (330 grant, foundation grant, FQHC reimbursements), in order to remain fiscally viable.

The more "profit" a health center dental clinic generates beyond its operating expenses, the more subsidized dental care can be provided to indigent patients. In this way, health center dental clinics fulfill the mandate of the original 330 legislation to create access to dental care for individuals otherwise unable obtain services.

Discussion

With this context, the author would like to revisit the myths, assumptions, and opinions mentioned at the start of this article. CHC dental clinics do not see patients "for free." They cannot deny emergency services because of an individual's ability to pay, which means that occasionally, an individual who receives emergency care may eventually not pay their bill, but is this any different than private practice? Patients in routine comprehensive care are expected to have payment at the time of their visit or they will be billed for services as in private practice.

CHC dental clinics may indeed be "in competition" with private practice dentists in some cases. As in real estate, location is everything. In a rural area, the CHC dental clinic may be the only dental provider in the area and there is no competition. In other locations, the CHC may be the only dental provider in the area that accepts government-sponsored insurance plans like Denti-Cal, Healthy Families, or Healthy Kids. Again, there is no competition for patients covered by those particular plans.

PATIENTS IN ROUTINE comprehensive care are expected to have payment at the time of their visit or they will be billed for services as in private practice.

Certainly, in some areas where private practice providers accept government-sponsored insurance plans, there may be competition between private practices and CHCs. This is rarely the case since CHCs provide less than 2 percent of all Denti-Cal services in California.[7] The vast majority of Denti-Cal visits occur in the dental schools or in private practice. Besides, is there inherently anything wrong with competition in a marketplace? Let the private practice and the CHC compete for Denti-Cal patients based on traditional criteria such as accessibility, office appearance, staff friendliness, and perceived quality of care.

CHC dental clinics could be in competition with private practice for indigent patients, but this is also highly unlikely. As mentioned previously, 200 percent of the 2008 federal poverty level is $20,800.[5] Indigent patients making $20,800 a year or less will most likely not be able to afford full-fee dental care after meeting their basic needs for food and shelter.

Lastly, the idea that clinics somehow have an unfair advantage because "they are funded by the government" is not true. As has been seen, the amount of a health center's total 330 grant allocated to the dental program is not guaranteed and covers only a portion of total expenses. The vast majority of CHC revenues come from patient and third-party reimbursements.[4]

Conclusion

There are some differences in the manner in which CHC dental programs are funded compared to private practice, but ultimately both private and public entities must achieve fiscal balance and viability in order to continue to serve patients.

CHCs and their dental clinics are providing needed health care services to millions of Americans who could not otherwise access care. CHCs provide a unique and valuable opportunity for collaboration and partnership between the private practice sector, which makes up the overwhelming majority of dentists in practice today, and the public nonprofit sector. Examples of collaboration could include accepting referrals to treat certain CHC patients in your practice at

the sliding scale fee or providing services at a CHC dental clinic as a volunteer or employee a few times a month. Find out where the nearest community health center is located and call the dental clinic to ask how you can assist them.

"So let us summon a new spirit of patriotism, of responsibility, where each of us resolves to pitch in and work harder and look after not only ourselves but each other."

PRESIDENT-ELECT BARACK OBAMA
Nov. 4, 2008

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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.

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.

"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 declining 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]

IT SHOULD NOT BE assumed that a health center's federal grant will cover all costs if severe negative cash flow situations arise.

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, scheduled 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.

A HEALTH CENTER dental program must be realistic in terms of resources and ability to meet the needs of their service population.

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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Issues Faced by Community Health Centers

JANE GROVER, DDS, MPH

ABSTRACT Federally qualified health centers face numerous issues with regard to marketplace competition, staffing, and reimbursement streams that assure financial viability. Positioning the dental department of a health center to a high community profile strengthens the health center in professional educational development leading to a pipeline of workforce members, effective dental directors, and innovative fund-raising. A new dental team member developed by the American Dental Association can be utilized in health centers to make all traditional auxiliaries more productive.

AUTHOR

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Dental directors of federally qualified health centers face significant challenges in treating a large population with multiple dental needs and financial restrictions. These issues have no easily known remedies posing rapid resolutions: They are more like dilemmas, having no final solution but requiring some innovative operational strategies.

Professional Relationships and Stature

A major problem reported by dental directors of federally qualified health centers in a recent survey was the feeling of professional isolation.[1] The sharing of clinical success and failure is difficult to address if no time is built into the dental director's schedule to actively partake in the company of other dental practitioners with similar types of patients. It is particularly necessary to do, especially when treating a significantly sized financially disadvantaged population with dramatic disease.

Networking with other dental directors is a most valuable activity. This is the main way to find relief in the knowledge that many oral health program directors face similar issues. Visioning effective strategies to cope with what can feel like a continuous flow of disease is best accomplished with a team approach. Many new dental directors report faster acclimation to their environment by interacting with more seasoned directors. Proactive health center executive directors could realize cost savings in this exercise, as problems, which seem overwhelming to their new dental directors, have been faced and solved by the more experienced ones.

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Many state primary care associations do not formally construct personal networking opportunities for dental directors like they do for medical directors. It is up to the leaders of each state to make this happen, or meet at the National Primary Oral Health Care Conference meeting convened each year by HRSA through the National Network for Oral Health Access.

One major issue facing CHC dental programs, which can escalate the feeling of isolation of the dental director, is the climate of misconceptions that often arise from the private practice dental community, other health providers, or the public in general about the services that are offered to patients.

Oral health programs that begin in a CHC often open their doors without widespread local knowledge in the dental community. Some practitioners may even doubt the need for these services and doubt the levels of unmet need.

As a result, many new programs have local dentists expressing a fear of "losing patients" to the health center from their private practices. They also may hear dental office gossip about the health center and create distress in the dental community about the dental director.

Fear that the health center *could* become a closed panel of providers for the local hospital or a local manufacturing plant, thus putting the private practitioners out of business, can be well managed by using the best sociological tools possible: information and time.

Being a member of the local dental society gives a CHC dental director the opportunity to dispense accurate information. A health center's federal grant requirements, service area, scope of services and populations of focus are examples of what can be delivered on an informal basis monthly at the local constituent meetings.

Formal programs including a PowerPoint presentation given yearly to the local dental society displaying statistics, payer mix, and several photographs added in for those who doubt the existence of rampant decay in any community, send a powerful message, especially during February, which is recognized as Children's Dental Health Month.

Some health centers have had success in linking the local dental provider population by having a prominent local dentist serve on the board of directors of the health center. This person can frequently serve as an ambassador to the dental community. Other centers have had success by developing a dental advisory committee.

BEING A MEMBER of the local dental society gives a CHC dental director the opportunity to dispense accurate information.

Hosting the local dental hygiene society at the health center dental clinic for one of their official monthly meetings is another tactic to combat local misinformation. Providing updates on current activities helps spread the mission/vision of the center. Most attendees will be excited to go back to their offices to transmit this information to the dentists they work with. Many health centers develop an impressive volunteer force from this simple strategy.

Dental directors who write a yearly update for the local newspaper raise the community profile of their programs by informing the whole community of what the dental clinic achieved during the previous year. Providing data on the number of patients seen, the most utilized services, and how the local physicians can assist with medically integrated care for dental patients establishes the health center as a hub for community care.

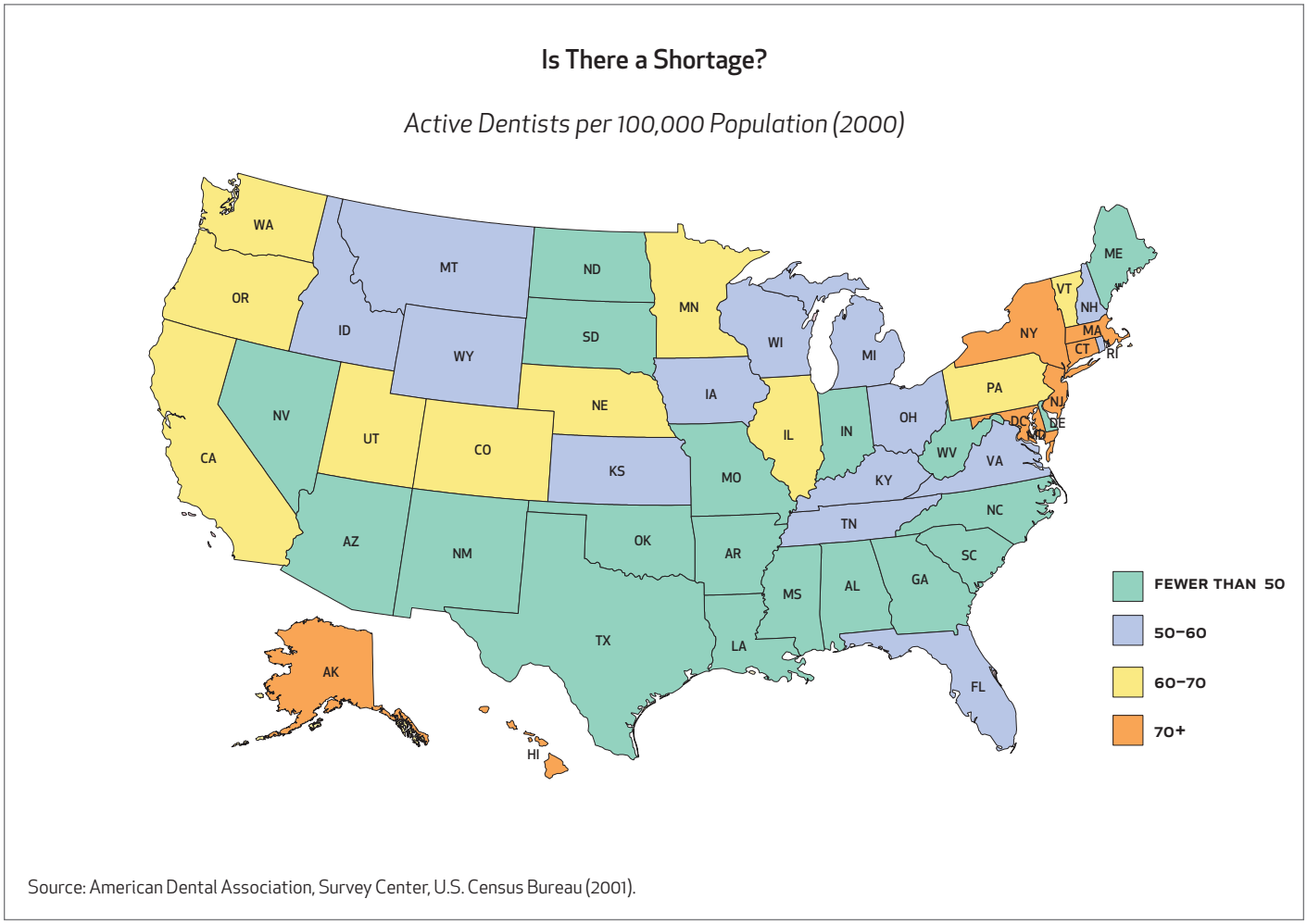
Multiple layers of public relations information lead to professional transparency and the building of pride in the dental department. This usually leads to a climate of trust and support by a collateral community that may have been very skeptical of the health center dental program in the beginning stages.

Dental directors would be wise to utilize all forms of media in educating the community. Walking into the studio of the local disc jockey who does a daily live talk radio show gives the valuable opportunity to update the listening audience on the latest dental information, from the oral health-systemic health connection to the important first oral exam for establishing the dental home. Local television stations, anxious to increase viewer ratings with health information, are also good opportunities for dental directors to highlight their health centers and programs.

Another point to remember in local talk radio: Legislators have staff whose job descriptions entail listening to these types of shows and reporting what they heard. This becomes an efficient way for health centers to promote their activities to legislators (**FIGURE 1**).

Workforce

Perhaps no other issue that a health center faces is more critical than workforce. Oral health professionals must continually look over their shoulders to hear footsteps of who will come



Source: American Dental Association, Survey Center, U.S. Census Bureau (2001).

FIGURE 1.

after the current workforce retires.

Having a high community profile is one key to attracting personnel. Statistics tell us that only 2 percent of the nation's dentists work in health centers. If the number of health centers is to double in the next 10 years, as some predict, from where will the dental staff come?

Having dental residents and students from local dental schools is a valuable way to achieve a pipeline of dentists. Part of dental education in the future has to involve health centers, which can provide experience, loan forgiveness, and a keen perspective on public health. The dental school A.T. Still in Arizona certainly personifies this. More dental schools are set to open within the next two years and many current schools have outreach programs as part of the undergraduate curriculum.

The actual number of practicing dentists is supported by data, but that data does not tell us which dentists treat patients 40 hours per week, or 20 hours per week. Whether or not there is a shortage of dentists remains a hotly contested topic of debate. The primary focus should be on health centers to recruit and retain dentists with adequate salary packages, perhaps to the level that physicians working at health centers receive at present. Health centers in rural areas are particularly vulnerable to workforce demands and should actively recruit dentists, or contract with local private practitioners to provide care (**FIGURES 2 AND 3**).

Strategies to eliminate decay and reduce oral health disparities must involve a team, not just more dentists. This is one reason that the ADA has designed a new member: the community dental health coordinator.

The ADA House of Delegates has continued to support the CDHC, both in funding and curriculum development, by a vote of more than 80 percent. Sites have been selected to pilot this program and the value of this new team member cannot be overemphasized.

With a one-year term of classroom training and on-job rotations through community health center dental departments, the CDHC will do some tasks

that dental staff currently struggle to perform. Coordination of care, navigation of care, and community education are just a few of the duties of the CDHC. Some executive directors are ready to hire them now and the pilot programs have not even been completed yet.

Some believe that dental assistants can do these functions. The majority of assistants, however, are needed to perform their expanded functions and assist chairside. Sending dental assistants to the Women, Infants and Children program in an attempt to educate that agency's staff about the carious process, the county school nurses meeting, the school board meeting and other community meetings to promote oral health does not make the dentists of a health center more productive.

Dental hygienists provide their professional value on hygiene services for the health center: not focusing on broken appointments, screening kids at school health fairs, and scheduling specialty appointments. Chairside efficiency and productivity are the major incentives for dental hygienists, particularly when preventive services remain the most highly reimbursed of state insurance plans. The CDHC would provide valuable information to the clinical time expectations of the dental hygienist and reduce their professional stress.

The CDHC can help all dental providers be more efficient, reduce no-shows, help link the underserved to continuing care. This culturally competent auxiliary will be similar to the promotoras (community health workers) in California who are so effective at working with families to provide oral health education and promotion.

Funding Challenges

A critical issue for community health centers is funding. Financial strength can give a dental department significant professional leverage and high community profile in treating the underserved.

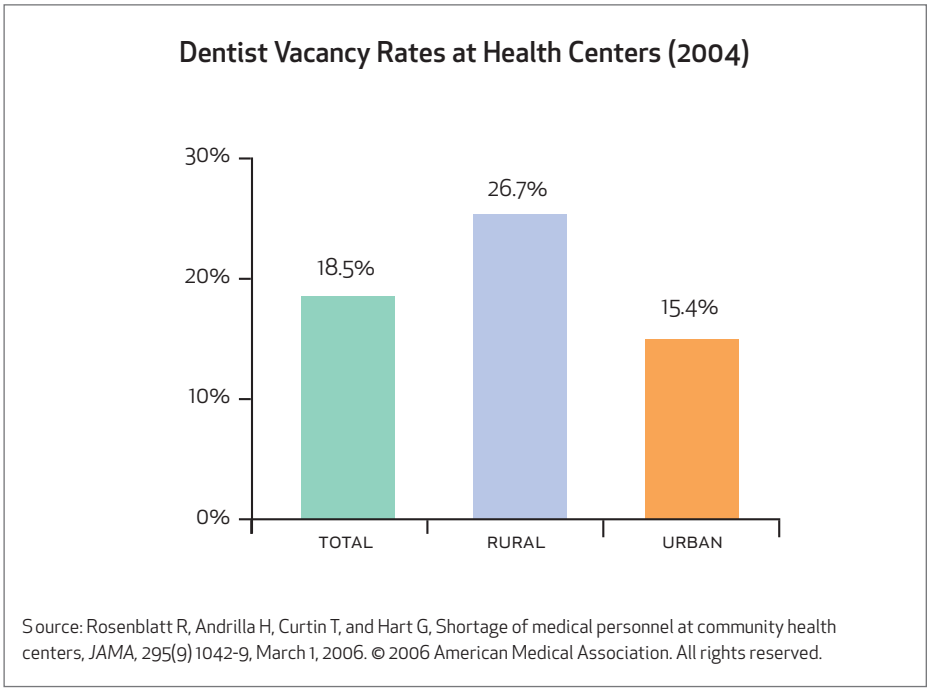
The major source of health care coverage for almost 40 percent of the average FQHC population is Medicaid.[2] Most states report a low participation rate in Medicaid among private practice dentists. As a result, most dental programs in FQHCs depend on Medicaid revenues for financial sustainability. These dental programs in FQHCs also are the only treatment source for the uninsured that can also link these patients to medical services for comprehensive health care.

This uninsured growing segment of the population can place a strain on the financial viability of the health center dental department, which has inherently higher costs of delivering care than the medical side. Equipping and maintaining a dental operatory involves significantly more funding that may be poorly understood by administration. Dental directors must be active as well as creative in partnering with community groups who can provide a financial stream to offset losses, which occur in treating the uninsured in a climate of unpredictable state budgets.

Typically, health center dental departments depend on state Medicaid reimbursement mechanisms, including negotiated "wrap-around" payments to supplement on a quarterly basis what is "written off" as bad debt. Utilizing these cost-based reimbursement monies, along with the annual federal grant helps cover many, but not all, costs.

Every community has influential groups and individuals who are opinion leaders within organizations with expendable resources. Many organizations actively look for worthy projects to support. The opportunities are remarkable, if the right parties are involved.

A logical place to begin is with the service groups. The Rotary, Kiwanis, and Lions clubs are built upon membership, which may include retired dentists, dedicated to serving the community. An invitation to present a program on what dental needs exist in the community often prompts the question, "How much do you need for a new dental chair or mobile dental unit?"



Source: Rosenblatt R, Andrilla H, Curtin T, and Hart G, Shortage of medical personnel at community health centers, *JAMA*, 295(9) 1042-9, March 1, 2006. © 2006 American Medical Association. All rights reserved.

FIGURE 2.

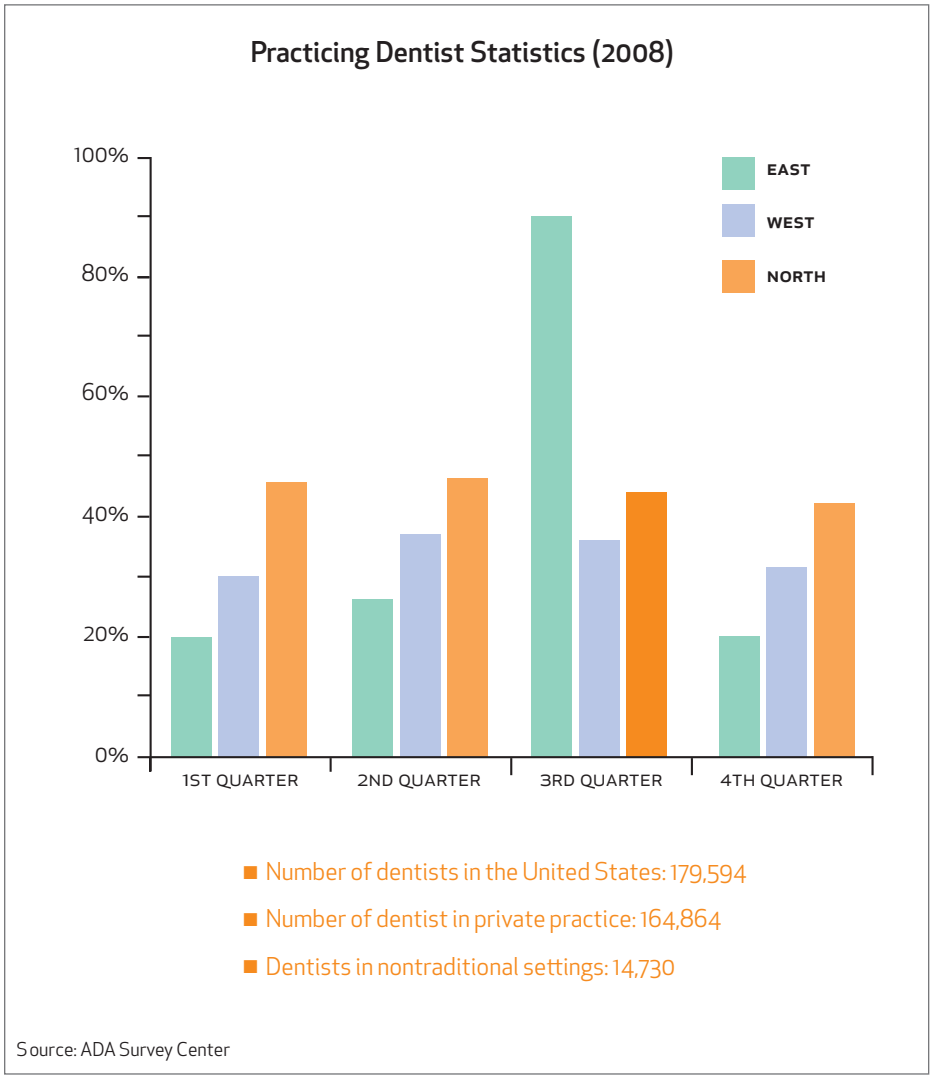


FIGURE 3.

One dental director found herself invited to a prominent social tea where 300 women in attendance wanted to hear about children's oral health in the community. This dentist was pleasantly surprised when they all took out their checkbooks and made a total group contribution of $13,000 to the health center dental clinic.

Financial support must come to health centers in a variety of ways. In this day and age, health centers must be ready to engage any community group, local foundation, or civic-minded philanthropist to supplement revenues. Some health centers having wine tastings, silent auctions, and other creative events to raise awareness and funds for oral health programs. The relationships formed by these events are of permanent benefit to the health center.

Summary

The highlighted issues here are only a few of the ones facing community health centers today. More surveys and studies are needed to identify and prioritize others. The recently passed stimulus package (The American Recovery and Reinvestment Act) from the federal government calls for dramatically increased funding for health centers and the opening of 126 new sites. Becoming familiar with this system of care would be of benefit to all dental providers.

With a positive outlook and community team support, health centers can face their best days ahead. Promoting preventive strategies and reducing disease, enhancing oral health education, and establishing dental homes can enable health centers to cope with these issues and thrive — not just survive. ■■■■

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Picture-Perfect Pearlies

Promoting everything today from panty girdles to milk, teeth are framed with suitably enhanced lips frequently the size of small sofa pillows.

Robert E. Horseman, DDS

ILLUSTRATION BY CHARLIE O. HAYWARD

I have an average practice in an average town, and my patients are — well, arguably the same. I also believe in the Law of Averages or, at least I did until recently, when it finally dawned on me that it had either been repealed or declared unconstitutional at some time when my attention was diverted.

If it were still on the books or enforced, I would have in my patient base at least one person who resembled the young women who grace the monthly pages of *Vogue, Mirabella, Glamour,* et al. These are the publications featuring, in addition to impossibly robo-perfect women, powerful, olfactory-intensive perfumes at $75 bucks a quarter-ounce impregnated in a foldout section of the pages.

In immediate danger of hyperventilating to the point of requiring medical intervention is any testosterone-heavy male who accidentally wanders through these publications because *Field and Stream* isn't available. Should he succumb to curiosity and rub a little of the page on his wrist when he thought nobody was looking, he could only conclude that all the brands smell exactly the same. Only highly trained drug-sniffing dogs or any female over the age of 10 can tell the difference.

Of interest to dentists are the featured women of the magazines who appear to be of an indeterminate age somewhere between puberty and 30. Although not participating in the scratch-and-sniff advertisements, they all have one thing in common: perfect dentition. Whether this is the result of selective breeding, cosmetic augmentation, or an impossibly good orthodontic result, it poses a diagnostic puzzle.

I find it difficult to accept all these teeth erupted into perfect arch forms naturally. Not a single lateral overlaps a central, no bicuspid is grayed-out from multiple-surfaced amalgams. Lower anteriors are in impeccable alignment. ***Who are these people?*** More importantly, who

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DR. BOB, CONTINUED FROM 358

are their dentists? And why, in 65 years, has one of these dental masterpieces never crossed my threshold?

Average, I've got — the diastema-plagued anteriors in shade C4, the rotated centrals in lingual version, the picket fence grins and missing bicuspids. But where are these Lumin B1 ravers who could put a typodont to shame, who have never known the 3 ½ hour sensory loss of a mandibular block or tried to reapply gloss to an infiltrated lip?

Dentists have needs, too. Think what it would do for your morale if one of these gifted ladies waltzed into your daily schedule once in a while. Even if you never made a dime from her visit, the sheer lift would be incalculable. "Mama mia!" you'd exult. "That'sa whatta teeth are all about — I'd almost forgotten."

Promoting everything today from panty girdles to milk, teeth are framed with suitably enhanced lips frequently the size of small sofa pillows. Grateful for all the attention to their profession, dentists are forced to speculate that in spite of the fact at least 10 women's magazines each devote a minimum of six pages every issue to the display of oral perfection, the owners of the smiles will eventually be revealed to be just one woman.

Yes! A busy woman to be sure, flitting from coast to coast like a demented butterfly, changing contact lenses and wigs between photo shoots with practiced skill. It would account for why she's yet to show up in my office and the best I can hope for is showing her likeness in the "After" section of my "Before and After" album.

I hope I never hear a rumor confirmed that those teeth are right out of a Bioform mold guide, even though it might offer a reasonable explanation of why they are so perfect. I don't think I could ever recover if all she ever needed was an adjustment and a little Benzodent dabbed on a sore spot.

Yes, I know the guys in *GQ* magazine exhibit much the same kind of flawless dentition, but the emphasis is more on tonsorial scruffiness and hip apparel appropriate to rich movie stars and homeless people.

In the meanwhile, if anybody has proof that the phantom lady with the perfect teeth is just the product of an Adobe Photoshop high-tech imaging system, I'd like to know so I can stop waiting. ■■■■