Operations Manual
For Health Center Oral Health Programs

Chapter One: Health Center Fundamentals

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Version 1.1

NNOHA
National Network for Oral Health Access

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The mission of the
National Network for Oral Health Access (NNOHA)
is to improve the oral health status of the underserved
through advocacy and support for Health Centers.

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Executive Summary

Health Center Dental Directors, Chief Executive Officers, and other Health Center leaders have a need for operations resources that are specific to the populations they serve and the unique challenges of running a Health Center oral health program. New Health Center Dental Directors are sometimes overwhelmed by a learning curve that includes productivity standards, training issues, program management, Federal Tort Claims Act questions, quality management and other issues specific to serving low-income, vulnerable populations that are unique to Health Centers. The National Network for Oral Health Access (NNOHA) consistently heard from its membership of the need to share information and experiences among Health Center Dental Directors and their teams. This manual strives to share information among Health Center oral health teams so that no one has to 'reinvent the wheel' when it comes to operating strong oral health programs with high quality dental services for underserved populations.

Health Center oral health programs serve a unique need that the private practice dental community generally is unable to meet. Health Center patients typically have more oral disease than their more affluent counterparts. Most private practice dentists are inadequately trained to handle patients who have unique cultural, linguistic or health care needs. In many ways, dedicating a career as a dentist or dental hygienist to serve underserved populations is a calling that requires peer support, specific information and training. NNOHA has been charged with developing the resources to support the unique needs of Health Centers.

In 2008, the National Network for Oral Health Access received a Cooperative Agreement from the Health Resources Services Administration. One of the main objectives of the Agreement is to develop Practice Management resources that meet the specific needs of a Health Center oral health program. This Fundamentals Chapter is the first in an ongoing series of chapters in a "Health Center Oral Health Program Manual." In the future, the manual will include information on Financials, Risk Management, Leadership, Best Practices, Workforce, and Quality Management among other topics.

Oral Health in Health Centers

With more than 40 years of experience, Health Centers have evolved as a primary source of care for America's underserved population. Their success in providing affordable, culturally competent, high quality services is well recognized. They have proven to be a valuable asset in reducing medical inefficiencies, such as overuse of emergency rooms and lowering health care costs. [1]

Health Centers are at the core of a new health care movement to further reduce health care costs by shifting emphasis from treatment to prevention or "total body health." Concepts such as "Health Homes" are developing primary care "gatekeepers" that direct patients with health risks to proper care managers before the risks develop into disease states. Quality systems are being developed that include the patient as a partner in health management.

Research clearly demonstrates that dental must be an integral part of this team. Oral bacteria, which cause local infections can enter the bloodstream and travel throughout the body. Oral pathogens or their antigens have been isolated in blood vessels, arterial plaque and placental tissue. These oral pathogens have been associated with blood proteins, such as C-Reactive Protein, which is a risk factor for heart disease and Tumor Necrosing Factor, which adversely affects insulin efficiency. Although research has not defined the actual level of risk or exact biological mechanism, it is generally accepted that oral disease enhances the risk of heart disease, stroke, and adverse birth outcomes. It is well documented that a relationship exists between diabetes and periodontal disease. The Surgeon-General has recognized that we cannot have total health without oral health.[2]

This poses a perplexing problem for Health Center oral health programs. The population served has an overwhelming disease burden with multiple complex treatment needs, such as extractions, restorations, and replacing missing teeth as well as periodontal infections. Balancing this with the call for initiating oral health by 12 months of age is daunting. Since the only way to reduce the disease burden is through prevention and disease management, Health Center oral health programs must develop meaningful preventive programs. Many oral health programs have targeted the most vulnerable population – children, as well as educating mothers to the transmissibility of oral pathogens and other causative factors. The future is an integrated "dental home" into the health home model with prevention being a primary focus. All Health Center oral health programs are deeply encouraged to seek innovative ways to improve their preventive and disease management efforts.

Many oral health programs have extended their scope of practice to include conscious sedation, implants, hospital dentistry and oral surgery. There has been a significant increase in Dental Residency programs throughout the country and the Health Center is becoming a more attractive venue for providers with post-graduate residency certificates as they can better utilize their skill with a close relationship with the medical team. This expands Health Centers' abilities to expand their scope of practice.

The Health Center oral health team is in a unique position to lead the practice of dentistry into the next dimension. The quality of leadership from Health Center providers and administrators will determine whether this actually occurs.

[1] National Association of Community Health Centers – "Investing in Community Health Centers," http://www.nachc.com/invest-in-chcs.cfm

[2] A list of multiple citations for the research referencing oral health's relationship with overall health can be found on NNOHA's website at http://www.nnoha.org/goopages/pages_downloadgallery/download.php?filename=8584.pdf&orig_name=citations_for_oral_health10_09.pdf&cdpath=/citations_for_oral_health10_09.pdf

October 1, 2009

Some of you are probably new to the Health Center world or possibly new to your career in dentistry, and some of you are skilled Dental Directors that could be looking for some advice. NNOHA's Practice Management Committee is writing this Health Center Oral Health Program Manual with Dental Directors in mind, but we hope it will be a valuable resource for CEOs or Executive Directors looking to expand, Financial Officers looking for more information on what it means to finance an oral health program, dental clinic managers who want to better understand the Health Center world, or other oral health providers looking to enhance their leadership skills. This document is based on available guidelines, research, and the experience of your peers.

Having a leadership role in a Health Center oral health program has the potential to be the most rewarding thing you'll ever do in your career. NNOHA also recognizes that to be successful, there are a lot of questions that you have to address:

- How do I provide quality care with limited resources?
- What makes a Health Center different from private practice?
- What are the federal regulations that guide my program?
- How can I meet the needs of my whole community?

What we have tried to do is cover the most relevant issues for Health Centers – where there are legal requirements or guidelines, we include those references, where there are gray areas, we've tried to give you the recommended best practices from the wealth of Health Center providers and leaders that have gone through this before you. This manual is a developing resource, and we expect that it will continue to evolve and be updated through at least 2011. Please give us feedback on what has helped your program and areas where you still look for guidance.

You are not in this alone. We hope that this manual will be a valuable resource for you in developing your oral health program. The common adage goes, "If you've seen one Health Center, you've seen one Health Center." Here's to making your 'one Health Center' the most efficient, productive and high-quality center it can be.

Sincerely,

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NNOHA Executive Director

Martin Lieberman, DDS
Practice Management Committee Co-Chair

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Health Center Fundamentals

1. Introduction

For more than 40 years, Health Centers in the United States have provided comprehensive health care to medically underserved populations and patients in underserved areas, regardless of their ability to pay. Health Centers are known as a growing source of care for America's underserved population, and they are also venues that provide high-quality, innovative care using the latest in evidence-based research, new technologies and multidisciplinary health care. This section provides the fundamentals for anyone interested in having a successful oral health program. This manual will emphasize that comprehensive health care includes oral health services. One of the goals of this training manual is to remind Health Center staff about the core competencies required to effectively manage an oral health program within a Health Center, consistent with standards and guidelines established by HRSA's Bureau of Primary Health Care, which sets policies for all Health Center programs. Where there are legal requirements or guidelines, references are included. Where there are gray areas, there are recommendations from the available wealth of experienced Health Center providers.

2. Learning Objectives

After reading this chapter, one should be able to:

- Understand the regulations that govern Health Centers;
- Understand how Health Centers fit in a larger system of health care;
- Recognize the importance of oral health as an integral part of primary care; and
- Understand common terms used to reference Health Center oral health programs.

3. History of Health Centers

The 1964 Economic Opportunity Act established the first grant program that supported Community Health Centers (CHCs)[3], a model that combined local community resources with federal funds to reduce health disparities. The Health Center Consolidation Act of 1996 combined authority for various Health Center grant programs, such as Migrant, Healthcare for the Homeless, Public Housing Primary Care, and Community Health Centers, under Section 330 of the Public Health Service Act (PHSA). This act firmly established Health Center programs as an extension of public health grant programs administered by the Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care (BPHC)[4]. Section 330 of the Public Health Service Act will be referenced frequently throughout this document.

Health Centers have grown to serve people in communities that otherwise confront financial, geographic, language, cultural and other barriers. Though Health Centers primarily serve medically underserved populations, anyone can seek health care at a Health Center, regardless of insurance or ability to pay. Health Center oral health programs are an integral part of the Health Center and, must follow the same regulations and requirements as the medical program and the entire Health Center program. Being a part of the key management team as a Dental Director is important to understanding the big picture of the Health Center program as it relates to users, encounters, productivity, medical capacity and sliding fee discounts. Health Center oral health programs have seen a large increase in services in the last 10 years due in part to President Bush's Health Center Initiative in 2002 and more recently to the capital expansion projects supported by President Obama's American Recovery and Reinvestment Act (ARRA) of 2009.

For more about the history of Health Centers, visit http://bphc.hrsa.gov/success/.

Talking Terminology

"Health Center" is the term commonly used to refer to Community Health Centers, migrant and seasonal worker health centers, health centers that treat the homeless, and centers that treat residents of public housing.

"Federally Qualified Health Center" or FQHC is a Medicare/Medicaid/SCHIP term related to reimbursement, which includes Section 330 funded centers, sub-recipients (e.g. sub-grantees) and look-alikes.

Authorizing Section 330 legislation has officially changed the term "Community Health Center" to the accepted term "Health Center" and that is the term used throughout this manual to refer to the above listed types of grant-supported entities.

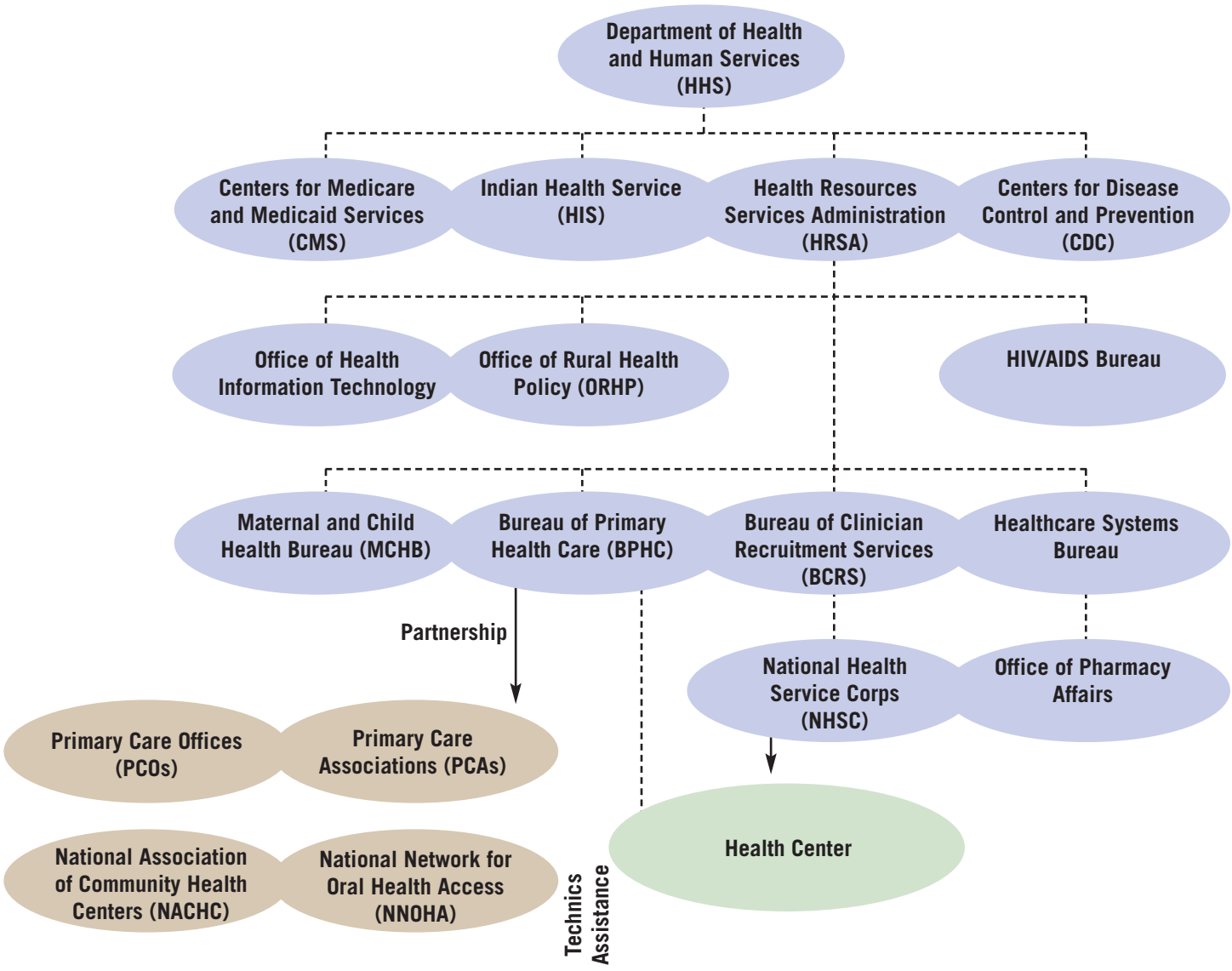
Dental Health vs. Oral Health – NNOHA uses the term "oral health" throughout this manual to encompass health aspects of the mouth beyond dentition. It is important to note that BPHC does not distinguish between oral health and dental health in their writings so both terms may be found interchangeably in linked documents.

[3] The Health Center Program – An Overview: http://bphc.hrsa.gov/success/

[4] The Bureau of Primary Health Care was called the Bureau of Health Care Delivery and Assistance (BHCDA) until 1996, when the Health Care Consolidation Act took effect.

Health Center Environment

Health Centers are part of a larger system of interrelated federal entities designed to improve the overall health of Americans. The following chart is a limited organizational chart to show some of the key players involved in the Health Center world and their influence on oral health programs in Health Centers. Additional entities in the Department of Health and Human Services are not listed here but can be found online at www.hrsa.gov/about/orgchart/default.htm. Descriptions of each of these entities follow the chart.



For more a more detailed flow chart, please visit: http://www.hrsa.gov/about/orgchart/default.htm

DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) — The principal federal agency responsible for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. HHS includes more than 300 programs, covering a wide spectrum of activities. **http://www.hhs.gov/**

HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA) — Agency within HHS charged with increasing access to health care for those who are medically underserved. HRSA's programmatic portfolio includes a range of programs or initiatives designed to increase access to care, improve quality, and safeguard the health and well-being of the nation's most vulnerable populations. **http://hrsa.gov/**

BUREAU OF PRIMARY HEALTH CARE (BPHC) — One of the six Bureaus of HRSA. This bureau works to improve health outcomes, and eliminate health disparities for underserved populations. **http://bphc.hrsa.gov/**

NATIONAL NETWORK FOR ORAL HEALTH ACCESS (NNOHA) — Membership network of Health Center oral health providers committed to improving the oral health status of the underserved. **http://www.nnoha.org/**

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) — A part of the HHS, the CDC conducts and supports public health activities in the United States. The Center's mission is to use collaborative process to create the expertise, information, and tools that people and communities need to protect their health – through health promotion, prevention of disease, injury and disability, and preparedness for new health threats. **http://www.cdc.gov/**

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) — Formerly the Health Care Financing Administration (HCFA), the CMS, administers Medicare, Medicaid, related quality assurance programs, and other programs. It also makes certain that its beneficiaries are aware of the services for which they are eligible, that services are accessible, and that they are provided in an effective manner. **http://www.cms.hhs.gov/**

HEALTHCARE SYSTEMS BUREAU, OFFICE OF PHARMACY AFFAIRS — Bureau under HRSA which administers the 340B Drug Pricing Program, through which certain federally funded grantees (including Health Centers) and other safety-net health care providers may purchase prescription medication at significantly reduced prices. **http://www.hrsa.gov/opa/**

HIV/AIDS BUREAU — One of the six Bureaus of HRSA, it oversees the Ryan White HIV/AIDS Program which provides primary care, support services and antiretroviral drugs for approximately 530,000 low-income people. The program also funds training, technical assistance and demonstration projects designed to slow the spread of the epidemic in high-risk populations. **http://hab.hrsa.gov/**

THE INDIAN HEALTH SERVICE (IHS) — Agency within HHS responsible for providing federal health services to American Indians and Alaska Natives. The IHS provides a comprehensive health service delivery system for approximately 1.9 million American Indians and Alaska Natives who belong to 562 federally recognized tribes in 35 states.[5] **http://www.ihs.gov/**

[5] IHS – Indian Health Service Introduction: http://www.ihs.gov/PublicInfo/PublicAffairs/Welcome_Info/IHSintro.asp.

MATERNAL AND CHILD HEALTH BUREAU (MCHB) — Bureau within HRSA that provides national leadership, in partnership with key stakeholders, to improve the physical and mental health, safety and well-being of the maternal and child health population. This includes women, infants, children, adolescents, and their families, including fathers and children with special health care needs. **http://mchb.hrsa.gov/**

NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS (NACHC) — Primary national, non-profit, professional membership and advocacy organization that represents Health Centers. **http://nachc.org/**

THE NATIONAL HEALTH SERVICE CORPS (NHSC) — Through scholarship and loan repayment programs, NHSC helps Health Professional Shortage Areas (HPSAs) in the U.S. get the medical, dental, and mental health providers they need to meet their desperate need for health care. Approximately 3,800 physicians, dentists and other NHSC primary health care clinicians are currently working in underserved communities nationwide — in small towns in the frontier west and in the most distressed inner-city neighborhoods.[6] **http://nhsc.hrsa.gov/**

OFFICE OF HEALTH INFORMATION TECHNOLOGY (OHIT) — An office of HRSA, the OHIT promotes the adoption and effective use of health information technology (HIT) in the safety net community. **http://www.hrsa.gov/healthit/**

OFFICE OF RURAL HEALTH POLICY (ORHP) — Office within HRSA, works with federal, state and local levels of government and with the private sector, associations, foundations, providers and community leaders – to find solutions to rural health care problems. **http://ruralhealth.hrsa.gov/**

STATE PRIMARY CARE OFFICES (PCOs) — Assist in the coordination of local, state, territorial and federal resources that contribute to improving primary care service delivery and workforce availability in the state or territory to meet the needs of underserved populations. PCOs work with Health Centers, professional organizations, public and private entities and other community-based providers of comprehensive primary care.

STATE/REGIONAL PRIMARY CARE ASSOCIATIONS (PCAs) — Private, non-profit organizations that provide training and technical assistance to Health Centers and other safety-net providers, support the development of Health Centers in their states, and enhance the operations and performance of Health Centers.

[6] HRSA – Fact Sheet: Clinician Recruitment and Service, http://www.hrsa.gov/about/factsheets/bcrs.htm.

4. What is a Health Center?

Health Centers are public or private not-for-profit organizations that provide preventive and primary health care services to populations with limited access to health care. Health Centers are located in all 50 states, in rural and urban areas, and include centers large and small. The defining attributes that make them different from other types of health care providers are: 1) the designation is available only to programs that meet the five requirements of what used to be called Community/Migrant Health Centers (C/MHCs) or Community Health Centers (CHCs), listed below, and 2) Health Centers receive federal grant funds under Section 330 of the Public Health Service Act. There are additional requirements that Health Centers must adhere to, but these five are fundamentals. [7]

The Five Program Fundamentals dictate that all Health Centers must be:

1) **Located in or serve a high need community** (designated Medically Underserved Area or Population).

2) **Governed by a community board** of which 51 percent or more must be Health Center patients who represent the population served. No more than 25% of the board can make more than 10% of their income from health care.

3) **Provide comprehensive primary health care services,** as well as supportive services (education, translation, transportation, etc.) that promote access to health care.

4) **Provide services available to all** with fees adjusted based on ability to pay.

5) **Meet other performance and accountability requirements** regarding administrative, clinical and financial operations.

Because of the increasing cost of health insurance and serious access point shortages, Health Centers will continue to be an important model to serve uninsured and underinsured people. The mission of Health Centers makes them a valuable part of addressing access to oral health care.

5. Other Types of Health Centers

In addition to grant-supported Health Centers receiving funding under Section 330, federal law identifies two other types of Health Centers:

- **Federally Qualified Health Center Look-alikes** are Health Centers that have been identified by HRSA and certified by the Centers for Medicare and Medicaid Services as meeting the definition of "Health Center" under Section 330 of the PHS Act, although they do not receive grant funding under Section 330 or FTCA coverage.
- **Outpatient health programs/facilities operated by tribal organizations** (under the Indian Self-Determination Act, P.L. 96-638) or urban Indian organizations (under the Indian Health Care Improvement Act, P.L. 94-437).

[7] HRSA – What is a Health Center? http://bphc.hrsa.gov/about/

HEALTH CENTER SNAPSHOT

- In 2008, there were 1,087 Health Center Program grantees receiving funding under Section 330 of the Public Health Service Act nationwide.
- In 2008, Health Centers employed **113,000** Full-time Equivalent (FTE) employees.
- Health Centers provided services to approximately **17 million** medical and dental patients in 2008.
- Between 1998 and 2008, the total number of patients at Health Centers increased by **96%.**
- 36% of patients at Health Centers are on Medicaid.
- There were **6.6 million** uninsured patients in 2008 (38% of all patients).

ORAL HEALTH SNAPSHOT

- Nationwide in 2008, Health Centers employed **2,300** (FTE) dentists and **900** dental hygienists.
- More than **850** Health Centers (80%) across the country offered on-site dental services as of 2008.
- In 2008, Health Centers provided dental care to **3.1 million** patients with **7.3 million** visits. During that same year, Health Centers provided medical care to **14.9 million** patients.
- Between 1998 and 2008, the number of dental patients at Health Centers increased by **158%** (from more than 1.2 million in 1998 to 3.1 million in 2008).
- NNOHA estimates that more than **12 million** Health Center patients do not have access to dental services.
- There are an estimated **40 million** Americans without Medical Insurance and an estimated **120 million** without dental insurance.

*2007 and 2008 UDS Data

6. Relevant Regulations

One of the main differences between private practice dentistry and Health Center oral health programs is the requirement to adhere to additional federal regulations. The following are the main regulations related to Health Center oral health program operations. These regulations date back to 1976 and said little about oral health. Most of what is included in the regulations regarding oral health services is not mandated, but is highly encouraged. Requirements under statute and regulation are limited, but they have become key criteria for grant applications. It is important to note that whenever HRSA documents reference 'clinical' services, dental is included without being specifically mentioned. [8] The requirements for oral health services contained in these documents are summarized in a table in the "Scope of Services" section of this chapter.

[8] This statement reflects in-person discussions held by HRSA in developing its Program Expectations. NNOHA supports this interpretation.

a. Authorizing Legislation - Section 330 of the Public Health Service (PHS) Act

http://bphc.hrsa.gov/about/legislation/section330.htm

Section 330 is the main authorizing legislation for Health Centers. This document provides definitions, information on grants, population focus, audits and other general information. The entire text can be found by following the link above.

b. Implementing Regulations

http://law.justia.com/us/cfr/title42.html

42 CFR Part 51c

42 CFR Part 56.201-56.604

42 CFR Part 491 - Medicare regulations

http://law.justia.com/us/cfr/title45/45cfr74_main_02.html

45 CFR Part 74 - Grants administration regulations

c. Migrant Health Program Regulations

http://tinyurl.com/MigrantRegs

These provisions include the requirements specific to Migrant Health Center programs. Follow the link above for the full documentation.

d. Federal Tort Claims Act

http://bphc.hrsa.gov/FTCA/

Under this Act, Health Centers are considered Federal employees and are immune from lawsuits, with the Federal government acting as their primary insurer.

e. Policy Information Notice 2008-01: Defining Scope of Project and Policy for Requesting Changes

http://bphc.hrsa.gov/policy/pin0801/

This document describes policy for an approved scope of project for Health Centers funded under section 330 of the Public Health Service (PHS) Act, the five components of an approved scope of project, and the policy and process for Health Centers seeking prior approval to make changes in the approved scope of project.

f. Policy Information Notice 98-23: Health Center Program Expectations

http://bphc.hrsa.gov/policy/pin9823/default.htm

This document describes expectations of entities funded by the Bureau of Primary Health Care (BPHC) under section 330 of the Public Health Service Act as amended by the Health Centers Consolidation Act of 1996.

g. 1987 Regional Program Guidance

http://tinyurl.com/1987-RPG

This guidance on dental policy was published by HRSA's Bureau of Health Care Delivery and Assistance in March of 1987. An updated guidance is in development.

7. Funding

Health Centers, including oral health programs, receive much of their funding from traditional reimbursement sources, such as third-party payor revenues from insurance plans and patient fees. What makes Health Centers unique is the funding they receive under Section 330 of the Public Health Service Act. Ideally, oral health programs will have a cost center that utilizes Section 330 funds. A Health Center and its oral health program can also have additional funding sources, such as private grants and donations. Health Centers are designed to serve the health care needs of a community – Section 330 funding covers services for all members of the community (or special populations), not just the financially or medically underserved - they are not entitlement programs. More information on the revenue sources, definitions, as well as the benefits of working in a Health Center are included in the Financials chapter of this manual.

8. Federal Tort Claims Act Coverage

The Federal Tort Claims Act (FTCA) is the federal legislation that provides coverage for Health Centers, their employees, and certain contractors against parties claiming to have been injured by negligent actions. FTCA considers Health Center employees to be employees of the United States, subsequently, any claims would be brought against the federal government.

For FTCA coverage, Health Centers must apply to HHS for the coverage and go through a deeming process which focuses on risk management and credentialing. If deemed, FTCA then protects Health Centers, their employees, and certain contractors, but does not provide coverage with respect to claims for malpractice involving services that are out of scope of project, volunteers, or moonlighting employees.

More details on FTCA are included in the "Risk Management" chapter of this manual and at http://bphc.hrsa.gov/FTCA/.

9. 340B Drug Pricing Program

The 340B Drug Pricing Program resulted from enactment of Public Law 102-585, the Veterans Health Care Act of 1992. Section 340B requires drug manufacturers to provide covered outpatient drugs to certain federal grantees, including Health Centers, at reduced prices. Eligible entities must submit a request to participate to the Office of Pharmacy Affairs (OPA) with their Medicaid billing information.

The 340B price defined in the statute is a ceiling price, meaning it is the highest price a covered entity would have to pay for a given outpatient drug. As a result, 340B prices have been found to be roughly 50% of the Average Wholesale Price.[9]

There are some risk management issues associated with the 340B program that oral health programs need to be aware of. 340B drugs are to be sold only to patients whose treatment is within a Health Center's scope of project. Fees for outpatient drugs, including drugs acquired at 340B pricing, should be set at or close to the prevailing rate or

[9] HRSA Pharmacy Services Support Center – What is the 340B Program? http://pssc.aphanet.org/about/whatisthe340b.htm.

charge in the community for the drug. Simply passing on the Health Center's acquisition costs for a drug (plus, presumably, a dispensing or administrative fee) is not consistent with Section 330 requirements in two respects: (1) with regard to the fee structure itself, and (2) insofar as it provides a discount off of locally prevailing rates to patients who are not entitled to a discount, i.e., patients who are insured or are beneficiaries of a health program and uninsured or underinsured patients with annual incomes exceeding 200% of the poverty guidelines. Moreover, this approach fails to maximize a health center's revenue, as required by Section 330 regulations.

As part of the original 340B legislation, the government was also required to establish a Prime Vendor Program (PVP). The program currently provides access to 340B sub-ceiling prices for over 2,800 drug products, access to multiple wholesale distributors at favorable rates, and access to other related value-added products. The PVP is free to all 340B covered entities, but the covered entity must enroll in the PVP.

For more information on requirements and regulations, visit: http://www.hrsa.gov/opa/.

10. Administration

Board of Directors: Health Centers 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 include holding monthly meetings, approval of a Health Center's grant application and budget, selection of services to be provided and hours of operation, and establishment of general policies for the Health Center. The volunteer board composed of professionals and patients must have at least nine members, but no more than 25.[10]

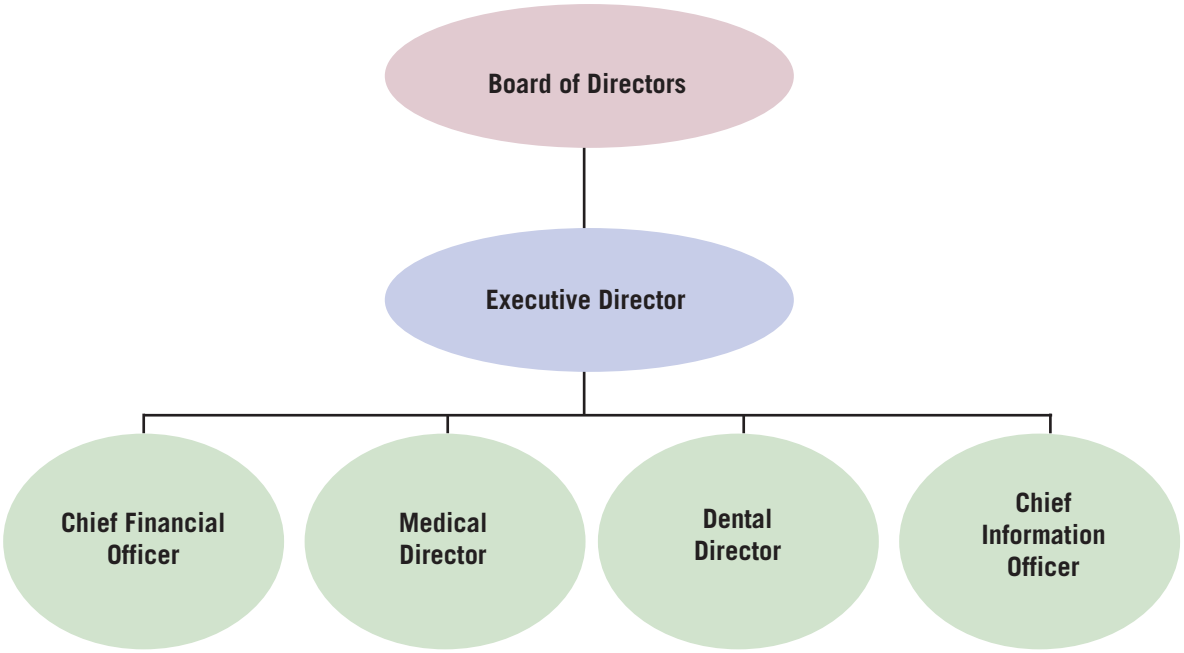
To help ensure the Health Center is meeting the needs of the patients it serves, the majority of the board (51% or more) must be patients who are utilizing its services. Board members customarily have different professions by day. Whether they are attorneys, farm workers, stay-at-home parents or community leaders, they all should share a commitment to leading a not-for-profit organization. Non-consumer Board members 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." [11]

Executive Director: In order to oversee the day-to-day operations of a Health Center, HRSA requires the board to be responsible for hiring an administrator or Executive Director (ED). An ED manages the daily functions of the Health Center and oversees the performance of health care given to the patients with Medical and Dental Directors. The ED is responsible to lead the center and work with the board. The board sets the qualifications needed for the job, sets the parameters, and monitors the performance of the ED. The ED hires and evaluates the rest of the Health Center staff. [12]

Key Management Team: "Health Centers are most effectively managed by a team of individuals with the skills to provide leadership, fiscal management, clinical direction and management information system expertise."[13] In addition to the ED, the team typically consists of a Chief Financial Officer (CFO), Chief Information Officer, Clinical/Medical Director, and a Dental Director, who usually report to the ED. The functions associated with some positions might be combined and performed by the same person.

[10] The Health Center Program: Requirements, http://bphc.hrsa.gov/about/requirements.htm
[11] The Health Center Program: Requirements, http://bphc.hrsa.gov/about/requirements.htm
[12] PIN 98-23 Program Expectations, ftp://ftp.hrsa.gov/bphc/docs/1998pins/PIN98-23.PDF
[13] PIN 98-23 Program Expectations, ftp://ftp.hrsa.gov/bphc/docs/1998pins/PIN98-23.PDF

Sample Structure of a Health Center



Although other scenarios have been successful for different programs, NNOHA's general recommendation is to have the Dental Director report to the Executive Director to assure a voice at the decision making table.

11. Health Center Staffing

Health Centers' staffing patterns will depend on the mix of services they offer. Many Health Centers benefit from an interdisciplinary team of providers. Types of providers employed by Health Centers include, but are not limited to: Physicians, Nurse Practitioners, Physician Assistants, Nurses, Midwives, Dentists, Dental Hygienists, Psychiatrists, Case Workers, and Outreach Workers.

All Health Centers are expected to maintain a core staff of primary care providers with training and experience appropriate to the culture and identified needs of the community. It is preferable that the Health Center directly employs the core clinical staff, or at least the majority of the providers. Health Centers should also hire culturally and linguistically competent staff, according to the needs of the community they serve.

Current program guidance dictates the following: "Applicants are also expected to demonstrate that the proposal will address the major health care needs of the target population and will ensure the availability and accessibility of essential primary and preventive health services, including oral health, mental health and substance abuse services, to all individuals in the service area." [14]

The Bureau of Primary Health Care, which directly funds Health Centers under HRSA, requires that any Health Center with an oral health program provide preventive and emergency dental care and screening for all children.

[14] Health Center Program – Program Guidance, Fiscal Year 2010: https://grants.hrsa.gov/webexternal/DisplayAttachment.asp?ID=47D66540-4F91-4D5F-B226-5ECCC613AD99

If the Health Center does not have an oral health program on site, it is required to make arrangements for referrals to a private practice or other clinics through a contractual agreement.[15]

The training and the mix of providers at the Health Center can also influence the types of care provided. Most Health Center oral health programs employ general dentists, who, in order to successfully take care of their patients' needs, must have experience or develop competency in all aspects of general dentistry, including pediatric and geriatric care, oral surgery, and endodontics. Some Health Centers are able to recruit specialists, which allow them to provide more specialty services to their patients. (More information on this topic can be found in a successive chapter on hospital-based pediatrics as one example). Demand for oral health services typically far exceeds a Health Center's capacity to provide care. It is not uncommon to see a new clinic reach its capacity shortly after it opens. A wait of three months or longer for an appointment is not unusual, even though the number of Health Centers with oral health programs continue to grow.

Because some Health Center patients may be receiving dental care for the first time in their lives, patient education on disease prevention is extremely important. The staff must be skilled in explaining the etiology, treatment and prevention of common oral diseases and providing the patients with tools to encourage self-management of disease.

12. Licensure, Credentialing and Privileging

A Health Center's oral health professionals must be licensed in accordance with applicable statutes and/or licensing regulations for each state. Professional staff must maintain necessary, professional certification and licensure, which may vary depending on the state where their Health Center is located. Dental providers at Health Centers are no different from private practitioners in that they must abide by the same licensing requirements dictated by each state. A list of links to individual state practice acts can be found on NNOHA's Website at: http://tinyurl.com/StPracticeActs. The American Dental Association also has a link to its national registry for state regulations that apply to dentists who were trained outside of the United States: http://www.ada.org/prof/prac/licensure/index.asp.

HRSA PIN 01-16 (http://bphc.hrsa.gov/policy/pin0116.htm) coordinates policies on credentialing and privileging. Credentialing is the process of assessing and confirming the qualifications of a health care practitioner. HRSA requires that all Health Centers assess the credentials of each licensed or certified provider to determine if they meet Health Center standards. Privileging is the process that health care organizations employ to authorize practitioners to provide specific services to their patients.[16] A Health Center must verify that its providers possess the requisite skills and expertise to manage and treat patients and to perform the medical procedures that are required to provide the authorized services.

To ensure the appropriateness of care and the safety of the patient population served, HRSA, other regulators, and accrediting bodies conduct inspections, audits, and other reviews of Health Centers that are not always found in the private sector. This oversight may start with a state-specific licensing of the facility and the individual providers.

Assuring that care providers have the proper credentials and licensure is a direct responsibility of the Health Center Board of Directors. Generally, the Executive Director develops policies and procedures for credentialing all staff

[15] PIN 98-23 Program Expectations, ftp://ftp.hrsa.gov/bphc/docs/1998pins/PIN98-23.PDF

[16] PIN 01-16 Credentialing and Privileging of Health Center Practitioners, http://bphc.hrsa.gov/policy/pin0116.htm

providers, which are then approved by the Board. All providers must have graduated from an accredited educational institution or met requirements that recognize graduates from a foreign educational institution. Graduation must be verified through copies of diplomas and institutional documents. It is also imperative to obtain professional letters of recommendation from colleagues, professors or previous institutions of employment. Most Health Centers require three professional recommendations.

Health Center oral health programs must also comply with State Licensure regulations. Before dentists are allowed to treat patients, they must pass a state or regional examination and be properly credentialed and licensed through a State Dental Board of Examiners. Some states will recognize licensure from other states. Most state Medicaid programs also require a registration process that includes obtaining a provider number. In addition, a Controlled Substance Registration Certificate is needed and many Medicaid programs will not issue a provider number until the provider obtains a Controlled Substance Certificate. If a provider begins work before obtaining the Controlled Substance Certificate, Medicaid may refuse to pay for any services rendered by the provider until after approval. Sample Human Resources forms and checklists can be found on NNOHA's website at http://www.nnoha.org/dentallibrary.html.

Almost all states require a minimum number of Continuing Education (CE) credits annually. CE is necessary to maintain an ongoing level of competency and is critical to quality of services. Providers generally are on the honor system, but are required to maintain copies of course credits. These are checked through random audits by the State Board of Dental Examiners. The number of credits varies among states; therefore, it is necessary to check state requirements.

13. Patient Population

Health Centers are designed to serve the community. Some examples of the populations Health Centers serve are: Medically underserved and low income people, migrant and seasonal agricultural workers and their families, homeless adults, families and children, and residents of public housing; however, Health Centers are available to everyone in the community regardless of personal resources or lack of resources. Health Center patients generally have more rampant disease, fewer resources, and greater barriers to getting the care they need, such as transportation, language, and child care. Health Center patients should receive care that is at least as good as that in private practice and follows the latest evidence for the best health outcomes.

"We have to be better dentists, because our patients can least afford any mistakes."

Janet Bozzone, DMD, FAGD, MPH, Director of Dentistry at Open Door Family Medical Centers in New York

14. Developing Cultural Competency

Cultural competency is developed by acquiring and integrating knowledge, awareness and skills about cultures and their differences. This will enable health care professionals to provide optimal care to patients of various racial, ethnic and cultural backgrounds.[17]

Culture is the integration of patterns of human behavior that include language, thoughts, communications, actions, customs, beliefs, values and institutions of different racial, ethnic, religious and social groups. The easiest way for Health Centers to obtain cultural background data is by participating in community stakeholder coalitions to obtain community survey data. Health Centers should assess the communities they serve by conducting regular target population surveys.

Health Centers should seek to engage and become part of community organizations representing cultural, racial and ethnic groups in order to regularly evaluate the various groups that make up the target population. This information should be stored in a database and updated and shared with staff regularly. Clinical and educational materials should be developed with cultural relevance for the target community. Cultural characteristics are dynamic and subject to change. Information on cultures should be specific to the target community, not limited to generalizations from broad-based national data. This level of sensitivity can only be obtained through community-based stakeholders directly associated with the target population. Regular sensitivity surveys of providers and staff should be conducted to determine areas of weakness that may need improvement.

15. Community Health Needs Assessment

Each Health Center must conduct a needs assessment of their community.[18] This assessment will be used to justify project plans, prevention and treatment needs, service mix, organization of care, and staffing requirements. The recommended elements of an oral health program needs/demand assessment include:

1. Estimated number of users, specifying the 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 need.
3. Predominant characteristics of service population, such as race, sex, age, ethnicity, primary language, income, etc.
4. Oral health status, prevention, and treatment needs of the population. If this data is unavailable, Health Centers should conduct a small scale assessment of the oral health status of community members.
5. Barriers to access/availability to comprehensive oral health care services.
6. Description of needs and treatment of special populations, such as people living with HIV, the homeless or migrants.

[17] Cultural Competence in Cancer Care: A Health Care Professional Passport, HRSA Office of Minority Affairs, Rockville Maryland

[18] http://bphc.hrsa.gov/policy/pin9823/default.htm

Health Centers use this assessment to develop a primary oral health care plan that addresses those needs listed in the assessment. This needs assessment also identifies resources and providers in the community to provide necessary services. 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 programs, projected revenue, other resources and grant support.

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 the collaboration and linkages with dentists, dental schools, dental societies and other health care providers in the community.

16. Patient Care: Scope of Service

A. Required Services

Section 330 of the Public Health Service Act (Section 330) requires Health Centers to provide "required primary health services" to all residents of the area served by the center. (Section 330 legislation can be referenced at http://bphc.hrsa.gov/about/legislation/section330.htm) See 42 U.S.C. § 254b(a)(1). Primary health services are defined in the statute to include "dental screenings for children" and "preventive dental services." See 42 U.S.C. § 254 (b)(1)(A)(i)(III) (ff) & (hh). The Section 330 statute, itself, does not define the scope of "preventive dental services." However, the implementing regulations define "preventive dental services" to include

services provided by a licensed dentist or other qualified personnel, including (i) oral hygiene instruction; (ii) oral prophylaxis, as necessary; and (iii) topical application of fluorides, and the prescription of fluorides for systematic use when not available in the community water supply.

See 42 C.F.R. § 51c.102(h)(6). In addition, BPHC Program Expectations express BPHC's expectations that Health Centers will provide emergency dental services as well as preventive dental services listed in the statute and regulations. See BPHC Policy Information Notice (PIN) #98-23, Section II.B.1.a, at p.13. (PIN 98-23 can be viewed at http://bphc.hrsa.gov/policy/pin9823/default.htm).

If the Health Center does not directly provide required oral health services, it is required to make these minimal services accessible through referral or other contractual arrangements with other community dental providers. See BPHC Policy Information Notice (PIN) #98-23, Section II.B.1.a, at p.13.

B. Additional / Recommended Services

In addition, Health Centers can obtain approval from the Department of Health and Human Services (HHS) to provide "supplemental health services," which can include "dental services other than those provided as primary health services," within their Scope of Project See 42 C.F.R. § 51c.102(j)(6).[19] However, in order to include additional services as part of its Scope of Project (which is a pre-requisite to accessing the related reimbursement and other benefits for such services), the Health Center is obligated to offer such care to all residents of its service

[19] A fundamental concept impacting Health Center operations is its federally-approved "Scope of Project." As explained in the Health Center Fundamentals chapter, "scope of project" involves five key elements: (1) service delivery sites/locations; (2) scope of services provided; (3) service providers; (4) geographic service area; and (5) target population served. With respect to (2), the scope of dental services made available to Health Center patients are formally set by the Health Center's Board of Directors and must meet the minimum statutory and regulatory standards and should relate back to the Health Center's community needs assessment. The inclusion of the Health Center's oral health services in its Scope of Project is a prerequisite to accessing unique FQHC benefits (e.g., cost-related Medicare, Medicaid, and S-CHIP reimbursement, FTCA, 340B drug discount program) available to the Health Center with respect to such oral health services.

area, including those persons who are publicly or privately insured and those who are uninsured, regardless of ability to pay or payor source, and subject to Section 330 discount and sliding fee schedule requirements. As is the case with the required services described above, any supplemental services brought into the Health Center's Scope of Project that cannot be provided directly by the Health Center must be made accessible through referral or other contractual arrangements with other community dental providers. See BPHC Policy Information Notice (PIN) #98-23, Section II.B.1.a, at p.13. The inclusion of additional services in a Health Center's Scope of Project is necessary to access reimbursement, FTCA coverage and other FQHC benefits for the provision of such services.

NNOHA encourages all Health Centers to provide comprehensive oral health services that improve the health of the community, whether or not required by Section 330, regulations or agency guidance, and wants to emphasize the flexibility (as additional or supplemental services) that the law affords each Health Center in determining its appropriate scope. The type of treatment and scope of service provided by a Health Center's oral health program should be no different from services provided by the private sector. Health Center patients are encouraged to become regular patients who have comprehensive exams and follow-up treatment. The concept of having a "health home" is the recommendation for all community oral health programs.

Primary oral health care is personal oral health care, delivered in the context of family, culture and community including a range of services that meet all but the most specialized oral health needs of the individuals and families being served. Primary oral health care integrates those services that promote and preserve oral health; prevent oral disease, injury and dysfunction; and provide a regular source of care for acute and chronic oral diseases and disabilities.

The primary oral health care provider incorporates community needs, risks, strengths, resources and cultures into clinical practice. The primary oral health care provider shares with the primary care team an ongoing responsibility for oral health care.

This table represents the levels of service which BPHC and NNOHA have agreed best describes the prioritization of oral health clinical services.

ORAL HEALTH CLINICAL SERVICES

Phase 1 = Prevention, maintenance and/or elimination of oral pathology that results from dental caries or periodontal disease. This includes: oral cancer prevention and early diagnosis; prevention education and services; emergency treatment; diagnostic services and treatment planning; restorative treatment; basic periodontal therapy (non surgical); basic oral surgery that includes simple extractions and biopsy; non-surgical endodontic therapy; and space maintenance and tooth eruption guidance for transitional dentition. Phase I includes the various levels of services described below:

- **Level I - Emergency Dental Services** include diagnosis and treatment of acute episode of pain, infection, swelling, hemorrhage or trauma. Keep in mind, if a center does not have the ability to offer Level I and II services on site, they must be available through contractual arrangements with other providers (for programs developed since 1998).[20]

- **Level II - Preventive Dental Care and Diagnosis** Include oral health education; oral hygiene instructions; dietary counseling; trauma prevention; fluoridation; periodontal prophylaxis and self-prophylaxis; topical application of fluoride; supplemental fluoride therapy (tablets and drops); community and school water fluoridation assessment; oral cancer detection and prevention principles; and pit and fissure sealants as appropriate.

- **Level III - Expected Services** include basic dental care and those services related primarily to the disease process. Examples include restorative dental services, basic endodontic, periodontal and oral surgery (routine extractions) services; occasional single crowns; and space maintenance.

Phase 2 = rehabilitative services, such as dentures, partials, crown and bridge, elective oral surgical procedures, periodontal surgery, and orthodontics (Elective dental procedures.) Phase 2 includes the services described below:

- **Level IV - Recommended Services** are those generally designated as rehabilitative dental services, which primarily restore oral structure. If a Health Center can find low cost solutions to replace dentition, their patients may be assisted in obtaining employment, education or enhancing self esteem. Examples include: removable prosthetic services; fixed prosthetic services (bridges and multiple crowns); oral surgery services (elective or complicated); and other-than-routine specialty services. NNOHA recommends Health Centers offer as many of these listed services as possible to meet the needs of their patients and community.

Information on the minimum services that are required by statute or regulation can be found in Section 330 of the Public Health Service Act (42 USCS § 254b), tp://bphc.hrsa.gov/about/legislation/section330.htm. and in PIN 98-23 Program Expectations, ftp://ftp.hrsa.gov/bphc/docs/1998pins/PIN98-23.PDF

[20] PIN 98-23 Program Expectations, ftp://ftp.hrsa.gov/bphc/docs/1998pins/PIN98-23.PDF

No two Health Center oral health programs are alike. Because each Health Center responds to the specific needs within a community, it is nearly impossible to compare one Health Center to another. The common saying goes: "If you've seen ONE Health Center, you've seen ONE Health Center."

As with patients in the private sector, oral disease prevention is often a difficult concept for Health Center patients. Many patients may opt for no treatment due to limited financial resources, a common reality that sometimes frustrates providers. In private practice and Health Centers alike, every treatment has to be explained to patients very clearly to ensure the patients are making well-informed decisions.

Literature supports the link between an individual's oral and general health status, so it's critical that a Health Center's dental staff form strong relationships with their medical counterparts. Dental Directors must take the lead in fostering improved communication among departments, as well as greater respect and understanding of their counterparts' contributions. The unique Health Center model demonstrates that collaboration between medical and dental entities is possible and will benefit the organization, staff and patients.

The goal is to arrest and control disease in the community.

17. Contracting with Outside Providers

As stated previously, Health Centers are required under Section 330 to provide primary health services to all patients. In addition, Health Centers may provide additional services based on the needs of the community, by including those services in their "scope of project." Services can be provided by the Health Centers directly, or through a written referral or contract.

When Health Centers lack the structural capacity to provide on-site required services, they may choose to contract with outside, private dentists. It is important to note that Health Centers cannot just contract to serve CHIP or Medicaid patients. Dentists provide services on behalf of the Health Center under the terms and conditions of their joint contract, not under the Medicaid Program, therefore, contracted services must be accessible to the whole patient population, regardless of the individual's or family's ability to pay or of payor source. Health Centers must allocate funds to pay for required services for the uninsured patients.

For more information about contracting, including how to define and change scope, payment and billing mechanisms, and a model contract, refer to *Increasing Access to Dental Care Through Public/Private Partnerships: Contracting Between Private Dentists and Federally Qualified Health Centers* available at http://www.cthealth.org/matriarch/documents/handbook.pdf.

18. Quality Management

Regardless of whether the dental services are provided on or off site, under section 330, Health Centers 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. Health Centers are expected to establish a quality

management program for oral health care service delivery that is integrated within and coordinated with the overall Health Center quality management system. The system should be an ongoing evaluation of processes and outcomes of oral health care delivery for patients and populations served by the center. The goals of the quality management system should be to:

- assure and improve the quality of oral health care delivery,
- improve oral health care status of the community, and
- integrate quality into the long term operational planning and management of the center.

"Health Center dental providers have unique competencies and proficiencies. For example, Health Center dentists are already comfortable treating infants and toddlers, pregnant women, and people with complex social or medical histories. These are still the most underserved individuals and the Health Center dentist has an important role in the health of this population."

~ Scott Wolpin, DMD
Choptank Community Health System
Chief Dental Officer

Health Centers are expected to establish oral health care clinical protocols and practices that reflect accepted standards of care and best practices reflecting the needs and demands of the populations served. These protocols must meet or exceed accepted therapeutics and clinical guidelines of the American Dental Association, as well as other professional guidelines, federal program regulations, and program expectations. Protocols must be reviewed and revised periodically. Chart audits by key professional staff at the Health Center and external audits by consultants or clinical networks should be done periodically to evaluate quality and appropriateness of care, as well as to plan for improvement of care to meet the needs of the populations served.[21]

In the spirit of continuous improvement, NNOHA recommends that Dental Directors have an ongoing conversation with the quality improvement staff at their Health Center to monitor the quality and effectiveness of the services provided to the community. Additional details and sample outcome measures will be available in successive chapters of this manual. Sample quality measures related to prenatal care and young children can be found in the Oral Health Collaborative Pilot work on NNOHA's Website:

http://tinyurl.com/OH-Collab-Manual

The National OPR Measures can be found at
ftp://ftp.hrsa.gov/opr/clinicalmeasures/detailsheet11.pdf

[21] http://bphc.hrsa.gov/policy/pin9823/default.htm

19. The Health Center Primary Care Advantage

Health Center oral health programs have a unique and important partner in their Medical and Behavioral Health Program counterparts. Ideal health care integrates all aspects of overall health, and Health Centers are primed to reinforce this concept by collaborations between medical, mental, and dental departments and often co-located services as well. Interdepartmental collaboration between clinics can be beneficial in a number of ways:

- Mutual education and training between staff;
- Sharing of resources, including case management, nurse assistance in emergency triage, medical consultation services, anticipatory guidance by medical providers to parents of infants and young children, and cross-practice referrals;
- More eyes to monitor the oral health status of mutual patients; and
- The oral health program also gains effective advocates to support its need for increased oral health resources.

More information on the Oral Health Collaborative Pilot, which emphasized medical and dental integration, can be found at: http://www.nnoha.org/oralhealthcollab.html.

20. Health Centers – Key Components of Dental Public Health

Health Centers are a critical component of the dental public health infrastructure. Public health dentistry in Health Centers is primarily focused on the collective oral health status of the communities they serve. This perspective is not always adequately taught in schools of dentistry, leaving many Health Center dentists unprepared to address it.

"Dental public health is the science and art of preventing and controlling dental disease and promoting dental health through organized community effort. It is that form of dental practice which serves the community as a patient rather than the individual: It is concerned with dental education of the public, applied dental research, and administration of group dental care programs, as well as the prevention and control of dental disease in the community." [22]

[22] Definition developed by the American Board of Public Health Dentists, and accepted by the American Dental Association, Dental Health Section of the American Public Health Association, and the American Association of Public Health Dentists

21. Basic Dental Public Health Concepts:

A Health Center oral health program is built upon the foundation of public health principles. These principles should be engrained in the dental provider undertaking the challenge of a Health Center-based "safety net" oral health program.

There are two essential principles:

- Public health is "people health," and
- Public health's focus is on the collective health status of a group of people.

Traditional dental training and practice focus on the oral health of a particular patient, not the community as a whole. The public health dental practitioner must focus on the community environment and conditions that impact the dental health of the community. The goal of a public health oral health program is to maintain or restore the public's oral health by eliminating environmental causes of disease and restoring oral health to the population. Below are concepts a provider should consider in the practice of Health Center dentistry.

- Services provided should be based on the disease pattern of the target population, rather than the individual patient.
- The target population demand and the resources available to address that demand should be considered.
- Continuous surveillance of the target population should assess the dental disease rate, perceived need for services, actual demand for services, and projected need for future services.
- While individual patients pay for private practice dental services, Health Centers and public health oral health programs are financed through a graduated patient payment structure and partially via a budget approved by a public or private funding agency.
- Both individual patient treatment planning and surveillance of total population needs should be part of an efficient Health Center oral health program.
- Service and treatment option priorities should be based on availability of resources, size of the target population, disease pattern and demand of the population, and a reasonable definition of oral health verses ideal restoration.
- The patient population is the community.

22. Summary

These are the basics of the Health Center world. This chapter was designed to provide the fundamentals on the structure, regulations, and concepts related to Health Center oral health programs. To fully understand the Health Center world will require additional research, and there are many ways to go beyond the minimum and create a program that excels. Successive chapters in this manual will include discussions on Risk Management, Financials, Best Practices, and Leadership. NNOHA aims to provide the necessary tools to assist providers, patients, oral health programs, Health Centers, and communities.

23. Basic Contact Information

National Network for Oral Health Access (NNOHA)	**Address:** PMB 329, 3700 Quebec Street, Unit 100 Denver, CO 80207-1639 **Phone:** 303-957-0635 **Website:** www.nnoha.org
Health Resources and Services Administration (HRSA)	**Headquarters** **Address:** 5600 Fishers Lane, Rockville, MD 20857 **Phone:** 1-888-275-4772 **Email:** ask@hrsa.gov **Website:** http://www.hrsa.gov/ **Regional Offices** http://www.hrsa.gov/about/staff/oprstaff.htm
Bureau of Primary Health Care (BPHC)	**Address:** 5600 Fishers Lane, Rockville, MD 20857 **Phone:** 301-594-4110 **Website:** http://bphc.hrsa.gov/
State Primary Care Offices (PCO)	http://bhpr.hrsa.gov/Shortage/pcos.htm
American Dental Association (ADA)	**Main Site:** www.ada.org National Registry for state regulations for dentists trained outside of the United States: http://www.ada.org/prof/prac/licensure/index.asp/
Primary Care Associations (PCAs)	http://www.nachc.com/nachc-pca-listing.cfm
National Association of Community Health Centers (NACHC)	**Address:** 7200 Wisconsin Ave, Suite 210, Bethesda, MD 20814 **Phone:** 301-347-0400 **Website:** http://nachc.org/
National Healthcare for the Homeless Council	**Address:** 604 Gallatin Avenue, Suite 106, Nashville TN 37206 **Mailing Address:** PO Box 60427, Nashville, TN 37206-0427 **Phone:** 615-226-2292 **Website:** http://www.nhchc.org/

24. Glossary of Key Terms

1. **330 Grantees –** Another name for Health Centers taken from the Health Center Program, Section 330 of the Public Health Service Act.
2. **CHC - Community Health Center,** now simply referred to by federal regulations as "Health Center."
3. **Entitlement Program -** A federal program that guarantees a certain level of benefits to persons or other entities who meet requirements set by law, such as Social Security, farm price supports, or unemployment benefits.
5. **FQHC –Federally Qualified Health Center.** This is a term that was developed for Medicare/Medicaid billing purposes and refers to organizations that receive Section 330 funds to operate Health Centers. FQHCs include Health Centers that receive 330 funds, sub-recipients of such funds, and look-alikes. Although FQHC is often used as a general term for Health Centers, it was originally a billing term and NNOHA recommends using the term Health Center.[23] All 330 grantee Health Centers are FQHC's, but not all FQHC's are 330 grantees.
6. **FQHC Look-alike -** A Health Center that meets all requirements to be a FQHC, but does not receive any Section 330 federal grant support.
7. **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 services, 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 health centers, or centers that treat residents of public housing (refer to 330-legislation).
8. **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. Each area is assigned a score based on the level of need.
9. **National Association of Community Health Centers (NACHC) –** membership organization representing Health Centers nationwide.
10. **National Network for Oral Health Access (NNOHA) –** national membership organization representing Health Center dental providers and partners with an interest in supporting oral health programs.
11. **Nominal Fee –** A Health Center can charge a small fee, approved by the Board of Directors to all patients, providing it is not a barrier to care for any patient.
12. **Public Health Service (PHS) Act –** The Public Health Service Act of July 1, 1944 (42 U.S.C. 201), consolidated and revised, sets forth all existing legislation relating to Public Health Service, including a variety of PHS-administered grant programs including section 330 which regulates Health Centers.

[23] Policy Information Notice 2003-21, http://bphc.hrsa.gov/policy/pin0321.htm
[24] PIN 2003-21 Federally Qualified Health Center Look-Alike Guidelines and Application, http://bphc.hrsa.gov/policy/pin0321.htm

13. **Safety Net -** All Health Centers, local county health departments, public hospitals, non-profit clinics, and other health-care entities that provide health services to underserved populations, regardless of their ability to pay.

14. **Sliding Fee –** Health Centers provide access to services regardless of a person's ability to pay. After establishing a schedule of charges consistent with locally-prevailing charges designed to cover the Health Center's costs, a corresponding schedule of discounts of charges establishes the amount patients who are uninsured or underinsured with annual incomes at or below 200% of the Federal poverty level can afford to pay; no more than a "nominal fee may be charged for services provided to uninsured or underinsured patients with income at or below 100% of the Federal poverty level."[24]

15. **UDS - Uniform Data System.** UDS is a federal system used to track 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 is collected annually.

25. Frequently Asked Questions

Q: What is a FQHC Look-alike?

A: A FQHC Look-alike is an organization that meets all of the eligibility requirements to receive a PHS Section 330 grant, but does not receive grant funding.

Q: Are Health Center dental providers licensed?

A: Yes. Health Center dental providers must meet the criteria for licensure in the state where the Health Center is located.

Q: Are there location requirements for Health Centers?

A: It depends. Each Health Center that receives PHS 330 grant funding must meet the requirements of that grant. Health Centers must serve a Medically Underserved Area (MUA) or Medically Underserved Population (MUP). To determine if your area qualifies, you can search the MUA/MUP database at http://bhpr.hrsa.gov/shortage/muaguide.htm. Migrant Health Centers, Health Care for the Homeless and Public Housing Primary Care Programs do not need to meet the MUA/MUP restriction. Health Centers may be located in both rural and urban areas.

Q: Is a sliding fee scale required?

A: Yes, Health Centers must use a sliding fee scale for all services included in their scope of project for patients between 100%-200% of the Federal Poverty Level (FPL). A sliding fee discount cannot be applied to anyone above 200% of the FPL or below 100% of the FPL. The sliding fee scale includes discounts based on patient family size and income in accordance with federal poverty guidelines. Health Centers must be open to all, regardless of their ability to pay. If you provide services outside of your scope of project, you must bill separately, but are not required to slide the fee.

Q: Are Health Centers "free clinics?"

A: No. Health Centers do not provide free care to patients. Health Centers are required to serve all people regardless of their ability to pay. When a patient falls below 100% of the poverty guidelines, a nominal fee or no fee is charged. Most Health Centers have a nominal payment that is expected from the patient, regardless of the percentage of sliding fee discount for which one qualifies. If a patient cannot afford to pay even the nominal fee, the Health Center may not refuse to provide services.

26. Links

- National Network for Oral Health Access: www.nnoha.org
- American Association of State & Territorial Dental Directors: www.astdd.org.
- The American Dental Association link to the national registry for state regulations for dentists who were trained outside of the United States: http://www.ada.org/prof/prac/licensure/index.asp.
- Authorizing Legislation (Section 330 of the Public Health Service Act): http://bphc.hrsa.gov/about/legislation/section330.htm
- Community Health Center Program Regulations: http://tinyurl.com/HCRegulations
- Health Resources and Services Administration, Bureau of Primary Health Care website: www.bphc.hrsa.gov
- Increasing Access to Dental Care Through Public/Private Partnerships: Contracting Between Private Dentists and Federally Qualified Health Centers: http://www.cthealth.org/matriarch/documents/handbook.pdf
- Indian Health Service: http://www.ihs.gov/
- Migrant Health Program Regulations: http://tinyurl.com/MigrantRegs
- MUA and MUP Guidelines for designations: http://bhpr.hrsa.gov/shortage/muaguide.htm
- National Measures from what was formerly the Office of Performance Review: ftp://ftp.hrsa.gov/opr/clinicalmeasures/detailsheet11.pdf
- Ohio Dental Safety Net Information Center: www.ohiodentalclinics.com
- Safety Net Dental Clinic Manual: http://www.dentalclinicmanual.com.
- State practice acts can be found on NNOHA's Website at: http://tinyurl.com/StPracticeActs.

Health Center Basics Worksheet

1. Which term has its origins as a Medicaid billing term?

a. Health Center
b. Community Health Center
c. Safety-net
d. Federally Qualified Health Center (FQHC)

2. Can a for-profit clinic be a Health Center?

a. Yes
b. No
c. Depends on other factors

3. Which of these services is not required, by legislation or regulation, to be part of your Health Center's services?

a. Preventive Dental Care
b. Emergency Dental Services
c. Treatment of Disease
d. Pediatric Dental Screenings

4. What governmental office oversees Health Centers?

a. Center for Disease Control
b. Health Resources Services Administration
c. Office of Management and Budget
d. American Dental Association

5. What are the highest oral health needs in your community?

6. What populations in your community have the highest oral health needs?

7. Write your elevator speech for why you chose to work at a Health Center:

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NNOHA
National Network for Oral Health Access

Membership Application

For calendar year 2010 (January 1st through December 31st)

Applicant Contact Information

Name:

Title:

Organization:

Name of Health Center: (if different from Organization name)

Address:

City: State: Zip Code:

Phone: Fax:

E-mail:

NNOHA Membership Category:

❑ Individual Member (dues $25) ❑ Organizational Member (dues $250)

If you are applying as an Organizational Member, please attach a list of the names, titles, and E-mail addresses of the employees you wish to include in the membership.

Referred by: (name of NNOHA Member)

Paying by (select one):

❑ Check (made payable to NNOHA) ❑ Bill Me

❑ Credit Card – Card Number:

Security Code: Expiration Date:

Signature

❑ Check here If you are interested in receiving information on the current NNOHA committees and opportunities to get involved.

Please complete this form and mail it to:

NNOHA, PMB 329, 3700 Quebec Street, Unit 100, Denver, CO 80207-1639

An online application is also available at http://www.nnoha.org/membership.html

For more information, contact:

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National Network for Oral Health Access

The mission of the National Network for Oral Health Access (NNOHA) is to improve the oral health status of the underserved through advocacy and support for Health Centers.

The National Network for Oral Health Access (NNOHA) is a nationwide network of Health Center dental providers. 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.

For more information on NNOHA, visit www.nnoha.org or call 303-957-0635.

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Operations Manual
For Health Center Oral Health Programs

Chapter Two: Leadership–Becoming an Outstanding Dental Director

2

Version 1.1

NNOHA
National Network for Oral Health Access

Operations Manual

For Health Center Oral Health Program

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Executive Summary

NNOHA recognizes that the leadership of an oral health program can have a great impact on the overall success of the program. In this chapter, NNOHA discusses elements of leadership and has compiled resources to assist members of the Health Center team in running a strong practice. Key points of the chapter include:

- Relationships with members of the Executive team (Executive Director, Chief Financial Officer, Medical Director, and the Human Resources department) can be important for the oral health program and should be strengthened;
- NNOHA recommends that the Dental Director report directly to the Executive Director;
- The Dental Director should be involved in developing and managing the organization's budget;
- Teambuilding can be an effective way to strengthen the oral health team (samples of exercises are included);
- Being in management requires building a different skill set than being a clinician;
- Finally, the chapter also includes an ongoing discussion about the philosophy of leadership and how developing leaders can analyze themselves to improve their leadership capabilities.

To effectively lead a Health Center oral health program, one needs to acquire a unique set of clinical and administrative skills, as well as the vision and overall picture for program development. No matter how skilled someone is in leadership, there is always room for improvement. NNOHA recommends this chapter for new Dental Directors, experienced Dental Directors, and anyone with an interest in developing their leadership skills.

LEADERSHIP

Becoming An Outstanding Dental Director

1. Introduction

People who influence oral health have a perplexing problem. Although the developed world enjoys better oral health today than ever before, oral diseases remain the most common bacterial infections. An even more alarming trend is that the incidence of oral disease in young children is rising. These infections are typically easy to manage, yet providers tend to focus on repairing the damage rather than preventing and/or eradicating the infections. Disease management challenges are most acute in Health Centers where oral diseases are highly concentrated and more pronounced. It is clear that Health Centers require the utmost attention in evaluating and improving the methods of treating oral diseases. Health Centers need to change their approach to oral health through **effective, innovative leadership**.

"We can do no better in our lives than lead people to excellence, fulfillment, and collective achievement. We need people who can rise above the fast-paced changes the world presents us and conquer the barriers. We need leaders with vision and courage who ignite intentional transformation and bring new ways to a new world. We need leaders who are not afraid to think and act differently."

(Excerpts from "Becoming a Resonant Leader," by Mckee, Boyatzis and Johnson, Harvard Business Press)

The dental world may not be perceived as rapidly changing, but over the last 30 years, there have been significant changes—and they are accelerating. The "total health" concept will bring enormous changes in the future. Dental care will become more integrated with primary medical care to create the health home environment, and disease management may be provided by a wide variety of yet undefined practitioners or team members. Great dental leaders will need to integrate dental and medical care for the optimal health of their patients.

Dentists have a reputation for being good leaders in the military environment where many have become hospital administrators. Also, many have had political careers as high up as the U.S. Congress. This speaks especially well for dental leadership aptitude, since dental schools provide minimal leadership training and leadership skills are generally learned outside academia.

In spite of this aptitude, many dentists who open their practices immediately after graduation find themselves on a steep learning curve when it comes to effectively running a business. Dentists who choose a career in a clinical health setting often find themselves involved in clinical leadership positions early in their careers, and they may lack sufficient training or experience in budgeting, public health, management and grant writing. As a result, many Health Centers with rapidly growing oral health programs have dentists who assume leadership roles before they've had an opportunity to fully develop their skills as good clinicians and leaders.

[1] Drucker and Theaker, The Ten Most Common Questions about Oral Bacterial Infections, Infectious Diseases in Clinical Practice 2000; 9(8): 315-318; Balakrishnan et al, Dental caries is a preventable infectious disease, Aust Dent J. 2000 Dec;45(4):235-45.

[2] U.S. Government Accountability Office – Medicaid: Extent of Dental Disease in Children Has Not Decreased: http://www.gao.gov/products/GAO-08-1176T; Children's Dental Health Project – Early Childhood Caries Trends Upward: http://www.cdhp.org/system/files/3.%20CDHP%20Issue%20Brief%20Early%20Childhood%20Caries%20Trend%20Upward.pdf.

Careers in Health Centers and other public dental health venues can be among the most rewarding.

"I practiced in Northern Virginia near Washington D.C. for almost 30 years. Yes, it was a thrill to have many influential patients, but they were very demanding – wanting the perfect smile with no pain and no side effects. I found myself wanting to quit and just play golf. After two years of retirement, I missed the patient contact and ended up as a Health Center Dental Director in Idaho. Getting away from cosmetics and providing fundamental dentistry to very appreciative, needy patients changed my whole perspective. I wish I would have done it many years ago." – Dan Watt, DDS

Health Center Dental Directors are expected to not only have exemplary clinical skills, but also to run their departments and be strong participants in corporate leadership. This is difficult to do when they have not mastered the basics. This is a conundrum the Health Resources Services Administration (HRSA) has acknowledged and which provided the impetus for creating this manual.

Successful oral health programs in Health Centers typically have clinical leadership including a Dental Director, Director of the Oral Health Program, Chief Dental Officer (CDO) or Chief Dentist. For this manual, the term Dental Director will be used to refer to the leader of the oral health program. The Dental Director is responsible for clinical services and programs. Ideally, the Dental Director should be a dentist, (D.M.D. or D.D.S.) with substantial clinical, administrative and public health experience to provide oral health leadership for the Health Center.

NNOHA HAS SEVERAL RECOMMENDATIONS TO HELP THE DENTAL DIRECTOR BECOME THE BEST LEADER POSSIBLE:

- Participate actively in the management and decision-making activities of the Health Center.
- Report to the level of administration that effectively links the oral health program to resources, input into the budget, and the grants process.
- Be the key advocate for the oral health program to the Health Center's entire management team.
- Become an oral health champion in the local, state and national communities.
- Provide critical input that benefits the Health Center's quality management system and the integration of oral health in its overall clinical policies.
- Develop, along with the administration and Board of Directors, the Principles of Practice for the oral health program, describing the scope of services to identified populations.

In addition to these administrative recommendations, there are also many philosophical issues to consider, which are explored later in this chapter.

2. Learning Objectives

After reading this chapter, the reader should be able to:

- Identify a Personal Model of Leadership and opportunities for improvement;
- Identify ways to strengthen relationships with the executive team, staff and Board of Directors;
- Understand the parameters of a Dental Director position;
- Develop ideas for how to interact with staff;
- Create a vision of how to lead;
- Develop a professional vision of the dental department;
- List opportunities for positive change within the Health Center; and
- Meet social responsibilities.

Although some individuals may seem to have natural skills, it does not mean leadership skills cannot be developed. This manual is designed to help individuals sharpen their skills and become better leaders. The exercises and guides provided here were modified from the book, "Becoming a Resonant Leader," published by The Harvard Press. This book is a valuable resource to have on hand.

3. What Makes A Great Leader?

Most people can describe how they would like to be led, but find it difficult to actually lead.

Leaders should:

- Inspire cohesiveness with a shared vision and purpose focused on the quality of work;
- Create a positive work environment and a winning team that is productive, creative and talented;
- Give motivation, meaning, direction, and focus to the dental team;
- Communicate the organization's expectations and goals while hold the department accountable:

The Value of Trust

A Blue and Gold Navy recruiter was presenting the virtues of the Naval Academy to a group of high school students when one boy sneeringly shouted, "How can you expect us to accept the Navy's honor code that says you have to rat on a classmate for any cheating violation no matter how small when nobody else saw the violation?" The officer smiled as if he relished answering the question. He said, "Let's try a scenario where our country suddenly faced war and all of you were drafted. You ended up on my ship and we headed into harm's way. What is the number one trait you would hope I had as your commanding officer?"

The students bantered about for a short time before agreeing that the number one trait would be trust. Trust is built through integrity, empathy, effective communication skills and by example.

- Use self-awareness, mindfulness and compassion. (Example: A supervisor's negativity can be toxic. Staff will sense destructive stress and may feel overworked, underappreciated and unhappy. A leader who exudes vision, positivity and hope has no bounds.)

- Lead by example. (Set a good example by treating patients and staff compassionately, ethically, and by working hard.) The bottom line is that leadership begins within.

4. Fostering Relationships With The Executive Team

It may feel like a Dental Department exists as a silo; however, the Executive Team can be an important part of the program's success. The following are thoughts to consider regarding relationships with the Executive Director, Medical Director, Chief Financial Officer and Human Resources Department.

Executive Director

It is important to understand the Health Center Executive Director's expectations. An Executive Director (ED) has a huge responsibility and relies on the Dental Director's expertise to identify problem areas in his or her dental department. An ED who has to ferret out problems and bring them to the attention of the Dental Director will question that person's performance. Listed below are some tips for working effectively with the ED:

- Dental Directors who keep things running smoothly and effectively are usually greatly appreciated. However, when there are problems, the ED needs to be informed early. Potential issues include treatment risk exposures; equipment needing replacement; provider/staff problems; community involvement that may involve press coverage; and outside professional involvement, such as a state oral health coalition, NNOHA or other organizations. The ED should be informed early, and Dental Directors should not be afraid to ask for help. The role of the ED is to be supportive of a Dental Director's direct reports, but they do not like surprises, unless it is all good news!

- In general, a Dental Director should communicate regularly with the ED through regular meetings and stay in touch via e-mail and the phone. EDs need to be "in the know" about everything going on within the organization. They especially do not like to be caught in embarrassing situations, unaware of something significant happening within their departments.

- A Dental Director should manage his or her own budget, but if there will be major expenditures for new equipment or new positions, the ED should be kept informed and consent to those expenditures before they are executed. The worst case scenario is to be at odds after the deed is done.

- A solicitation for money or equipment should only be conducted once the ED is made aware of those intentions. The ED and others in the organization may be communicating with the same parties, and it is always wise for the right hand to know what the left hand is doing.

- EDs love positive public relations. Whenever possible, a Dental Director should do something that reflects positively on the organization in the minds of its constituencies and the general public. On the other

hand, a public relations event should not come as a surprise to the ED, who should participate in the event whenever possible. The Dental Director should not engage in an interview without first obtaining approval.

- Quarterly action plans need to be shared with the ED to ensure that everyone is on the same page regarding priority objectives. The Dental Director should discuss with the ED timelines and the progress, or the lack thereof, being made.
- Special effort should be made to understand the broad corporate perspective on issues at Corporate Leadership Team meetings. A Dental Director may advocate for the program, keeping in mind the greater good of the organization, because they are not only the director of the program, but also a key leader in a larger organization of diverse parts.
- A Dental Director should foster a mutual trust with the ED, who typically wants to be supportive, but this support must be earned.

Medical Director

The Dental Director should have a close and positive relationship with the Medical Director. As we move away from independent departments that resemble silos to a Health Home concept that intimately connects all health providers, this relationship becomes even more important. The Dental Director should present oral health issues to the medical staff via invitation from the Medical Director. Presentations on systemic effects of oral diseases help to cement oral health as an integral part of overall health. Training medical personnel on preventive measures, such as fluoride varnish applications, nutritional aspects of oral health, and oral hygiene are also integral to a comprehensive preventive model.

REPORTING STRUCTURES

Although other scenarios have been successful for different programs, NNOHA's general recommendation is to have the Dental Director report directly to the Executive Director to assure a voice at the decision making table. This may not be the case in some programs with inexperienced Dental Directors, but it still should be the goal.

Note: In NNOHA's 2009 Salary & Retention Survey, Dental Directors who reported to a CMO/Medical Director were 2.2 times more likely to indicate intent to leave the Health Center practice than those Dental Directors who reported to a CEO/Executive Director.

Chief Financial Officer

The financial complexities of a Health Center can be difficult to understand. The many income streams might include funding sources such as federal, state, city, United Way, local grantors and community organizations. Grants vary from one year to the next, trying to maintain a balanced budget can be nothing short of a circus act.



The Dental Director should be able to identify and have timely access to the necessary financial data that will assist in the evaluation of the fiscal status of the oral health program. It is crucial to develop a strong relationship with the Chief Financial Officer (CFO). The CFO wants the program to be successful and balanced, so a Dental Director should keep the following tips in mind:

- CFOs are there to help a Dental Director manage the financial picture on a daily, monthly, quarterly and annual basis. A CFO offers financial expertise and helps keep the oral health program operating efficiently and under budget. A CFO is a great asset when there is a need to expand or buy something new.

- A CFO will look for variations and compare changes to benchmarks. A Dental Director should meet with the CFO regularly.

- A Dental Director should establish the budget and take responsibility for monitoring it. If a Dental Director does not provide input, the CFO will automatically look at historical data and gauge changes in the budget accordingly. Most budgets are established well before the beginning of the fiscal year and are essential to the annual federal grant request. This means that a Dental Director needs to look at least six months out at possible changes in the departmental budget and discuss them with the CFO. Changes in fee schedules, pending grants, changes in staffing patterns and equipment needs are best planned at this time. The Health Center's budget must be approved by the Board of Directors. The budget is the estimated income and cost for the coming year. CFOs do not like to see changes in costs, unless it is clearly offset by income. Because the Dental Director is accountable for the department, he or she has to know the budget and should ask for it if necessary.

- CFOs issue monthly reports typically called Management Reports, Financial Statements, or something similar. They expect the Dental Director to read and understand these reports and to use them as a tool to keep the budget in balance. Key financial concepts and terms will be discussed in *Chapter Three: Health Center Financials*.

- Dental Directors should be aware of the benchmark values available for Health Centers across the country. Based on the 2009 Uniform Data System (UDS) results, the average annual encounter rates are 2,726 per dentist and 1,352 for dental hygienists. The productivity of a Health Center is dependent on multiple factors, such as the scope of service allowed in each state, the number of support staff, equipment, patient mix, patient needs, and a multitude of other factors. Each facility should consider all of those factors be to make a goal that is right for the organization and allow for the program to be sustainable. It is important for a Health Center to avoid being on either extreme of having either too few or too many encounters, as both

can lead to poor patient outcomes or a failed business plan. It is important to know that these numbers are not quality indicators, but simply averages to help in business planning.[3] A Dental Director should work with the Executive Director and/or IT team to begin developing a system to produce key data for monitoring the program. Examples are found in the subsequent Quality chapter of this operations manual.

- The CFO will look closely at net charges and collections. This is an area that should be observed regularly. These numbers vary from one Health Center to another, but should remain relatively consistent within a Health Center.

- The Dental Director should also receive a quarterly cost report to help ensure spending is within the budget. The cost of supplies should be watched. Bulk ordering and standardizing supply usage among the Health Center's dentists is imperative. All staff dentists should be using the same endodontic techniques, resins, amalgam, etc. There should not be drawers full of supplies that no one is using. Take advantage of the NNOHA supply discounts. Contact info@nnoha.org for information.

- Bottom line. CFOs look for accountability. If a Dental Director has a track record of meeting budgets and projections, CFOs are more likely to look favorably on expansion or new equipment plans.

The Chief Operating Officer

The Chief Operating Officer (COO) generally oversees all aspects of administrative operations at a Health Center. The COO's responsibilities may include supervising communications, marketing, purchasing, information technology, risk management, and quality management. If commensurate with his or her background, the COO may oversee clinical operations. In some cases, one person may fulfill the roles for both CFO and COO. Health Center COOs ideally work closely with Dental and Medical Directors to ensure a smooth operation and development of each department. While NNOHA recommends that Dental Directors directly report to EDs, it is very critical for them to also maintain open and consistent communication with COOs. While EDs ideally focus on strategic and external aspects of Health Center operations, COOs are responsible for day-to-day business management. Dental Directors may find common ground with COOs in areas such as risk management, improving staff productivity, and managing patient flow." Each Health Center situation is unique, however if the Dental Director works to communicate to the COO the importance of appropriate dental care to the overall health of the patient, the program is far more likely to be successful. This is becoming more critical as health care funding becomes more outcome focused.

The Human Resources Department

Recruiting and retaining key personnel is essential. The Human Resources (HR) department can help the Dental Director understand the basics of good interviewing techniques, as well as managing staff issues. But the burden for staffing falls on the Dental Director, and the more he or she knows about dealing with personnel, the better the department will be. The HR department can aid the business manager in the day-to-day personnel issues, design

[3] 2009 HRSA BPHC UDS Data: http://www.hrsa.gov/data-statistics/health-center-data/NationalData/2009/2009_national_staffing.html

provider contracts, help recruit providers, aid in designing training platforms, help manage customer relations issues, and be an excellent sounding board for solving professional budget issues. The HR department's major function is to provide support. This includes keeping track of immunizations and licenses and assisting in employment interviews and exit interviews. HR staff can also help a Dental Director develop an orientation packet for employees and providers. HR can be a wonderful resource for training managers, as well as the Dental Director. For smaller Health Centers, there may be no HR department, and it will become another skill set that the Dental Director will need to develop.

5. Communicating With The Board

"Every action in our lives touches on some chord that will vibrate in eternity.

– Edwin Hubbel Chapin

The Board of Directors must hear a voice for oral health. The best representative for that is generally the Dental Director. At least 50% of the members of the Board are patients of the Health Center–this is an important audience to reach. The Dental Director needs to review the Board Meeting agenda, which is usually sent out days before the meeting, and be prepared to address any oral health issues. Many times, the ED or Medical Director may not see how certain issues also include oral health. It is recommended that the Dental Director approach the ED about attending board meetings when there are relevant oral health issues on the agenda. NNOHA recommends that Dental Directors be prepared to present an annual *State of the Dental Department* to the Board. In some cases, only the CEO or Executive Director reports to the Board regularly. In those cases, the Dental Director's role is to inform their board representative of relevant oral health issues and get them on the agenda.

6. Owning Personal Power

The Dental Director is a department head and part of the corporate leadership within the Health Center. Dental Directors have a great deal of power within the Health Center. Young, inexperienced Dental Directors may not understand the responsibility that accompanies this position or may be afraid of making mistakes and shy away from taking control. It is crucial to embrace this power and figure out how it fits with one's vision. A Dental Director should consider their sphere of influence within their center and maximize these relationships.

Many think good leadership comes from being smart. This is a myth; intellect and technical knowledge do not make great leaders, but are good starting points. Emotional and social intelligence make the difference. Smarts can get someone in the door, but emotional intelligence enables leaders to deal with their own internal responses, moods and states of mind. Under stress, these leaders are intensely in touch with the feelings of those around them, and can inspire hope and well-being at just the right times. This creates an environment that is exciting, challenging and supportive.

Effective leaders possess emotional intelligence. Good emotional intelligence begins with self-awareness. People often think a person's intelligence is what pulls them through a crisis. However, analytical sense takes time and often requires thoughts to marinate for a time to "gel." Emotions, on the other hand, come at the speed of light. It is important to understand this quickness and how powerful it is. Good leaders have a "presence" and a self-confidence that seems to emanate like an aura. People can **feel** their confidence and know they know themselves and their capability, as well as their limitations and principles. First a person must know how they feel, then they

need to be able to *manage* their emotions. It is not easy. Most people have to work hard to control impulses. And then emanate from body language, tone of voice, "mood" and action. Emotional awareness is something great leaders tap into all the time. Emotions are natural and a constant part of life. They drive people to want or not want to do something—and they are contagious.

Leadership is not just about budgets and schedules; good leadership is about people and relationships. Once a leader is able to "own their personal power," they are better able to develop self-awareness and self-control that people respond to and respect. A leader who owns his or her personal power can support and inspire the team.

7. Personal Model Of Leadership

This section will help check emotional intelligence and leadership qualities. The chart below aids in determining a personal model of leadership. A dot can be placed in each pie-shaped area indicating the percentage of experience for each category from 0% in the center to 100% on the outer edge:

- **Self-Awareness:** Rate your understanding of the tenets of leadership, the level of trust from your staff and your current effectiveness. How well do you understand your own emotions and your level of integrity and conviction?
- **Social and Professional Awareness:** Rate your understanding of the culture of your organization, the barriers to optimal quality, the hurdles you face with your staff and your depth of understanding regarding the complexities of being a Dental Director.
- **Self-Management:** Rate how well you manage both your positive and negative emotions, the emanation of your energy and mental clarity.
- **Relationship Management:** Rate how well you guide the tone of your staff, coach and develop their emotional skills, and manage conflict.
- **Intellect and Technical Experience:** What is your level of professional experience, education and management experience?

Adapted from "Becoming a Resonant Leader," published by The Harvard Press

These rankings will help reveal areas for improvement. It is not easy to face the fact that we are not as good as we would like to be. Not everyone can rise to great leadership, but an assessment such as this one will provide a framework from which to improve. Revisiting this assessment once a year can be helpful. As long as a leader is improving, he/she can be assured that they are becoming a more effective leader. No one scores 100 percent, so everyone has room for improvement, and even the greatest leaders need to take the time to reflect on their skills. The closer a Director's real self comes to their ideal self the better leader they will be.

Positive actions and attitudes can be contagious. It is important for directors to manage their department by example both clinically and administratively. The Health Center staff should be inspired to work diligently as a team focused on delivering high quality patient-centered care that is administered effectively, efficiently and compassionately. Often the every-day challenges of working in a Health Center environment can result in high stress levels for directors, providers and support staff alike. Although a certain amount of stress can foster increased productivity and creativity, directors who can manage this hard work with a positive mental attitude can energize their entire staff. Finding this equilibrium can prevent the destructive tendencies and negativity that might otherwise result. Remembering to acknowledge staff accomplishments under fire can promote an increased level of pride and commitment to the mission of the organization.

"Do not go where the path may lead, go instead where there is no path and leave a trail."

– Ralph Waldo Emerson

A good leader uses the concepts of self-awareness, mindfulness and empathy to maintain positive relationships in order to build sustainable, effective leadership. A good leader understands that negativity can be toxic, and realizes the importance of harnessing emotions in high pressure situations to avoid transmitting these harmful feelings to others. A Dental Director who is mindful, aware and awake, values the need to foster a positive work environment where all members of the dental team believe they are an essential part of the unit's overall accomplishments. A successful director is able to bolster staff self esteem so that feelings of being overworked and underappreciated can be minimized. A sincere "thank you" or a compliment delivered at the end of the day can often be as effective as financial incentives to improve job performance.

A creative leader who exudes positivity, hope and vision has no bounds. New challenges are always arising and success is measured in increments. A wise leader will not accept complacency. It is not only what a good leader has done yesterday, but also what is being done today and planned for tomorrow that is important. A great motto to live by is "We are the best, but we can do even better."

8. Taking Charge Of The Department

The Dental Director's first take-charge item is the dental department budget. Many Dental Directors are overwhelmed and allow the Chief Financial Officer to dictate the budget. It is *the Dental Directors department*! The CFO is a partner who can share valuable expertise, but to run a department, the Dental Director needs to own the budget, be accountable for it, and scrutinize it to find ways to make the dollars more effective. The budget's first line item is the cost per encounter. The national average for this expense is about $150.[4] Health Centers are bound by expensive procedures; the more expensive the procedures, the higher the cost per encounter. The costs skyrocket if the procedures include molar root canal, dentures, or crown and bridge work.

Be mindful of the community being served. If a Health Center is turning away patients needing Phase I services because the schedule is full of expensive, time-consuming Phase III procedures, the Health Center may better serve the community by limiting the more time-consuming procedures. The community's needs should be the primary goal. At the same time, a Health Center must retain its staff dentists and allow them to perform procedures they were trained to do, so a Dental Director has to find that fine line.

[4] 2009 HRSA BPHC UDS Data: http://www.hrsa.gov/data-statistics/health-center-data/NationalData/2009/2009nattotsumdata.html

If it takes more than three months for a patient to get an exam appointment, the Dental Director should advocate for expanding the practice. The Dental Director will be involved in grant writing and should also look for other opportunities to increase income.



9. Facing Fiscal And Environmental Challenges

As part of the Health Center management team, the Dental Director is expected to make fiscal and operational recommendations. Good, data-driven information and a review of current and future environmental changes facing the oral health program are essential in making wise management-level decisions. These decisions must be fiscally sound and consistent with federal policy and the overarching mission of the Health Center.

Health Centers face many challenges in attempting to provide health services to low-income populations. As a fiscal matter, the Health Center is obligated by federal statute to provide or arrange for its federally approved scope of dental services to all residents of its designated medically underserved service area (or medically underserved population), regardless of ability to pay or insurance status. At the same time, the Health Center is obligated to maximize all revenues by setting charges consistent with locally prevailing rates, while offering discounts to uninsured and underinsured individuals and families with incomes below 200% of poverty[5]. In most communities, this dilemma is particularly acute for dental services, as the need for such services far outstrips the available resources. This places an enormous strain on the Health Center's dental resources, requiring a proactive management approach to maximize such resources.

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. For example, it is important to monitor demographic changes and population profile data to anticipate service needs and opportunities, as well as to solicit other funding resources that may become available. Moreover, *HRSA Policy Information Notice 98-23: Health Center Program Expectations* states that each Health Center must conduct a needs assessment of its community, including the number of estimated users, oral health status and description of existing providers[6]. This assessment will be used to justify project plans, prevention and treatment needs, service mix, organization of care and staffing requirements.

[5] Section 330(k)(3) of the Public Health Service Act (42 U.S.C. §254b(k)(3)); Also, See 42 C.F.R. §51c.303(g); HRSA Bureau of Primary Health Care Policy Information Notice 98-23, bphc.hrsa.gov/policy/pin9823/managementandfinance.htm. August, 1998 Accessed March 2, 2009

[6] PIN 98-23 Program Expectations, ftp://ftp.hrsa.gov/bphc/docs/1998pins/PIN98-23.PDF

Patient Base

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 time allocation for dental services; revenue generation and payor mix ratios; the ratio of emergency walk-ins versus comprehensive regular care seekers; after-hours and extended office hours coverage; and patient flow. A Health Center that simply allows a passive open access policy without management faces the risk of poor performance due to environmental changes. This can threaten the longevity of the dental program.

A Health Center is legally obligated to serve all residents in its designated service area or applicable designated service population, for example, migrant and seasonal farm workers, the homeless and public housing residents. More specifically, it needs to provide services available to all populations with fees adjusted based on ability to pay[7]. This means that Health Centers cannot implement a matrix or quota system based solely on patient payor status where the effect is to discriminate between patients based on payor source. A Health Center cannot close its doors to uninsured residents within its service area to serve insured residents to meet the matrix or quota. On the other hand, implementing a system based on medical priority may be appropriate as long as it is applied evenly to all patients.

Fees

Health Centers are required to establish a schedule of fees or payments for the provision of oral health care services to cover reasonable cost of operation and a corresponding schedule of discounts adjusted on the basis of the patient's ability to pay. The fees charged prior to discount should be comparable to fees charged by other providers in the market place. The sliding fee scale provides a full discount (100% off of the cost of the service) to individuals and families with annual incomes at or below the Federal Poverty Level guidelines found at **http://aspe.hhs.gov/poverty/09poverty.shtml** and no discount to individuals and families with incomes greater than 200% of those in the guidelines. The sliding fee scale must be available for all services defined within the scope of oral health services provided by the Health Center. Health Centers may set the sliding fee scale for oral health services to assure that revenues collected are maximized to support the oral health program. More information on the sliding fee scale is found in the Financials Chapter of this manual.

In addition, a Health Center can make reasonable decisions regarding the ability to make services available to individuals from outside the facility's service area. This flexibility can involve determining what cap needs to be applied for services to such non-service area residents, and whether to adjust the charges applied for services and any corresponding discounts. In providing this flexibility, it is advisable that Health Centers be aware of and anticipate responding to potential complaints and/or negative publicity that may result from individuals who are denied access to services or charged more than residents.

Services

Dental service mix decisions must retain good quality of care within acceptable dental therapeutic guidelines and the dental resources available. For instance, if a filling can be considered adequate, verses a full or partial cast

[7] HRSA – What is a Health Center? http://bphc.hrsa.gov/about/

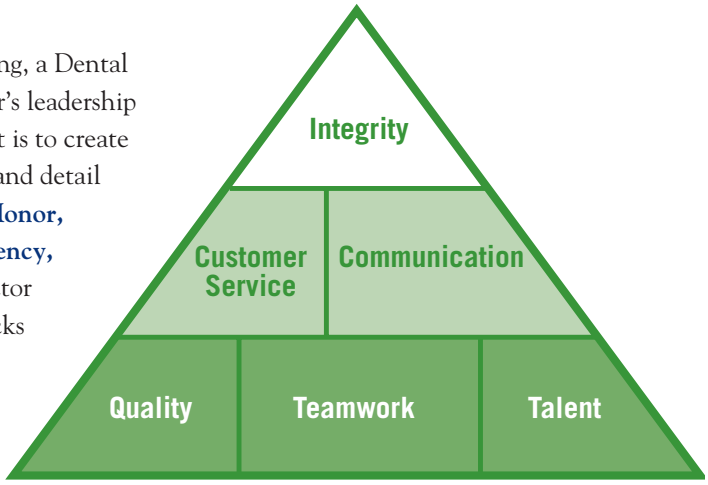
crown, the filling is deemed a more economical option. In making this determination, Health Center management must evaluate the level of services it can afford to provide to its patients as a whole and at the individual patient level (e.g., routine care being available only every six months). The Health Center's services must be evaluated to determine which options—beyond statutorily required preventive care services – can be made available to all residents in its service area without regard to their ability to pay. In some cases, a Health Center may determine that some portion of its dental services program should be provided outside of its federal scope of project. If a Health Center decides to provide services out of the scope of project, this frees the Center to provide services not bound by the sliding fee scale. However, it will also exclude them from certain benefits allowed for services provided within the scope, including cost-based reimbursement from Medicaid and CHIP and Federal Tort Claims Act (FTCA) protection in case of a malpractice claim. More information on FTCA can be found in the Financials chapter—the other chapters of NNOHA's *Operations Manual for Health Center Oral Health Programs* can be found at **http://tinyurl.com/OMHCOHP** as they are released.

Although it is not legal to schedule patients based on payor mix, Health Centers must create a positive and successful business plan that relates to the needs assessment. A Dental Director must consider multiple factors when trying to achieve fiscal sustainability. In some communities the Health Center may be the only Medicaid provider, and the only provider for uninsured patients. In another community there may be multiple providers. Dental Directors need to consider the payor mix of the community, patient demographics, the Health Center mission and the community needs assessment while advocating for the underserved.

10. Team Building

Dentistry can be repetitive and tedious. It is easy to get bored and lose focus. An offensive lineman on a football team also has a repetitive and tedious job. However, he acknowledges how critical his role is in his team's success, and enjoys the praise when the team wins. He also has a coach telling him how he can improve. Dental Directors can become mired in production and caring for their patients and may be hesitant to instruct their colleagues. But a Dental Director is also the team's coach. The Dental Director should be aware of and encourage every team member. One way that works well is holding regular staff meetings where specific issues are addressed and the team is encouraged to offer solutions. Oral health programs without regular staff meetings would do well to start organizing one today—these should not be optional.

Because personnel have different backgrounds and training, a Dental Director should help them understand the Health Center's leadership values and what is expected of them. One way to do that is to create a values pyramid. The pyramid can be configured in size and detail as appropriate and could include values like, **Integrity, Honor, Empathy, Communication, Talent, Team Work, Efficiency, Effort, Customer Service or Quality**. The Dental Director can make presentations on how each of the building blocks fits into the team or, preferably, assign team members to give a presentation on each value. This requires a bit of research to identify what each value means to the program. To the right is a sample pyramid used by one Health Center.



Sample Pyramid of Virtues

If the organization has more than one clinic, it is important to include site visits. Every member of the staff should feel that they are valued. One Health Center created a 'Triple E' award for 'efficiency', 'effectiveness' and 'effort' that is given annually to the clinic that scores the highest in selected criteria such as production, net charges, collections, income/FTE, cost/FTE, supply cost/production, unexcused absences, appointment wait time and patient satisfaction surveys.

Team building is not a silver bullet for fixing dysfunctional teams, or assuring that all of the teams will work well. But team building exercises can be helpful in developing effective teams. Included here are a selection of additional exercises that focus on five critical issues that may enable teams to strengthen their foundation[8].

An example of a teambuilding exercise designed so that the team becomes aware of, and experiences their interdependence is "Desert Survival."

In this exercise, teammates individually rank the importance of items they will need to survive after a plane crash in the desert. The team then comes to consensus on the rankings of the items.

Team rankings, almost invariably, are more accurate than most individuals' rankings.

Teamwork Exercises

Cohesiveness

Team building exercises that have a component of fun or play are useful in allowing social cohesiveness to develop. Examples include: designing a team logo, sharing information about first jobs, or participating in activities to discover characteristics that team members have in common. To develop task cohesiveness, activities that allow the group members to assess one another's talents, strengths and weaknesses are useful.

Roles and Norms

An exercise which would help teammates use roles effectively might ask them to select the roles which are most needed to accomplish the task at hand and to assign those roles to team members.

Communication

There are many ways of facilitating the learning of effective communication skills. Active listening exercises, practice in giving and receiving feedback, and practice in checking for comprehension of verbal messages are all aimed at developing skills.

Goal Specification

A simple, but useful, team building task is to assign a newly formed group the task of producing a mission and goals statement.

Interdependence

This is the issue of how each team member's success is determined, at least in part, by the success of the other members. The structure of the cooperative learning task should be such that it requires positive interdependence: students in a team should "sink or swim" together. Functioning independently of other group members or competing with them should lead to poor performance for the entire group. Both cooperative learning tasks and teambuilding tasks should have such a structure.

[8] Darwyn Linder, Department of Psychology & Susan Ledlow, Instructional Innovation Network, Arizona State University, "Five Issues to be Considered in Team Building."

11. Effective Meetings

Staff meetings should be effectively managed for best results. Most business meetings have a facilitator who directs the meeting. This person solicits input from others regarding topics to address and sets the agenda. Time increments are set for each agenda item. A timekeeper is assigned to help keep the facilitator on track and a recorder takes minutes. The facilitator keeps the focus on the agenda item and, if the direction of the discussion is leading to a different topic, the facilitator will identify it as a separate issue and place it in a "parking lot" that can be added to the agenda in future meetings. The facilitator needs to be well versed on agenda items to keep the discussion going or, if needed, ask someone else to facilitate certain portions of the discussion.

This format will keep meetings orderly and productive. As the coach, a Dental Director makes the assignments accordingly and helps inexperienced facilitators gain confidence. Since many Health Center oral health programs are small, the Dental Director may be the facilitator most of the time, but encouraging staff participation promotes team spirit and gives less experienced members a chance to develop their leadership skills.

A typical month may include a variety of meetings such as: Corporate Leadership Team, Quality Team, Dental Leadership Team, All Dentists Meeting and Dental Staff Meeting. If the department is large enough to justify holding all these meetings, a dental business manager may be needed to aid the Dental Director in setting agendas and tracking progress. Most meetings have a facilitator, a gatekeeper to keep the agenda items on schedule, and a secretary or minutes manager. A significant portion of the meeting should be set aside for training issues. The agenda should be established and sent to the staff in advance, along with the assignments for presentations.

Sample Agenda For Monthly Dental Staff Meeting

1. Reports from the various clinics on issues that have surfaced **– 30 min.**
2. Overall state of the Dental Department – examining quality improvement measures, successes and problem areas **– 15 min.**
3. Training topics such as risk management, incident reports, outreach, scheduling, evidence-based dentistry, cultural sensitivity, etc. **– 45 min.**
4. Individual achievements of staff members **– 15 min.**
5. Reports from staff members who have taken CE courses **– 15 min.**

This sample agenda is for a two-hour meeting. If the team is able to meet weekly, times can be adjusted accordingly or topics can be rotated.

As a member of the Corporate Leadership Team, the Dental Director will be actively participating in developing and implementing the Corporate Strategic Plan and providing input outlining dental strategies. Most of these plans run in cycles of two to three years. These plans have various names, but the Dental Director represents the dental needs for the future and should be proactive in the plan's development. If there is no Corporate Leadership Team or if the oral health program is represented by the Medical Director, the Dental Director must meet with his or her representative to ensure the needs of the oral health program are considered.

12. Staff Delegation

The size of an organization dictates how much time the Dental Director will spend on clinical duties versus administrative duties. If the department has a large number of operatories, clinical time will be reduced, but it is always a good idea to spend time in the clinical setting to keep apprised of the operational challenges at the ground level. If the department is small (less than four dentists), the Dental Director will likely spend the majority of the time in the clinical setting. The Dental Director will need a business manager to track staff's daily operations, time off, supplies and other day-to-day operations that are impossible to do while treating patients. Depending on the number of sites and dentists (approximately five or more) the program will require a lead dental assistant to track supplies, follow up on pre-authorizations, interface with billing and collections, and train new dental assistants. Delegation to staff is a delicate matter, and most dentists have had little training in this area.

Job descriptions for business managers or lead dental assistants should be well defined, and new staff require proper training. Once the job description has been clearly explained and the staff person has been trained, a Dental Director should be able to trust in the staff's ability to perform the respective job unless given reason to believe otherwise. If the staff is not meeting their obligations, then the Dental Director, in consultation with the HR department, should plan to implement progressive discipline where expectations regarding improvement are well-stated and clearly understood. Both of these positions, business managers and lead dental assistants, require detail-oriented professionals with pragmatic personalities who will not participate in office gossip. These staff members play the role of assistant coaches, and will be immersed in the honor, integrity and work ethic established by the Dental Director. These staff members will be expected to assist in minimizing malicious gossip, manipulative behavior and other morale busters.

13. Social Responsibilities

A Dental Director and the dental staff should be advocates for oral health in the community. The Dental Director should strive to develop collaborative arrangements that improve the oral health of the community. Whether they realize it or not, patients depend on the Health Center to represent their interests at the local, state and even the national level. **Be involved!** In an urban area the Dental Director could contact and involve others such as dental schools, public health departments or state agencies interested in the health of the underserved. Local, state and national policymakers are seeking guidance on issues that impact Health Centers and their patients. Many rural states have few public health entities representing oral health. In these areas, the Health Center can pioneer initiatives. The Dental Director should get to know the state and local dental association leaders, as well as the city and state health department representatives. Find out who is handling the Maternal and Child Health (MCH) programs in the area, such as Head Start and WIC. Can the Health Centers help to integrate oral health into medical health programs in the community?

Many states have oral health coalitions where stakeholders meet to coordinate common goals. These coalitions have become powerful unified voices for promoting oral health. Health Center input may be extremely valuable to the coalition. Getting involved in NNOHA is another way to contribute. The more dental providers involved, the stronger force it will become in promoting oral health. It is important to be a part of the broad community of oral health support networks. In addition to sharing expertise, Dental Directors can also find resources/assistance, insight into developing best practices, funding information and collegial support.

For suggestions on successful collaborative partnerships, see appendix one.
For suggestions on working with Community-based preventive services, see appendix two.

14. Diverse Skill Sets

Management is an important element in a Dental Director's role and requires a different skill set than being a clinician. Below is a chart that demonstrates the different thinking patterns. The most common challenge for a Dental Director is recognizing the need to transition from a clinician's mindset to a managerial role. Dental Directors who work well as participatory, interdependent leaders will do well in this position. Mark an X next to skills that are your strengths to reveal areas that may need improvement. This chart may also be used as an evaluation tool to identify areas of growth for staff members who are taking on new managerial roles.

CLINICIANS	MANAGERS
❑ Doers	❑ Planners / Designers
❑ 1:1 Interactions	❑ 1:n Interactions
❑ Reactive Personalities	❑ Proactive Personalities
❑ Require Immediate Gratification	❑ Accept Delayed Gratification
❑ Decision-makers	❑ Delegators
❑ Value Autonomy	❑ Value Collaboration
❑ Independent	❑ Participatory / Interdependent
❑ Patient / Community Advocate	❑ Advocate for the Organization
❑ Identify with Profession	❑ Identify with Organization
❑ Independent	❑ Interdependent

15. Summary

Health Centers need leaders who are ready to learn and grow and be stronger tomorrow than they are today. Health Center Dental Directors have a substantial responsibility. They oversee the staff, maintain a budget, provide direction for the department, often provide clinical care, and report to the executive team and the board, all while embracing the responsibility of improving the overall health of the community. It is a lot to ask and a lot to live up to. Those who have chosen to work at a Health Center have already revealed a great deal about their character. Now there is an opportunity to lead people to excellence, fulfillment and collective achievement. Dental Directors can build a vision and gain the courage that ignites intentional transformation and brings new ways of thinking to a new world. Health Centers and the nation's communities need leaders who are not afraid to think and act differently.

"I've been in private practice 17 years, managed care clinics four years; and spent the past year in a CHC. This past year has been the best, most satisfying and most rewarding."

– Comments from a NPOHC conference evaluation

16. Frequently Asked Questions

Q: **What should the reporting structure be at my Health Center?**

A: NNOHA recommends that Dental Directors report directly to the Executive Director.

Q: **How much time should Dental Directors spend on administrative vs. clinical duties?**

A: There are many variables that may add to or take from administrative time or clerical duties, because some corporate administrators take more or less of this burden. A rule of thumb is that most programs with four to seven professional providers require at least one fifth of the Dental Director's time for administrative duties. A business manager and a lead dental assistant can handle many of the clerical duties, such as scheduling staff, ordering supplies, payroll, monitoring time off, running production and producing other reports. If the Dental Director has to do any of these functions, it adds to the needed administrative time.

Q: **How involved should I be in the budget?**

A: The Dental Director is ultimately responsible for preparing and advocating for the dental budget. The CFO, HR department and staff can greatly contribute, but the Dental Director must understand the budget and provide the direction. CFOs know far more accounting methods and can guide you, but they are not dentists; the Dental Director has the best vantage point to understand the department's needs.

NNOHA strongly recommends that the Dental Director be at the table when corporate budget decisions are made. If the Dental Director cannot create the budget, he or she needs to be very familiar with it, as this is one of many tools needed to run the program effectively. NNOHA recommends that *Dental Directors review Chapter 3, Financials*, at **http://tinyurl.com/OMHCOHP**.

17. Links

The following links may be helpful for developing leadership skills:

- NNOHA's Practice Management Resources: **http://www.nnoha.org/practicemgmt.html**
- Training available through NACHC: **http://www.nachc.com/complete-list-of-trainings.cfm**
- Harvard School of Public Health, Leadership Courses: **https://secure.sph.harvard.edu/ccpe/index.cfm**
- American College of Physician Executives: **http://www.acpe.org/education/Institutes/Summer/index.aspx**
- Harvard Business Review: **http://hbr.harvardbusiness.org**
- California Dental Association: **http://www.cda.org**
  Thank you to the California Dental Association – some pieces of this chapter were originally published in the May 2009 CDA journal.
- The Good Practice – Treating Underserved Dental Patients While Staying Afloat: **http://www.chcf.org/topics/view.cfm?itemid=133706**

18. Worksheet

HEALTH CENTER LEADERSHIP WORKSHEET

NNOHA
National Network for Oral Health Access

1. **How involved are you with your department's budget?**
   - **a.** Extremely – I know every detail of what is going in and out.
   - **b.** Very – I know the big picture of how our department is doing.
   - **c.** Somewhat – I get occasional updates.
   - **d.** Not at All – I am not involved with the budget or finances at all.

2. **If you are only "Somewhat" or "Not at All" involved with your budget, what can you do next to get more involved?**

   _____

   _____

   _____

3. **Identify ways to strengthen your relationships with:**

   Your Executive Team: _____

   Your Staff: _____

   Your Board of Directors: _____

4. **Review the "Personal Model of Leadership" in this chapter. What is your strength?**

   _____

   _____

   _____

   Where can you improve? _____

   What will you do in the next month to become a stronger leader? _____

   _____

   _____

5. **What do you want to see as your legacy as a Dental Director?**

   _____

   _____

   _____

Appendices

Appendix One

Building Successful Collaborative Relationships:

A strong Dental Director will look for strategic partnerships to help achieve his/her vision. Partnerships are voluntary collaborative agreements between two or more groups in which all participants agree to work together toward a shared mission.

What Is The Power Of Partnership?

If two horses can pull about four tons, how many tons could four horses pull? Simple arithmetic tells us eight tons, but this answer is not correct. Four horses can actually pull more than 15 tons! How is this possible? Synergy occurs and the sum of the parts becomes greater than the whole.

Synergy is the muscle behind strategic partnerships. By sharing risks, responsibilities, resources and competencies with others, the Dental Director is enabled to focus on projects that he/she considers most important.

Principles Of Partnerships

- All stakeholders must share a common interest.
- Mutual dependency arises from the sharing of risks, responsibilities, resources and competencies.
- Synergy is the goal.
- An unequivocal commitment is needed from all partners. Each partner needs to understand his/her role and responsibility.
- Partners must work together at all levels and recognize any constraints of all partners.
- Partners must provide complementary support.
- Regular communication is essential.

It is imperative for Dental Directors to participate in community organizations that have a stake in oral health. NNOHA has found that the most successful programs reach beyond clinic walls. These programs can lead to potential grant opportunities with sponsors who can help a Dental Director advance a program, as well as provide opportunities to improve leadership skills. There are many opportunities available to Dental Directors to build strong partnerships in the Health Center's community and state. These opportunities include:

- Academia (faculty or student programs, mentoring dental students, residents, fellows)
- Hospitals
- Area Health Education Centers (AHEC): **http://bhpr.hrsa.gov/ahec/centers.htm**
- State and local dental societies: **http://www.ada.org/statelocalorg.aspx**
- State Coalitions: **http://www.astdd.org/docs/BPAStateCoalitions.pdf**
- State and local health departments: **http://www.cdc.gov/mmwr/international/relres.html**
- Head Start, WIC and other mother-child health organizations
- Community Councils that work with migrant workers

Appendix Two

Community-Based Preventive Services

A strong dental leader will participate in community-based preventive services. This is a great opportunity to support oral health as part of overall health and to improve the health of the whole community. There are many community-based services and issues to be involved with, that may include:

- Prevention of early childhood caries
- Promotion of water fluoridation
- Elimination of school-based soda machines
- Preventing tobacco/spit tobacco use
- Migrant schools for Health Centers seeing migrant and seasonal farm-worker patients school-based sealant programs
- Assuring local screening programs include follow-up treatment access
- Head Start programs

Credits

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NNOHA
National Network for Oral Health Access

The National Network for Oral Health Access (NNOHA) is a nationwide network of Health Center dental providers. 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.

NNOHA
National Network for Oral Health Access

Membership Application

For calendar year 2011 (January 1st through December 31st)

Applicant Contact Information

Name:

Title:

Organization:

Name of Health Center: (if different from Organization name)

Address:

City: State: Zip Code:

Phone: Fax:

E-mail:

NNOHA Membership Category:

❑ Individual Member (dues $25) ❑ Organizational Member (dues $250)

If you are applying as an Organizational Member, please attach a list of the names, titles, and E-mail addresses of the employees you wish to include in the membership.

Referred by: (name of NNOHA Member)

Paying by (select one):

❑ Check (made payable to NNOHA) ❑ Bill Me

❑ Credit Card – Card Number:

Security Code: Expiration Date:

Signature

❑ Check here If you are interested in receiving information on the current NNOHA committees and opportunities to get involved.

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Operations Manual
For Health Center Oral Health Programs

Chapter Three: Health Center Financials

3

Version 1.0

NNOHA
National Network for Oral Health Access

Operations Manual
For Health Center Oral Health Programs

Chapter Three: Health Center Financials

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NNOHA
National Network for Oral Health Access

The mission of the National Network for Oral Health Access (NNOHA) is to improve the oral health of underserved populations and contribute to overall health through leadership, advocacy, and support to oral health providers in safety-net systems.

First printing - May 2011

Note: The information in this document was accurate to the availability of known reference sources and legal reviews at the time of this printing. As regulations and information regarding Health Centers are not static, NNOHA recommends readers verify any critical information with different state regulations and changes that may have occurred since printing.

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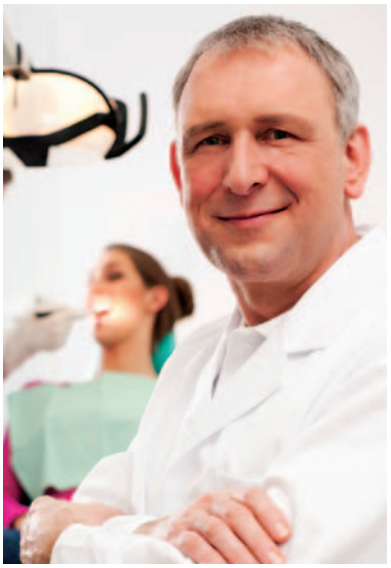
Executive Summary

The familiar saying goes "no money, no mission." Chapter 3 in NNOHA's Operations Manual for Health Center Oral Health Programs is all about Financials. The first step towards providing quality care to your patient population is to make sure the dental department is fiscally in order. This does not necessarily mean that the oral health program operates in the black, but that the leadership knows from where their income derives, what the expenses are, and understands all of the crucial legal requirements.

Key points in this chapter include:

- Understanding the main sources of funding for Health Centers;
- Adhering to the legal requirements relating to setting of fees and discounts and to patients' ability to pay;
- Identifying ways to diversify funding for sustainability;
- Understanding and making use of the financial benefits of being a Health Center: This Chapter highlights benefits that have a significant financial impact on Health Center operations; and
- Making use of the tools–such as dashboards, utilizing correct financial terms, and other resources.

Finally, it is important to continue to build your financial communications with your administrative leadership team and to use the resources you have available to develop strong leaders and a solvent program. When the finances are in order, it frees the department and the providers up to spend their time on the most important aspect–providing quality care to those in need.



FINANCIALS

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1. Introduction

Perhaps no aspect of the Health Center oral health program engenders more questions than financial management. Externally, there are many myths, assumptions, and opinions about how Health Center oral health programs are funded, from where the operating income originates to how patients are charged for services. There is a common misconception that Health Center oral health programs treat patients "for free," are "in competition" with private practice dentists, and somehow have an unfair advantage because "they are funded by the government."

Internally, it is vitally important for Dental Directors, Health Center Management, and the Board of Directors to understand oral health program costs, how clinic revenues are derived, and how to manage payor mix and schedules of discounts to maintain fiscal sustainability while complying with Health Resources and Services Administration (HRSA) program requirements, board mandates, and the organizational mission. This is not always a skill set that Dental Directors start with, but having a strong understanding of how Health Center finances operate can lead to a stronger department, which leads to better patient care.

"There is a common misconception that Health Center oral health programs treat patients "for free," are "in competition" with private practice dentists, and somehow have an unfair advantage because "they are funded by the government."

This chapter will provide a general overview of the Health Center financial structure for oral health programs, explain common fiscal terms, and give some recommendations on how Dental Directors can enhance their financial expertise. This chapter will also illuminate the many financial advantages built into the Health Center system and how those advantages are a part of assuring the ability to continue to serve underserved and vulnerable populations.

2. Learning Objectives

After reading this chapter, one should be able to:

- Explain common Health Center financial terms;
- Understand basic financial tools used in operating a successful oral health program;
- Understand the advantages of working in a Health Center from the financial perspective; and
- Locate helpful resources.

3. Relevant Laws, Regulations and Guidance

The Fundamentals Chapter in this series explains the overarching legislation which authorizes grant funding for development and operations of Health Centers including financials operations. more information can be found in *Chapter One: Health Center Fundamentals*: http://tinyurl.com/HCBasics.

- **Authorizing Legislation–Section 330 of the Public Health Service Act**
  http://bphc.hrsa.gov/policiesregulations/legislation/index.html

- **Section 330 Implementing Regulations – 42 C.F.R. Parts 51c and 56**
  http://bphc.hrsa.gov/policiesregulations/legislation/index.html

- **Policy Information Notice 98-23: Health Center Program Requirements**
  http://bphc.hrsa.gov/policiesregulations/policies/pin199823.html

There are 19 key program requirements for Health Centers receiving 330 Grant Funds. Many of them impact the Financial Department (staffing, scope of project, etc.) but these three are the most specific regarding financials[1]:

SLIDING FEE DISCOUNTS:

Health center has a system in place to determine eligibility for patient discounts adjusted on the basis of the patient ability to pay.

- This system must provide a full discount to individuals and families with annual incomes at or below 100% of the poverty guidelines (only nominal fees may be charged) and for those with incomes between 100% and 200% of poverty, fees must be charged in accordance with a sliding discount policy based on family size and income.
- No discounts may be provided to patients with incomes over 200% of the Federal poverty level.

(Section 330(k)(3)(G) of the PHS Act and 42 CFR Part 51c.303(f))

FINANCIAL MANAGEMENT AND CONTROL POLICIES:

Health center maintains accounting and internal control systems appropriate to the size and complexity of the organization reflecting Generally Accepted Accounting Principles (GAAP) and separates functions appropriate to organizational size to safeguard assets and maintain financial stability. Health center assures an annual independent financial audit is performed in accordance with Federal audit requirements, including submission of a corrective action plan addressing all findings, questioned costs, reportable conditions, and material weaknesses cited in the Audit Report.
(Section 330(k)(3)(D), Section 330(q) of the PHS Act and 45 CFR Parts 74.14, 74.21 and 74.26)

BILLING AND COLLECTIONS:

Health center has systems in place to maximize collections and reimbursement for its costs in providing health services, including written billing, credit and collection policies and procedures.
(Section 330(k)(3)(F) and (G) of the PHS Act)

[1] For the most current information, visit http://bphc.hrsa.gov/about/requirements/index.html

4. Sources of Funding

Sources of funding for Health Centers include, but are not limited to:

- Section 330 grant funding;
- Medicare, Medicaid and CHIP reimbursement;
- Commercial insurance payments;
- Patient payments;
- Private grants and donations; and
- Other public funds, such as tobacco taxes.

This section will focus on the sources that are the most regulated, and are often the most proportionally significant in Health Centers' mix of funding sources.

A. Section 330 Grant Funding

Section 330 of the Public Health Service Act defines federal grant funding opportunities for organizations to provide care to underserved populations. Types of organizations that may receive 330 grants include: Community Health Centers, Migrant Health Centers, Health Care for the Homeless Programs, and Public Housing Primary Care Programs. Programs that receive grants under section 330 must meet certain requirements and follow specific regulations. The regulations that guide 330 programs are detailed more thoroughly on the Bureau of Primary Health Care (BPHC) website at http://bphc.hrsa.gov/about/requirements/index.html.

The original purpose of section 330 of the Public Health Service Act was to increase access to health care for low income and indigent populations without access to other healthcare resources, as well as individuals facing other barriers to care (e.g., geographic, linguistic, and cultural barriers).

Though Health Centers primarily serve medically underserved populations, anyone can seek care at a Health Center, regardless of insurance or ability to pay, and Health Centers must serve all residents of their service areas who present for services. While Health Centers are nonprofit organizations or public entities, they must be financially viable to continue to provide health care services to the community. As a part of the Health Center, the oral health program is under the same constraints. Just like any private practice or other Health Center departments, an oral health program must be self-sustaining over the long term, or it will not survive. Health Centers must find their own path towards providing services to any members of the patient population while building a viable program.

Grant Allocation

NNOHA recommends that a Health Center oral health program be allocated an equitable portion of the Health Center's 330 grants. The proportion allocated to the oral health program might be based on a variety of factors, such as percentage of floor space, percentage of uninsured patients utilizing dental services, proportion of total patients who are dental patients, or share of operating expenses etc. Each Health Center can decide what formula the assigned revenue is based upon, but it should be a logical and equitable distribution. An oral health program may also have additional funding sources, such as private grants and donations.

"Federally funded health centers provide health services to underserved populations. This includes all people who face barriers in accessing services because they have difficulty paying for services, because they have language or cultural differences, or because there is an insufficient number of health professionals/resources available in their community."[2]

Health Centers are required to assure that services are 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 payors and from patients to the extent they are able to pay. Any excess revenues (a.k.a revenues over expenses or "profit") generated by the oral health program can be utilized to provide care for indigent patients who are without resources to pay. The specific requirements are found in the 330 Grant Funding requirements, http://bphc.hrsa.gov/policiesregulations/legislation/index.html, section (k)(3)(G), and HRSA's Policy Information Notice 98-23: Health Center Program Expectations: http://bphc.hrsa.gov/policiesregulations/policies/pin199823.html. While they are summarized here, readers are encouraged to be familiar the source documents.

Health Centers

- Should charge patients whose annual income is above 200 percent of the federal poverty level, without applying any discounts;
- Must apply the sliding fee scale to charges for uninsured and underinsured patients whose annual income is above 100 percent and at or below 200 percent of the federal poverty level; and
- May apply a full discount or collect, nominal fees from uninsured and underinsured patients whose annual income is at or below 100 percent of the federal poverty level.[3] It is noted that the government has never defined the parameters of a "nominal fee."

Health Centers are required to establish "a schedule of fees or payments for the provision of its services consistent with locally prevailing rates or charges and designed to cover its reasonable costs of operation"[4]. A corresponding schedule of discounts, commonly known as a "sliding fee scale", is applied to such charges and is adjusted on the basis of the patient's individual or family income.[5]

In terms of the schedule of fees, Health Center oral health program costs of operation are the same as those in any private practice, including salaries, supplies, utilities, laboratory costs, and capital equipment. Additionally, the oral health program may be assigned its proportionate share of administrative overhead for the entire Health Center.

The sliding fee scale allows for some revenue to be generated for the program to help cover the cost of providing care while keeping the fees reasonable and affordable for low-income patients. The sliding fee scale must be applied to **all** oral health services provided by the Health Center that are included within the Health Center's federally approved scope of project.

[2] HRSA – Policy Information Notice 98-23: Health Center Program Expectations: http://bphc.hrsa.gov/policiesregulations/policies/pin199823.html

[3] Authorizing Legislation of the Health Center Program: http://bphc.hrsa.gov/policiesregulations/legislation/index.html, *Id. See also* 42 C.F.R. § 51c.303(f).

[4] Authorizing Legislation of the Health Center Program: http://bphc.hrsa.gov/policiesregulations/legislation/index.html

[5] See Section 330(k)(3)(G)(i).

With certain exceptions, Health Centers are not authorized to provide sliding fee scale discounts for services to patients who earn annual incomes greater than 200% of the federal poverty level. Also with certain exceptions, Health Centers are required to charge and use best efforts to collect from such patients the full charges in accordance with their fee schedules, without taking into account any discounts.[6]

The development of a sliding fee scale for oral health services is both an art and a science. The nominal fee is determined by the Board at an amount that supports the costs of the oral health program, but does not impede access to care. Both the sliding fee scale and the nominal fee in oral health programs can be different from the nominal fee charged for medical services. A small sample of Health Center oral health programs indicated their nominal fees were between $20-$30, but the fees can vary widely based on the decisions of the Board. For more information see the National Association of Community Health Centers (NACHC) document "Establishing and Collecting Fees for Health Center Services" at http://nachc.org/client/documents/Establishing_and_Collecting_Fees.pdf.

There are no specific requirements as to how a Health Center structures its schedule of discounts for patients whose income is within the 101% to 200% of the federal poverty level range. The discount also may vary by type of service, the unifying principle in all cases being that discounts must take into account the patient's ability to pay so as not to impose a barrier to care.

Even in the context of Health Centers' schedules of fees and discounts, Health Centers must assure that

- No individual will be denied health care services due to an inability to pay for such services; and
- Any fees or payments required by the Health Center for such services will be reduced or waived to fulfill assurance of access to care.[7]

To determine whether patients qualify for discounted services, Health Centers should re-verify patients' income level at least annually. Once a Health Center establishes that a patient qualifies for discounted services, or that the patient has a third party payor source, a Health Center must make "every reasonable effort" to:

- Secure payments from patients in accordance with its fee schedule and corresponding schedule of discounts;
- Collect appropriate reimbursement for services provided to persons covered by third party payors.[8]

If new schedules of discounts need to be established, NNOHA suggests utilizing the online recommendations located at http://www.dentalclinicmanual.com/ in the finance chapter.

[6] See Section 330, sections h & i

[7] Authorizing Legislation of the Health Center Program: http://bphc.hrsa.gov/policiesregulations/legislation/index.html, 42 U.S.C. § 254b(k)(3)(G)(iii).

[8] See also 42 U.S.C. § 254b(k)(3)(G)(ii).

B. Federal Health Care Programs

To generate program revenue, Health Centers are expected to participate in and collect reimbursement from government health insurance programs, such as: the Medicare program; State Medicaid programs; and CHIP programs.

The Medicare program reimburses Health Centers on a cost-based methodology. Under the Patient Protection and Affordable Care Act, this reimbursement will shift to a Prospective Payment System (PPS). However, it is important to note that Medicare currently does not pay for the basic oral health services that are routinely provided at Health Centers. Medicare will pay for some dental services that are an integral part either of a covered procedure (e.g., reconstruction of the jaw following accidental injury), or for extractions done in preparation for radiation treatment – for more information, see http://www.cms.hhs.gov/MedicareDentalCoverage/.

This section will address Medicaid and CHIP reimbursement.

Medicaid

The major source of health care coverage for 36 percent of the average Health Center population has been Medicaid.[9] Most states report a low participation rate in Medicaid among private practice dentists. As a result, Medicaid revenues provide financial sustainability for most Health Center oral health programs. Oral health programs in Health Centers are often the only treatment option for a community's uninsured patients. The growing uninsured population can place a strain on the financial viability of Health Center dental departments.

Health Centers are typically reimbursed by Medicaid in a different manner from that offered to private practitioners. In a private practice, Medicaid visits are billed on a fee-for-service or capitation basis.

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) established a PPS for Health Center reimbursement under state Medicaid programs. This system, which has been in place since January 2001, replaced the previous cost-based reimbursement system. The PPS establishes a per visit payment rate for each Health Center. Visits are defined differently, state by state. Generally, a dental visit consists of a face to face encounter between a patient and a doctor of dental surgery (DDS) or a licensed dental hygienist (under the direct supervision of a licensed dentist).

The 2001 payment rate was based on the average of each Health Center's reasonable costs per visit in FY 1999 and FY 2000. Since FY 2002, payments made under this system have been adjusted annually for inflation using the Medicare Economic Index. Payments also are adjusted based on increases or decreases in change in scope of services provided.

The PPS rate is a floor, not a ceiling on reimbursement for Health Center services. No Federal law prevents, prohibits, or precludes a state from paying Health Centers above the PPS rate. Indeed, Congress explicitly allows states to use an alternative payment methodology so long as it "results in payment to the center or clinic of an amount which is at least equal to the amounts otherwise required to be paid to the center or clinic" under PPS.[10]

[9] 2009 UDS Socioeconomic Characteristics: http://www.hrsa.gov/data-statistics/health-center-data/NationalData/2009/2009_national_socioeconomic.html

[10] 42 U.S.C. § 1396a(bb)(6)(B).

The implementation of the PPS reimbursement is different state by state. There are generally 3 scenarios:

- A Health Center receives the same PPS rate for services rendered in both its medical and dental departments;
- The state has carved dental services out of its PPS reimbursement system, resulting in a different methodology used to reimburse Health Centers for dental services; and
- The state has implemented an Alternative Payment Methodology (APM).

Dental Directors should check in with their CFOs to understand how the rate is determined for each center and contact the state Medicaid agency or Primary Care Association for variations in their state. The 2009 NACHC report," Update on the Status of Medicaid and CHIP Prospective Payment Systems in the States," which details variations in each state can be found at http://www.nachc.com/client/2009%20PPS%20Report1.pdf.

"In order to insure you are receiving the appropriate cost-based reimbursement rate for the levels of care you deliver, it is imperative that you code accurately for all the services you provide. Some providers don't realize the importance of this since reimbursement is at the same rate for each visit, but this can eventually be reflected during periodic rate adjustments."

Janet Bozzone, DMD, FAGD, MPH
Open Door Family Medical Centers

People may also hear the term "wrap-around."
This is a payment mechanism where states reimburse Health Centers if there is a difference between the PPS payment rate and the amount they received under their contracts with Medicaid managed care organizations.

Issue Brief–Understanding PPS for Health Centers: http://www.nachc.org/client/documents/health-center-information/health-center-growth/UnderstandingMedicaidforFQHCs.pdf

Children's Health Insurance Program

The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 reauthorized the Children's Health Insurance Program (CHIP). CHIPRA finances CHIP through FY 2013, preserving coverage for the millions of children who rely on CHIP and providing the resources for states to reach millions of additional uninsured children.

Under CHIPRA, dental services have become a required benefit as CHIP coverage has been expanded to services necessary to prevent disease and promote oral health, restore oral structures, and treat emergency conditions. CHIPRA allows states the option to provide dental-only supplemental coverage (supplemental dental wrap-around benefit) for children who otherwise qualify for a state's CHIP program, but have other health insurance without dental benefits. Moreover, under CHIPRA, CHIP programs are required to reimburse Health Centers using the same PPS methodology as that required under the Medicaid program. Additionally. with this legislation, Health Centers are allowed to enter into a contractual relationship with private practice dental providers for the provision of oral health services.

C. Additional Funding Opportunities

Equipping and maintaining a dental operatory involves significantly more funding than may be understood by the administration. Dental Directors must be active, as well as creative, in partnering with other community resources that can provide a financial stream to offset losses that occur when treating the uninsured. The opportunities are remarkable if the right parties are involved.

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 have wine tastings, silent auctions and other creative events to raise awareness and funds for their oral health programs. The relationships formed by these events may become a permanent benefit to the Health Center. Events often have long-term benefits for the community in raising awareness of the importance of oral health as well as raising needed funds. It is the role of the Dental Director to nurture these partnerships for the greater good of the oral health program and the community's overall health.

Dental Directors must be active, as well as creative, in partnering with other community resources that can provide a financial stream to offset losses that occur when treating the uninsured.

NNOHA cautions Health Centers regarding possible fraud and abuse violations under federal and state laws, including but not limited to the Anti-Kickback and Stark laws and their state equivalents. The federal anti-kickback statute, 42 U.S.C. § 1320a-7b(b), states that individuals who knowingly and willfully receive or pay anything of value to influence the referral of federal health care program business, including Medicare and Medicaid, can be held accountable for a felony.[11] Stark law governs physician self-referral for Medicare and Medicaid patients – the practice of a physician referring a patient to a medical facility in which he has a financial interest, be it ownership, investment, or a structured compensation arrangement.[12]

[11] HHS Office of Inspector General – Fact Sheet: Federal Anti-Kickback Law and Regulatory Safe Harbors: http://oig.hhs.gov/fraud/docs/safeharborregulations/safefs.htm.

[12] Stark Law – http://starklaw.org/stark_law.htm.

ALTERNATIVE FUNDING SCENARIOS

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

- One Dental Director found herself invited to a prominent social event 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's oral health program.

- One Dental Director initiated a clinical trial where pregnant mothers were shown microscopic slides of their periodontal bacterial flora and given a caries risk test. The patients who were deemed at risk were given an irrigator and an antiseptic plus home care instructions. Both the mom and her baby are being followed to see if their level of disease has been reduced. The trial was presented to a Women's Foundation to help cover the cost of materials and increase the number of patients seen. They offered the largest gift ($25,000) to the project.

- Private fund raising efforts may include something as simple as pot-luck suppers or bake sales to golf outings and rock concerts. While not all efforts raise funds equally, Health Centers should never miss the opportunity to publicize what they do and their need for additional funding support. In 2009, one New York center successfully raised over $2 million with several events and independent donations from generous benefactors.

- Working with the County Supervisors, the county public health department, a local community college and the City Council, a Health Center was able to open a second site with four operatories without any capital improvement costs to the Health Center. The second clinic is co-located with the dental assistant program on the college campus. Case management is even provided by the county and the equipment maintenance costs are provided for 5 years by the City.

- An engaged Dental Director will consider non-traditional grant funders like the Rural Health Association, or State tobacco restitutions. Keeping involved with the community may lead to new opportunities.

"The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) established a prospective payment system for FQHCs. This system, which has been in place since January 2001, replaced the previous cost-based reimbursement system for Health Centers under Medicaid. The prospective payment system establishes a per visit payment rate for each FQHC in advance. The 2001 payment rate was based on the average of each FQHC's reasonable costs per visit in FY 1999 and FY 2000. Since FY 2002, payments made under this system have been adjusted annually for inflation using the Medicare Economic Index. Payments also are adjusted based on increases or decreases in change in scope of services provided."

Dennis Smith
Director, Center for Medicaid and State Operations Centers for Medicare and Medicaid Services
http://www.hhs.gov/asl/testify/t020613.html

5. Best Practices for Health Care Reimbursement Systems

Health Centers often use three major types of reimbursement systems which require conformable health care practices to ensure accurate and compliant billing. By closely following the policies outlined for each reimbursement plan, Health Centers avoid billing errors or potential misuses of the system. Auditors look for suspicious billing patterns that may indicate potential cases of provider fraud; the following paragraphs are designed to guide Health Centers with establishing sound billing practices and to avoid a fraud investigation by local, State or federal financial auditors.

Fee-for-Service (FFS) systems are designed to reimburse providers for services and procedures performed for each patient visit. Some centers attempt to redeem financial shortfalls by performing and billing for multiple procedures per visit that may be of questionable value to the patient or not clinically indicated. The practices of over-treating or separating necessary treatment into additional procedures, however, are considered misuses of the system. Any suspicious billing activities expose the Health Center to investigations of its reimbursement practices and discredit the valuable services performed by its providers. When Health Centers adhere to the appropriate fees for reasonable services, they are good stewards of grant funds and ensure the success and continuation of providing care to underserved populations.

Capitation reimbursement systems are designed for pre-paid plans under which the Health Center receives a fixed payment per patient each month. Some providers minimize the number of patient visits to remain within the boundaries of capitation; however, they may jeopardize good health care practices. Providers need to intricately balance fiscal responsibility with quality patient care. If a center does not perform or neglects clinically necessary treatment to minimize the number of patient visits, which allows the practice to retain more of the capitation payment, it is at risk of being investigated for reimbursement misuse and provider fraud. The consequences of a provider fraud investigation, regardless of its outcome, negatively affect the Health Center's reputation.

Prospective Payment System (PPS) reimbursement systems issue payments of a predetermined, fixed amount based on a classification system of services. The PPS rate is designed to cover 100 percent of the Health Center's costs of providing Medicaid-covered services while retaining professional and community standards of quality care. Under this type of payment methodology, some Health Centers risk negative legal and financial consequences when providers practice "churning," which is bringing patients back for more visits than necessary.

The current standard of care is to provide quadrant dentistry, and NNOHA recommends that Health Centers follow this professional standard. There are times when a dentist has to appropriately limit care and additional treatments given the constraints and clinical indicators at the time.[13] Situations may differ, but generally, churning results in poor outcomes for patients, and negative reputations for dentists and oral health programs.

[13] The November 2009 edition of NNOHA News has an article on completed treatment plans, which may be helpful: http://tinyurl.com/NNews08-09

6. Top 10 Financial Benefits Of Health Centers, And Their Application To Oral Health

Working in a Health Center presents unique challenges and unique benefits. This section describes 10 benefits that have a significant financial impact on Health Center operations and offers some thoughts on how those benefits impact the Dental Department.

Benefit One: Cost-Based or PPS Reimbursement for Medicaid Services

As described earlier in this chapter, Health Centers are reimbursed by state Medicaid and CHIP programs using a PPS methodology or other APM that provides reimbursement equal or greater to that provided under PPS. In states where dental services are included in the Health Center's PPS or APM, reimbursement for dental visits can be significantly higher than the reimbursement that would be received for similar services under a FFS system.

Benefit Two: Federal Tort Claims Act Protection (FTCA)

The FTCA (http://bphc.hrsa.gov/ftca/) provides malpractice liability coverage to Section 330- funded Health Centers that have sought such coverage by submitting a "deeming" application and that have been "deemed" eligible by HRSA. FTCA provides federal malpractice liability coverage for the Health Center organization, as well as its board members and employees, including Health Center employed clinicians and certain contracted clinicians, for activities:

- conducted within the scope of the Health Center's federally approved scope of project;
- conducted within the particular clinician's scope of employment/contract; and
- provided to Health Center patients generally served at Health Center sites.

TOP 10 FINANCIAL BENEFITS AVAILABLE TO HEALTH CENTERS

1. Cost-Based or Prospective Payment System Reimbursement under the Medicare, Medicaid, and CHIP programs
2. Federal Tort Claims Act Protection
3. Section 340B Discount Drug Program Pricing on Pharmaceuticals
4. Section 330 Grant Funding
5. National Health Service Corps Resources
6. National Network for Oral Health Access
7. National Association of Community Health Centers Resources
8. State and Regional Primary Care Associations
9. Benevolent Support
10. Academic Affiliations

at no cost to the organization. A Health Center may be deemed eligible to participate in this program by meeting a set of criteria related to credentialing, quality assurance, and other quality performance measures and applying to the Bureau of Primary Health Care (BPHC) to be *"deemed"* eligible. Contact the BPHC's FTCA Help Line at (866) FTCA-HELP for more information.

Generally speaking, if deemed eligible for FTCA coverage, a Health Center no longer has to pay for commercial malpractice insurance for services provided within its scope of project and within its clinicians' scopes of employment/contract. Therefore more dollars go to patient care. Instead their insurance company becomes the United States government, and their legal defense team becomes the U.S. Department of Justice. FTCA coverage is not a license to practice bad medicine. It is quite the contrary, as FTCA comes with additional requirements and oversight.

There are some things to be aware of with FTCA coverage:

- Since it is the U.S. Government that is the named defendant in the case (as opposed to the Health Center or the individual clinician), the U.S. Government can, and frequently does, settle the case without the clinician's permission. When a payment is made on behalf of a practitioner in settlement of a malpractice case, the entity making the payment is required to make a report regarding the practitioner and the settlement to the National Practitioner Database (NPDB). The NPDB is a database of practitioners whose practice has been limited in any way as a result of disciplinary actions. More information is included in the Risk Management chapter.

- Because the Health Center and its clinicians are replaced by the U.S. Government as the defendant in the case, and thus the Department of Justice's client is the U.S. Government, it is frequently difficult to get status reports on the case's processing from the Department of Justice.

- FTCA coverage is only applicable to services provided under the individual Health Center's scope of project and its clinicians' scope of employment/contract. It does not cover certain contracted providers or volunteer clinicians as well as certain services provided outside the Health Center's facility. For some of these reasons, some Health Centers purchase what is sometimes called "Gap" insurance coverage. The "Gap" insurance is backup coverage, intended to cover the center and/or its providers if by some chance the FTCA coverage does not cover a particular event.

FTCA coverage is a valuable service. Dental services have not been as historically high risk as services such as obstetrics, critical care and psychiatric care, but it is comforting to know that Health Centers have this support service in place when needed. More information on FTCA can be found at http://bphc.hrsa.gov/ftca/.

Benefit Three: Public Health Service Act Discount Pricing (Section 340B) on Pharmaceuticals

Public Health Service Act Discount Pricing (Section 340B) on Pharmaceuticals Health Centers provide a lot of health care: 67 million encounters and 17 million patients in 2008 alone. An inherent part of health care is the provision of affordable medications. Health Centers can buy pharmaceuticals to be dispensed to Health Center patients at a discount, as required under Section 340B of the Public Health Service Act, also known as Public Health Service (PHS) Act Discount Pricing. Though the average savings achieved through purchasing drugs at 340B discount drug program prices is 19 percent nationally[14], one Health Center reported pharmaceutical costs decreasing by 60 percent in the first year of purchasing at 340B discount drug program prices, despite dispensing 14 percent more prescriptions than it had under non-PHS pricing the year before.[15] For current information regarding 340b pricing, please visit http://pssc.aphanet.org/what-is-the-340b-program/.

- The average 340B discount is about 19 percent lower than the Medicaid net price and 50 percent lower than the wholesale price.[16]
- States can benefit from the 340B program when Medicaid clients purchase pharmaceuticals through participating Health Centers.
- States have a variety of reimbursement mechanisms for drugs purchased at 340B discount drug program prices. In some states, when Medicaid recipients obtain pharmaceuticals under the 340B program, Medicaid is billed for outpatient drugs at the lower 340B acquisition price, plus a reasonable dispensing fee.

[14] National Governors Association, NGA Center for Best Practices – Fact Sheet: The 340B Drug Pricing Program, http://www.nga.org/Files/pdf/032503FACTS340B.pdf
[15] National Governors Association, NGA Center for Best Practices – Fact Sheet: The 340B Drug Pricing Program, http://www.nga.org/Files/pdf/032503FACTS340B.pdf, and HRSA Pharmacy Services Support Center – What is the 340B Program? http://pssc.aphanet.org/about/whatisthe340b.htm.
[16] National Governors Association, NGA Center for Best Practices – Fact Sheet: The 340B Drug Pricing Program, http://www.nga.org/Files/pdf/032503FACTS340B.pdf

Benefit Four: Section 330 Grant Funding

Eligibility for Section 330 grant funding from HRSA is the single most direct financial benefit of being a Health Center. Obtaining a Section 330 grant is a competitive process. Typical "New Start" grant funding averages $650,000 annually. In some years, there have been inflationary "base adjustments" added to the grant amount. Health Centers also can add to their base grants by applying for and securing "expansion" funding, provided such grant opportunities are available. Health Center 330 grants are generally five years in duration. There are specific requirements to meet and reports to submit as part of the annual continuation of the grant process. The Health Center also must compete in a competitive renewal process to maintain continued federal support.

It is important to establish a dental cost center within the overall Health Center fiscal operation. That perspective began changing in the past 10 years, to the extent that HRSA began dramatically expanding Section 330 grant opportunities in oral health. These expansion opportunities generally expand the entity's base Section 330 grant by adding targeted funding for specific oral health projects by up to $250,000 per year. Given that all Section 330 grant application opportunities are extremely competitive, the savvy Dental Department leadership team prepares for Section 330 oral health expansion grant opportunities months, if not a year, in advance of the application cycle being announced. The 330 grant is a great means of support for serving underserved patients.

TIP

Have one or more members of the Health Center's leadership team enroll as HRSA grant reviewers, and gain as much experience as is possible serving on the review panels for the various Section 330 grant opportunities.

To sign up to become a candidate for grant reviews, visit https://grants.hrsa.gov/webReview/

What is a Cost Center?

Setting up a separate "dental cost center" means having an accounting structure where the dental department can track all of its own income, revenues, and expenses separately from the rest of the Health Center. This enables a Dental Director to understand their own expenses and budget and to have a knowledgeable financial picture of the costs of running a dental department. This may prove to be challenging at Health Centers that work on a "total budget" and submit financial reports based on that total budget. NNOHA advocates for Dental Directors to better understand their costs per patient and to monitor expenditures. Creating the dental cost center affords a Dental Director to work collectively with the CFO and CEO in keeping costs low and providing more services to the community.

Benefit Five: National Health Service Corps Resources

National Health Service Corps (NHSC) resources, through scholarship and loan repayment programs, encourages medical, dental and mental health providers to work in Health Professional Shortage Areas (HPSAs).[17]

The scholarship program is one in which students pursuing careers in primary health care–medical, oral health, or mental health–may apply for a NHSC scholarship to pay their health profession education tuition and fees and receive a living stipend (wage). In exchange for a scholarship, the student agrees to practice primary care in an approved site within a high-need HPSA for a number of years proportionate to how many years they have the scholarship (minimum of two years service).

The NHSC Loan Repayment Program (LRP) is one in which primary health care providers serving in an underserved area can apply to NHSC for tax-free loan repayment awards. The initial commitment is for two years for the full-time option, in which the clinician will receive up to $60,000 towards educational debt repayment, or two to four years for part-time options, where the clinician is eligible for an award of $30,000 or $60,000 respectively. This award is above and beyond whatever compensation the center pays the provider and is available to scholars that have completed their scholar obligation term. It is the expectation of the NHSC that the employing Health Center pay a fully competitive salary for the services of the health care provider. The NHSC encourages clinicians in the LRP to apply for additional years of service in exchange for additional loan repayment. Providers willing to stay for a longer time period may receive up to $170,000 in loan repayment for completing a five-year service commitment and, with continued service, may be able to pay off all eligible student loans.

All Health Center facilities are automatically deemed "facility HPSAs" for the particular Health Center site by virtue of their Health Center status. However, Health Centers must still compete for NHSC scholars and LRP participants based on the specified scoring procedure. Once a site is determined to be eligible to participate in the NHSC, appropriate job opportunities are posted on the NHSC scholarship and/or loan repayment vacancy lists.

NNOHA's suggested reading is *Community Health Centers, a Movement and the People Who Made It Happen*, by Bonnie Lefkowitz.

More information on the NHSC can be found at http://nhsc.hrsa.gov/ or by calling the NHSC Call Center at 1-800-221-9393.

"More than 78 percent of National Health Service Corps clinicians continue to work in underserved communities beyond their service commitment to the Corps."

"52 percent of NHSC alumni remain in service to underserved communities between 1 to 15 years after fulfilling the service commitment."[18]

[17] More information on HPSAs can be found at http://bhpr.hrsa.gov/shortage/hpsadesignation.htm

[18] HRSA Factsheet – Clinician Recruitment and Service: http://www.hrsa.gov/ourStories/factSheets/scholarships.shtm

Benefit Six: National Network for Oral Health Access (NNOHA)

NNOHA is a nationwide network of dental providers who care for patients in the safety net, including Health Centers. The benefits of NNOHA to a Health Center oral health program include mentoring for new Dental Directors, a job bank for posting safety-net dental vacancies, online practice management resources, a discussion forum devoted to the unique concerns of safety-net oral health programs, and sponsorship of the annual National Primary Oral Health Conference. Through HRSA support for NNOHA's services, NNOHA is able to provide support to Health Center oral health programs for minimal membership fees. NNOHA's mission is to improve the oral health of underserved populations and contribute to overall health through leadership, advocacy, and support to oral health providers in safety-net systems. NNOHA provides resources, support and a network of dental providers to help Health Centers run the most effective oral health programs possible.

Benefit Seven: National Association of Community Health Centers Resources (NACHC)

NACHC is the primary national, non-profit, professional membership and advocacy organization that represents federally-funded Health Centers and Federally Qualified Health Center (FQHC) look-alike entities. NACHC's mission is to promote the provision of high quality, comprehensive health care that is accessible, coordinated, culturally and linguistically competent, and community directed for all medically underserved people. NACHC's advocacy efforts include, but are not limited to, a congressional advocacy website and a Washington D.C.-based team of advocates. NACHC also provides educational opportunities and serves as a source of information, analysis, research, and training regarding medically underserved individuals and communities. Visit their website for more information at www.nachc.com.

Benefit Eight: State and Regional Primary Care Associations

Primary Care Associations (PCAs) are non-profit organizations representing Health Centers and other primary care (safety-net) providers at state or regional levels. PCAs provide a variety of services in support of community-based primary care. Such services may include centralized clinician recruitment, technical assistance in a variety of clinical, management and governance areas, training, conferences and more. PCAs are actively involved in health policy reform at the state level. Some associations oversee a pooled program of liability or group health/medical insurance for their members; some manage statewide information systems or practice management networks. PCAs are a valuable resource for assistance and advice. PCAs have been incredibly important in the development and expansion of Health Centers. Many PCAs have accepted the notion of oral health care being an integral aspect of overall health, and they have made remarkable progress on a statewide basis in gaining more equal funding for oral health services, especially from state Medicaid programs. PCAs have been integral in driving the development of state oral health coalitions and being strong advocates for oral health issues within each state. A savvy Dental Director would take note of the importance of working with his or her state's Dental Director, PCA leadership, and state coalitions in furthering efforts that support oral health issues.

Benefit Nine: Benevolent Support

Many Health Centers have traditionally received a tremendous amount of charitable support. The good that Health Centers do—phenomenal amounts of high-quality, low-cost primary care to the most vulnerable of our nation—has not gone unnoticed by those with resources to share. The area of oral health services is a growing charitable focus for many Health Center benefactors. Their benevolence has resulted in Health Centers receiving millions of dollars dedicated to constructing and operating dental clinics, especially those focused on serving pregnant women and children. Dental Directors should work with their executive team and development department to plan and develop funding proposals to address oral health in their community.

Benefit Ten: Academic Affiliations

Health Centers and graduate dental education programs may establish collaborations whereby a Health Center serves as a residency rotation site (and/or as a site for other educational/training activities). Such collaborations often enable Health Centers to expand clinical provider capacity, while allowing the dental residency program to offer dental residents a unique opportunity to hone their clinical skills in community-based settings serving diverse, underserved patient populations across all life cycles. Although residency program models vary, graduate dental education programs are typically limited to third and fourth year dental residents that have month-long rotations at the Health Center under the supervision of the Health Center's dentists.

The Health Center must retain responsibility and control over activities related to provision of direct patient care services and service delivery, including decisions regarding the scope, location and scheduling of services. It is also critical that the Health Center provide the necessary operatories to accommodate the residents. Health Center dentists often serve as the faculty preceptors (subject to their appointment to the training program), and are accordingly charged with supervising and evaluating the residents' involvement in the provision of dental services to Health Center patients. The residents must provide services in accordance with the Health Center's oral health policies and procedures to ensure quality of care for the patient and the safety for the resident.

The dental residency program retains responsibility for the planning, administration and execution of teaching/training activities at the Health Center's site, and for otherwise operating the residency program in a manner that satisfies applicable accreditation requirements. Teaching/training activities for which the residency program has primary responsibility and control include activities such as classroom teaching, retreats, orientation programs, undergraduate training, faculty/program meetings, curriculum development, resident/program evaluation, resident/student recruitment and selection, and general teaching program administration.

Each Health Center that enters into an arrangement with a dental residency program should execute a formal written agreement to define the responsibilities and duties of each party and to formally document the proper allocation of graduate medical education (GME) teaching/training costs to the GME recipient. Such agreement should specify that the residency program, as the party receiving GME, will be responsible for the payment of residents'/students' salaries and benefits, as well as a fair allocation of overhead costs directly attributable to any teaching activities, and the purchase of sufficient malpractice/professional liability insurance for the residents.

In addition, the agreement should specify that the cost of space and/or equipment which is used primarily or exclusively for teaching activities would be covered by the residency program. Under most Health Center-dental teaching program partnerships, revenues produced by the students have been retained by the site and faculty training and continuing dental education associated with that training are generally provided at no cost or reduced fees to the dentists or to the organization.

"For over a decade, the Department of Dental Medicine has strengthened its commitment to care for underserved communities by pioneering and forging collaborative alliances and partnerships with Health Centers and other public agencies that serve as catalysts for developing exciting models for dental residency training."

– Dr. Neal Demby, LMC Dental Director and NNOHA Board Member

State licensure laws vary with regard to the requirements for allowing dental residents to provide dental services. In order to allow dental residents to provide care, under most states' licensure laws, a fully licensed employed or contracted Health Center dentist must directly supervise the care that is provided. The standard for such supervision varies among states. Similarly, payors have set varying standards of supervision required for services rendered by residents to be billable. Assuming proper supervision is provided, the services rendered by residents may be billable by the Health Center. Billing for services performed by residents under appropriate supervision is often done using the teaching physician, not the resident, as the rendering provider. Health Centers should seek the advice of qualified counsel to determine what level of supervision is necessary to meet state licensure and scope of practice requirements as well as to ensure that the services are billable to federal, state, and commercial payors.

Health Centers should not enter into a residency agreement expecting the program to be a revenue generator—there are resources required to run a successful program and they do not always increase productivity. However, in the long run, academic affiliations can be good for the residents, the Health Center, and the patients.

Financially, the Health Center is generally barred from assuming the costs of true teaching/training activities not directly related to the provision of oral health services. Accordingly, such costs must be incurred by the educational program or another third party. If a collaboration involves a residency program for which a hospital is receiving federal graduate medical education (GME) reimbursement for the time spent by the resident at the Health Center, that hospital must ultimately incur the related training costs, including the residents salaries and benefits, incurred at the Health Center.

The benefits to having an affiliation with an academic institution include, but are not limited to, the following:

- Having more people to provide care to the most vulnerable populations in the community;
- Exposing students to the Health Center model and available career opportunities;
- Helping recruitment for the involved programs; and
- Engaging Health Centers as part of the teaching community.

Post-graduate dental residencies at Health Centers are becoming more common. Lutheran Medical Center (LMC) places dental residents at Health Centers for their advanced clinical training. These dental residents practice under the supervision of Health Center dentists, who are also residency trained, and focus on providing care relevant to their residency training. Lutheran Medical Center dental residents are matched to a Health Center within the Lutheran Healthcare Network for an entire year or two of clinical training. Distance Learning technologies link residents and faculty in a live, interactive advanced education didactic curriculum on a weekly basis and online forums are utilized for literature review and educational discussions of dental disciplines.

The Arizona School of Dentistry and Oral Health (ASDOH), a school of A.T. Still University, has developed a very innovative program: ASDOH's Integrated Community Service Partnerships (ICSP) place students in community settings to complete a portion of their clinical training during their third and fourth years. ASDOH is unique, in that it searches for dental student applicants with strong community service backgrounds, integrates and emphasizes community and public health principles in their didactic curriculum graduating dentists with a unique understanding of, and desire to serve communities in need. "Our mutual goal is to make a difference in the oral health of those we serve. By becoming partners in the education of the future of the dental profession we can change the face of dental education, and in the process, improve access to oral health care across the nation."

– Wayne Cottam, ASDOH Associate Dean of Community Partnerships, and NNOHA Board Member

7. The Balancing Act – Funding and Costs

Health Centers must develop a sound business plan for oral health delivery. The principle elements of a business plan include:

- a linkage between the budget and the goals and objectives specified in the clinical plan and overall Health Center plan; and
- specific costs such as salaries, equipment, supplies, rent, etc.

The program should operate and be tracked as a Cost Center for analysis of cash flow, revenue generation, program costs, and utilization. A Cost Center is a department or unit that is accountable for their expenditures and expenses. This analysis should reflect the degree to which the budget and financial plan assures the appropriate utilization of resources, meets service objectives, and projects the likelihood that the program will remain viable.

Some experts who have been working for a long time with Health Centers suggest that sources of funding for a sustainable oral health program should be equally divided among federal grants, patient revenues and other sources. The ideal revenue mix will be based on the needs assessment and the resources available to address those needs. However, as stated above, a Health Center cannot control or establish a set payor mix if it means closing the Health Center doors to certain groups based on payor source. For example, a Health Center may not state that no more appointments are available for uninsured or medical assistance program patients because the anticipated payor mix is skewed from the ideal. This has become an even more difficult task in certain states with limited or no dental benefits for adult Medicaid patients. Health Centers may have to make certain strategic priorities in order to continue to provide essential dental services with shrinking third party revenue. A Dental Director may need to request additional grant support from their organization in order to insure that patients can continue to access oral health care and at the same time insure that their fee structure does not become a barrier to obtaining dental care.

A Health Center which was once providing a full range of comprehensive adult services may need to look closely at limiting their scope of care in order to remain financially viable if their Medicaid revenues are being severely cut. Expansion of care for those with continued coverage, usually children, may need to be prioritized so that sufficient revenue can be generated to help insure that those without coverage can continue to receive care.

It is important remember that one of HRSA's expectations is to "maximize revenue from non-federal sources." Sources of funding aside from the 330 Grant include: Medicaid and CHIP reimbursement; private third party insurance reimbursement, patient payments; private grants and donations; and other public funds, such as tobacco, liquor or sweetened beverage taxes. Patients need to understand that oral health services are not free and Health Centers are obligated to show "due diligence" in attempting to collect fees for services rendered. Each organization must develop a fee structure based on the federal poverty level which does not present an undue burden for their patients to pay. It is important to revisit funding sources often to maximize the diversity of a Health Center's revenue stream in order to insulate the program from unexpected loss of funding from any one source.

DENTAL COST BASICS SAMPLE

BUILDING/LEASEHOLD COSTS

CENTRAL COSTS

Central Equipment, Instrument/Supply Costs	$76,234.00
Central Cabinetry Costs	$42,000.00
Office Equipment and Computers	$11,785.00
Total Estimated Central Costs	**$130,019.00**

OPERATORY COSTS

Operatory Equipment Supply Costs	$46,917.00
Cabinetry Costs	$4,200.00
Central Equipment (compressor, vacuum, sterilization, etc.)	$20,000
Total Estimated per Operatory Costs	**$51,117.00**
Leasehold Improvements	$85 / Sq Ft.
Build	$165 / Sq Ft.

Example – 3 Operatory Facility

2000 Sq. Ft.

Central Costs	$130,019.00
3 Operatories	$153,351.00
Leasehold	$170,000.00
Build	$330,000.00
Total 3 Operatory Facility Costs – Leasehold	**$453,370.00**
Total 3 Operatory Facility Costs – Build	**$613,370.00**

Example – 6 Operatory Facility

3000 Sq. Ft.

Central Costs	$130,019.00
6 Operatories	$306,702.00
Leasehold	$255,000.00
Build	$495,000.00
Total 6 Operatory Facility Costs – Leasehold	**$691,721.00**
Total 6 Operatory Facility Costs – Build	**$931,721.00**

8. Dental Clinic Costs

A. Dental Clinic Start-Up Costs

There are some basic costs associated with starting up an oral health program. Here is a sample of start-up costs based on real-life data from a rural site in Colorado. Please be aware that costs vary by region and each center's final costs will likely be different. Note that this sample does not include IT costs that may be included with electronic dental records or digital radiography. Additional information on what is included in the categories below can be found in Appendix A. Additional samples can also be found in the online Safety Net Dental Clinic Manual at www.dentalclinicmanual.com.

OPERATING COSTS

Dentist Salary	$125,000
Dental Hygienist Salary	$68,000
Dental Assistant Salary	$30,000
Fringe	$55,440

COSTS FOR A 3-OPERATORY FACILITY

Annual Supply costs – 3 Operatory	$40,000
Operating costs (rent @ 27/Sq Ft – for 2000Sq Ft)	$54,000
Contractual costs (mainly dental lab)	$10,000
Education, Training, Conferences	$8,000
Maintenance and Repair	$5,000
Dues	$3,000
Recruitment	$10,000
Contractual (specialty care)	$10,000
Administrative costs	$47,213

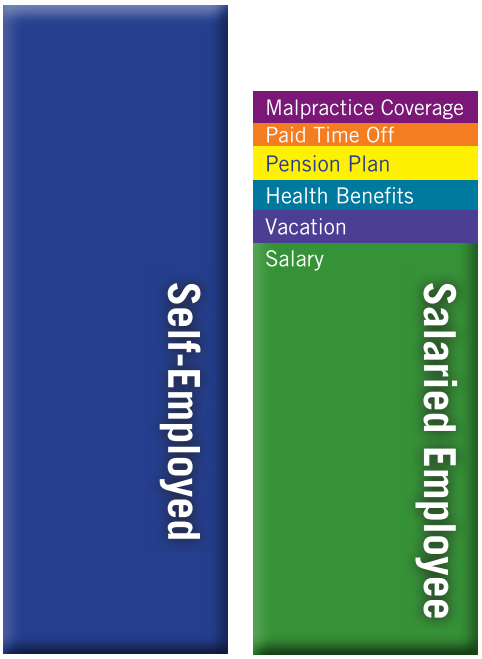
Example 1 Dentist, 1 Dental Hygienist Health Center Practice

Dentist	$125,000
Dental Hygienist	$68,000
Three Dental Assistants	$90,000
Fringe of 24% for $283,000	$67,920
Total	**$350,920**
Annual Supply Costs–3 Operatories	$40,000
Operating Costs (rent $27/ft)	$54,000
Contractual costs (dental lab)	$10,000
Education, Training, Conferences	$8,000
Maintenance and Repair	$5,000
Dues	$3,000
Recruitment	$10,000
Contractual (specialty care)	$10,000
Administrative costs (12%)	$96,058
Total	**$236,058**
Total	**$586,978**

Data compiled by Dr. John McFarland, Ft. Lupton, Colorado. Original data from March 2008. Salary information updated March 2010.

B. Salaries

Salaries are generally the largest portion of the budget. A Health Center administration's responsibility is to pay Health Center employees an equitable salary for the skills they offer based on competitive and comparative rates in the area. When benefits and bonuses are factored into salaries, they can be comparable to compensation offered in private practice. NNOHA and the Baylor College of Dentistry conducted a salary survey in 2009-2010. The final results are available on NNOHA's website. http://www.nnoha.org/workforce.html.



All dentists participating in the survey were grouped into five salary categories for statistical purposes. The category of $95,000-$110,000 had the highest percentage of respondents at 26.7%. Next was the category of $110,001-$125,000 (24.6%), followed by >$140,000 (19.0%). Similarly, dental hygienists were grouped into five salary categories. The $50,001-$60,000 category (35.5%) was the largest category chosen by respondents. This was followed by $40,000-$50,000 (25.2%), then by $60,001-$70,000 (15.0%). In contrast, non-salaried or part-time dentists reported a mean hourly wage of $63.17 with a median of $60/hour. According to the American Dental Association, the reported mean income for private practice General Practitioners surveyed in 2009 was $207,210.[19] Dental hygienists reported a mean hourly wage of $29.64 with a median of $30/hour. According to data it released in 2009, the Bureau of Labor Statistics (BLS) states that Dental Hygienists in the U.S. earn an average annual salary of $67,860 or $32.63 per hour.[20] Salaries will be covered more in depth in the Workforce & Staffing chapter.

The benefits of working at a Health Center can be substantial. When a prospective employee compares straight starting salaries, they may not realize how all of the benefits of working in a Health Center can add up. An Employer Compensation Analysis allows for a side-by-side comparison of the value of working in a Health Center. One example can be found on NNOHA's website: http://www.nnoha.org/?page_id=46011. This tool is useful to illustrate to prospective job applicants or current staff the value of employer provided benefits.

SOME EMPLOYER-PROVIDED BENEFITS COULD INCLUDE:

- Vacation Time
- Continuing Education Time & Costs paid
- Personal Time
- Paid Sick Leave
- Paid Holidays
- Other days off with pay
- Professional Organization Dues
- Malpractice premiums
- Employer contribution towards health benefits
- Life Insurance
- Disability benefits
- Pension plans
- Other fringe benefits

[19] American Dental Association, Survey Center, Surveys of Dental Practice
[20] Bureau of Labor Statistics: http://www.bls.gov/oes/2009/may/oes292021.htm

9. Dashboards

A dashboard is a brief, easy-to-read report that gives a director highlights of the financial status of the department. Whether this data is readily available may be a good indicator of the status of the oral health program in a Health Center. Frequently, the financial aspects of an oral health program are not well understood by Health Center administration. Data that may be routinely provided for the medical program is either not determined for the oral health program or it is not made available to the Dental Director for review. It is important for the Dental Director to request and review this data on a regular basis.

The first step to managing the fiscal status of an oral health program is to ascertain if the information in the sample dashboard is being produced on a monthly basis. If not, the CEO/CFO and/or IT staff should be approached to begin developing a system to produce this key data. It is important to develop a collaborative relationship with the CFO and IT staff of the Health Center, to work together on the oral health program data requirements, which may change over time.

The following is a sample dashboard that has some basic information that a Dental Director may want to track:

Your Health Center

SAMPLE MONTHLY FINANCIAL DASHBOARD

	Total	Provider A	Provider B	Provider C	Private Insurance	Schedule of Discounts	Medicaid
Number of Encounters							
Gross Charges							
Net Revenues							
Direct Expenses							
Indirect Expenses							
Cost per Visit				Revenue per Visit			
Number of Services Provided per Visit							
Number of No-Shows				Percentage of No-Shows			
Number of Emergency Visits				Percentage of Emergency Visits			
Number of Unduplicated Patients				Number of New Visits			

Data checklist adapted from The Good Practice: Treating Underserved Dental Patients While Staying Afloat. Published by the California HealthCare Foundation August 2008.

10. Monitoring An Oral Health Program

Very few dentists have received formal training in finance or accounting. To most effectively manage an oral health program and serve the largest number of individuals, it is essential to understand the terms and financial reports that are being used to discuss the program. The Dental Director should be able to identify and have timely access to the necessary financial data that will assist in the evaluation of the fiscal status of the oral health program. The previous sample dashboard can be used by a clinical leader who is interested in understanding fiscal management of the oral health program. It includes key fiscally related information that a Dental Director should have available on a monthly and yearly basis to evaluate their oral health program. Readers of this chapter are encouraged to attempt to fill in the information to test how much is readily known or available. Please note that this sample only includes financial measures. The vitality of a Health Center is not measured by finances alone – a complete dashboard must include clinical quality measures appropriate to the individual center's setting and treatment modalities provided. Sample quality measures will be included in a subsequent chapter on Quality.

Knowledgeable staff should understand the terms and accounting language that may be used to discuss the program. It may be a new skill set for some staff. Not all of the following terms will be necessary to know, but they may be useful in discussing oral health programs with the CFO.



BASIC ACCOUNTING TERMS

Accounts Payable – Money owed by an organization to its suppliers and/or vendors for goods or services purchased.*

Accounts (or Grants) Receivable – Money owed to an organization by its suppliers and/or vendors for goods and services sold (or money committed to an organization through a grant or donation).*

Accrued Expenses – Expenses incurred, but not yet paid for, during an accounting period. Generally recorded as a current liability on the balance sheet. Examples include: accrued wages payable, accrued sales tax payable, and accrued rent payable.*

Administrative Overhead – Costs that cannot be identified with a program activity but are needed for the general administration of the organization. This expense is often distributed among programs based on a formula.***

Balance Sheet – Statement showing an organization's financial position (i.e., the magnitude, distribution and nature of assets, liabilities and net assets) at the close of business on a particular date. Also known as statement of financial position.*

Budget – Detailed breakdown of estimated income and expenses that can be used as a tool for projecting revenue and expenditures for the ensuing fiscal year.****

Cost Center – Organizational unit headed by a manager or a group of managers that are accountable for costs/expenses.

Direct Expenses – Expenses that can be traced directly to cost for the oral health services. It includes expenses for labor, material, etc. Also called "direct costs."

Financial Statement – Written report that quantitatively describes the financial health of an organization. A complete financial statement includes a balance sheet, income statement, statement of cash flows, and often a statement of functional expenses. Financial statements are usually compiled on a quarterly and annual basis.*

Indirect Expenses or Indirect Costs – Costs that are shared by many services concurrently, for example, maintenance, administration, advertisement, equipment, electricity, water. Also referred to as overhead costs.

Income Statement – Summary of the revenue and expenses of an organization during an accounting period. Also known as statement of activities or profit and loss statement.*

BASIC ACCOUNTING TERMS (cont.)

Liabilities – Items owed by an organization or claims against its assets. Examples include: accounts payable, accrued salaries and benefits, accrued payroll taxes, deferred revenue, lines of credit, construction loans, current portion of long-term debt, short-term notes payable, and long-term debt. See assets and net assets.*

Net Assets – Difference between total assets and total liabilities. In for-profit accounting, known as the net worth or equity of an organization. Net assets can be categorized as unrestricted, temporarily restricted, or permanently restricted.*

Payor (Payer) Mix – Combination of reimbursement sources (payers) that pay for patients' dental care [or other services].*****

Revenue per Encounter – Total revenue divided by total number of encounters.

Revenue Sources – Sources of income for an organization. For Health Centers, they include federal, state or foundation grants, contracts, Medicaid, CHIP, Medicare, Insurance and Patient Payment.

Statement of Cash Flows – Summary of the sources and uses of cash that reconciles cash at the beginning of the year with cash at the end of the year. Organized into the following three categories:

cash flows from operating activities – Cash changes in working capital items, such as accounts and grants receivable, inventory, accounts payable, accrued liabilities and deferred revenue.

cash flows from financing activities – Payments and receipts from lines of credit, notes payable, term loans, etc.

cash flows from investing activities – Payments and receipts from acquisitions or sales of marketable securities, as well as from fixed assets, such as plant, property, and equipment.*

* Nonprofit Finance Fund's Glossary of Financial Terms
http://www.barlowandassociates.com/NFF%20Glossary.pdf

**NACHC Information Bulletin #8: Financial Information Needed by Health Center Boards for Effective Oversight

*** Nonprofits Assistance Fund Glossary of Financial Terms
http://www.nonprofitsassistancefund.org/pages/glossary

**** Nonprofit Good Practice Guide: Glossary
http://www.npgoodpractice.org/Glossary/Default.aspx

*****Safety Net Dental Clinic Manual
http://www.dentalclinicmanual.com/chapt3/1_11.html

11. Resources for Self-Learning

NNOHA has compiled five recommendations for how Dental Directors can maximize their understanding of the fiscal management of oral health programs:

a) Partner with the CFO, Executive Director and IT Staff

It is strongly recommended that each Health Center Dental Director develop and nurture a relationship with their Health Center's Chief Financial Officer (CFO), and the Executive Director (ED). Health Center CFOs generally know little about clinical dentistry; but they have an outstanding understanding of the intricacies of Health Center finances. This includes the financial benefits that Health Centers have (explained in an earlier section of this chapter) and their expertise can be invaluable in the development and success of the Dental Director and Dental Department. The most successful Health Center Dental Directors have a great working relationship with their CFO. In many cases, the Dental Director and CFO have regularly scheduled (weekly, semi-weekly or monthly) meetings, and assist each other in the achievement of the Health Center's and the Dental Department's respective mission and goals.

b) Attend NNOHA's National Primary Oral Health Conference

The conference is a unique gathering of Health Center dental providers and the resources, education, networking, and support opportunities. The Dental Director should bring his/her Health Center's CFO and ED to the National Network for Oral Health Access' (NNOHA) annual National Primary Oral Health Conference. CFO attendance at NNOHA's annual conferences with the Health Center's Dental Director can be a sentinel event in the development of successful Dental Directors and Dental Departments.

c) Consult the Online "Safety-Net Dental Clinic Manual"

The Safety-Net Dental Clinic Manual (DCM) is available for free at www.dentalclinicmanual.com.

The DCM was developed and is maintained by the Indian Health Service; the Ohio Department of Health, Bureau of Oral Health Services; the Association of State and Territorial Dental Directors, and NNOHA. The website is hosted by National Maternal and Child Oral Health Resource Center. The DCM has a user's guide, introduction, and five content chapters:

1. Partnerships and Planning
2. Facilities and Staffing
3. Financing
4. Clinic Operations
5. Quality Assurance/ Improvement

The User's Guide, chapters, and appendices are downloadable.

Chapters 1 and 2 are particularly useful in the planning phases for developing a new Health Center oral health program. Chapter 3 has useful information on revenue sources, payer mixes, and financial feasibility. Chapter 4 covers staffing and how to establish policies and procedures, and Chapter 5 covers quality assurance and accreditation. The manual was not designed for Health Center programs, but for safety-net dental programs, so some advice may not be a perfect fit for Health Centers; however, acquiring and carefully reading the DCM will improve the learner's knowledge on how to lead a successful Health Center oral health program.

d) Attend the National Association of Community Health Centers' Two-Day Seminar on Health Center Financial and Operations Management

As mentioned in the NNOHA Health Center Fundamentals publication, http://tinyurl.com/HCFundamentals, the Dental Director should be considered an integral part of the overall Health Center leadership/management team. This training is received by new Health Center EDs, CFOs, and Chief Operating Officers (COOs). There are three levels of training (Beginning, Intermediate and Advanced) that the Dental Director should attend in sequence. Overall course content ranges from what are the distinguishing characteristics of a Health Center to understanding and negotiating managed care contracts. Ideally, the Dental Director would attend all three sessions with his/her CFO and Executive Director to facilitate better dialogue and understanding between that leadership team. This would be true even if the CFO and Executive Director had attended the sessions before and perhaps even multiple times. Their attendance with the Dental Director will help immeasurably in the subsequent application of the coursework. Information about course offerings and other information that supports Health Center dental services are available at www.nachc.com.

e) Attend Commercially-Focused Dental Practice Conferences

The Dental Director and CFO should attend commercially focused dental practice seminars together. While it is true that Health Center oral health operations have some unique aspects, and a commercially-focused dental practice seminar simply would not be an appropriate first step in gaining an understanding of successful Health Center oral health operations, it is also true that Health Center dentistry can learn a lot from the private, commercially focused dental practice world. One example would be to have a private practice dentist sitting on the Health Center's Board. Another outstanding conference held annually is called the Business of Dentistry (www.businessofdentistry.com). Focus areas include maximizing practice income; learning effective leadership skills; increasing practice productivity; strengthening practice management software knowledge; and continually developing and improving the practice environment – all worthy goals of both Health Center and other dental practices.

There are additional sources available for support, but NNOHA believes that if a new Dental Director were to follow these five recommendations, it could improve Health Center Dental Directors' knowledge base and their oral health programs for the better.

12. Resources for Starting an Oral Health Program

The number of Health Centers initiating or expanding their oral health programs is at an all-time high. Oral health is clearly a service option that has a need, momentum, and opportunities. If a center's administration finds that they are ready to pursue a new start or an expansion of oral health services, the first recommendation is to review the BPHC/HRSA regulations and guidance found in section 3 of this chapter, then, the following may be helpful resources for the developmental phases of a program:

RESOURCES

- The Online Safety Net Dental Clinic Manual, particularly Chapter 1, *Partnerships & Planning and Chapter 2, Facility Design & Staffing*. The manual is not geared specifically towards Health Center programs, but provides valuable recommendations for safety-net programs: http://www.dentalclinicmanual.com/.

- Safety Net Solutions offers support services for new start Federally Qualified Health Center programs. The staff is highly respected and experienced, though centers should be aware it is a paid service: http://www.dentaquestinstitute.org/safetynetsolutions/new-dental-startup/.

- Capital Link is an organization that assists Health Centers and primary care associations in accessing capital for building and equipment purchases. They provide extensive technical assistance throughout the entire capital development process, from initial idea through completion of the new facility or implementation of new equipment. Capital Link is partially supported by a HRSA Cooperative Agreement: http://caplink.org/.

- The Clinical Directors Network (CDN) has a variety of resources including a series of webinars related to oral health, some coordinated by NNOHA: http://www.cdnetwork.org/NewCDN/LibrarySearch.aspx

- NNOHA's website has compiled some resources on *How to Start a New Dental Clinic* on the website at http://www.nnoha.org/practicemanagement/startclinic.html. Some resources include equipment recommendations, staffing guidelines, and information on mobile/portable programs. Successive chapters of this operations manual series are also recommended.

- Peer to Peer support may be the most valuable resource as few learning opportunities compare to learning from someone who has already gone through the same challenges. Staff of proposed new starts are highly encouraged to contact their peers either through the state Primary Care Association, state oral health networks, national oral health conferences (such as NNNOHA's National Primary Oral Health Conference), or through NNOHA.

13. Summary

Health Center Dental Directors have a unique opportunity to provide needed health care to underserved populations and to be strong leaders by participating in the financial decisions that are made for the Health Center's oral health program. This chapter summarized basic financial terms and tools to support Dental Directors in running a high-quality oral health program. There are a number of financial benefits that help Health Centers along the path of providing health care to those in need. There are differences in the way Health Center oral health programs are funded compared to private practice, but ultimately both private and public entities must achieve fiscal balance and viability to continue to be able to serve patients. Health Centers and their dental clinics are providing needed oral health care services to millions of Americans who could not otherwise access care – becoming knowledgeable about the financial aspects of the Health Center will help the program become more efficient, productive, and ultimately able to provide more care to the patients in the community.

"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 Barack Obama

14. Frequently Asked Questions

Q: Does a Health Center's fee schedule and sliding fee scale for dental services have to be the same as that used for medical services?

A: No.

Q: Can a Health Center implement a different nominal fee for dental services from that charged for medical services?

A: Yes. The Health Center management team, in conjunction with the Health Center's Board of Directors, can determine what nominal fee makes the most sense for each department (e.g., medical, dental, behavioral health).

Q: Should some portion of a Health Center's Federal (Section 330) grant be allocated to dental services?

A: Yes. 330 funds are not provided for "medical" or "dental." They are provided to support the provision of all services rendered within the Health Center's scope of project to underserved clients who are at or below 200 percent of the federal poverty level. The funds are to be used to supplement the nominal fee charged to patients at or below 100 percent of poverty, and the schedule of discounts charged to patients between 101-200 percent of poverty.

Q: Can a Health Center charge a co-pay (down payment) for the next dental appointment to prevent no-shows? For instance, can we charge a $15 payment for a patient to schedule an appointment for treatment?

A: There are numerous reasons why charging a co-pay for a service not yet rendered would not be appropriate or pass legal muster, including, but not limited to the prohibition on Health Centers' allowing the patient's inability to pay to become a barrier to care. In the circumstance you describe, requiring payment before care (or an appointment for care) is given can be interpreted as an improper barrier to care based on ability to pay. Additionally, a co-pay is a payment made in exchange for medical/dental services rendered, not as compensation for an agreement to schedule such services. This situation is different from common fiscally prudent practices, such as not initiating a rehabilitative service that involves a laboratory fee (e.g. crown or denture) until the patient has paid a certain percentage of the sliding scale fee (usually enough to cover the lab expense).

Q: If my Health Center doesn't receive any 330 funds targeted for dental services, can't we do whatever we want in regards to services?

A: No. It is not uncommon to think that because a center does not have 330 funds targeted to dental that they don't have to abide by scope of project & scope of practice regulations; however, 330 funds are supporting the entire Health Center, regardless of whether a portion of the funds were awarded to target specific services.

Q: What are the average and starting salaries of staff dentists, dental hygienists and Dental Directors at Health Centers?

A: Based upon surveys done in 2009 by NNOHA in partnership with Texas A&M's Baylor College of Dentistry, the average salaries for staff dentists are $110K-$125K. The average salaries for hygienists are $50K-$60K. More information on adequate salary and benefits will be included in the subsequent Workforce & Staffing chapter of this manual.

Q: Are dental hygienists financially viable providers?

A: Dental hygienists are an integral part of the oral health team, and for the purposes of this chapter, we examine only the financial aspects. Historically, dental hygiene programs have been net revenue producers: the revenue they generated exceeded the costs of running the program. And if nothing else, these programs precluded having to use a dentist's time to do work a dental hygienist could perform at a lower cost. What has changed, and continues to change, is what dental hygienists are legally allowed to do. Health Center dental hygienists should work to the full scope of practice allowed in their particular state. Note that dental hygienists are reimbursed differently by Medicaid in different states: http://www.adha.org/governmental_affairs/downloads/medicaid.pdf

14. Frequently Asked Questions Cont.

Q: How do you establish starting salaries?

A: Reasonable salaries are determined by several factors. "It is important to know the market in which you are competing for staff, and to determine what you can afford to pay and sustain relative to the market. Higher compensation generally will attract more experienced people who may be more productive."[21] To get some ideas, you may check regional salary surveys (http://www.dentalclinicmanual.com/chapt3/1_16.html). In addition to experience, you have to account for benefits you are including in the package. It should be noted that salaries could be about 60-70 % of your overall budget.

Q: How do I set up a schedule of discounts?

A: First, make sure the overall fee schedule is consistent with locally prevailing rates and covers the reasonable costs of operation. e.g.: Do not charge $60 per extraction as a full fee when the market rate is $125. Then, set the sliding fee scale for patients with annual incomes between 101-200% of the federal poverty level appropriately, such as 25 percent of a $125 fee, instead of 50 percent of a $60 fee. This way you won't devalue the services provided, and if someone has insurance, you will collect the actual charge of providing care. Set a nominal fee that does not create a barrier to care for patients with incomes at or below 100% of the federal poverty level. Update your fee schedule, sliding fee scale, and nominal fee annually.

Q: Can you limit your program for Medicaid-only patients?

A: No. Health Center programs may not limit access to their services based on ability to pay, financial status, or payor source. Health Centers may give priorities to populations of focus such as pregnant women or children, which in turn could affect payor mix, but only if the Health Center needs assessment clearly demonstrates a need for these populations.

Q: Can I get paid on a fee-for-service basis for Medicaid dental services?

A: Each state has different nuances in dealing with the PPS rate. Contacting your State Medicaid Office is the best way to get your answer. Find a list of state contacts at http://www.medicaiddental.org/index.html.

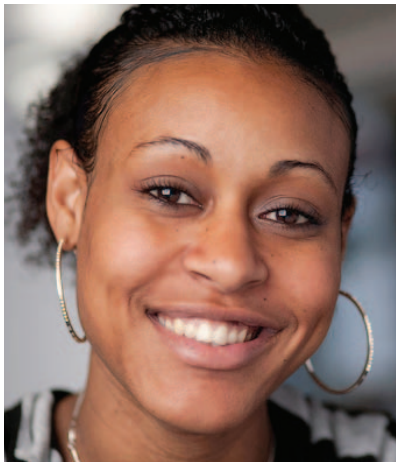
[21] Safety Net Dental Clinic Manual, http://www.dentalclinicmanual.com/chapt3/1_16.html

Q: How do I provide service to everyone without regard for payment and still be able to operate my program?

A: Not all programs can have the "ideal" patient mix and must maintain a close eye on their bottom line. Each program needs to analyze their sources of revenue and develop strategies to maximize collections from all sources. Although Health Centers are not permitted to deny services based on a patient's inability to pay, no one states that the need for payment should be totally disregarded. If a program does not generate and collect sufficient revenue, it may cease to be sustainable. No margin... no mission! Patients should be encouraged to pay what they can at the time of service and efforts should be taken to collect the balance. Remember, the chances of collecting the fees generated by your providers diminish significantly once the patient has left your office, and selecting the right individuals for collecting this payment is crucial. More information is included in the section of this chapter entitled "The Balancing Act."

Q: Are Health Centers "free clinics?"

A: No. Health Center dental clinics do not see patients "for free." They cannot deny services to any individual because of an individual's ability to pay. This means that, occasionally, individuals who receive care may not pay their bills, but this is no different than private practice. Patients receiving routine comprehensive care are expected to make payment, based on the Health Center's sliding fee schedule and corresponding schedule of discounts, at the time of their visit, or they will be billed for services, as they would be at a private practice.



Q: Do Health Center oral health programs create unfair competition with private practice?

A: Health Center oral health programs may indeed be "in competition" with private practice dentists in some cases. As in real estate, location is everything. In a rural area, the Health Center oral health program may be the only dental provider in the area and there is no competition. In other locations, the Health Center may be the only dental provider in the area that accepts government sponsored insurance plans, such as Medicaid. Again, there may be little to no competition for patients covered by those particular plans.

Certainly, in some areas where private practice providers accept government sponsored insurance plans, there may be competition between private practices and Health Centers. In those instances, private practices and Health Centers compete for patients based on traditional criteria, such as accessibility, office appearance, staff friendliness and perceived quality of care.

Generally, Health Center oral health programs are not in competition with private practice for indigent patients. As mentioned previously, 200 percent of the 2009 federal poverty level is an annual income of $21,660 for an individual. Individual indigent patients with incomes of $21,660 a year or less will most likely not be able to afford full-fee dental care and will most likely not be covered for dental services by commercial health insurance.

Q: Do Health Center oral health programs have an unfair advantage because "they are funded by the government?"

A: 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 oral health program covers only a portion of total expenses.

Section 330 grants are intended to support costs of care provided to low-income and indigent patients, typically defined as at or below 200% of the federal poverty level. Therefore, as stated above, Section 330 grant funds are not helping Health Centers compete for patients seen by private practices—insured patients and self-pay patients with resources.

Health Centers may also serve as a referral base to private practice. NNOHA encourages private practice providers to serve Medicaid and uninsured patients and encourages its members to partner with their private practice counterparts to benefit the health of their communities.

15. Links

The following resources may be beneficial for a Health Center developing a new start oral health program or for centers looking for guidance on Financials as they relate to dental clinics.

- 340b Program: http://www.hrsa.gov/opa/
- American Academy of Pediatric Dentistry: www.aapd.org
- American Dental Association: www.ada.org
- Association of State and Territorial Dental Directors: www.astdd.org
- Balanced Budget Act of 1997 – Medicaid Implications for Health Centers: http://bphc.hrsa.gov/policiesregulations/policies/pin199810.html
- Business of Dentistry Conferences: www.businessofdentistry.com
- California Dental Association: http://www.cda.org/
  Thank you to the California Dental Association –portions of this chapter were original published in the May 2009 CDA journal focused on Health Center dental practice. http://cda.org/page/Library/cda_member/pubs/journal/jour0509/index.html
- Capital Link: http://caplink.org/
- Children's Dental Health Project: www.cdhp.org
- Clinical Directors network: http://www.cdnetwork.org/NewCDN/LibrarySearch.aspx
- Dental Pipeline Program: http://www.dentalpipeline.org/
- Employer Compensation Analysis: http://www.nnoha.org/workforce.html
- Environmental Drift in Health Center Dental Practice Management: http://www.cda.org/library/cda_member/pubs/journal/jour0509/russell.pdf
- Establishing and Collecting Fees for Health Center Services: http://nachc.org/client/documents/Establishing_and_Collecting_Fees.pdf
- The Good Practice –Treating Underserved Dental Patients While Staying Afloat http://www.chcf.org/topics/view.cfm?itemid=133706
- Hometown Partnerships for Oral Health: http://www.atsu.edu/asdoh/community/hometown.htm
- Lutheran Medical Center: http://www.lutheranmedicalcenter.com/

- Medicaid/SCHIP Dental Association: www.medicaiddental.org
- National Association of Community Health Centers, Inc.: www.nachc.org
- Health Center Financial and Operations Management Seminars
- National Center for Health in Public Housing: www.healthandpublichousing.org
- National Health Care for the Homeless Council: www.nhchc.org
- National Health Service Corps: http://nhsc.hrsa.gov/
- National Maternal and Child Oral Health Resource Center: www.mcoralhealth.org
- National Network for Oral Health Access: www.nnoha.org
- NNOHA Salary Survey: http://www.nnoha.org/generalpage.html
- Nonprofit Finance Fund's Glossary of Financial Terms: http://www.barlowandassociates.com/NFF%20Glossary.pdf
- Safety Net Dental Clinic Manual: www.dentalclinicmanual.com
- Safety Net Solutions: http://www.dentaquestinstitute.org/safetynetsolutions/new-dental-startup/
- Sliding Fee Scale Requirements: http://www.bphc.hrsa.gov/technicalassistance/taresources/slidingrequirements.html

16. HEALTH CENTER FINANCIALS WORKSHEET

1. **Should a Health Center oral health program be assigned a reasonable portion of the total Health Center 330 grant?**
   - **a.** Yes
   - **b.** No
   - **c.** Depends on the situation

2. **Are Health Centers obligated to apply a sliding fee scale to charges for services provided to patients with annual incomes between 101 and 200 percent of the federal poverty level (FPL), and, at most, charge a nominal fee for patients at or below 100% of FPL?**
   - **a.** Yes
   - **b.** No

3. **How many of the "Top 10" financial benefits of working in a Health Center can you name:**

   1._____ 5. _____ 8. _____
   2. _____ 6. _____ 9. _____
   3. _____ 7. _____ 10. _____
   4. _____

4. **What service(s) does the National Health Service Corps provide?**
   - **a.** Scholarship program **b.** Job Board
   - **c.** Loan repayment program **d.** All of the above

5. **What area(s) of the financial operations of your Health Center are the most challenging for you? What is one thing you could do to become savvier about financials?**

   _____
   _____
   _____

6. **What three things can you provide to your Executive Team or CFO to help them better understand the business of dentistry?**

   _____
   _____
   _____

Appendix A

Dental Cost Basics Category Details:

Central Equipment Costs	Equipment/Instrument Costs
• Asistina Handpiece Station	• ADEC Cabinets
• Miele dishwasher	• Cavitron
• Processor, X-Ray	• Patient Chair
• X-Ray Daylight Loader	• Doctor's Stool
• Dark-Room Light	• Assistant's Stool
• N20 Manifold Alarm	• Doctor's Mount Tubing
• Autoclave X 2	• Track Light
• Sterilization Items	• View Box
• Lab	• Slow Speed Motor
• Vacuum Pumps	• X-Ray Unit
• Compression	• N20 Flow Meter
• Rotary Equipment	• Hoses for N20
• X-Ray Duplicator	• Curing Light
• Vitality Scanner	• Wig L Bug
• Panorex, X-Ray	• Instrument Cassettes
	• X-Ray Holder
	• X-Ray Apron
	• Floss Dispenser
	• Gauze/Etc for Tubs
	• Amalgam Instruments/3 Cassettes
	• Composite Instruments
	• Endo Instruments/Sm and Lg
	• Crown Instruments
	• Tubs, Probs, Mirrors, Explorers
	• Rubber Dam Forceps, Frames,
	• Mouth Props, Snap a Rays, Etc.
	• Handpieces

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NNOHA
National Network for Oral Health Access

The National Network for Oral Health Access (NNOHA) is a nationwide network of Health Center dental providers. 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.

NNOHA
National Network for Oral Health Access

Membership Application

For calendar year 2011 (January 1st through December 31st)

Applicant Contact Information

Name:

Title:

Organization:

Name of Health Center: (if different from Organization name)

Address:

City: State: Zip Code:

Phone: Fax:

E-mail:

NNOHA Membership Category:

- ❑ INDIVIDUAL MEMBERSHIP ($50.00)
- ❑ DENTAL HYGIENIST / DENTAL ASSISTANT ($30.00)
- ❑ ORGANIZATIONAL MEMBERSHIP ($350.00)
- ❑ ASSOCIATION MEMBERSHIP ($350.00/$150.00)
- ❑ STUDENT MEMBERSHIP (Free)

If you are applying as an Organizational Member, please attach a list of the names, titles, and E-mail addresses of the employees you wish to include in the membership.

Referred by: (name of NNOHA Member) _____

Paying by (select one):

- ❑ Check (made payable to NNOHA)
- ❑ Bill Me
- ❑ Credit Card – Card Number: _____

Security Code: Expiration Date:

Signature

❑ Check here If you are interested in receiving information on the current NNOHA committees and opportunities to get involved.

Please complete this form and mail it to:

NNOHA, PMB 329, 3700 Quebec Street, Unit 100, Denver, CO 80207-1639

An online application is also available at http://www.nnoha.org/membership.html

For more information, contact:

Colleen Lampron, NNOHA Executive Director
colleen@nnoha.org
Phone: 303-957-0635 / Fax: 866-316-4995

What Is NNOHA?

The National Network for Oral Health Access (NNOHA) is a nationwide network of dental providers who care for patients in safety-net systems. The members of NNOHA recognize the importance of oral health as part of overall health and are committed to improving the health of the country's underserved individuals. NNOHA was founded in 1991 by a group of Health Center Dental Directors who recognized the need for peer-to-peer networking and collaboration to effectively run Health Center oral health programs.

NNOHA's VISION

Individuals and communities are aware of the importance of oral health to overall health, engage in recommended oral health practices, and receive affordable, high quality oral health services.

NNOHA
National Network for Oral Health Access

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Operations Manual
For Health Center Oral Health Programs

Chapter Four: Clinical Risk Management

4

Version 1.0

NNOHA
National Network for Oral Health Access

Operations Manual
For Health Center Oral Health Programs

Chapter Four: Risk Management

Version 1.0

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NNOHA
National Network for Oral Health Access

The mission of the National Network for Oral Health Access (NNOHA) is to improve the oral health of underserved populations and contribute to overall health through leadership, advocacy, and support to oral health providers in safety-net systems.

First printing – September 2011

Note: The information in this document was accurate at the time of this printing. As regulations and information regarding Health Centers are not static, NNOHA recommends readers verify any critical information with different state/federal regulations and changes that may have occurred since printing.

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NNOHA
National Network for Oral Health Access

Executive Summary

Risk management is an important component of the overall operation of the Health Center. It aids organizations in providing quality services while reducing liabilities, and protects both the providers and patients from negative consequences. This chapter explores topics related to clinical risk management in Health Center oral health programs, including:

- Definitions of risk management;
- Risk management tools;
- High risk areas;
- Addressing practitioner mistakes and patient complaints; and
- The Federal Tort Claims Act.

The first step in risk management is avoiding risks. Knowing common mistakes and high risk areas enables providers to prevent errors and make sure that the services are provided with utmost care. When mistakes are made, providers should address them properly in order to ensure not only the protection for the Health Center, but also the safety of patients. NNOHA provides this chapter so that these key points are at the fingertips of the Health Center oral health program team.

CLINICAL RISK MANAGEMENT

TABLE OF CONTENTS

1. Introduction

Risk management is important for organizations to understand and apply in order to reduce liabilities while providing quality services. For Health Centers[1], this concept is especially vital, because they provide services and care to underserved populations who tend to have more complex dental needs and more opportunities for risk. Most risks are preventable, and identifying the potential areas of risk for an oral health program protects the providers and their patients. This chapter provides an overview of the elements of clinical risk management that are relevant to Health Center oral health programs. Clinical practice and malpractice issues are only one type of risk facing Health Centers. Other types of risk may include legal, financial, or operational, but the purposes of this chapter will mainly be to address the clinical issues that face Health Center Dental Directors. Knowing relevant regulations and standards, as well as common problems and errors, will empower Dental Directors and other oral health providers to manage risks and provide quality care to patients in a safe environment.

2. Learning Objectives

Upon completing this chapter, the reader will gain a better understanding of:

- What risk management is;
- Common risks involved in the practice of oral health care;
- Ways to prevent common risks;
- How the Federal Tort Claims Act (FTCA) can protect Health Centers and their providers; and
- How ethics and risk management work together.

[1] Terminology: "Health Center" is the term commonly used to refer to Community Health Centers, migrant and seasonal worker health centers, health centers that treat the homeless, and centers that treat residents of public housing. Authorizing Section 330 legislation has officially changed the term "Community Health Center" to the accepted term "Health Center" and that is the term used throughout this manual to refer to these listed types of grant-supported entities.

3. Relevant Documents

AUTHORIZING LEGISLATION - SECTION 330 OF THE PUBLIC HEALTH SERVICE ACT

http://bphc.hrsa.gov/policiesregulations/legislation/index.html

Section 330 is the authorizing legislation for Health Centers. It provides the legal basis for the Health Center program, including definitions, information on grants, populations of focus, audits, and other requirements. The entire text is available at the link above.

HEALTH CENTER PROGRAM REQUIREMENTS

http://bphc.hrsa.gov/about/requirements/index.html

This page contains a summary of Health Center program requirements on the need, services (including staffing), management and finance, and governance, based on the statute and regulations.

THE FEDERAL TORT CLAIMS ACT (FTCA)

http://bphc.hrsa.gov/FTCA/

FTCA is the federal legislation that allows parties claiming to have been injured by negligent actions of employees of the United States to file claims against the federal government for the harm they suffered. The FTCA also provides authority for the federal government to defend against such claims.

POLICY INFORMATION NOTICE 2011-01: FEDERAL TORT CLAIMS ACT (FTCA) HEALTH CENTER POLICY MANUAL

http://bphc.hrsa.gov/policiesregulations/policies/pin201101.html

This document consolidates and incorporates ten (10) older policy documents into one notice and serves as BPHC's primary source of FTCA information.

THE FEDERALLY SUPPORTED HEALTH CENTERS ASSISTANCE ACT (FSHCAA)

http://uscode.house.gov/download/pls/42C6A.txt

Later codified as 42 U.S.C. Section 233 (a) – (n), the FSHCAA makes federal employees of deemed Health Centers, which includes their employees, officers, directors, and certain contractors. The purpose of defining specific Health Center staff as *employees* is to provide medical/dental malpractice insurance, thereby, conferring FTCA protections on these organizations and individuals.

4. What Is Risk Management?

Risk management is the identification, assessment, and prioritization of risks (*the effect of uncertainty*) and the application of resources to minimize, monitor, and control the probability or impact of adverse events. It specifies information needed by providers, leaders, and staff to minimize risks for their oral health programs, and next steps if an error occurs.

This chapter will deal primarily with risk management to prevent and mitigate adverse events in relation to clinical practice and patient outcomes. However, risk management is much more than addressing clinical errors– it has broader applications. At an organizational level, many types of risks are being managed. Examples include compliance with *Health Insurance Portability and Accountability Act of 1996* (HIPAA) regulations to avoid the risk of improper disclosure of personal information, risks resulting from facility operations that could cause injury to patients and employees, and inadequate or improper personnel policies and procedures that put the organization at risk. For Health Center-wide issues that do not relate directly to clinical practice in the oral health program, Dental Directors should be working in conjunction with other staff (e.g Chief Executive Officers, HIPAA compliance officers, privacy officers, Chief Operations Officers, office managers etc.) to develop and implement center-wide risk management policies and procedures in the dental clinic.

Successful risk management involves developing and implementing systems that minimize the probability of adverse events in all aspects of providing care. Dental Directors should insure that the oral health program is in compliance with all aspects of the HIPAA regulations and is following Health Center policies and procedures regarding release of records. Those policies should be consistent with state and federal laws and regulations.

Physical facilities are another area of risk management. This includes compliance with relevant regulations regarding the American Disabilities Act (ADA) access and establishment and implementation of policies and procedures to prevent work-related injuries and illnesses. Another area of concern is provision of appropriate translation services in compliance with Culturally and Linguistically Appropriate Services (CLAS) standards. Again, these activities are conducted on a Health Center-wide basis, but are implemented in the oral health program.

Most Health Centers, as part of their quality improvement plan, have an incident reporting system in place which can be utilized when adverse incidents occur in all aspects of Health Center operations. Through this process, lessons are learned to prevent future similar incidents.[2] These lessons become part of future risk management activities.

[2] A sample Incident Form can be found on NNOHA's website at http://tinyurl.com/IncdForm.

Additional Definitions

- *Risk management includes any activity, process, or policy to reduce liability exposure.*

(OIG Final Report: Risk Management at Health Centers, OEI-01-03-00050 Feb. 17, 2005)

- *Risk management: creating and applying a system of procedures to reduce exposure to various types of liability.*

(NACHC Information Bulletin #8: Implementing a Risk Management Program for Your Health Center, December 2003: http://www.nachc.com/client/documents/publications-resources/rm_8_03.pdf)

- *Risk management is something you do to provide the best possible care for your patients; it is not about avoiding a lawsuit.*

– David Rosenstein, DMD, MPH

5. Risk Management And Quality Assurance

In terms of clinical practice, risk management and quality assurance (QA) are often used synonymously; however, while related, they have conceptual differences. QA refers to activities that help define, design, assess, monitor and improve the quality of health care.[3] QA activities may be integrated with supervising health care providers and other efforts to improve productivity, provider performance, and the overall quality of health services. QA is a means of accomplishing risk management in a specific area – clinical practice. It certainly is not, on its own, the equivalent of a risk management program.

Risk management, as described by The Indian Health Service, has proactive and reactive components.[4] Proactive activities prevent adverse occurrences or losses, help to *improve the quality of patient care, and reduce the probability of an adverse outcome turning into a medical malpractice claim*. Efforts that prevent and minimize risks contribute to QA, which is one area where QA and risk management overlap. Reactive actions include responses to adverse occurrences or claims.

Most importantly, risk management and QA are both essential elements of patient safety. Providers are responsible for assessing and controlling risks, as well as monitoring and improving quality of services, which ensure their patients receive the best treatment possible.

[3] The Quality Assurance Project, Sustaining Quality of Healthcare: Institutionalization of Quality Assurance: http://www.chs-urc.org/pdf/monographinstitQA.pdf

[4] Indian Health Service, Risk Management & Medical Liability: A Manual for Indian Health Service & Tribal Health Care Professionals, http://www.ihs.gov/nonmedicalprograms/nc4/Documents/RM2_a.pdf.

6. Standard Of Care

In common law, a *tort* is a wrong that involves a breach of duty owed to someone else, that causes injury. The person who suffers injury is entitled to receive damages from the person or people responsible. In health care/dentistry, the most prominent tort liability is negligence or malpractice. In order for negligence to exist, the following four elements must be found:

1. A duty (standard of care) was owed by the dentist to the patient.
2. The dentist violated the applicable standard of care.
3. The plaintiff suffered a compensable injury.
4. Such injury was caused in fact and proximately caused by the substandard conduct.[5]

Standard of care is an important concept of risk management and is defined in court case Blair vs. Eblen (and adapted here for dentists) as: "[A dentist is] *under a duty to use that degree of care and skill which is expected of a reasonably competent* [dentist] *acting in the same or similar circumstances*."[6] The *standard of care* can change over time based on emerging clinical practice, prevailing knowledge and court case precedent. Providers are advised to keep abreast of changes in dental practice. As there can also be geographic variations in the standard of care, the American Dental Association (ADA) regularly updates its *Principles of Ethics and Code of Professional Conduct*[7] but also recommends consulting local counsel regarding the prevailing standard of care in a provider's community.

7. Ethical Practices And Risk Management

Ethical practices are the foundation of risk management programs, and both ultimately benefit the patients and improve the Health Center's quality of care. When providers practice ethically, they mitigate many of the Health Center's risks–it can act as a tool to manage risks.

Ethics in oral health programs apply moral principles to the practice of dentistry and include five general principles expressed in their code of ethics:

1. Patient autonomy (self-governance)
2. Nonmaleficence (do no harm)
3. Beneficence (do good)
4. Justice (fairness)
5. Veracity (truthfulness)

[5] Joseph P. Graskemper, D.D.S., J.D. (2004). The standard of care in dentistry: Where did it come from? How has it evolved? *The Journal of the American Dental Association*, 135 (10), 1449-1455.(Author references King JH. *The law of medical malpractice in a nutshell*. 2nd ed. St. Paul, Minn.: West Publishing; 1986)

[6] Blair v. Eblen, 461 S.W. 2d 370, 373 (Ky 1970).

[7] ADA Code of Ethics: http://www.ada.org/194.aspx

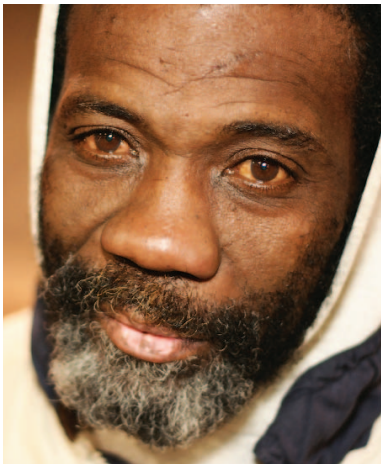
Unethical practice causes risks for providers and their patients. The first principle of patient autonomy refers to the patient's right to be informed about his or her treatment and protection of confidential patient information. Providing full informed consent prior to dental procedures, followed by appropriate documentation, are important elements of risk management in an oral health program. If the first ethical principle is compromised, it violates legal statues and exposes the practice to liability. Protection of patient information, coupled with complete and accurate progress notes, are the best supporting documentation in a malpractice defense. Each of the five principles has a risk management component, providing an effective barometer for a risk management program. While ethical practice is the foundation for risk management, human error can occur even when providers are acting ethically–a complete risk management program provides a framework to control for human error as well.

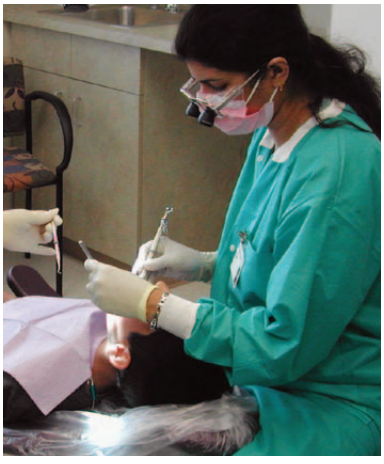
8. Top 10 Clinical Practice Risks

The following list represents the ten most common reasons for FTCA dental torts claims based on a consensus of consulting dentists, which were contracted to review malpractice claims. The list of risk areas is instrumental for Health Center leaders in the process of developing or enhancing their risk management programs.

TOP 10 POTENTIAL RISK AREAS FOR HEALTH CENTER ORAL HEALTH PROGRAMS:

1. LACK OF INFORMED CONSENT
2. FAILURE TO DIAGNOSE
3. LACK OF A THOROUGH EXAM
4. FAILURE TO FOLLOW-UP ON EMERGENCIES
5. TREATMENT OF THE WRONG TOOTH
6. SURGICAL COMPLICATIONS
7. REMOVABLE PROSTHETICS
8. LACK OF/INADEQUATE TREATMENT PLAN
9. INCOMPLETE TREATMENT
10. INAPPROPRIATE PROCEDURES





❶ Lack Of Informed Consent:

The American Medical Association (AMA) defines informed consent as the *process of communication between a patient and a physician that results in the patient's authorization or agreement to undergo a specific medical intervention.* Providers may find it helpful to think of informed consent as the process of getting the patient's permission to pursue a certain course of treatment.

It is important to have a *signed* informed consent form, as well as: **1)** a statement of the diagnosis in the treatment record; **2)** proposed treatment options; **3)** procedure to be performed, and **4)** a statement that risks and benefits were discussed with the patient. Detailed information that is shared with patients and well documented helps patients understand exactly what is involved in their treatment, and minimizes conflicts later. If the patient is non-English speaking, the communication should be provided in his or her preferred language. It is the provider's responsibility to ensure the form is signed and dated by the patient, the dentist, and a witness. According to the UDS data 37% of patients are pediatric. Refer to the AAP website for their latest guidance on informed consent in children: http://pediatrics.aappublications.org/content/119/2/405.full.pdf

Providers also realize that having a signed consent does not completely protect them from a lawsuit. Employing best practices of quality care, providers listen to what is important to the individual. They use clear and culturally-sensitive terminology when discussing the patient's expectations, the risks and benefits of specific procedures, and alternative treatment options regardless of the ability to pay for procedures. At the end of the discussion, it is always good practice to ask if there are additional questions. The conversation is then documented in the chart notes and indicates that all questions were answered and understood by the patient. It should be documented that the patient verbalized an understanding of the nature of the treatment/procedure, including the risks and benefits.

In some cases, the best treatment is no treatment. Most dental problems can be safely postponed until the patient demonstrates a full understanding of what the provider is proposing or until after the patient receives another opinion. However, if a patient has a serious acute emergency, providers ensure he or she understands the ramifications of delaying definitive care. Having a patient sign an *informed refusal of care* form, similar to a hospital's *against medical advice* discharge, and documenting it in the chart notes is a tactful precaution. Each organization needs to have procedures in place that adhere to the regulations of individual States. Informed consent gives the patient the opportunity to weigh and respond to risks. It allows the patient to understand the nature of the treatment or procedure and to be a part of the decision-making process regarding his or her own health.

When treating a patient who is a minor, providers assume that, in most situations, minors are legally unauthorized to give consent and parent or guardian authorization is necessary. Health Centers are required to have policies regarding consent for minors taking into account state laws and regulations, with documented potential exceptions, and ensure providers are aware of these policies. In addition to age, there should also be some consideration of obtaining consent from individuals with decreased competency for other reasons such as mental or developmental disability. Informed consent needs to be geared towards the individual patient to assure that they understand the procedures, the risks, and any other options.

❷ Failure To Diagnose:

This area overlaps with the next risk, *Lack of a Comprehensive Exam*, because performing a thorough examination assists providers in providing patients with an accurate diagnosis. Common examples include:

a. Failure to diagnosis and document periodontal disease status is the leading problem in this area. Documentation of pocket depth is insufficient. Additionally, it is important to document diagnoses. There are some cases where providers confuse treatment procedures with diagnoses. For instance, it is common to find "tooth #9, MIF composite," instead of "MIF dental caries on tooth #9."

b. Missing signs of early oral cancer lesions or other oral pathology are other common diagnostic failures. Dental providers are responsible for performing a comprehensive oral cancer examination, including a review of the patient's medical and dental history. Comprehensive examinations enable providers to avoid potential legal liability and, more importantly, provide the best care for their patients. Suspicious lesions that persist longer than a week should be biopsied. Such a referral is followed up to ensure the patient presented for biopsy. If not, follow-up procedures are documented clearly in the patient record. There should be a "protocol" regarding referrals and follow-up care, similar to the medical follow-up for a positive pap smear.

c. Failure to diagnose X-ray anomalies, which may require additional investigation. Patients are informed and the conditions noted, even if care is not immediately indicated (for example, asymptomatic supernumerary teeth). With the availability of electronic health records, intraoral and extra-oral photographs of pathology lesions are recommended as part of the patient's health record, because they document baseline comparison for future exams.

d. Increasingly, failure to refer a patient to a medical provider or social services can place dental practitioners at risk. This includes a patient who may present with the oral manifestation of a systemic illness (HIV infection, bulimia, diabetes, etc.), or for an individual who needs follow up for management of a chronic disease (high blood pressure etc.). Dental radiographs may also detect individuals with poor bone density, which may be a sign of osteoporosis. A patient who presents with evidence of physical and mental problems and signs of abuse, that are obvious to an observant practitioner, also receives appropriate referrals. The patient is asked if he or she is seeing a provider for these problems, and the answers are documented.

e. Failure to diagnose other common conditions, such as, cracked tooth syndrome, temporal mandibular joint dysfunction, orthodontic conditions, and endodontic pathology can also be a source of claims in this area.

❸ Lack Of A Comprehensive Exam:

Providers are responsible for conducting a detailed examination and documenting it. This includes a medical history, all diagnoses, a periodontal exam and charting, evaluation of the patient's occlusion, soft tissue/oral cancer evaluation, and a sequential treatment plan. All findings are recorded.

A complete medical history is documented and updated at each visit. The patient is asked if there were any changes since the last visit in medical history, new medications, allergies, and pain assessment., Explanations for all yes responses are included. The ADA recommends taking a patient's blood pressure at every visit based upon findings of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure.[8]

Appropriate x-rays and any other diagnostic tests are performed and documented. Providers always obtain appropriate diagnostic x-rays. This recommendation includes pregnant patients. It is considered negligence if x-rays are not taken before providing treatment. If the patient is concerned about the cost or radiation exposure, a signed waiver for refusal to take x-rays may be an inadequate defense in a malpractice suit. The best risk management strategy is for providers to communicate with the patient and encourage consent to what is necessary for a diagnosis. If that strategy fails, then providers may politely tell the patient they cannot provide care without adequate diagnostic information.

A comprehensive treatment plan is developed, discussed and documented for conditions noted during the exam. For some conditions no treatment will be the desired option. Other conditions may require referrals to outside providers for care beyond the clinic's scope of service.

> *"A provider's first line of defense is thoroughly documenting a patient's history. If it is not in the record, you have not done it. It is not enough that the patient writes it down. There has to be an indication that you have looked at that. You have to have everything that you have found in the mouth in your records…. You need to note everything, not just what you are going to do."*
>
> **– David Rosenstein, D.M.D., M.P.H.**

❹ Failure To Follow Up On Emergency Cases:

A well-managed Health Center has a policy and protocol to deal with emergency patients. Not every individual needs a post-op visit, but some follow-up is required for every patient; patients with acute infections especially require careful observation. Calling patients 24 to 48 hours after a surgical procedure is considered a best practice for quality care. It allows providers to catch any complications early, and assures patients that the Health Center prioritizes their health. An effective strategy used by providers is a pre-printed *post-procedure follow-up* form for the chart. Emergency patients are always cautioned to go to the emergency room if their condition worsens or fails to improve after office hours. A hospital-like emergency discharge form is both retained in the records and given to patients when they leave, in addition to any post-op instructions. The form includes information about the procedure performed, a need for follow-up care, and risks for the patient, if care is delayed.

Even patients who require off-site referrals for acute emergency care benefit from follow up. A best practice is to schedule the referral appointment with the patient present in the Health Center dental clinic. It is equally important to ensure the information is discussed with the patient using a literacy level appropriate to the patient's cognitive level and to document patients verbalization of understanding.

[8] More information on blood pressure protocols can be found on the ADA's website at http://www.ada.org/.

❺ Treatment Of The Wrong Tooth/Wrong Site:

A frequent malpractice claim filed against providers is for treating the wrong tooth or site. Instituting operational procedures coupled with patient education can mitigate these risks. First, providers ensure there is a documented diagnosis for every tooth considered for extraction, and the informed consent process is completed on the day of the procedure. This is followed by a verification procedure by the patient, surgical assistant, and oral surgeon to reconfirm which tooth will be extracted. Both the surgeon and the assistant again confirm the tooth before its actual removal. When providers reaffirm verbally the procedure and location with their patients before it is performed, it is known as a *Time-Out* period.

TIME-OUT

- The Joint Commission, an independent, not-for-profit organization that provides accreditation and certification for health care organizations, established the *Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery*. One principle is to perform a **Time-Out** before the procedure (UP.01.03.01). All clinics accredited by the Joint Commission are required to follow this guideline.

- The purpose of the Time-Out is to conduct a final assessment that the correct patient, site, and procedure are identified. This requirement focuses on those minimum features of the time-out. Some believe that it is important to conduct the time-out before anesthesia for several reasons, including involvement of the patient. An organization may conduct the time-out before anesthesia or may add another time-out at that time. During a time-out, activities are suspended to the extent possible so that team members can focus on active confirmation of the patient, site, and procedure.

- A designated member of the team initiates the time-out and it includes active communication among all relevant members of the procedure team. The procedure is not started until all questions or concerns are resolved. The time-out is most effective when it is conducted consistently across the organization.

Source: http://www.jointcommission.org/assets/1/6/2011_NPSGs_OBS.pdf

Allegations of removing the wrong tooth are also particularly common when a patient comes in with an emergency and points to a particular tooth as the source of pain. Providers educate patients on the possibility of referred pain, or that adjacent teeth may be involved. For example, a provider advises the patient that the tooth in question has a problem and should be extracted; however, there may be other teeth with problems that can contribute to the pain he or she is experiencing. After this tooth is extracted, the patient may notice pain from the other teeth. That does not necessarily mean the wrong tooth was removed; it usually indicates there is more than one problem. This is why it is important to document the subjective and objective diagnostic information that led to the decision to extract or treat a particular tooth.

6 Surgical Complications:

The only sure way to completely avoid surgical complications is to never perform any surgical procedures. Eventually, providers encounter surgical complications regardless of how carefully they practice. The best strategy to manage these risks is to discuss them with the patient before the procedure is started, and include these discussions in the informed consent documentation. Written and verbal post-operative instructions are given to the patient in his or her preferred language. Possible surgical complications include:

- **Infection –** Many teeth extracted at Health Centers are extracted due to the presence of infection. The patient may not understand that the severe caries or periodontal disease necessitating a tooth extraction is due to a pre-existing infection. Providers need to inform the patient that they are extracting a tooth in the presence of an infection. Most times, removing the source of infection resolves the problem, but there is a chance that infection may worsen. Providers are advised to prescribe antibiotics judiciously when indicated, and inform the patient to return immediately if the swelling worsens, particularly when it involves the infraorbital area, or the submandibular space. The patient is instructed to go to the emergency room when a provider is unavailable. This information should be included in the post-op instructions.

- **Sinus Perforation –** X-rays should be carefully examined before extracting teeth in the posterior maxilla for sinus floor proximity. Referral to an oral surgeon is an option. When the tooth needs to be removed but the sinus may be exposed because of the tooth's close proximity to the sinus, it is recommended that providers show the patient the x-ray and help him or her to visualize the potential risks. Providers also communicate to the patient that additional procedures and costs may be incurred in association with closing a sinus exposure, should one occur. If providers are willing and able to perform this type of extraction, they also should be familiar with how to close an oral-antral communication or have a location where patients can be referred immediately.

- **Fractures –** Providers are alert for conditions that may make the patient more susceptible to fracture, and look for signs of osteoporosis or tooth position that increase this risk. An angular lower third molar impaction or isolated terminal maxillary tooth is approached with care and requires good surgical techniques, or referral to a specialist.

- **Nerve Damage –** Most often, nerve damage is a result of removing the lower third molars with close proximity to the inferior alveolar nerve, although there have been cases associated with nerve block local anesthetic injections. This requires careful examination of the radiographs. If a patient develops paresthesia after an extraction or the administration of a local anesthetic, the patient must be followed-up and a referred to an oral surgeon is indicated if the paresthesia does not resolve within a certain time frame.

- **Miscellaneous –** If a patient experienced elevated blood pressure before or during the procedure, blood pressure is taken post-extraction as well. Every tooth extracted is visually examined with care to ensure the entire root structure was removed. When in doubt, providers can take a post-operative x-ray to verify. If providers discover they extracted the wrong tooth or made any error that can potentially harm a patient, they first talk to the patient, contact their compliance officer, and then document the events appropriately.

With all these possible surgical complications, anticipation is the key to mitigating risks, and patients appreciate the knowledge and expertise in correctly diagnosing the potential problem. Providers always give patients the option of referral to a specialist, and only attempt these types of extractions if they have proper training and experience in performing the procedures. Any time a surgical complication is faced it is important to have a close relationship with the oral surgeon and based on the severity of the event, to call them, explain the complication in a detailed way, and follow their recommendation. Most times the surgeon will validate the general dentist's management of the situation, and all the times they will make recommendations that align with the standards of practice of the specialty. It is very important that the provider document that conversation in the patient's record.

7 Removable Prosthetics:

The most common risks when providers create or repair dentures for their patients are mitigated through effective communication and patient education. Patients often have unrealistic expectations about the end results, and the provider needs to determine the patient's expectations before starting. Patient satisfaction increases when providers set expectations of what dentures can and cannot accomplish in practical and understandable terms, and explain that functionality of dentures is dependent on patient anatomy, ridge morphology, and adaptive capacity. The provider can remind the patient that dentures are not a substitute for teeth; they are a substitute for NO teeth. Attitude is critical. Talk about the possible need for adhesive, acclimation time for speaking and eating with "new" teeth, anticipated life expectancy for the prosthetic, etc. When repairing or replacing a set of deteriorating dentures that a patient has worn for many years, providers take time to explain that the repaired set may feel differently and require a period of adjustment, and may never feel like the "old set." These conversations are also documented in the patient's chart. Providers are also responsible for educating their patients on new technologies such as implants, which may improve denture function, even if the patient cannot afford this intervention or this service is not offered. Providers should be cautious about taking on cases that might not work or are beyond the scope of their competency and should always have a signed consent form.

8 Lack Of Or/Inadequate Treatment Plan:

Treatment planning is defined as the process of *formulating a rational sequence of treatment steps designed to eliminate disease and restore efficient, comfortable, esthetic masticatory function to a patient.*[9] A complete treatment plan, based on a thorough assessment and discussion with the patient, is critical in assuring the quality of care; it is the road map for the next steps. An inadequate or absent treatment plan creates risk for the Health Center as does a plan that is undocumented. While providers may understand the next steps and processes for their patients, not having it documented in the chart raises issues if another provider unfamiliar with the case reviews the charts. Providers are also responsible for reviewing the treatment plan with the patient and documenting the review in the chart.

[9] Hook, Charles R., et al. (2002). Treatment Planning Processes in Dental Schools. *Journal of Dental Education*. 66(1), 68-74.

9 Failure To Complete Procedures:

Treatment started in good faith is sometimes not completed for a variety of reasons. For example, a patient does not understand multiple visits are needed to complete the treatment or fails to attend follow-up appointments or referrals. Often, a patient believes that the absence of pain means further treatment is unnecessary, or fees become barriers to care. Providers are responsible for ensuring the patient follows the proposed treatment once it has been initiated. In the interest of providing the best care while being conscious of potential risks, providers should develop a system that follows up on patients' care once they leave the Health Center. A good system includes documenting the communication of which patients are aware their treatment is incomplete and know the recommended next steps; documentation of all follow-up communication, such as, phone calls and letters is also kept in the chart.

MALPRACTICE SCENARIOS

- Dr. A at Best Care Health Center gave his patient, who presented with a carious lesion extending into the pulp, the options of extraction, endodontic care, or no treatment. The patient decided to start endodontic treatment, and Dr. A removed the pulp and referred the patient to an endodontist. Dr. A informed the patient verbally and on the written referral slip (a copy of which was placed in the chart) that if the endodontic treatment was not completed, there could be further complications. When the patient learned of the cost for the endodontic treatment, coupled with currently being out of pain, he chose not to continue with endodontic treatment. A year later, the patient's tooth became symptomatic and broke off below the gum line, and the patient required a surgical extraction to remove the tooth. The oral surgeon asked the patient, "Who started the root canal and did not finish it?" The patient sued Dr. A. A review of the case showed that the patient had selected to start endodontic treatment and there was documented evidence that the patient had been informed of the possible complications of non-treatment in both verbal and written form. The case did not proceed.

- Dr. B, a Health Center dentist, extracted tooth #17 on a patient. The patient was scheduled to return the following week for suture removal but did not attend the appointment. The patient returned 5 months later stating that his lip was numb. Dr. B told the patient to return in two months for follow-up, but the patient did not return. Approximately 2 years after the extraction, the patient went to an oral surgeon for a consult regarding the numbness. By this date, too much time had elapsed from the date of injury for successful nerve reconstruction surgery to be performed. The patient sued Dr. B. A review of the case by the insurance/dental consultant revealed that the provider was at fault because of improper follow-up within the appropriate time-frame after the adverse outcome had been identified.

AVOIDING ABANDONMENT CLAIM

Dentists can be charged with allegations of abandonment if they terminate the doctor-patient relationship without reasonable notice or reasonable opportunity for their patients to arrange for dental care with a new provider. Providers are legally responsible to continue care for their patients until services are no longer required, the patients terminate the relationship, or providers give sufficient notice for their patients to withdraw from care. Dentists are required to follow their Health Centers' policies before deciding to withdraw from care.

10 Inappropriate Or Unnecessary Procedures:

Inappropriate or unnecessary procedures such as unnecessary endodontic treatment, excessive bleaching, or other questionable care, can leave providers at risk for malpractice claims. For example, a provider should be careful when deciding to remove functioning silver fillings to be replaced with composites. Be cautious if the patient believes that dental amalgams are the source of ongoing medical problems. If the medical condition fails to improve, the patient may find fault with the work, develop dental hypersensitivity, or become upset that they have incurred an unnecessary expense. Providers may want to exercise caution with any procedures whose primary function is not about improving oral health.

PATIENT FEE DISPUTES

Fee disputes are not professional negligence and are not covered by the FTCA. However, fee disputes can be a source of patient complaints and could lead to malpractice claims. It is worth considering ways to avoid fee disputes with patients.

If oral health program policies and procedures regarding fees, billing and collection are followed, and patients understand what their financial responsibilities will be, fee disputes are often avoided. Part of that discussion is to ensure patients understand the fee is an *estimate* for planned services, and to prepare for unexpected issues that arise, which incur additional charges. This documented discussion also becomes part of the signed treatment estimate. After a patient complains about charges, it is more challenging to diffuse the situation and may not be worth the money or effort to engage in a confrontation.

If a provider has started an irreversible procedure on the patient (endodontic or fixed prosthetic care, for example), he or she cannot refuse to complete the case, even if the fee has not been paid in full. Refusing to complete the procedure is a potential legal risk, because a claim of patient abandonment can be filed. When providers satisfactorily complete the procedure, they can remind the patient about the outstanding balance before beginning other treatment.

9. Documentation And Clinical Risk Management

The purpose of an electronic or written chart is to maintain a patient's records and treatment. When a chart is legible, minimizes the use of abbreviations, and thoroughly documents a patient's case, it makes successive treatment for the patient more efficient and appropriate and increases quality of care. Additionally, there are connections between documentation and risk to the Health Center/ practitioner. Many malpractice cases are lost as a result of poor documentation hindering the ability to defend a malpractice suit, rather than poor care. Poor documentation may also result in an inability to substantiate billing, posing risk of the appearance of fraud.

The following recommendations can mitigate risk from documentation errors in paper and electronic dental records:

- Make sure each entry is dated and signed clearly (in blue or black ink if paper record) with appropriate identifier for the treating provider as required by state or organizational requirements (initials, last name, numerical identifier etc.).
- Include any discussions with the patient in the progress note.
- Record amount, quantity, and names of materials used in procedures performed. For surgical extractions document and explain the specifics. For example, indicate if flap reflected, bone removed, number and type of sutures placed, etc.
- Developing electronic templates for every procedure code takes time initially, but the investment makes the process more efficient later. It is more difficult in offices with more than two providers.
- If a patient is on Coumadin, aspirin, or other medication that affects the delivery and outcome of treatment, identify that condition for medical alerts (for example the yellow flag in some EDR systems).

TOP TYPES OF ERRORS IN RECORD KEEPING

1. Treatment plan is not documented.
2. Health history is not clearly documented or updated regularly.
3. Informed consent is not documented.
4. Informed refusal is not documented.
5. Assessment of patient is incompletely documented.
6. Words, symbols, or abbreviations are ambiguous.
7. Telephone conversations with patient are not documented.
8. Treatment rendered is not clearly documented.
9. Subjective complaints are not documented.
10. Objective findings are incompletely documented.
11. Illegible documentation (paper records).
12. Lack of signatures or illegible signatures (paper records).

(Adapted from the American Dental Association, CMIRP Malpractice Survey, 2005.)[10]

[10] Providers can use the following resources to organize the charts and ensure patient safety: The Joint Commission Official "Do Not Use" List of Abbreviations: http://www.jointcommission.org/assets/1/18/Official_Do_Not_Use_List_6_111.PDF, American Dental Association "Dental Abbreviations, Symbols and Acronyms": http://www.ada.org/sections/professionalResources/pdfs/dentalpractice_abbreviations.pdf

- Scan all documents that contain necessary information that cannot be recorded in electronic dental records.
- Additions or amendments to records must be documented appropriately to avoid the appearance of surreptitiously altering treatment records to cover up adverse incidents. In paper charts additions must be dated and initialed. In EDR, providers should use the append notes function (or similar) to add to their notes.
- Invest time and resources to configure the electronic system or paper forms (exam charts, consent forms, post-op instructions) to maximize compliance with good recordkeeping and risk management practices.
- Follow Health Center policies and procedures regarding creation of medical records. Those policies should be consistent with state and federal laws and regulations.
- Remember, **if it is not documented, it didn't happen**.

SOAP PROGRESS NOTES

SOAP notes can serve as a useful tool when organizing progress notes in the patient record. Typically, **SOAP** progress notes include the following components:

Subjective – the patient's experience of the condition

Objective – the physical findings during clinical examination

Assessment – the updated diagnosis and current status

Plan – the list of interventions to be performed for the patient now and in the future

10. Working Outside Of Competency

There is a fine line between getting training in performing some procedures and being proficient at them. Health Centers must be extremely careful whenever a decision is made to expand services, especially in specialty fields. Health Centers employ very competent dentists who generally have a heart for serving the underserved. Both providers and administrators want to make services available to patients that would not be able to afford them otherwise. Before expanding services CEOs should be educated about the standards of care for the specific specialty and the minimum requirements to designate a provider as proficient in a specific area.

Dentists may find themselves in situations where they feel they are obligated to perform various procedures, some of which may be outside their expertise or competency. When a dentist is inexperienced or uncomfortable with specific procedures, the patient should be referred to a specialist. Dentists employed at Health Centers are in a unique situation. They are aware that they may be the only dental providers in a community of great need

and that many of their patients will experience financial hardship by having treatment performed by a specialist. This may cause a provider to try and perform procedures beyond their level of competency and experience in order to "help" a patient, out of a sense of altruism. This places both the dentist and the patient at risk. The first duty as a dental professional is to safeguard the patient. In addition, dentists should not work outside of the privileges granted to them by the Health Center regardless of their competency to perform the procedure. Doing so would jeopardize FTCA coverage in the event of a claim.

11. Informed Refusal

When a patient disagrees with the recommended procedure and refuses treatment, providers should fully disclose to the patient the risks associated with the refusal and document that the risks associated with the decision were fully discussed with the patient and the patient refused treatment.

The online Safety Net Dental Clinic Manual provides guidelines on handling the informed refusal process:[11]

- If the patient refuses the recommended care, the provider asks about the reasons for doing so.
- If the patient states, or if it appears, the refusal is due to a lack of understanding, the provider re-explains the rationale for the procedure or treatment, emphasizing the probable consequences of the refusal.
- Use of audiovisuals, such as brochures, dental models, videos, or flip charts is helpful.
- The provider documents that: the patient refused the recommended care; the patient's reasons for refusal; the consequences of refusal were re-explained in terms the patient understands, and the patient still refused the recommended treatment. Emphasis is placed on the point that the patient understood the risks of refusing care.
- The provider attempts to obtain the patient's signature on the form or in the chart, which attests he or she was fully aware of the risks and refused the care.
- If the patient is uncooperative, the signature or initials of a witness to this discussion and refusal is entered in the chart or on the form as an alternative.[12]
- The dentist should follow Health Center policies and procedures regarding informed refusal. Those policies should be consistent with state and federal laws and regulations.

[11] Safety Net Dental Clinic Manual: http://www.dentalclinicmanual.com/chapt4/6_14.html

[12] NNOHA's Dental Forms Library hosts various forms related to Health Center Oral Health Programs. For examples of refusal forms, visit: http://www.nnoha.org/dentallibrary.html

Q: How do I document a patient's refusal to undergo a necessary intervention?

A: Your documentation of a patient's refusal to undergo a test or intervention should include:

- an assessment of the patient's competence to make decisions;
- a statement indicating a lack of coercion;
- a description of your discussion with him (or her) regarding the need for the treatment;
- alternatives to treatment;
- possible risks of treatment, and potential consequences of refusal; and
- a summary of the patient's reasons for refusal.

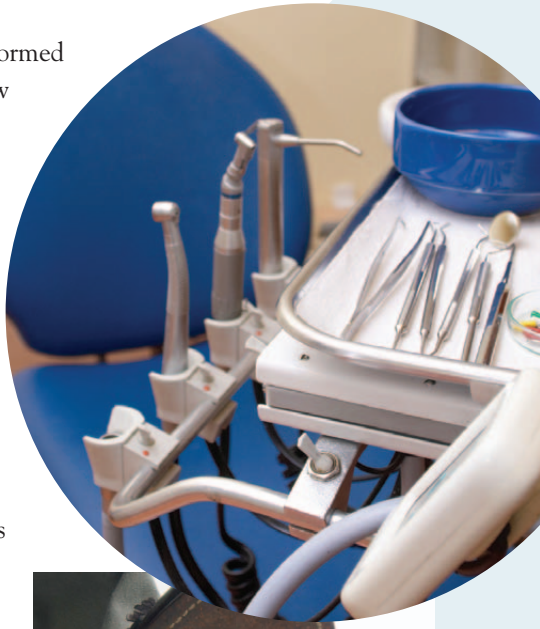
12. Dealing With Patient Complaints

Providers can avoid escalation of a difficult situation or outcome by listening to patients and offering them opportunities to voice their concerns. The best way to deal with patient complaints is to listen, address and satisfy their concerns, learn from the experience, and implement a plan to avoid similar complaints in the future. Providers should follow Health Center policies and procedures regarding patient complaints.

"A patient complaint can be seen as a complaint, and something you have to deal with, or it can be seen as a gift—information that we can use to improve the quality of our patient care."

– Martin Lieberman, DDS

13. Professional Peer Review



Peer review can have several applications in terms of risk management. When performed for quality assessment within a Health Center, peer review generally involves review of dental charts and clinical observation by other providers. This process can identify areas of improvement in documentation and clinical practice in a collegial environment.

The process of *professional* peer review in organized dentistry provides a means for resolving differences of opinion or dispute between a dentist and patient or between a dentist and a third party, and is meant to resolve issues before entering the legal system. There are many different models across the country; the reviewers may be State dental societies, State agencies, State dental examiners, dental quality assurance entities, etc. The ADA's peer review process includes each constituent (State) or component (local) dental society organizing a committee, which consists of dentists, dental specialists, and sometimes laypersons, who volunteer their time and expertise to consider questions about the appropriateness or quality of care, fees and other issues.[13]

14. Next Steps Following A Mistake

Everyone makes mistakes. Having an organized chart and good communication with the patient can help prevent errors, but does not grant immunity from errors. What happens after an error determines the probabilities of the best outcomes for all parties. The professional puts the patient first and everything else second. If a provider becomes aware of an error or problem during the appointment, they are encouraged to not be defensive, remain calm and seek immediate assistance from colleagues or help from an appropriate, evidence-based source, including referral to the appropriate specialist if indicated. It is advisable to stop the procedure, and check references to make sure the situation is being handled as currently recommended. The provider acknowledges the error and documents everything in the chart or electronic dental record. Error disclosure is not easy to do, but is important to the patient and can be a good risk management strategy.

The provider involves the Health Center risk manager, QA department, Health Center management and clinical leadership, or other similar responsible party in the process from the beginning. The patient should not be blamed. A professional provider lives up to their mistakes and is forthright throughout the process.

[13] American Dental Association "Peer Review Resources": http://www.ada.org/1623.aspx

15. The Health Center FTCA Medical Malpractice Program

The Federal Tort Claims Act (FTCA) is the federal law that waives the sovereign immunity of the United States, which permits parties claiming to have been injured by negligent actions of employees of the United States to file claims against the federal government for the harm they suffered. The FTCA also provides authority for the Federal government to defend against such claims.

The Federally Supported Health Center Assistance Acts (i.e. FSHCAA) of 1992 and 1995 stipulate that deemed Health Centers and certain persons, referred to as "covered individuals", are to be treated as employees of the U.S. Public Health Service for purposes of medical malpractice liability coverage. These covered individuals include governing board directors and officers, employees, and certain individual contractors of deemed Health Centers.

Covered individuals are defended by the Federal government against medical malpractice claims for covered activities (acts or omissions) in the performance of medical, surgical, dental, or related functions resulting in personal injury occurring within the scope of employment and within the approved scope of project of a deemed Health Center. A Health Center's scope of project defines the approved service sites, services, providers, service area(s), and target population.[14]

Only Health Centers that are funded under Section 330 of the Public Health Service Act (not look-alikes) are eligible to be deemed. Health Centers must demonstrate in the deeming application that they conduct complete and thorough credentialing and privileging of their providers, that they have implemented appropriate policies and procedures to reduce the risk of malpractice and lawsuits arising out of any health or health-related functions performed by the covered entity including a quality assurance program. Health Centers must submit an application annually to continue to be covered entities in the Health Center FTCA Medical Malpractice Program.

BENEFITS OF FTCA PROGRAM COVERAGE:

- Health Centers no longer have to purchase commercial malpractice insurance. Because of this, these savings can be used to increase patient care.
- Coverage is similar to occurrence-based rather than claims-made insurance and does not have a specific coverage limit with a monetary cap. Therefore, any coverage limits required by other organizations, such as hospitals, are met under the FTCA.
- Covered individuals are immune from personal liability for claims of medical malpractice arising from their deemed employment, contract for services, or duties as an officer or director of the deemed Health Center.
- Suits are brought against the Federal government rather than the provider. Claimants must first seek an administrative remedy by presenting the claim to the Health and Human Services (HHS) Office of the General Counsel within two years after the claim accrues, generally the date of the injury. Cases that make it to trial are heard in federal district court with the plaintiff defended by U.S. Department of Justice attorneys.

[14] For more information about scope of project, see Policy Information Notice 2008-01, "Defining Scope of Project and Policy for Requesting Changes" at http://bphc.hrsa.gov/policiesregulations/policies/pin200801.html.

Who is covered under FHSCAA and the FTCA?

- Medical malpractice protection applies to employees and certain individual contractors of deemed Health Centers. Dentists who are the Health Center's employees i.e. (receive a W-2 form) may be full-time or part-time and receive coverage. There is no requirement on the minimum number of hours or percentage of full-time equivalent (FTE) for part-time employees if they are on the organization's payroll.
- Dentists who are individual contractors (i.e. receive Form 1099) and work more than 32.5 hours per week (i.e. full-time) for the period of the contract for the deemed Health Center.
- Part-time individual contractors who provide family practice, obstetrics and gynecology, general internal medicine, or general pediatric services are covered.

Who is not covered under FHSCAA and the FTCA?

- Volunteer physicians and part-time contract dentists are not covered. In the case of non-covered individuals, such as volunteer physicians and part-time (i.e., averaging less than 32.5 hours per week) contract dentists providing services within the scope of the approved Federal section 330 grant project, the covered entity remains covered, while the individual is not.
- Students or residents training in a Health Center are not covered by FTCA. Malpractice protection for these individuals should be provided through a means other than FHSCAA and the FTCA (generally carried by the academic institution). Heath Center oral health programs participating in residencies and other training programs must have clear contracts with the residency sponsoring organization defining malpractice coverage for attendings and preceptors, students and trainees.

If a patient files a claim under the FTCA, the process includes:

- A complaint filed with HRSA
- A review of the complaint by experts
- A decision by the Department of Health and Human Service (HHS), Office of General Counsel regarding the claim (pay, deny, attempt to settle)
- If there is no payment or settlement of the claim, there is potential for the claimant to file suit against the United States
- FTCA coverage is restricted to acts or omissions of a covered entity that are within the scope of employment of a covered individual. Providers should consult with the appropriate individual within the center (CEO, Risk Manager, Medical/Dental director) regarding FTCA questions. Providers can also call the FTCA Hotline at 1-866-FTCA-Help (382-2435) with questions or concerns

Payments for settlements and judgments come from an account funded with money taken from the section 330 appropriations, funds that would have otherwise been used to make grants to Health Centers. Additional information about Health Center FTCA Medical Malpractice Program is available in Policy Information Notice 2011-01, "Federal Tort Claims Act (FTCA) Health Center Policy Manual" at http://bphc.hrsa.gov/policy/pin1101/.

16. National Practitioner Data Bank

National Practitioner Data Bank (NPDB) was enacted because the U.S. Congress believed that the increasing occurrence of medical malpractice litigation and the need to improve the quality of medical care had become nationwide problems that warranted greater efforts than any individual State could undertake.[15] The intent is to improve the quality of health care by encouraging State licensing boards, hospitals, other health care entities, and professional societies to identify and discipline those who engage in unprofessional behavior; and to restrict the ability of incompetent physicians, dentists, and other health care practitioners to move from State to State without disclosure or discovery of previous medical malpractice payment and adverse action history. Adverse actions can involve licensure, clinical privileges, professional society membership, and exclusions from the Medicare and Medicaid programs.

The NPDB is primarily an alert or flagging system intended to facilitate a comprehensive review of health care practitioners' professional credentials. The information contained in the NPDB is intended to direct discrete inquiry into, and scrutiny of, specific areas of a practitioner's licensure, professional society memberships, medical malpractice payment history, and record of clinical privileges.

What is reported to the NPDB? If one of the following occurs, a report to NPDB is warranted:

- A provider's practice is limited in any way as a result of disciplinary actions
- A payout is made to a patient
- Any action of the Department of Health

Individuals protected by the FTCA may be reported to the NPDB if a payment is made on their behalf. When a provider applies for a position at a Health Center, the provider is subject to a credential search. (This is not the case in most private practice situations.) A listing in the NPDB does not mean a dentist is barred from practicing or employment, but may require follow-up and explanation.

[15] National Practitioner Data Bank: http://www.npdb-hipdb.hrsa.gov/resources/aboutLegsAndRegs.jsp

17. Summary

Risk management is an important part of managing a Health Center oral health program. Risk management is not only about avoiding claims. It is about developing systems that facilitate providing safe, quality, evidence-based care to Health Center patients by reducing organizational and individual provider risk.

For many areas of risk management, the oral health program will be implementing and/or adapting policies and procedures that are being followed by the entire Health Center organization. As related to clinical dental practice however, the Dental Director is the leader in developing and maintaining the risk management program. This includes:

- Establishing a peer review system
- Keeping current with changes in treatment guidelines and the standard of care
- Understanding the primary areas of clinical risk
- Developing standards and systems for documentation of paper or electronic records
- Analyzing adverse events that occur in the clinic as part of a quality improvement process
- Creating a patient-centric environment

Risk management is an ongoing process that yields continuing benefits for the provider, organization, and patients.

18. Frequently Asked Questions

Q: If a new patient who is pregnant comes into the clinic and refuses x-rays for fear of harming the baby, but she is in pain, what should I do?

A: Do not treat this patient without an x-ray. It is beneath the standard of care to provide treatment without proper diagnostic information. Explain about the safety of x-rays and the need to have them for proper diagnosis and treatment. The California Dental Association Foundation released, *Oral Health During Pregnancy and Early Childhood: Evidence-Based Guidelines for Health Professionals* in 2010. It can be downloaded from: www.cdafoundation.org/guidelines.

Q: Should we take full-mouth x-rays on all non-emergent, new patients?

A: Take the necessary x-rays that enable you make a complete and comprehensive diagnosis and treatment plan. Panoramic and bite-wings would suffice the definition of FMX. The ADA has developed guidelines on the type and frequency of x-rays suggested throughout the life cycle: *The use of dental radiographs: Update and recommendations*. It can be downloaded from: www.ada.org/sections/professionalResources/pdfs/report_radiography.pdf

18. Frequently Asked Questions Cont.

Q: Are part-time dentists covered by FTCA?

A: Part-time dentists who are employees of the Health Center (i.e., receive a W-2 form) are covered. Part-time dentists who are contractors are not covered unless they are contracted for at least 32.5 hours per week.

Q: Are volunteers covered by FTCA?

A: Volunteers are **not** covered by FTCA at the time of this writing.

Q: Are visits made to a patient's home covered under our "scope"?

A: Both the site and service must be covered under the organization's scope of project to be covered and considered under "scope"[16]. "Home visits" may be added to a Health Center's scope of project. A Health Center need not add each patient's individual home as a site (they likely would not qualify as sites).

Q: A patient desires a fixed bridge but does not want a full exam or any other treatment due to financial concerns. Should I make the bridge?

A: You cannot provide treatment without first conducting the appropriate exams. This is beneath the standard of care.

Q: What if I work for an organization that does not do quadrant dentistry, but encourages providers to spread out treatment into multiple appointments?

A: NNOHA recommends quadrant dentistry should be practiced whenever possible. Although there are scenarios and patients where different treatment sequences are advised, splitting treatment out into multiple visits for non-clinical reasons is unethical and not consistent with the standard of care. This may also violate encounter-based billing rules.

[16] See Policy Information Notice 2008-01, "Defining Scope of Project and Policy for Requesting Changes" at http://bphc.hrsa.gov/policiesregulations/policies/pin200801.html.

19. Links

- ECRI Institute (ECRI): www.ecri.org/clinical_RM_program
- Evidence Locator: http://www.ada.org/sections/scienceAndResearch/pdfs/evidence_locator.pdf
- Federal Tort Claims Act (FTCA) Health Center Policy Manual (PIN 2011-11): http://bphc.hrsa.gov/policiesregulations/policies/pin201101.html
- The Health Center Program – Federal Tort Claims Act: http://bphc.hrsa.gov/FTCA/
- The Joint Commission: http://www.jointcommission.org/
- *Journal of the American Dental Association:* Joseph P. Graskemper, D.D.S., J.D. (2004). The standard of care in dentistry: Where did it come from? How has it evolved? 135 (10), 1449-1455: http://jada.ada.org/
- NACHC Clinical Issues – Risk Management: http://www.nachc.com/clinicalriskmanagement.cfm
- Ohio Dental Clinics – "Clinical Operations for Safety Net Dental Clinics in Ohio: Informed Consent": http://www.ohiodentalclinics.com/curricula/operations/mod5_9.html
- OSHA Manual for Dentists: http://www.oshamanual.com/dental_OSHA.html
- Safety Net Dental Clinic Manual: http://www.dentalclinicmanual.com/

16. HEALTH CENTER FINANCIALS WORKSHEET

1. **Who is covered by FTCA coverage?**
   a. Volunteers
   b. Part-time employees
   c. Students

2. **What is the number one potential clinical risk area in Health Center dentistry?**
   a. Dentures
   b. Lack of informed consent
   c. Sexual harassment
   d. Poor charting

3. **List ways that you can avoid errors in charting and record-keeping:**

   _____

   _____

   _____

4. **In what area do you think your Health Center is most at risk?**

   _____

   _____

   _____

5. **Explain the "standard of care." How does this fit in your practice?**

   _____

   _____

   _____

6. **How do ethics relate to risk management?**

   _____

   _____

   _____

7. **Which of these is an example of a practice that increases risk?**
   a. Completing a small O on tooth #20, and a small O on tooth #21 in one visit.
   b. Completing a small O on tooth #20 on one visit, and completing a small O on tooth #21 on a separate visit.
   c. Completing sealants on teeth #s 2 and 3 in one visit.
   d. Completing a sealant on tooth #2 on one visit, completing a sealant on tooth #3 on a separate visit.
   e. (b.) and (d.) above

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The National Network for Oral Health Access (NNOHA) is a nationwide network of dental providers in safety-net settings. 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.

For more information on NNOHA, visit www.nnoha.org, send an Email to info@nnoha.org, or call 303-957-0635

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Operations Manual
For Health Center Oral Health Programs

Chapter Five: Workforce and Staffing

Version 1.0

NNOHA
National Network for Oral Health Access

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NNOHA
National Network for Oral Health Access

The mission of the National Network for Oral Health Access (NNOHA) is to improve the oral health of underserved populations and contribute to overall health through leadership, advocacy, and support to oral health providers in safety-net systems.

First printing – November 2011

Note: The information in this document was accurate at the time of this printing. As regulations and information regarding Health Centers are not static, NNOHA recommends readers verify any critical information with different state/federal regulations and changes that may have occurred since printing.

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NNOHA
National Network for Oral Health Access

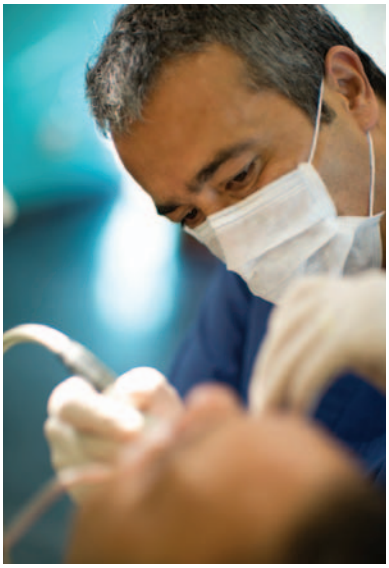
Executive Summary

Workforce issues are a primary concern for Health Center oral health programs that are struggling with recruitment, retention, training, salary and benefit packages and high turnover rates. NNOHA recognizes that a well-trained and committed workforce is required for Health Centers to manage the growing needs for dental services, and to enable the Health Center to fulfill its mission of providing excellent oral health care to its patients while improving the overall health of the community.

This chapter provides helpful tools and resources for tackling the issues related to workforce, and addresses the following questions:

- What are the recommended staffing and equipment ratios?
- What staffing models are applicable for Health Center oral health programs?
- What are some recruitment strategies for Health Center oral health programs?
- What should be included in oral health job descriptions?
- How can Health Center oral health programs retain their staff?
- How can oral health providers work effectively and efficiently as part of the Health Center team?

Health Center oral health programs face the vital task of serving a growing number of patients in the years to come. To meet this growth in demand, the number of oral health providers needs to increase at an unprecedented rate. By adopting creative workforce strategies, Health Centers can view this challenge as an opportunity to increase their capacity and address disparities in care.



WORKFORCE AND STAFFING

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1. Introduction

Health Center[1] oral health programs have grown significantly over the past decade. In 2010, more than 800 Health Centers (72 percent of all Health Centers) offered dental services on-site, compared to 430 in 1999.[2] Health Care Reform will provide access to government health care programs to an estimated 32 million Americans, in addition to 7 million children.[3] This will present extraordinary challenges and opportunities for Health Centers in meeting the needs of the underserved in coming years. As Health Centers add more dental programs, the need for quality providers committed to caring for underserved patients will grow as well.

Health Center oral health providers have the challenging mission of eliminating oral health disparities in underserved communities where patients generally exhibit greater degrees of dental disease due to lack of access and awareness. Health Centers have provided care for over 3.75 million dental patients (approximately 1.2% of the total population of the US) in 2010 and employed or contracted with approximately 1.5% of 186,000 professionally active dentists in the country.[4] While on the surface, this may seem appropriate, (1.5% of the dentists serving 1.2% of the population), the greater needs of the underserved vastly increase the workload of the Health Center dentists. Effectively managing and expanding the Health Center oral health workforce could be one piece of the puzzle in addressing the ever-increasing needs in underserved communities.

This chapter provides helpful tools and resources related to workforce, one of the top concerns for Health Center oral health programs. It offers insights on the subjects of frequently asked questions such as productivity standards, nontraditional staffing, recruitment strategies, and salaries.

2. Learning Objectives

Upon completing this chapter, the reader will gain a better understanding to:

- Identify recruitment and retention strategies for the Health Center oral health program
- Work effectively and efficiently with the Health Center team
- Create a collaborative working environment
- Develop an ideal staffing ratio for their program
- Develop ideas and strategies for training and evaluating staff
- Locate beneficial resources

[1] Terminology: "Health Center" is the term commonly used to refer to programs funded through Section 330 of the Public Health Service Act. It includes 330(e),Community Health Centers, 330(g) migrant health centers,330(h) healthcare for the homeless and 330(i) healthcare for residents of public housing.

[2] Uniform Data System – Health Resources and Services Administration (2010).

[3] Under the Affordable Care Act, more than 32 million uninsured Americans will have access to coverage options (http://www.healthcare.gov/law/infocus/providers/index.html) and CHIP will double the number of children enrolled from 7 million to 14 million.

[4] American Dental Association – "Frequently Asked Questions": http://www.ada.org/sections/professionalResources/pdfs/06_dod_highlights.pdf

3. Relevant Authorities

A. SECTION 330 OF THE PUBLIC HEALTH SERVICE (PHS) ACT

http://bphc.hrsa.gov/policiesregulations/legislation/index.html

Section 330 of the Public Health Service (PHS) Act (Section 330) is the main authorizing legislation for Health Centers. It provides definitions, information on grants, population focus, audits and other general information. The entire text is available at the link above.

B. FEDERAL TORT CLAIMS ACT (FTCA)

Medical Malpractice Program for Health Centers

http://bphc.hrsa.gov/ftca/index.html

FTCA is the federal legislation that allows parties claiming to have been injured by negligent actions of employees of the United States to file claims against the federal government for the harm they suffered. The FTCA also provides authority for the federal government to defend against such claims. For these purposes, health centers that have been deemed covered by the Health Resources and Services Administration, as well as their directors, officers, employees, and certain contractors are considered employees of the United States for claims alleging injury resulting from the performance of medical, surgical, dental, or related functions.

C. POLICY INFORMATION NOTICE 2008-01: DEFINING SCOPE OF PROJECT AND POLICY FOR REQUESTING CHANGES

http://bphc.hrsa.gov/policiesregulations/policies/pin200801.html

This document describes policy for an approved scope of project for Health Centers funded under Section 330, the five components of an approved scope of project, and the policy and process for Health Centers seeking prior approval to make changes in the approved scope of project.

D. HEALTH CENTER PROGRAM REQUIREMENTS

http://bphc.hrsa.gov/about/requirements/index.html

This page contains a summary of Health Center program requirements on the need, services (including staffing), management and finance, and governance, based on the statute and regulations.

E. P.L. 111-148: PATIENT PROTECTION AND AFFORDABLE CARE ACT P.L. 111-152: HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010

http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf

http://www.gpo.gov/fdsys/pkg/PLAW-111publ152/pdf/PLAW-111publ152.pdf

These Public Laws comprise the Health Reform Law, which contains several provisions related to oral health workforce, such as establishment of the Title VII Training Program for dental separate from medicine, National Health Service Corps (NHSC) improvements, and primary care residency funding. Most of the provisions stand as amendments to the Public Health Service Act mentioned above.

4. Recruiting and Hiring Oral Health Professionals

Delivery of quality oral health care services requires well-trained providers and support staff who are dedicated and motivated to support the mission of the program. Recruiting qualified and experienced team members can be challenging when confronted by urgent oral health needs of a community; however, taking time to carefully screen and select appropriate candidates provides long-term benefits for the oral health program. Doing so can build support and collaboration among partners, patients, board members, the community, and current team members, as well as reduce turnover and recruitment costs.

An important consideration when hiring providers is their understanding of the program's mission. New graduates and others unfamiliar with Health Centers should be trained through orientation, mentoring, and observation. Studies showed that when a provider does not understand a Health Center's purpose or does not demonstrate an interest in furthering its mission, the provider is less dedicated to the patients or the center and more likely to leave the program. The *Survey of Health Center Oral Health Providers: Dental Salaries, Provider Satisfaction, and Recruitment and Retention Strategies*[5] published by NNOHA in 2010, identified 39.1 percent of current Health Center dentists chose a career in a Health Center because of their commitment to the dentally underserved. Those providers are less likely to leave the Health Center because of their dedication to the program's mission.[6] The same principle applies to support staff and dental auxiliaries.

Other factors to consider when hiring providers include the program's scope of services, productivity expectations, cultural competency and sensitivity, language considerations and the ability to function in an interdisciplinary team environment. It is important to select qualified providers with the appropriate skills to meet the oral health needs of the population served by the Health Center. The comfort level of the providers in delivering services expected by the community should also be considered. For example, if a Health Center provides a large number of endodontic oral surgery procedures or pediatric dental services, recruitment should focus on providers comfortable with delivering those services. Community-based practice can differ from private practice in that Health Centers

[5] National Network for Oral Health Access (NNOHA) – "Survey of Health Center Oral Health Providers: Dental Salaries, Provider Satisfaction, and Recruitment and Retention Strategies" (2010): http://www.nnoha.org/generalpage.html

[6] Ibid.

may be more likely to have patients with extensive, untreated dental disease, which requires providers skilled in oral surgery, treatment of acute dental conditions and oral medicine.

It is equally important that care be delivered in a manner that is both appropriate and acceptable to the patient population. Cultural sensitivity, experience and comfort with treating a diverse patient population are essential.

New providers should be offered support and training by the Health Center on these and other topics so they can acquire the specific competencies needed to serve the community and grow professionally. Health Centers, like any other employer, should be cautious to avoid violating any employment laws, such as prohibitions on discrimination, through their hiring practices.

SAMPLE STRATEGIES & RESOURCES FOR SUPPORT & TRAINING

There are several ways to improve a provider's clinical skills including observation and mentoring with an experienced provider, as well as online and in person continuing education courses. It is important for new providers to meet with the Dental Director and develop a plan for acquiring and/or developing the specific clinical skills with periodic assessment to monitor progress.

Resources for enhancing cultural competency including the U.S. Department of Health & Human Services, Office of Minority Health sponsored website (https://cccm.thinkculturalhealth.hhs.gov/) which contains an online practical guide to culturally competent care. The website will soon be adding content specifically targeted towards oral health providers. In addition, the National Primary Oral Health Conference also offers clinical and practice management sessions relevant to Health Center oral health programs: http://www.nnoha.org/conference/npohc.html.

A. Recruitment Strategies

In the *Survey of Health Center Oral Health Providers*, Executive Directors reported that advertising in local and national dental journals and recruiting from local dental societies are some of the most frequently-used methods.[7] Alternative methods may be more effective for other Health Centers, depending on their individual requirements.

There are similarities in recruitment strategies for **urban** versus **rural** Health Center locations. A candidate who grew up in a rural area is not necessarily interested in living in a rural community. Relocation to a different environment may be one of the candidate's goals. These examples illustrate the need for a Health Center to research and provide potential candidates with a wide range of information about the service area, such as housing opportunities, school districts, child care, and taxes. If the Health Center is in a rural community, know the distance to the nearest city that provides larger department stores, major concerts, sporting events, and the closest airport. When recruiting candidates, it helps to promote the social aspects of living in the community that align with the interests

[7] National Network for Oral Health Access (NNOHA) – "Survey of Health Center Oral Health Providers: Dental Salaries, Provider Satisfaction, and Recruitment and Retention Strategies" (2010).

of both the candidates and their families, such as local attractions, entertainment, and cultural events. Schools and quality of life are major factors in recruiting.

It is also helpful to inform potential candidates that Health Center careers often provide benefits that are unavailable to those in private practice. Such benefits may include: malpractice coverage; guaranteed salary; continuing education options; paid vacations; paid membership dues; retirement programs; and the ability to collaborate with multidiscipline health providers for the complete and comprehensive management of patients' needs.

There are specific channels through which Health Centers may recruit oral health providers:

i. Scholarship and Loan Repayment Programs

In the NNOHA *Survey of Health Center Oral Health Providers: Dental Salaries, Provider Satisfaction, and Recruitment and Retention Strategies*, currently-employed Health Center dentists ranked their primary reasons for being attracted to a Health Center dental career. Second to *felt a mission to the dentally underserved population* was that *loan repayment was available*. Many individual states offer loan repayment programs, but the largest and most well-known program available to Health Centers is through the National Health Service Corps (NHSC – http://nhsc.hrsa.gov).

Established in the early 1970s, the NHSC is a program of the U.S. Department of Health and Human Services (DHHS), Health Resources and Services Administration (HRSA). NHSC helps facilities and organizations located within Health Professional Shortage Areas (HPSAs)[8] recruit and retain medical, dental, and mental health providers through scholarship and loan repayment programs. Relationships with Dental Pipeline programs, student externships, and residency programs are viable pathways to recruit providers who understand the mission of the Health Center.

NHSC Scholarships (http://nhsc.hrsa.gov/scholarship/) are competitive, and pay for tuition, fees, and a living stipend to students enrolled in accredited dental and other selected clinical training programs. Upon graduation, scholarship recipients serve as primary care providers between two and four years in a community-based site in a high-need HPSA that has applied to and been approved by the NHSC as a service site.

As of November 2010, the **NHSC Loan Repayment Program** (http://nhsc.hrsa.gov/loanrepayment/) offers dentists, dental hygienists, and selected other clinicians up to $60,000 to repay student loans in exchange for two years serving in a community-based site in a high-need HPSA that is a NHSC-approved service site. After completing their two years of service, loan repayors may apply for additional years of support, up to $170,000 for five years of service commitment. In addition, NHSC now offers flexible options for completing service, including a two-year full-time contract, a four-year half-time contract, and a two-year half-time contract.

[8] A Health Professional Shortage Area (HPSA) 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. Each area is assigned a score based on the level of need. For more information, visit: http://bhpr.hrsa.gov/shortage/

Health Centers, rural health clinics, and other sites that care for low-income and uninsured people can become NHSC-approved sites where dentists, dental hygienists, and other clinicians who are eligible for loan repayment funding or have received scholarships can fulfill their service obligation. In order to be approved as a qualifying service site, organizations must be located in a HPSA, provide services on a discounted-fee schedule, and fulfill other obligations. To continue participation in the NHSC programs, it is important for Health Centers to update and maintain their HPSA scores through the appropriate state agency or organization.[9]

The responsibility for applying for and regularly updating HPSAs can lie in various state government or associated organizations. It should also be noted that updated HPSAs are not an automatic, regular occurrence in every state. In some states, re-application must occur with ample time for processing prior to the expiration of the current HPSA.

For more information about NHSC opportunities and requirements, please visit http://nhsc.hrsa.gov/.

Health Centers can also utilize state loan repayment programs. The amount offered and years of commitment vary from state to state.[10] Additionally, some state dental associations offer special loan repayment programs. For example, California Dental Association Foundation has a loan repayment program that pays up to $120,000 for a three-year commitment for dentists who work in underserved areas.

ii. Community Involvement

When recruiting a new dentist or dental hygienist, going outside of the Health Center to involve members of the local community can increase the likelihood to gain buy-in and support. Before approaching stakeholders within the community, as described below, consider conducting a needs assessment and economic impact analysis to prove the value of hiring the new provider. Then, contact these stakeholders, preferably in person, to discuss the benefits of their involvement:

- **Other medical/dental staff in the community**, and other healthcare organizations (e.g., nursing homes, home health agencies, pharmacists, etc.). These groups provide a base of cooperative co-workers, peers for consultation, and friendships for the provider and the family. By being involved, the community members are more likely to feel reassured that the new provider is not a threat to their businesses, may help with their workloads, and can help the economy of the entire community.

- **Community businesses** (e.g., bankers, grocers, schools, chambers of commerce, real estate agents, etc.) and local citizens (e.g., parents, senior citizens, civic groups, public information meetings, etc.). These contacts help the provider and family feel welcomed, help build the provider's patient base, and provide job networking opportunities for the new employee's significant other or spouse. These collaborators influence the attitudes of the community and can effectively communicate that the new hire will boost the local economy, may bring other new employees to the job market, and is an integral player in the health and wellbeing of the community at large.

[9] For more information regarding HPSA designation and its process, visit: http://bhpr.hrsa.gov/shortage/hpsas/index.html

[10] For more information, visit http://www.ada.org/sections/educationAndCareers/pdfs/loan_repayment.pdf, or contact the state loan repayment programs directly.

When Health Centers include one or more of these community members on the **recruitment team**, it can illustrate to candidates that the entire community is interested in their success and creates a welcoming atmosphere. Connecting new providers to other community members helps them feel integrated into the community, a key to both recruitment and retention. Having community members on the team is also a way to share the recruitment work load, provide candidates with easy access to information about the area, and spearhead networking options for the spouse and other family members.

iii. Utilizing Dental Schools, Residencies, and Dental Hygiene Schools

Dental schools, residencies, and dental hygiene schools are excellent sources of providers. Most have alumni departments and job placement or posting services for their outgoing students and alumni. Many allow a Health Center to advertise its openings at no charge. Many dental schools and universities have regularly scheduled recruitment fairs, while others allow Health Centers to present a "lunch-and-learn" or brown bag session to present available opportunities. These recruitment options are especially beneficial if information about Health Center careers is presented concurrently with the NHSC loan repayment option. NNOHA has developed a white paper with more specific information and recommendations regarding successful partnerships with students and residents. Please visit http://www.nnoha.org/generalpage.html for more information.

iv. Private Practices and Provider Associations

The results from the *Survey of Health Center Oral Health Providers* (2010) showed that more than half of dentists and dental hygienists that are currently working in Health Center practices are experienced, having come from private practice settings. Among the dentists, 31.9 percent (179 out of 561 respondents) were previously a private practice owner, partner, or associate dentist, while 18.5 percent (104 respondents) were a private practice dentist prior to their Health Center employment.[11]

For dental hygienists, 70.4 percent were previously private practice associates or employees. These results indicate this particular labor force is a viable recruitment source. Recruiting efforts can be directed to popular professional journals, ADA, ADHA, state/local dental associations, or other venues that private practice dentists and dental hygienists are exposed to on a regular basis.

[11] National Network for Oral Health Access (NNOHA) – "Survey of Health Center Oral Health Providers: Dental Salaries, Provider Satisfaction, and Recruitment and Retention Strategies" (2010).

Health Centers benefit when their dentists and Dental Directors are active members of the local dental society. In the *Survey of Health Center Oral Health Providers*, 69 percent of Health Center dentists reported being members of organized dentistry.[12] Being an active member greatly increases the familiarity of private dentists with Health Centers and opens up numerous avenues for potential recruitment for providers and potential volunteers.

v. Primary Care Associations

Primary Care Associations (PCAs) provide training and technical assistance to Health Centers and other safety-net providers, support the development of Health Centers in their states, and enhance the operations and performance of Health Centers. As part of their services, PCAs often provide recruitment and retention resource programs, such as candidate sourcing and hosting of job postings. Many PCAs utilize NNOHA's job bank (http://www.nnoha.org/dentalcareers.html) to recruit candidates for Health Centers they represent. Others maintain their own listing of state-specific vacancies upon their own website. For a complete listing of state and regional PCAs, visit: http://www.nachc.com/nachc-pca-listing.cfm. A majority of the PCAs also host job banks, and the list of links may be found on the NNOHA website: http://www.nnoha.org/otherbanks.html.

vi. Health Center Controlled Networks

A Health Center Controlled Network (HCCN) is defined as: "A group of safety net providers (a minimum of three collaborators/members) collaborating horizontally or vertically to improve access to care, enhance quality of care, and achieve cost efficiencies through the redesign of practices to integrate services, optimize patient outcomes, or negotiate managed care contracts on behalf of the participating members."[13]

HCCNs have come together to exchange information and establish collaborative mechanisms to meet administrative, IT and clinical quality objectives. Some networks have collaborated on both hiring and sharing of staff, including oral health staff. They have also collaborated on establishment of HIT systems, which could be of immense assistance to oral health programs that are embarking on an EHR selection and implementation process. The concept of sharing, collaborating and integrating in terms of workforce should be considered.

NNOHA'S JOB BANK

NNOHA coordinates a job bank to help connect Health Center dental openings with candidates looking for a career in service to underserved patients. NNOHA members and students looking for career opportunities at Health Centers may also submit an "Opportunity Wanted" ad. For more information, please visit: http://www.nnoha.org/dentalcareers.html

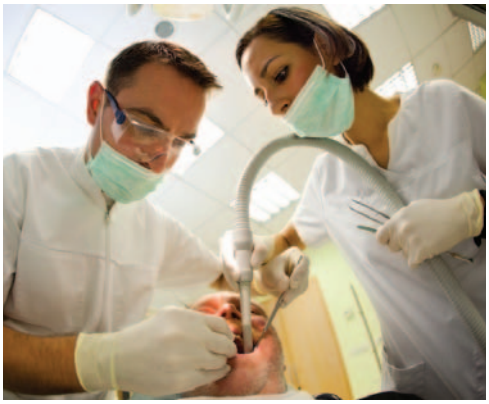
[12] National Network for Oral Health Access (NNOHA) – "Survey of Health Center Oral Health Providers: Dental Salaries, Provider Satisfaction, and Recruitment and Retention Strategies" (2010).
[13] HRSA – What Is a Health Center Controlled Network?: www.hrsa.gov/healthit/toolbox/HealthITAdoptiontoolbox/OpportunitiesCollaboration/abouthccns.html

B. The Hiring Process

i. Creating Job Descriptions

A detailed job description that is specific in terms of program expectations, qualifications, and roles and responsibilities is an essential tool for attracting the right person for any position. There are many online resources that provide guidelines for constructing an effective job description. NNOHA's website provides examples of job descriptions for oral health providers that were developed in partnership with the National Association of Community Health Centers (http://www.nnoha.org/dentallibrary.html). These templates offer an outline of the expectations of many oral health positions. Health Centers may add details that are specific to their programs. In addition, many Health Centers have human resource officers who can assist with creating job descriptions. At a minimum, a job description should contain:

- Job title
- Goals of the organization
- Description of reporting relationship
- General job purpose or function
- Major job duties – daily, periodic, and occasional
- Job responsibilities, including:
  - Nature of supervision, if any
  - Handling of physical or financial resources
  - Judgment- or decision-making requirements
  - Reporting requirements
  - Managing emergencies or on-call responsibilities
  - Education, training, skills or specialized knowledge needed for the position
  - Expected participation in, and compliance with, the compliance program
  - Amount of experience needed for the position
  - Personal characteristics or traits needed
  - Description of physical demands of the position



ii. Qualifications of a Dental Director

Dental Directors need to have a unique set of skills to direct the Health Center oral health team and serve as the liaison with the Executive Team. With their clinical background, they understand how to design and deliver oral health services. It may require additional skills to serve underserved patients. Qualified Dental Directors should also have administrative and management skills to successfully operate oral health programs. While they are often familiar with issues relevant to Health Centers, such as policy and advocacy, financial management, leadership, and public health, Qualified Dental Directors should also know how to work effectively with multidisciplinary teams at the clinical, administrative, and executive levels. Since they are the leaders of their Dental Departments, Dental Directors are responsible for resolving any conflicts that may arise in their programs.

The duties of Dental Directors vary from one Health Center to another depending on the level of responsibility. Because qualified Dental Directors possess clinical skills based on their knowledge and training, enabling them to establish fundamental clinical protocols for their dental departments, this document does not provide details on preventive, primary, and comprehensive treatments. However, the position does involve financial implications affecting Health Centers; therefore, Dental Directors are advised to engage with the Leadership Team for setting these guidelines.

Organizational responsibilities for Dental Directors may include:

- Develop a service delivery model
- Establish standards of performance and quality control
- Establish scheduling and patient flow guidelines
- Coordinate staff recruitment, development and training
- Establish priorities and develop budget
- Complete provider reviews
- Resolve conflicts
- Manage utilization
- Allocate resources
- Assist with the planning for expansion of services
- Ensure completion of customer service and patient satisfaction surveys
- Maintain internal and external communications related to mission and vision
- Develop and update policies and procedures
- Monitor and manage financial viability of the oral health program
- Participate in Senior Administration management team meetings and discussion
- Serve as member on the Continuous Quality Improvement Team for the Health Center
- Participate in annual meetings with the Health Center Board to present the State of Affairs in the oral health program

NNOHA has developed various resources to support the work of Dental Directors at Health Centers. Chapter 2 of this Operations Manual, *Leadership – Becoming an Outstanding Dental Director*, found on the NNOHA website at http://www.nnoha.org/practicemanagement/manual.htm, is particularly helpful. *The Safety Net Dental Clinic Manual* (www.dentalclinicmanual.com) is another useful resource for Dental Directors.

iii. Orientations

Immediately upon employment, new staff members should receive a thorough orientation. The Human Resources Department of the Health Center usually assumes responsibility for providing the orientation, especially with issues pertaining to Health Center administration and workforce regulations. However, Dental Directors or other supervisors should play a key role in providing a quality orientation to the dental aspects. In some smaller organizations, the Dental Directors may need to assume both roles.

Key elements of a good new-hire orientation could include:

- Introduction to the oral health program, office, and working area
- Description of the organization, including mission, history, administrative structure, Board makeup and functions, and funding mechanisms and departments
- Introduction to co-workers and supervisors
- Introduction to the compliance program
- Orientation to relevant Federal, State and local workplace regulations
- Comprehensive training on Occupational Safety and Health Administration (OSHA) Infection Control and Biohazardous Materials, Safety, and the Health Insurance Portability and Accountability Act (HIPAA)
- Explanation of benefits and enrollment
- Orientation to the schedule and scheduling practices
- Health Center's operational policies and procedures, including credentialing and privileging
- Description of the reporting and management structure
- Description of various committees an employee may join to participate in process improvement (i.e., quality assurance, infection control, and safety committees)

5. Staffing

Getting the right people to staff a Health Center is one of the key elements of a successful program. This section covers many of the different staffing models being used across the country, and also presents some of NNOHA's recommendations for a strong oral health team.

A. Staffing Models

Many staffing models are available for Health Centers to operate their oral health programs and meet the needs of their communities. Health Centers can consider their available workforce options and decide which ones to employ for providing the most efficient and effective oral health services within the scope of their practices.

i. Effectively Utilizing Dental Hygienists

Dental hygienists are an important part of the dental team; they provide preventive care and education for the patients. With changes in regulations, dental hygienists can "now practice in at least one setting under general supervision – a less restrictive arrangement than indirect or direct – *in 45 states, compared to only 30 states in 1993.*"[14]

Permitted functions of dental hygienists and supervision levels vary from state to state, depending on the state's Dental Practice Act, or similar legal and regulatory scheme (State Practice Act). For more detailed information, review the *Dental Hygiene Practice Act Overview*, provided by the American Dental Hygienists' Association: http://www.adha.org/governmental_affairs/downloads/fiftyone.pdf.

As of 2010:

- Fifteen states allow dental hygienists to receive direct reimbursement from Medicaid for prevention services provided by them. Oregon also pays for services provided by a person under the supervision of a limited-access permit dental hygienist.[15]
- Thirty-two states allow for direct access in some settings outside of the dental office.[16]

[14] Shelly Gehshan and Matt Wyatt – *Improving Oral Health Care for Young Children*, National Academy for State Health Policy (April 2007).

[15] ADHA – "States Which Directly Reimburse Dental Hygienists for Services under the Medicaid Program": http://www.adha.org/governmental_affairs/downloads/medicaid.pdf

[16] ADHA – "Direct Access States": http://www.adha.org/governmental_affairs/downloads/direct_access.pdf

In 2008, ten states signed bills into law that expanded the functions of dental hygienists that directly support the types of programs identified by the Department of Health and Human Services Oral Health Initiatives.[17] These changes in regulations mean that dental hygienists are allowed to perform certain functions with varying degrees of supervision by the dentist, thereby increasing the number of patients Health Centers can see. Health Centers should use all of their employees to the extent of their capabilities and authority. Expanding the functions of dental hygienists is a major step forward in lowering the incidence of oral disease in underserved populations. Health Centers need to consult appropriate state regulating bodies to determine the permitted functions in their states.

ii. Expanded Function Dental Assistants

In some states, dental assistants who are authorized to perform certain activities involving intra-oral manipulation, such as the exposure of dental radiographs, may have specialized titles, such as *expanded function dental assistants* (EFDAs). The range of functions that EFDAs are authorized to perform varies from state to state. In some states, dental assistants with appropriate professional training may perform all preventive procedures allowable, in addition to other procedures.[18] The dental assistant's job title also differs depending on the state in which the dental assistant is employed, even if he or she is allowed to perform the same duties. The different job titles of EFDAs are listed by the Dental Assisting National Board (DANB) at: http://www.danb.org/PDFs/JobTitles.pdf. DANB also compiles state-specific information on dental assistants at: http://www.danb.org/main/statespecificinfo.asp.

Health Centers that utilize EFDAs, following the regulations of the State Practice Acts, increase the efficiency of their oral health programs. Links to state dental boards can be found at: http://new.dentalboards.org/states/index.htm. Health Centers should consult appropriate state regulating bodies to determine the permitted functions in their states. Alternative workforce models may eventually be a beneficial option, but EFDAs can be utilized now.

iii. Contract and Short-Term Workers

Health Centers are permitted under Section 330 to provide required dental services *through staff and supporting resources of the center or through contracts or cooperative agreements*.[19] Furthermore, Section 503(d) of the 2009 Children's Health Insurance Program Reauthorization Act (CHIPRA) amended federal law to provide that states may not prevent a Health Center from entering into contractual relationships with private practice dental providers in the provision of Health Center services.[20]

[17] ADHA – "Bills Relating to Dental Hygiene Sent to the Governor July 2009 to June 2010": http://www.adha.org/governmental_affairs/downloads/bills.pdf

[18] Burton L. Edelstein DDS, MPH – "Training New Dental Health Providers in the U.S." (Prepared for the W.K. Kellogg Foundation): http://tinyurl.com/kelloggfdnreport.

[19] 42 U.S.C. §254b(a)(1).

[20] CMCS Informational Bulletin – "Recent Developments in Medicaid and CHIP Policy" (March 25, 2011): http://healthreform.kff.org/~/media/Files/KHS/docfinder/cms_guidance_Medicaid_birth_centers.pdf

Nonetheless, there are several factors a Health Center should consider before contracting for dental services.

For example, one factor to consider is the consequence that providing services at a location other than the Health Center may have on the Health Center's scope of project. Health Centers also should note that FTCA coverage is not available to all contracted dental providers. More details and clarification of the requirements for FTCA coverage can be found in *Chapter 4: Risk Management* of the Operations Manual for Health Center Oral Health Programs, as well as applicable HRSA policies.[21]

Contracting with dental specialists is becoming more common in Health Centers and provides access pathways for services that are often unavailable at the Health Center. Exploring pathways for contracting with private practitioners is an opportunity for education and collaboration that can increase access and further HRSA objectives for oral health. Ideally, the contracted dentists should be oriented to the mission of the Health Center so they understand the importance of their work and the environment in which the Health Center operates. This concept is further explored in NNOHA's white paper on *Health Centers and Hospital Based-Dentistry*.[22]

As contracting with dental providers is still a new practice for many Health Centers, there are many areas for which clarifications are needed. Children's Dental Health Project (CDHP) published and updates a helpful resource, *Increasing Access to Dental Care Through Public/Private Partnerships: Contracting Between Private Dentists and Federally Qualified Health Centers* (http://www.cdhp.org/resource/FQHC_Handbook), which answers questions regarding this topic. It also includes a chart for Health Centers to use in determining whether or not they should establish offsite specialty services, as well as a model contract for Health Centers to use when deciding if contracting is a viable option. More details and clarification of the requirements for FTCA coverage for contractors can be found in the FTCA Health Center Policy Manual, PIN 2011-01 (http://www.bphc.hrsa.gov/policiesregulations/policies/pin201101.html) as well as, *Chapter 4: Risk Management* of the Operations Manual for Health Center Oral Health Programs.[23]

iv. Volunteers

Health Centers may utilize volunteers, such as retired dentists or private practice providers who have additional availability. As with contractors and short-term workers, the factors a Health Center should consider before accepting volunteer work include any implications on scope of project and FTCA coverage. At the time of this writing, volunteers are ineligible for FTCA coverage. Volunteers usually carry their own insurances, and Health Centers should require that they do, unless private malpractice coverage is otherwise provided by the Health Center. A Health Center's emergency preparedness plan should address volunteers and their insurance needs. Like paid staff, volunteers also need to have an orientation to the health center so that they understand the organization's mission, policies, and processes.

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21 The chapter is available at: http://www.nnoha.org/generalpage.html. For more details on HRSA policies related to FTCA, refer to: http://bphc.hrsa.gov/policiesregulations/policies/pin201101.html

22 The whitepaper is available at: http://www.nnoha.org/generalpage.html

23 The chapter is available at: http://www.nnoha.org/generalpage.html

v. Private Sector Practitioners

A number of Health Centers utilize the part-time services of local retired private practitioners who can mentor younger dentists in both the clinical and business aspects of managing a dental program as their Dental Directors. Semi-retired local practitioners can strengthen a dental program through their contributions, be they one day per week or per month. It is an added bonus if these local practitioners happen to be specialists. NNOHA recommends that a local dentist be represented on the Health Center's board of directors to provide oral health expertise to the rest of the board. This local practitioner can provide links to community resources that keep a Health Center's oral health program strong and resilient.

As there are similarities and distinct differences between the business models of a private practice and a Health Center operation, it is important for the private practitioner working for a Health Center to have a clear understanding of the mission, clinical policies, and business principles of the Health Center, and an awareness of how Health Centers operate.

vi. New Dental Team Members

Currently, multiple types of alternative dental practitioners are in development to address unmet needs of the communities and improve access to care. The educational requirements and the scope of practice vary from one practitioner type to another. Some types only need training two years post high school, while others require a Masters level education. The list of alternative dental practitioners includes:

Advanced Dental Hygiene Practitioners – are "proposed as case managers and primary dental care providers who could assess risk, educate, provide preventive services and basic restorations, refer patients for more complex services and do follow-up."[24] This model was proposed by the American Dental Hygienists' Association (ADHA) and the background and FAQs can be found at: http://www.adha.org/media/backgrounders/adhp.htm.

Community Dental Health Coordinators (CDHC) – were proposed by the American Dental Association (ADA) as "community health workers with dental skills focusing on education and prevention."[25] The use of this type of practitioner targets improving access to care in underserved communities. A pilot program in Oklahoma, organized by ADA and modeled on the community health worker, was completed in November 2010. The program has graduated 5 coordinators.

[24] Pew Center on the States – "Help Wanted: A Policy Maker's Guide to New Dental Providers": http://www.pewtrusts.org/our_work_report_detail.aspx?id=52456.
[25] American Dental Association – "Community Dental Health Coordinators": http://www.ada.org/cdhc.aspx.

Dental Therapists – are "primary dental care providers focused on delivering basic preventive and restorative care to children, and in some places, adults".[26] In addition to the dental health aid therapists (DHAT) in Alaska, the University of Minnesota introduced both Bachelors and Masters degree programs in dental therapy in Fall 2009.

Patient Navigators and other Community Health Workers – serve as "member[s] of the healthcare team who help patients 'navigate' the healthcare system and get timely care. Navigators work with patients to identify their barriers to healthcare and connect them to the resources they may need such as financial assistance, counseling, language translation or transportation."[27] Dental patient navigators may work with other oral health providers, such as dental hygienists and dentists, to identify appropriate dental care and resources for patients. Patient navigators do not provide care and may not be considered part of the "dental team" to some, but they can be an important member of the team that ensures the patient receives the best possible care.

While it is too early to evaluate the effectiveness of these new team members, NNOHA is committed to providing updates in future revisions of this chapter and other publications. More information on the alternative dental workforce models can be found at the following:

- Pew Center on the States published a report in May 2009 titled, *Help Wanted: A Policy Maker's Guide to New Dental Providers* (http://www.pewtrusts.org/our_work_report_detail.aspx?id=52456). This report examines some of the new provider models and gives states and policy makers the tools they need when considering these providers.

- Commissioned from Children's Dental Health Project by the WK Kellogg Foundation, *Training New Dental Health Providers in the US* (http://www.cdhp.org/resource/training_new_dental_health_providers_us) was published in December 2009. This report provides information on training, scope of services, supervision and deployment of both conventional and alternative dental workforce models in the U.S and abroad.

NNOHA's position statement on alternative workforce model, voted by the NNOHA Board of Directors in March 2010, is included in the Appendix.

[26] Pew Center on the States – "Help Wanted: A Policy Maker's Guide to New Dental Providers."

[27] Colorado Patient Navigator Training website: http://patientnavigatortraining.org/

B. Health Center Oral Health Team

Health Center oral health programs that maintain sufficient staffing and equipment ratios can maximize their efficiency and productivity. Utilization of staff members depends on different definitions of direct supervision and indirect supervision and can vary state-by-state. Health Centers need to stay up-to-date with their own state regulations.

i. Staffing Requirements

Staffing a Health Center oral health program involves a number of considerations, including:

- Mission, vision and values of the program
- Service area and demographic knowledge
- Estimated number of expected patients
- Growth expectations
- Scope of services
- Patient demographic and payor mix
- Efficient productivity and maximal use of available facilities
- Cash flow needs
- State practice regulations and flexibility of dental workforce
- Patient satisfaction
- Quality management
- Clinic patient flow
- Unexpected needs beyond existing capacity

While there are no current evidence-based models that fit all situations, NNOHA recommends the following strategies:

DENTAL ASSISTANT-TO-DENTIST RATIO:

For Health Centers, NNOHA recommends **2.0 or more** full-time dental assistants per 1 full-time dentist for optimum service. This ratio usually can provide between 2,500 and 3,000 visits annually.

If there are fewer than 2.0 assistants available per dentist, the program is likely to experience difficulty in maintaining a smooth patient flow. An insufficient number of dental assistants can result in multiple operatories used inefficiently, because, under such circumstances, dentists will be working alone when it is more productive to have a chair-side assistant.[28]

[28] Safety Net Dental Clinic Manual: http://www.dentalclinicmanual.com

Some practice experts even recommend a minimum of 3.0 full-time dental assistants for 1 full-time dentist. This higher ratio is especially desirable if the state's Practice Act allows the use of Expanded Function Dental Assistants (EFDAs) or similar practitioners.[29] When a Health Center utilizes the maximum number of dental assistants and employs a flexible dental assistant support system that allows extra functions normally performed by dentists, it usually becomes more efficient and increases its patient capacity. Importantly, studies suggest that the higher dental assistant-to-dentist ratio comparably improves the efficiency and productivity of the dentist, whether measured in services provided, visits, or revenue generated.

DENTAL HYGIENISTS:

Preferably, dental hygienists should have a separate and dedicated operatory. One dental hygienist generally can provide 1,300 to 1,500 visits annually,[30] depending on the level of clinical periodontal needs and the emphasis placed on health promotion and disease prevention.

Dental hygienists are best added after a practice develops a sufficient recall list for preventive services, typically after the first 6 to 12 months of operation. A general guideline is that six months of operation establishes a recall volume that fully employs and validates the expense of a dental hygienist. This is highly dependent on the management expertise available within each facility. In situations where the State Practice Act allows dental hygienists to perform services with indirect supervision (without the physical presence of a dentist), NNOHA recommends having a full-time dental hygienist start with the dentists upon opening of the site. This allows school-based prevention programs, wherein the dental hygienist works part-time offsite providing preventive services and refers children to the clinic for treatment—an effective strategy for recruiting patients.[31] Since children of low-income families are often covered by State Medicaid or CHIP programs, this strategy can also increase a Health Center's revenue while promoting prevention within the community.

SUPPORT STAFF:

When resources allow, it is desirable to have a front desk staff dedicated to the oral health program because of the intricacies of scheduling and billing for oral health procedures. There are benefits if the front desk person has dental assistance experience, but it could be counterproductive for a Health Center's dental assistant to assume the duties of a receptionist or billing clerk in addition to his or her responsibilities as a dental assistant. Other clinic staff may include a site/office manager, patient care coordinator, and interpreter.

Complying with these recommendations, however, does not automatically guarantee a cost-effective and productive oral health program. An efficient and effective program requires capable Dental Directors who allocate and manage resources effectively, ensuring that programs operate smoothly. When Dental Directors manage their oral health program operations with sustained income and productivity, they can advocate higher staffing ratios while demonstrating support for their staff at the same time.

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[29] Dental Assistants that are authorized to perform activities involving intra-oral manipulation, such as the exposure of dental radiographs, may be called "expanded function dental assistants" (EFDAs) or other similar titles. For more information, see Sub-Section e of the Section 6, *Staffing Models*.

[30] According to the 2010 UDS data, average encounter rate for dental hygienists was 1,337.7 encounters per FTE annually. In addition, each operatory could produce 1,500 visits per year, including dental hygienist, if the patient mix is 50% adults and 50% children.

[31] Please note that the addition of these types of programs to a Health Center project would require prior approval via a change in scope request. As with all project changes, the Health Center should consult with its Project Officer regarding the need for a Change in Scope of Project before adding any sites or services.

For more information on staffing ratios, refer to the *Safety Net Dental Clinic Manual* at http://www.dentalclinicmanual.com.

ii. Equipment Ratios

NNOHA recommends having two dental operatories per 1 full-time dentist as a minimum, excluding those used primarily by the dental hygienist. If the ratio of dental operatories to full-time dentists is less than 2:1, the program is likely to experience bottlenecks in patient flow. A ratio of three operatories per full-time dentist enables the program to function at peak efficiency. If expanded functions and EFDA restorative services are available in the program, a minimum of three chairs should be available per 1 full-time dentist. For Health Centers that have students and residents, the ratio may vary, because providers spend time supervising and checking the work of their students and residents. The number or ratio of operatories, however, can remain the same if the provider and students are counted together as a dental team unit.

Studies such as "Differences in Characteristics of California Dentists Who Employ Dental Hygienists and Those Who Do Not" by Pourat (http://jada.ada.org/content/140/8/1027.full) show that dental hygienists greatly improve their efficiency and are able to see more patients if a dedicated dental assistant plus another operatory chair are added; i.e., two operatories per full-time dental hygienist.

Increased chair capacity provides significant benefits for Health Center oral health programs. When an extra chair is available, beyond what is needed for the daily scheduled patients, the Health Center can accommodate unexpected emergencies and short procedures, and it also enjoys less-crowded waiting rooms and increased patient satisfaction. In addition, there is opportunity for more daily encounters.

6. Working with a Health Center Oral Health Team

A. Reporting Structures

By virtue of the federal requirements, Health Centers are all similar, yet each is unique and has varying administrative structures. Each Health Center is governed by a Board of Directors that is representative of the community served. The Board hires an Executive Director to oversee and ensure the appropriate operations of the Center. The Executive Director, who reports to the Board, usually forms a Key Management Team to oversee the operational units of the Health Center, which may include the Chief Financial Officer (CFO), Chief Information Officer, Clinical/Medical Director, and Dental Director.

With Board oversight, the Key Management Team typically implements the Health Center's strategic plan; develops policies and procedures for daily operations; and establishes priorities for funding, space allocation, patient prioritization, and other resource allocations. These important discussions should be conducted on regular and ongoing basis.

Although other reporting structures are successful for different programs, NNOHA's recommendation is for the Dental Director to report directly to the Executive Director. This structure provides several advantages for the Dental Director, including:

- Assuring unfiltered and direct participation in the decision-making process
- Helping the Dental Director to determine the priorities and strategic direction of the Health Center
- Giving the oral health program organizational parity in relation to the other programs or departments of the Health Center
- Offering the Dental Director access to budget and finance information and allowing the Dental Director to determine if sufficient funds are allocated to effectively operate the oral health program. Ideally, the Dental Director should have such access and should determine if sufficient funds are allocated regardless of the reporting structure
- Providing a better perspective of the oral health needs of the community based on clinical experience

The *Survey of Health Center Oral Health Providers*,[32] showed a significant association with the title of the Dental Director's supervisor (i.e., CEO/Executive Director versus CMO/Medical Director) and intent to leave the Health Center practice. Dental Directors who reported to a CMO/Medical Director were 2.2 times more likely to indicate intent to leave the Health Center practice than those Dental Directors who reported to a CEO/Executive Director.

B. Managing & Motivating an Effective Staff

It is the Dental Director's responsibility to continually work on building a strong dental team. There are several key points to managing and motivating an effective team:

- **Clear mission of the practice:** When every person on the team understands the mission of the practice and its primary goals, the practice operates more smoothly. If the Dental Director outlines the priorities and explains the benefits of achieving these goals, increased buy-in from the staff occurs.
- **Precise and detailed job descriptions:** When staff and providers know exactly what their responsibilities are, clear lines of communication can be established. The Dental Director can pinpoint the source of issues quickly to mitigate risk, and conversely, staff knows where and from whom to seek assistance. The Dental Director and employees assume ownership of their responsibilities, which leads to improved job satisfaction and pride in their work.

[32] National Network for Oral Health Access (NNOHA) – "Survey of Health Center Oral Health Providers: Dental Salaries, Provider Satisfaction, and Recruitment and Retention Strategies" (2010).

- **Well-defined organizational charts:** When organization charts are well-defined, everyone understands where they fit into the overall organization, which allows employees to clearly visualize they are an integral part of the Health Center. Organization charts demonstrate where and how decisions are made, which often helps employees to buy into decisions and changes that affect their day-to-day jobs.

- **Open and clear channels of communication:** All employees need an opportunity to ask questions. Staff meetings are an important venue for communicating information to the staff, engaging in an open dialogue, and listening to questions or concerns. Periodic meetings with the entire organization improve communication and relationships between departments.

"I've been in private practice 17 years, managed care clinics 4 years, and for the past year in a CHC. This past year has been the best, most satisfying and most rewarding."

– National Primary Oral Health Conference Participant

- **Ensure all members of the dental team feel valued:** Positive feedback from the Dental Director provides intangible benefits for the Health Center, such as increased productivity, job satisfaction, and achievement of goals. Whether it is an individual contributor or team effort, recognition from the Dental Director is a powerful motivator.

- **Create a positive work environment.** All the factors above are important in creating a positive work environment, where staff feels satisfied and motivated. Having a supportive environment where colleagues have positive relationships with each other can have a great impact on the staff performance and productivity.

C. Encounter Rates and Productivity Standards

Dental Directors should be aware of the benchmark values available for Health Centers across the country. Based on the 2010 Uniform Data System (UDS) results, the average annual visit rates are 2,672 per dentist and 1,337 for dental hygienists.[33] The productivity of a Health Center is dependent on multiple factors, such as the scope of service allowed in each state, the number of support staff, equipment, patient mix, patient needs, and a multitude of other factors. Each facility should consider all of those factors and develop a goal that is appropriate and allows the program to be sustainable. Too few or too many visits[34] can signal possible poor patient outcomes or a failed business plan. These numbers are not quality indicators; however, they are simply averages to help in business planning.

[33] 2010 National UDS Data: http://bphc.hrsa.gov/uds/view.aspx?year=2010.

[34] For UDS reporting purposes, visits are defined as "documented, face-to-face contacts between a patient and a provider who exercises independent professional judgment in the provision of services to the patient." A dental hygienist is credited with a dental visit when the visit is independent from and not combined with the dentist encounter. Only one visit may be counted during a patient visit to the dental clinic in one day. For more information, see the 2010 UDS Reporting Manual (http://www.hrsa.gov/data-statistics/health-center-data/reporting/2010manual.pdf). Health Centers should note that some encounters that are "visits" for UDS reporting purposes may not be considered billable visits for purposes of billing Medicare, Medicaid, CHIP or other health care programs.

In addition to tracking encounter rates, two commonly used methods for tracking productivity are Relative Value Units (RVUs) and gross charge dollar value. Both systems have their attributes.

- Some Health Centers use the RVU system as a standard for productivity, as it enables a director to quantify the output of services performed by the provider. The RVU is a time-based measure that can serve as a common reference among providers and different programs to evaluate and compare dental performance. This time measurement remains constant over time, whereas a dollar or visit measurement may vary under different conditions. There are a number of successful uses of this measurement system, and there are several publications and presentations on the use of this system found in the literature.[35]

- Some Health Centers use the dollar value system because patients do not pay in RVUs nor are providers compensated in RVUs. It keeps the language for comparison the same from the CFO's office to the Dental Director's office.

One critical factor for productivity is retention of staff. It is difficult for a Health Center to maintain high productivity levels and quality service with new dentists or frequent staff changes. Retention, recruitment, pay, working conditions, quality assurance, productivity, and patient satisfaction are viewed as interdependent.

For more information about various productive measures, as well as their strengths and weaknesses, visit: http://www.dentalclinicmanual.com/docs/Productivity_measures.pdf.

[35] More information about the RVU system can be found in Appendix C.

D. Administrative vs. Clinical Time

In addition to providing patient services, Dental Directors perform administrative functions to operate and manage the oral health programs. Successful Dental Directors manage to balance the two responsibilities, as both are critically important. Some Dental Directors feel insufficient time is allotted for their assigned administrative duties. Juggling the needs for clinical productivity with administrative, development, and advocacy activities can be a source of tension between the administration of the Center and the Dental Directors. In the *Survey of Health Center Oral Health Providers*, 71 percent of respondents indicated there was not enough or no time allocated for assigned administrative duties.[36]

Each Health Center is unique, and many factors contribute to the amount of administrative time that is needed for its Dental Director, which makes it challenging to develop a general rule that defines sufficient administrative time. However, the following guidelines may be helpful:

- A general suggestion is that most programs with four to seven professional providers require at least one fifth of the Dental Director's time for administrative duties.
- If the Health Center provides oral health services at one site and all the dentists are in the same location, one hour per dentist per week is probably adequate.
- If there are multiple offices providing oral health services, 1.5 hours per dentist per week is realistic, given the need to travel between sites.
- Another variable is the number of meetings. If the Dental Director is on the senior corporate leadership team, more administrative time may be needed to accommodate the meetings he or she attends.
- If there are five or more dentists at the Health Center, it is ideal to have a business manager.
- A business manager and a lead dental assistant can handle many of the clerical duties, such as scheduling staff, ordering supplies, payroll, monitoring time off, running production, and producing other reports. If the Dental Director performs any of these functions, it adds to the needed administrative time.
- If staff dentists have additional administrative duties, they may need administrative time as well.

Executive Directors should carefully consider the expectations they have for their Dental Directors and in what activities they should be engaged. If the Dental Director is expected to participate and contribute to the discussions on development and strategic planning of the Health Center, be involved in advocacy on the local, state or national level, be involved in community outreach, oversee budgets and supervise support staff, adequate time is required for the participation and completion of these activities. Dental Directors, who are not allowed adequate time for these duties, may feel stressed, overwhelmed and dissatisfied. Retention and long-term cost savings can be realized by either reducing the administrative duties or allowing sufficient time to complete them.

[36] National Network for Oral Health Access (NNOHA) – "Survey of Health Center Oral Health Providers: Dental Salaries, Provider Satisfaction, and Recruitment and Retention Strategies" (2010).

7. Retention of Staff

Retention is a workforce issue that many Health Centers find challenging once qualified candidates are recruited and hired. This section explores strategies for retaining the Health Center's qualified dental providers.

A. Salaries

Competitive compensation is a key strategy, which requires Health Centers to know what their competitors, including private practice, are paying, and offer a compensation package that is comparable. When presenting a compensation offer, it is recommended to focus on all of its elements and their values, which may include base salary, benefits, sign-on bonus, potential loan repayment, vacation days, and annual and incentive bonuses. Salaries should be presented in writing with allowance for negotiations by an authorized official to negotiate and approve salary adjustments.

In the Survey of Health Center Oral Health Providers (2010), 26.7 percent of the dentists indicated their salaries were within the range of $95,000 to $110,000 (not including benefits, which typically is about 20 percent of salary), and 35.5 percent of the dental hygienists stated their salaries were within the $50,001 to $60,000 category. Salaries should be adjusted based on the local market rates. For more information, visit the website of the Bureau of Labor Statistics: http://www.bls.gov/oes/current/oes291021.htm.

B. Incentive Programs

Incentive programs motivate staff members and improve productivity by rewarding them for their performance. Income is not the only measure of good performance, but is one detailed here. Designing an incentive program involves certain components. First and foremost, the plan should be linked to performance rather than to events (e.g., giving bonuses during the holidays), or the length of the staff's employment. A Health Center should establish well-defined and objective standards to evaluate its staff performance and how their work is contributing to the mission and goals of the Health Center. Other decisions to make when developing an incentive program include the amount of bonus, how it is calculated, and who is included in the program.

There are four attributes to an effective incentive program:

1. Simple, easy to understand and manage.
2. Based on a target 'goal' that directly influences the organization's income.
3. Achievable and attractive
4. Frequent (e.g. monthly or quarterly, rather than annually)

Designing an incentive program involves participation and decisions of the Leadership Team. Factors, such as prior bonus amounts, financial performance and overall budget of the oral health program, economic conditions, and competition, affect the mechanisms of the incentive program. For Health Centers, other elements such as participation in community outreach programs or quality assurance programs may be involved in the criteria. When used effectively, incentive programs benefit both Health Center oral health programs and their employees.

C. Combating Burnout

Similar to strategies used for retention, there are recommendations to avoid burnout of the Health Center's dental providers, which may result in turnover of qualified staff. Frequent communication with providers and allowing their participation in policy decisions, their contract negotiations, and position descriptions help to establish solid relationships and show they are valued contributors to the mission of the Health Center. Maintaining commitments made to providers, such as awarding incentives on time is another way to demonstrate their value. The Health Center can mitigate burnout by ensuring the program has adequate resources with support staff, equipment and workspace. Above all, it is the responsibility of the Dental Director to ensure adequate coverage so providers may appropriately use their paid time off for vacation and sick days. Some Health Centers include stress management days and sabbaticals after 5, 10, and 20 years of service. In these situations, it may be necessary to bring in Locum clinicians[37] to ensure adequate coverage.

D. Continuing Education (CE) and Training

Allowing for quality CE and training for providers has two benefits. First, it helps to ensure that patients are receiving the most recent standards of care, which benefits patients and serves as an effective recruitment tool. Second, it allows providers to continue their professional development – a necessity for provider satisfaction and continued licensure. Health Centers may consider providing time off for CE opportunities and having a monetary allowance for travel and conference registration as part of their benefits package. On average, dentists receive $2,000 for CE reimbursement and dental hygienists receive $800.[38] Much of this CE can be obtained at conferences that also emphasize the particular needs of Health Centers and Public Health. Conferences, such as the National Primary Oral Health Conference (NPOHC – http://www.nnoha.org/conference/npohc.html) or the National Oral Health Conference (NOHC – http://www.nationaloralhealthconference.com) provide many of these opportunities.

[37] Locum clinicians (or locum tenens) most commonly refer to temporary clinicians who contract with recruitment agencies to perform medical services for a healthcare organization over a certain period of time.

[38] National Network for Oral Health Access (NNOHA) – Survey of Health Center Oral Health Providers.

A variety of opportunities also exist online, through video conferences or programs sponsored and hosted by Primary Care Associations and local and state health departments. It should be noted that while CE delivered electronically has the advantage of eliminating travel and lodging costs, it does not provide opportunities for networking and interaction with providers in similar situations. This type of networking helps reduce feelings of isolation while offering support and camaraderie among Health Center providers, which is known to influence long-term retention. Networking through CE opportunities encourages sharing of evidenced-based practices and models, lessons learned, and resolutions to relevant issues.

E. Staff Evaluation

Evaluation is an integral part of Health Center operations. Similar to incentive programs, it is a tool used to shape performance, increase productivity, and strengthen commitment to the mission of the program. It can also be an informational tool to increase retention. At the same time, the Health Center can ensure that the staff is a good fit for the organization, discuss provider satisfaction, and implement improvement plans. An effective evaluation is a two-way dialogue between the Dental Director and the provider being evaluated. A prearranged time should be scheduled for the provider and his or her supervisor to meet, after the provider has had the opportunity to read the criteria. A period of 2 to 3 weeks prior to the scheduled evaluation should be reserved for the provider and the supervisor to complete their separate portions of the evaluation. The evaluation meeting should focus on positive elements first, followed by areas for improvement, then reinforced with positive feedback again. A sample provider evaluation is attached as Appendix A.

8. Summary

Effective workforce planning and implementation are required for Health Center oral health programs to fulfill their mission and improve access to care. For many Health Centers, workforce issues are their primary concerns, as recruitment and retention of competent providers remain a challenge.

With the expected increase in dental patients under Health Care Reform, as well as the recent development of alternative dental workforce models, the environment in which Health Centers operate is constantly changing. These changes pose both opportunities and challenges for Health Centers. Health Center oral health programs are now required to be more innovative in their workforce-related strategies, and address workforce needs from multiple viewpoints to ensure the health of their community is improved by committed and qualified oral health providers.

This chapter described several models for structuring an oral health workforce, identified sources for potential recruitment, and discussed strategies and methods that Dental Directors and the Executive Team can employ to promote job satisfaction of their providers at the Health Center, thereby improving retention.

9. Frequently Asked Questions

Q: What are the recommended staffing and equipment ratios?

A: NNOHA recommends an optimal ratio of 2.0 or more full-time dental assistants per 1 full-time dentist. A ratio of 2.0 to 3.0 operatories per dentist will enable the program to function at peak efficiency. If expanded functions and EFDA restorative services are available in the clinic, 3.0 chairs should be available per dentist. In addition, a dental hygienist should have a separate, dedicated operatory.

Q: How do I convince my administrative team to hire more support staff?

A: Make your case by compiling the numbers. Run a test cycle using additional staff (for instance, if one provider is out for the day, have his or her support staff work with another provider). Prove that the additional staff will be productive and efficient and will enable you to provide high-quality care to the patients while not doing damage to the budget.

Q: Where can I find a sample contract form?

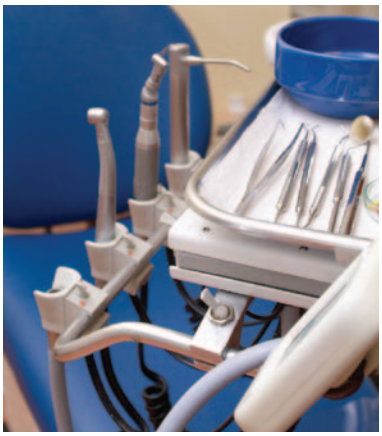
A: The Children's Dental Health Project has a Health Center Model Services Agreement available online: http://www.cdhp.org/resource/FQHC_contract

Q: What is the recommended annual visit rate?

A: According to the 2009 Uniform Data System (UDS) results, average annual visit rates are 2,726 per dentist and 1,352 per dental hygienist. The productivity rate of a Health Center is dependent on multiple factors, such as the scope of service allowed in each state, the number of support staff, equipment, patient mix, patient needs, and a multitude of other factors. Each facility should consider all of those factors be to make a goal that is appropriate for the organization and allows for the program to be sustainable.

10. Links

- Children's Dental Health Project – "Increasing Access to Dental Care Through Public/Private Partnerships: Contracting Between Private Dentists and Federally Qualified Health Centers": http://www.cdhp.org/resource/FQHC_Handbook
- Children's Dental Health Project and WK Kellogg Foundation – "Training New Dental Health Providers in the US": http://www.cdhp.org/resource/training_new_dental_health_providers_us
- National Health Service Corps: http://nhsc.hrsa.gov/
- National Network for Oral Health Access (NNOHA) – "Survey of Health Center Oral Health Providers: Dental Salaries, Provider Satisfaction, and Recruitment and Retention Strategies" (2010): http://www.nnoha.org/generalpage.html
- NNOHA's Workforce Resources: http://www.nnoha.org/workforce.html
- New Mexico Health Resources, Inc. (NMHR): http://www.nmhr.org
- Pew Center on the States – "Help Wanted: A Policy Maker's Guide to New Dental Providers": http://www.pewtrusts.org/our_work_report_detail.aspx?id=52456
- Safety Net Dental Clinic Manual: http://www.dentalclinicmanual.com
- 3RNet: https://www.3rnet.org



11. Worksheet

1. **How much administrative time do you need per week?**

   _____

2. **What are your Dental Department's productivity standards?**

   _____

   _____

   _____

3. **What factors affect your productivity?**

   _____

   _____

   _____

4. **Check the areas in which you have challenges:**

   ☐ Recruitment (e.g., dental vacancies unfilled for a long duration)
   ☐ Retention (e.g., high turnover rate)
   ☐ Low productivity
   ☐ Low staff motivation
   ☐ Communication with staff
   ☐ Clinical vs. Administrative time

5. **What are your strategies to address the issues above? What resources can you draw from?**

   _____

   _____

   _____

6. **What staffing models can be utilized more effectively in your program?**

   _____

   _____

   _____

Appendix A: Sample Evaluation Form

[Health Center Name]
Provider Performance Evaluation with Goals

Employee Name: _____

Department:_____ **Site:** _____

Job Title:_____ **Date:** _____

Last Review Date:_____ **Next Review Date:** _____

PERFORMANCE STANDARDS:

1. **Performs duties as outlined in job description and contract:**
   _____ Performing satisfactorily _____ Needs remediation

2. **Achieves productivity expectations:**
   _____ Performing satisfactorily _____ Needs remediation

3. **Patient/consumer/client satisfaction:**
   _____ Performing satisfactorily _____ Needs remediation

SELF REVIEW:

1. Accomplishments for performance review time period: _____

_____

_____

_____

2. List involvement in community activities related to the Health Center's mission. _____

_____

_____

3. List participation in professional development activities: _____

_____

_____

GOALS AND OBJECTIVES:

1. Supervisor-guided expectations for the next performance review time period:

In the spaces provided below, list two development goals, indicating key actions and milestones for each. Goals should be job/performance development related. The goals and objectives are considered a "living document" and should be reviewed and updated on a regular basis.

*Remember that well-written goals are **"SMART"** — Specific, Measurable, Attainable, Relevant, Time-bounded*

DEVELOPMENT GOAL #1	TARGET DATE
Key Action Items	

DEVELOPMENT GOAL # TRAINING PROGRAM	TARGET DATE
Key Action Items	

Employee signature: _____ Date: _____

Supervisor signature: _____ Date: _____

HR Review: _____ Date: _____

NNOHA Position Statement on New Dental Workforce Models

Health Centers provide oral health services for underserved populations at dental clinics throughout the United States. Between 1998 and 2008, the number of Health Centers offering on-site dental services increased from 411 to 850, and the number of dental patients went up by 158%. As dental capacity grows, the need for a dental workforce committed to caring for underserved patients is growing as well.

Given the growing demand, new types of dental providers, such as dental health therapists and advanced dental hygiene practitioners – sometimes called mid-level providers – have been proposed as a way to strengthen the dental safety net and to address unmet needs for dental services. If successful, such programs can not only facilitate a division of labor that allows dentists to manage and treat more acute and complex issues, but also can contribute to primary prevention of severe and expensive problems.

NNOHA EXPRESSES ITS POSITION ON NEW DENTAL WORKFORCE MODELS AS FOLLOWS:

- **NNOHA supports access to high quality oral health services.** NNOHA welcomes initiatives that help to improve the oral health status of the underserved, which is the mission of our organization. We believe that everyone should have access to quality care, regardless of his or her ability to pay.

- **NNOHA supports development and implementation of pilot dental workforce programs**, including, but not limited to, Dental Therapists, Community Dental Health Coordinators, Oral Preventive Assistants, and Advanced Dental Hygiene Practitioners. Several programs are currently in development and should be supported to determine if they can be successful.

- **NNOHA wants to see evaluation and ongoing monitoring of new dental workforce models.** To provide high quality services, comprehensive evaluation and ongoing monitoring of new dental workforce models are needed. We believe that new types of dental providers should go through performance evaluation, certification and other procedures to ensure that their experience and skills are sufficient to treat patients with complicated oral health problems, which are often seen at Health Centers.

- **NNOHA supports new dental workforce models working in partnership and collaboration with dentists and other medical providers.** New dental workforce models should complement the work of conventional dental providers, such as dentists and dental hygienists, rather than replace them. It is important to NNOHA that any new types of dental providers do not work in isolation and that they perform their tasks within an established system of supervision.

Appendix C: Relative Value Units

NNOHA WEBSITE

NNOHA website (http://www.nnoha.org/practicemgmt.html) **has a fee schedule based on RVUs and calculated costs per RVU**. You can enter your own cost per RVU ($45 is used for illustration) and your lab and/or supply costs for certain services. The Excel formulas will calculate the rest.

Dr. Janet Bozzone, Dental Director at Open Door Family Medical Centers and NNOHA Board Member, developed this resource. Please note that this uses Region II RVU values for known procedures. Since the Region II RVUs have not been updated recently, Dr. Bozzone extrapolated a guestimate indicated by an "E" in the first column. If you want to use the RVS data, you have to buy a copy of their PDF file and manually override the values that are already in there. Please check the latest version of the CDT if you have any questions.

The Dental Evaluation System which Region II implemented in the early 1980s to provide useful data on the management of Health Center oral health programs might offer some insights. The eight indicators used in the system were:

- RVU per Staff Personnel Equivalent Dentist
- Prevention and Diagnosis RVU as a Percent of All RVU
- RVU per Dental User
- Dental Users Age 5-19 as a Percent of Medical Users Age 5-19
- Direct Cost per RVU
- Users per Staff Personnel Equivalent Dentist
- The Ratio of Staff Personnel Equivalent Dental Assistant to One Staff Personnel Equivalent Dentist
- The Ratio of Operatories to One Staff Personnel Equivalent Dentist

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The National Network for Oral Health Access (NNOHA) is a nationwide network of dental providers in safety-net settings. 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.

For more information on NNOHA, visit www.nnoha.org, send an Email to info@nnoha.org, or call 303-957-0635

NNOHA
National Network for Oral Health Access

MEMBERSHIP APPLICATION

For calendar year 2012 (October 1, 2011 through September 30, 2012)

Applicant Contact Information		
Name:		
Title:		
Organization:		
Name of Health Center: (if different from Organization name)		
Address:		
City:	State:	Zip Code:
Phone:	Fax:	
E-mail:		

NNOHA Membership Category:

☐ Individual Member (dues $50) ☐ Dental Hygienist/Dental Assistant (dues $30)

☐ Organizational Member (dues $350) ☐ Association Member (dues $150)

If you are applying as an Organizational Member, please attach a list of the names, titles, and E-mail addresses of the employees you wish to include in the membership.

If you are applying as an Association Member, please contact NNOHA staff for the criteria for discounted membership.

For more details on the different types of memberships, please visit www.nnoha.org/membership.html and click on Membership Levels.

☐ Additional Donation $_____ ☐ $25 ☐ $50 ☐ $100 ☐ $500 ☐ $1000

Referred by:
(name of NNOHA Member)

Paying by (select one):

☐ Check (made payable to NNOHA) ☐ Bill Me

☐ Credit Card – Card Number:_____

Security Code:_____ Expiration Date: _____

_____
Signature

☐ Check here If you are interested in receiving information on the current NNOHA committees and opportunities to get involved.

☐ Check here if you would like to learn more about the Association of Public Health Dentistry

Please complete this form and mail it to:
NNOHA, PMB 329, 3700 Quebec Street, Unit 100, Denver, CO 80207-1639

For more information, contact:
Jennifer Hein
adminsupport@nnoha.org
Phone: 303-957-0635 / Fax: 866-316-4995

What Is NNOHA?

The National Network for Oral Health Access (NNOHA) is a nationwide network of dental providers who care for patients in safety-net systems. The members of NNOHA recognize the importance of oral health as part of overall health and are committed to improving the health of the country's underserved individuals. NNOHA was founded in 1991 by a group of Health Center Dental Directors who recognized the need for peer-to-peer networking and collaboration to effectively run Health Center oral health programs.

NNOHA's VISION

Individuals and communities are aware of the importance of oral health to overall health, engage in recommended oral health practices, and receive affordable, high quality oral health services.

NNOHA
National Network for Oral Health Access

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Operations Manual
For Health Center Oral Health Programs

Chapter Six: Quality

6

Version 1.0

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National Network for Oral Health Access

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NNOHA
National Network for Oral Health Access

The mission of the National Network for Oral Health Access (NNOHA) is to improve the oral health of underserved populations and contribute to overall health through leadership, advocacy, and support to oral health providers in safety-net systems.

First printing – February 2012

Note: The information in this document was accurate at the time of this printing. As regulations and information regarding Health Centers are not static, NNOHA recommends readers verify any critical information with different state/federal regulations and changes that may have occurred since printing.

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NNOHA
National Network for Oral Health Access

Executive Summary

Health Centers strive to deliver quality care that leads to positive patient outcomes. In 1990, the Institute of Medicine (IOM) defined quality of care as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."[1] Because of the pivotal role health care quality plays in service delivery, Health Resources and Services Administration (HRSA) requires all Health Centers to regularly measure and improve the quality of care within their programs.[2]

This chapter explores two facets of an oral health quality program: quality assurance (QA) and quality improvement (QI). QA is a set of processes focused on the continual monitoring of health care delivery. QI builds on baseline data from QA processes to develop a data-driven plan focused on improvement in oral health care. Both QA and QI focus on measuring success by achieving goals over a period of time. While there are several models for quality improvement, this chapter focuses on two utilized by the HRSA/BPHC Health Disparities Collaboratives–the Chronic Care Model and the Model for Improvement.

This chapter also emphasizes the importance of staying up-to-date with electronic dental record (EDR) developments and emerging health concepts, such as patient-centered health homes,* population-based care, and care integration and collaboration, as they will influence both the definition of quality, as well as improvement efforts. Several resources, tools, and links are also provided for oral health programs to implement or enhance their QI programs.

** NNOHA recognizes the current national movement of patient-centered medical homes. However, while NNOHA supports the concept, this term's focus on medical care is exclusive of other health care disciplines, such as oral health and behavioral health. As a result, NNOHA has chosen to advocate the more inclusive term "patient-centered health home" throughout this chapter.*

[1] Institute of Medicine – "Crossing the Quality Chasm: The IOM Health Care Quality Initiative": http://www.iom.edu/Global/News%20Announcements/Crossing-the-Quality-Chasm-The-IOM-Health-Care-Quality-Initiative.aspx

[2] Bureau of Primary Health Care – "Authorizing Legislation": http://bphc.hrsa.gov/policiesregulations/legislation/index.html

QUALITY

TABLE OF CONTENTS

1. Introduction

The current health care delivery system is experiencing major transformations. Clinicians must adapt to changes in payer and information systems, as well as rapid technological advances. The need to achieve and improve quality remains constant regardless of other change, and in fact quality is central to health care delivery system reform efforts. Oral health providers, especially those practicing in safety-net settings, such as Health Centers, are not exempt from these pressures. In fact, given their unique program focus, Health Centers are required to develop and incorporate methodologies demonstrating their ability to deliver quality health care.

The Institute of Medicine (IOM) defines health care quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."[3] The IOM further describes the following six domains as essential standards for the provision of quality health care services:

SAFETY: Avoid injuries to patients from care that is intended to help them.

EFFECTIVENESS: Provide services based on scientific knowledge to all who can benefit, and refrain from providing services to those unlikely to benefit.

PATIENT-CENTEREDNESS: Provide care that is respectful of and responsive to individual patient preferences, needs, and values, while ensuring that patient values guide all clinical decisions.

TIMELINESS: Reduce waits and harmful delays for those who receive and give care.

EFFICIENCY: Avoid waste of equipment, supplies, ideas, and energy.

EQUITY: Provide consistent quality of care for all patients regardless of gender, ethnicity, geographic location, and socioeconomic status.

Developed specifically for oral health programs, this chapter provides an overview of quality in Health Center dental settings and focuses on both quality assurance (QA) and quality improvement (QI) concepts. The goal of the chapter is two-fold: 1) provide the proper tools to assist oral health teams in achieving positive oral health quality outcomes, including improved patient satisfaction; and 2) demonstrate a methodology to measure and improve quality through the effective and efficient use of resources.

[3] Institute of Medicine – "Crossing the Quality Chasm: The IOM Health Care Quality Initiative"

2. Learning Objectives

After reading this chapter, the reader should be able to:

- Understand the importance of quality;
- Distinguish between quality assurance (QA) and quality improvement (QI) systems;
- Recognize, define, and measure quality;
- Determine sample metrics to establish relevant benchmarks for a Health Center;
- Develop systematic QI goals; and
- Integrate continuous QA and QI practices into a Health Center.

3. Relevant Authorities

Quality improvement/quality assurance (QI/QA) activities are an integral part of a Health Center program. Additionally, the new Federal Tort Claim Act (FTCA) deeming application process requires the submission of the Health Center's Board-approved QI/QA plan and QI/QA committee minutes to document quality of care activities.

BPHC outlines quality care as care that is evidence-based, appropriate, well coordinated, safe, and patient-centered.[4] BPHC's QI strategy focuses on five key activities: 1) develop and enhance care access points, 2) transform health care delivery system through use of PCMH model and/or HIT meaningful use, 3) recruit, develop, and maintain a skilled workforce, 4) integrate Health Centers into local health systems, and 5) align policies and programs where possible.[5] BPHC also provides various resources for Health Centers to use in creating and maintaining effective QI/QA programs.[6]

[4] Bureau of Primary Health Care, *Efforts to Expand and Accelerate Health Center Program Quality Improvement:* http://bphc.hrsa.gov/ftca/riskmanagement/healthcenterqualityimprovement.pdf

[5] Bureau of Primary Health Care: "Designing a Successful Quality Improvement Program: Teambuilding and Writing a QI Plan," Slide #5, http://www.hrsa.gov/publichealth/guidelines/qualityimprovement.html.

[6] Health Resources and Services Administration – "Technical Assistance Topics": http://bphc.hrsa.gov/technicalassistance/tatopics/qualitymanagementimprovement/index.html#Quality.

Health Center Program Requirements

Health center has an ongoing Quality Improvement/Quality Assurance (QI/QA) program that includes clinical services and management, and that maintains the confidentiality of patient records.

THE Q1/QA PROGRAM MUST INCLUDE:

- a clinical director whose focus of responsibility is to support the quality improvement/assurance program and the provision of high quality patient care;*
- periodic assessment of the appropriateness of the utilization of services and the quality of services provided or proposed to be provided to individuals served by the health center; and such assessments shall: *
  - be conducted by physicians or by other licensed health professionals under the supervision of physicians;*
  - be based on the systematic collection and evaluation of patient records;* and
  - identify and document the necessity for change in the provision of services by the health center and result in the institution of such change, where indicated.*

(Section 330(k)(3)(C) of the PHS Act, 45 CFR Part 74.25 (c)(2), (3) and 42 CFR Part 51c.303(c)(1-2))

4. Quality Assurance (QA)

The traditional approach to monitoring quality–often referred to as Quality Assurance (QA)–involves the development of a set of service standards, and the comparison of current services with the established standards. If standards are met, services are thought to be of adequate quality. If deficiencies are identified, plans of correction are developed to address the problem (WHO, 1994; WHO, 1997)[7]. In order to comply with HRSA regulations, Health Centers are required to establish a QA program that examines management practices and clinical care, including oral health services.[8] QA programs are also beneficial to Health Centers, as they provide accountability to the Board of Directors, community members, and funding entities through cohesive organizational goals and shared performance results.

[7] World Health Organization. (1994) Quality assurance in mental health care: check-lists and glossaries (Volume 1). Geneva: World Health Organization.; World Health Organization. (1997) Quality assurance in mental health care: check-lists and glossaries (Volume 2). Geneva: World Health Organization.

[8] Bureau of Primary Health Care – "Authorizing Legislation."

More specifically, QA programs ensure Health Center compliance with quality standards and provide quantifiable performance assessments. QA programs also assist Health Centers in examining aspects of patient care. Any metric that can contribute to answering the following questions can be considered an integral component of a QA program:

- How are we performing?
- Are we meeting our goals?
- How do we compare to our benchmarks (e.g., other Health Centers, local services)?
- Are we providing the highest possible quality services to our community?
- Are we focused on the patient experience from the first contact until case completion?
- Are we utilizing proper follow-up procedures?

The QA process in oral health settings is unique. Unlike medicine, dentistry does not routinely utilize diagnostic codes for billing. Despite advances in oral health technology, currently there are limited evidence-based standards to accurately assess patient risk, diagnose, or manage care for the most common oral diseases. Therefore, oral health QA processes must rely on additional methods to determine quality of care and appropriateness of services:

A. Objective dental record peer reviews utilize dental peers to examine and evaluate patient documentation against well-defined criteria. To conduct such reviews, a Health Center would randomly select a sample of patient dental records for review by either 1) dentists other than those who rendered the services, or 2) contracted expert reviewers. Regardless of the reviewer, NNOHA recommends that all Health Centers employ a peer-review process, as it is a relatively low-cost method to improve quality of care. Guidelines and criteria for establishing this process are outlined in A Comprehensive Quality Assurance System for Dentists.[9] A sample dental record peer review form is provided in Appendix A.

A supplemental approach to record review is utilization of a peer review knowledge assessment interview. The Federal Bureau of Prisons has used this approach since 2004 and has found that it helps clinicians stay on top of the current medical knowledge necessary for the dental management of medically complex patients, and improves patient safety. A sample peer review knowledge assessment interview, based on the Federal Bureau of Prisons form, can be found in Appendix B. The knowledge-based topics can be revised to focus on the common conditions and needs of the specific populations served by individual Health Centers. Care must be taken to continuously review the knowledge base related to the selected criteria, so that the interview tool reflects current knowledge and standards.

[9] Neal A. Demby, Murray Rosenthal, and Mary L. Angello. *A Comprehensive Quality Assurance System for Practicing Dentists: A Clinical Outcomes Management Approach.* Clinical Directors Network of Region II, Inc., 1990.

B. Objective information technology-tracked service use measures can be obtained from electronic practice management, billing, or registry systems, such as an electronic dental record (EDR), the Patient Electronic Care System (PECS), or Microsoft Outlook. For example, the National Healthcare Effectiveness Data and Information Set (HEDIS) is a set of measures developed for insurance plans to grade performance, which includes a measure for oral health–the number of plan members who had a dental exam in the previous year.[10] Another example of this type of measure is the treatment plan completion measure in which the number of patients who complete Phase I treatment within 12 months of their exam is tracked.[11] HRSA's HIV/AIDS Bureau includes this measure as one of it's HAB HIV Performance Measures for Oral Health Services, available to the public at: http://hab.hrsa.gov/deliverhivaidscare/files/habpmsoralhealth.pdf.

C. Subjective patient outcomes can be assessed with validated patient surveys, such as the Oral Health Impact Profile (OHIP-14) (see Appendix C). These surveys measure a patient's own perception of the effect of care on their oral health status. In order to maintain the validity of the survey, it should be administered as written. These surveys may be given in addition to the Health Center's patient satisfaction survey, which is usually administered on an annual basis. One example of a validated patient satisfaction survey is the Consumer Assessment of Healthcare Providers and Systems CAPHS survey.[12] Other oral health care surveys can be administered to patients by the entities that referred them to the Health Center (e.g., state and local agencies). These outside sources often achieve more credible results, as this patient feedback tends to be more objective than the feedback obtained from surveys administered directly by Health Centers.

5. Quality Improvement (QI)

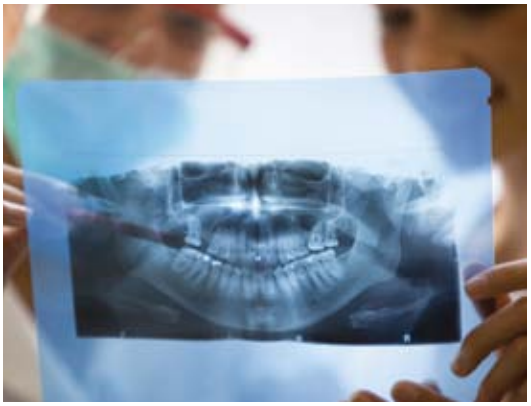
Quality Improvement is a formal approach to the analysis of performance and systematic efforts to improve it. QI involves both prospective and retrospective reviews. It is aimed at improvement – measuring where you are, and figuring out specific practice changes to improve. It specifically attempts to avoid attributing blame, and to create systems to prevent errors from happening.[13] Data is collected to establish a "baseline" for an aspect of the Health Center's dental program, and the QI process focuses on developing methods to improve future outcomes of the oral health program derived from the baseline data.

[10] Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service: http://www.ncqa.org/.

[11] Phase I Treatment includes prevention, maintenance and/or elimination of oral pathology that results from dental caries or periodontal disease.

[12] Consumer Assessment of Healthcare Providers and Systems: http://www.cahps.ahrq.gov/

[13] Duke University Medical Center website – "Patient Safety – Quality Improvement": http://patientsafetyed.duhs.duke.edu/module_a/introduction/introduction.htmlchealth/guidelines/qualityimprovement.html



An effective QI plan provides a roadmap for Health Centers, as well as satisfies external requirements for HRSA funding and third party accreditation.[14] QI plans are essential to organizational development, as they directly align services to program goals, provide specific measurable milestones or targets, and identify timelines. A QI team should be comprised of staff members representative of all areas within the Health Center, including different clinical and administrative departments as well as both provider and support staff. The QI team should be led by a staff member who is experienced with the targeted issues. With respect to data collection, the QI plan designates key staff and outlines collection methods, frequency, and evaluation procedures.

Once baseline metrics are established, oral health programs can more effectively determine where quality improvement opportunities reside and set goals for the program. Improvement decisions are influenced by numerous variables in Health Centers, including resources, talent, motivation, Board priorities, and population needs. Because program goals vary, each Health Center must develop unique steps to achieve its desired improvements.

6. Quality Improvement (QI) Tools

This section provides a brief overview of two models utilized in QI activities, the Chronic Care Model and the Improvement Model. NNOHA presents them as important tools for developing a QI process, although they are best understood with more intensive study and training. Additional tools, including sample quality measures and a case study, are provided in this section as a resource for Health Centers who are developing QI processes.

[14] Bureau of Primary Health Care: "Designing a Successful Quality Improvement Program: Teambuilding and Writing a QI Plan," Slide #8, http://www.hrsa.gov/publichealth/guidelines/qualityimprovement.html

A. Chronic Care Model

The Chronic Care Model (Figure 1) originated from a synthesis of scientific literature in the early 1990's and became part of a national program of Robert Wood Johnson Foundation in 1998. The goal of the model is to help people with chronic illness through a coordinated program of quality improvement, research and dissemination. Participants are provided with proven tools and information to assist them in making changes within their system to both improve care and outcomes. The Health Resources and Services Administration's Bureau for Primary Health Care also launched its ambitious program to reduce quality disparities among the clients of Community Health Centers in 1998, and selected the Chronic Care Model as the basis for the Health Disparities Collaboratives.[15] The model is now being used as a framework for organizations to develop and implement the PCHH concept.

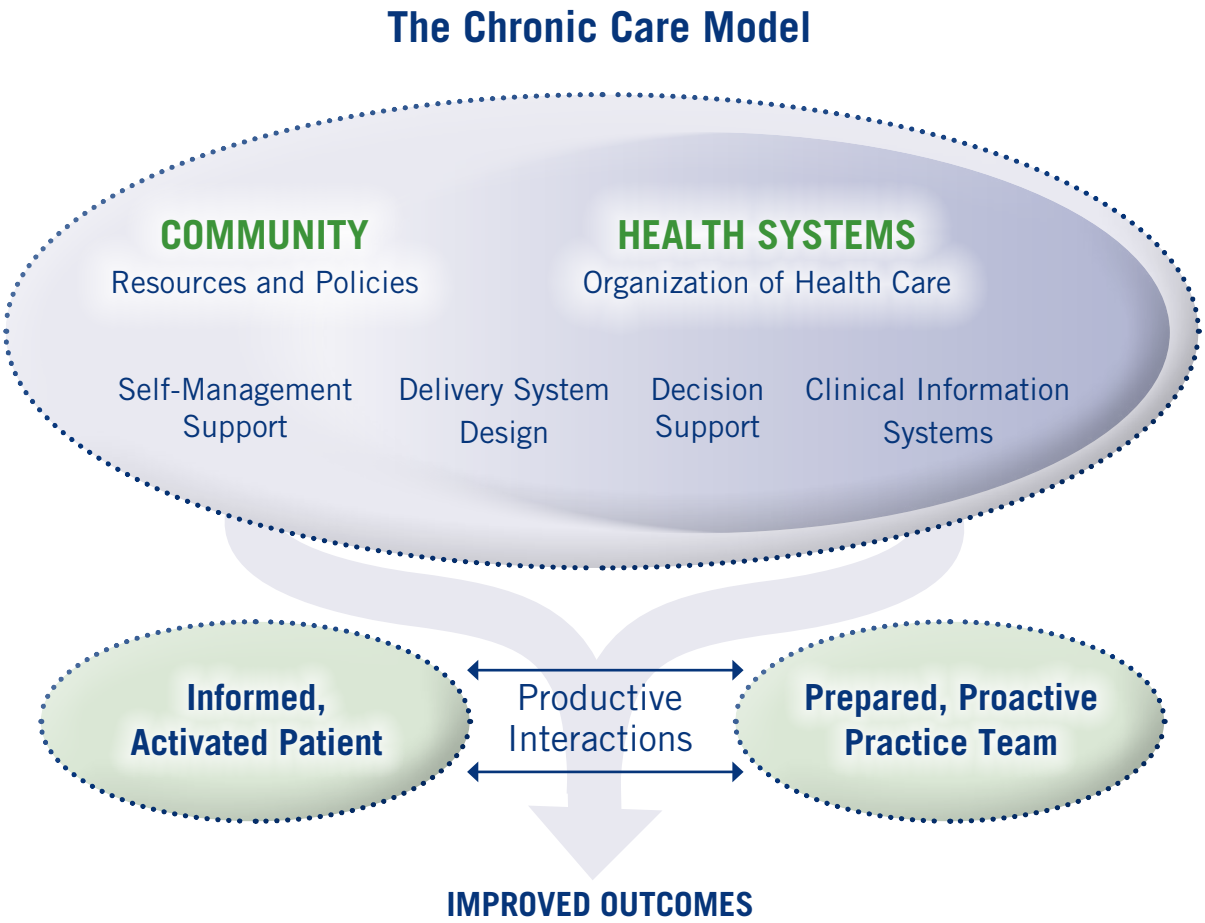


FIGURE 1: The Chronic Care Model
*Original Source: Improving Chronic Illness Care

[15] Improving Chronic Illness Care – "About ICIC and Our Work": http://www.improvingchroniccare.org/index.php?p=About_US&s=6

The model is built on the notion that positive interactions between a well-informed, empowered patient and a properly-equipped, proactive oral health team lead to improvements in health outcomes.[16] The Chronic Care Model identifies the following six elements[17] as essential to ensuring and improving the quality of care:

1. **Health Care Organization:** For an oral health QI program to succeed, it must have the full support of the organizational structure and senior leadership (e.g., CEO, Board of Directors, leadership committees).

2. **Community Resources and Policies:** Stronger links between the Health Center and community resources (e.g., outside health care providers, schools, health departments) may improve the effectiveness of the oral health program and its referral system.

3. **Self-Management Support:** Patients require support and appropriate information to better manage their health.

4. **Delivery System Design:** To truly integrate oral health care with medical and other health care services, a Health Center's entire delivery system must to be coordinated. The use of a multidisciplinary team approach, ensures patients access and receive care efficiently, while also allowing providers to maintain current and centralized information.

5. **Decision Support:** Oral health programs utilize evidence-based guidelines and protocols in daily clinical practice.

6. **Clinical Information Systems:** To make appropriate clinical decisions, oral health providers need timely and clinically relevant information about each patient, as well as their total patient population. Oral health teams can obtain this information through Health Centers' practice management systems, registries or independently created tracking models, such as those outlined at the end of this chapter.

NNOHA's Oral Health Disparities Pilot demonstrated the Chronic Care Model could be used to manage the most common chronic oral diseases – dental caries and periodontal disease.[18] The flexibility of the Chronic Care Model enables it to be successfully applied in various health care settings and target populations and for many chronic healthcare conditions. With consistent use, the model can result in healthier patients, more satisfied providers, and improved cost savings.[19]

[16] Agency for Healthcare Research and Quality – "An Overview Of Chronic Care Model": http://www.cahps.ahrq.gov/quality-improvement/improvement-guide/browse-interventions/communication/planned- visits/chronic-care-model.aspx

[17] Institute for Healthcare Improvement – "Changes to Improve Chronic Care"http://www.ihi.org/knowledge/Pages/Changes/ChangestoImproveChronicCare.aspx

[18] National Network for Oral Health Access – "Medical/Dental Partnerships": http://www.nnoha.org/oralhealthcollab.html

[19] Improving Chronic Illness Care – "The Chronic Care Model: Model Elements": http://www.improvingchroniccare.org/index.php?p=Model_Elements&s=18

B. The Model For Improvement

The Model for Improvement enables an organization to approach quality improvement through rapid cycles of change and continual feedback on the effectiveness of those changes. When used in conjunction with the Chronic Care Model, the Model for Improvement can lead to positive, sustainable changes in the quality of health care. Additionally, Health Centers can apply this model in conjunction with other established improvement processes

The Model for Improvement allows QI teams to evaluate whether the Health Center accomplished its goals, utilized resources effectively and efficiently, and performed activities to produce desired changes. The cornerstone of the model is the **Plan-Do-Study-Act (PDSA) Cycle** (Figure 2). PDSA is shorthand for using the scientific method to test a change by planning it, trying it, observing the results, and acting on what is learned.[20] More information on the Model for Improvement and PDSA Cycle can be found in Appendix D.

C. Sample Quality Measures

One of the most important steps in the improvement process is to establish measures for evaluation. Working towards improvement in the measures is what drives system change. Measures can be derived from national goals (i.e. Healthy People 2010), existing data sets (i.e. HEDIS, NQA), HRSA collaboratives or other metrics important to improving the oral health of the populations your Health Center serves.

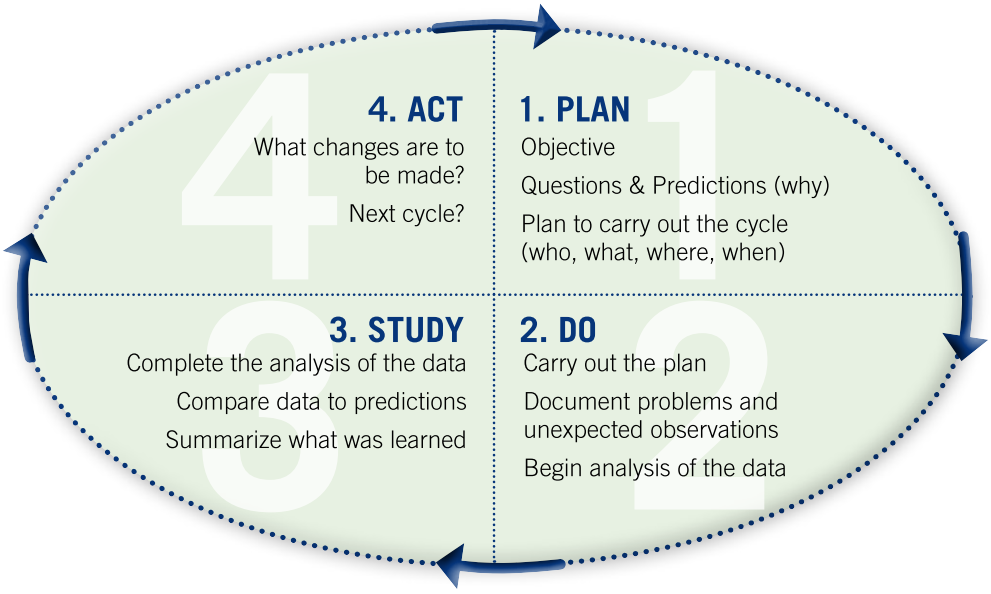


FIGURE 2: The PDSA Cycle*

*** The Plan-Do-Study-Act (PDSA) cycle was originally developed by Walter A. Shewhart as the Plan-Do-Check-Act (PDCA) cycle. W. Edwards Deming modified Shewhart's cycle to PDSA, replacing "Check" with "Study." [See Deming WE. The New Economics for Industry, Government, and Education. Cambridge, MA: The MIT Press; 2000.]**

[20] Institute for Healthcare Improvement – "Science of Improvement: How to Improve": http://www.ihi.org/knowledge/Pages/HowtoImprove/ScienceofImprovementHowtoImprove.aspx

Sample Quality Measures

MEASURE	SOURCE
Percentage of patients who had at least one dental visit during the measurement year	HEDIS®, NNOHA proposed Meaningful Use Clinical Quality Metric (CQM)
The percentage of children 2-21 years of age who had at least one dental visit during the measurement year	National Quality Forum measure #1388
Percentage of children age 1-17 years have had tooth decay or cavities in the past 6 months	National Quality Forum measure #1335
Percentage of patients who had a periodontal exam at least once during the measurement year	NNOHA proposed Meaningful Use CQM
Oral Cancer Risk Assessment & Counseling – Percentage of all patients who receive soft tissue screening, oral cancer exam and counseling	NNOHA proposed Meaningful Use CQM
Percentage of patients for whom a Phase I[21] treatment plan is completed within 12-months of the exam visit	NNOHA proposed Meaningful Use CQM
Percentage of children who received preventive dental care during the previous 12 months	National Quality Forum measure #1334 Healthy People 2020
Percentage of children with at least one topical fluoride treatment or fluoride varnish treatment during the measurement year	Healthy People 2020, NNOHA proposed Meaningful Use CQM
Percentage of children ages 6 to 21 years who received at least a single sealant treatment during the measurement year	Healthy People 2020, NNOHA proposed Meaningful Use CQM
Percentage of children who received primary caries prevention intervention as part of well/ill child care as offered by primary care medical providers	National Quality Forum measure #1419

[21] Phase I Treatment is defined as prevention, maintenance and/or elimination of oral pathology that results from dental caries or periodontal disease. This includes: oral cancer prevention and early diagnosis; prevention education and services; emergency treatment; diagnostic services and treatment planning; restorative treatment; basic periodontal therapy (non surgical); basic oral surgery that includes simple extractions and biopsy; non-surgical endodontic therapy; and space maintenance and tooth eruption guidance for transitional dentition. For more information, see "Chapter 1: Health Center Fundamentals" of the Operations Manual for Health Center Oral Health Programs (http://www.nnoha.org/practicemanagement/manual.html).

D. Case Study

The following case study is an example for oral health programs implementing a QI process. The case study describes how the Quality Team developed baseline metrics to select target measures for improvement, utilized the Model for Improvement to enhance quality measures, and examined the results. Although this example only focuses on a single quality metric (treatment plan completion rate), effective QI programs should address all unsatisfactory metrics:

The Community Health Center dental clinic realized they had a problem. The schedule was booked out months in advance. The same day new appointment schedules were opened, they were booked. If patients didn't have speed dial, they didn't get an appointment. By the time most patients would have been due for their recall appointments; their initial treatment plans hadn't been completed. No-show rates were high and production charges were low. Patient and staff satisfaction scores both showed room for improvement.

Soon after this, the entire Health Center including the dental clinic, participated in several weeks of quality improvement training. Each department formed its own quality team and was charged with selecting an area in which they wished to improve. The dental clinic elected to work on treatment plan completion.

DEVELOP A BASELINE:

The oral health quality team first established baseline clinical and management metrics in the dental clinic, including the sample metric, treatment plan completion rate (TPCR). The team identified all patients who presented for a comprehensive (ADA code 0150) and/or periodic recall (ADA code 0120) oral exam during January 2010 (denominator).

Next, the team randomly selected 50 patient charts during the same timeframe and identified patients who had completed Phase I treatment[22] within the subsequent 12 months (numerator).[23] For each patient, the following data elements were collected: patient name, visit date, examining provider, ADA code 0150 and/or 0120. The final equation to calculate treatment plan completion rate (TPCR) was:

$$\frac{\text{\# of patients who completed Phase I treatment by January 2011}}{\text{\# of patients seen during January 2010}} \times 100\%$$

[22] For definition, see footnote #21.

[23] Tracking patient charts through an electronic dental record (EDR) system is optimal. However, those without an EDR may collect smaller sample sizes over regular intervals to obtain adequate information for QI processes.

UTILIZE THE IMPROVEMENT MODEL:

The initial chart audit revealed a baseline 12-month Treatment Plan Completion Rate (TPCR) of 26 percent. The quality team set a goal of increasing the TPCR from 26 to 50 percent and began by implementing principles of the Model for Improvement, namely the Plan-Do-Study-Act (PDSA) cycle.

First, the team gathered information about factors contributing to the low TPCR. Patient satisfaction surveys, used to obtain information about barriers to treatment completion, revealed that patients found it difficult to schedule an appointment. Phone calls to 'no-show' patients divulged that many failed to keep their appointments because they were scheduled too far in advance. From these investigations, the team discovered there were insufficient appointment times available for patients to appropriately complete their treatment plans. Fundamentally speaking, supply did not match demand.

The team approached balancing the equation from both sides by increasing appointment supply, while also controlling demand. Supply was increased by 1) improving the dentist-to-dental assistant ratio, and 2) optimizing the scheduling system. The team conducted a PDSA cycle and found that increasing the ratio of dentists to dental assistants from 1:1.5 to 1:2 allowed them to schedule 25 percent more restorative appointments per provider. Next, the team focused on optimizing the scheduling system to ensure that the manageable number of patients were in active treatment at any given time. After performing a PDSA cycle, the team tested opening schedules one month at a time, with the goal of providing appointments for every patient who needed restorative care within a month.

Finally, to manage demand, the daily number of scheduled new patients was reduced from five to one per provider. Previous analyses had revealed that new patients required an average of 5.3 appointments to successfully complete Phase I treatment. As such, the team was able to reduce the number of new patients receiving treatment at one time with the ultimate goal of improving treatment compliance with subsequent appointments for all patients. Additionally, these adjustments created an opportunity for the clinic to work down the backlog of patients with unmet restorative needs.

EXAMINE THE RESULTS:

Over the next few months, the clinic observed a dramatic increase in overall production. Additionally, the number of 'no-show' appointments decreased, as all new exam patients left the clinic with their next appointment scheduled within a month. These improvements were a result of increasing supply through improving the dentist-to-dental assistant ratio and optimizing the scheduling system, allowing the clinic to increase the number of daily appointment slots.

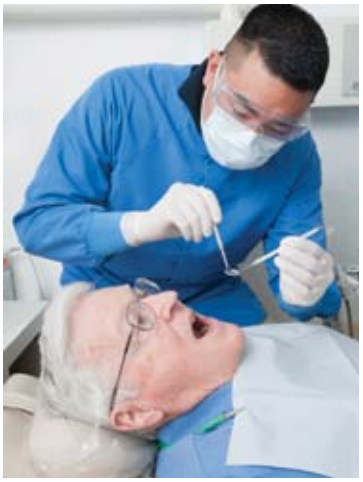
In the longer-term, nearly two years later, the clinic gradually increased the TPCR from 26 to 70 percent. Since the changes were implemented in a sustainable fashion, the TPCR has remained at 70 percent for more than three years. Additionally, the QI team observed an increase in both patient and staff satisfaction scores, indicating the scheduling changes were well received. It is important to note, however, that the improvements achieved in this case study may not function the same for every Health Center. Therefore, it is vital for each Health Center to find solutions that work for each setting through testing innovative changes that may result in quality improvements.

SAMPLE PROJECT-SPECIFIC QI PLAN

Project Goal:	By the end of 2011, increase the number of patients completing Phase I treatment within 12 months of initiating a treatment plan from XX% to YY%.
Project Team Leader:	Dr. Green or Ms. Brown (QI Director)
Project Team:	Dr. Blue, Ms. White (Dental Assistant), Ms. Red (Dental Hygienist), Ms. Black (Administrative Assistant)
Baseline:	To be determined
Project Timeline:	One year (include tasks, completion dates, and staff assigned to task)
First Team Meeting:	2-3pm on December 10, 2010

2011 PROJECT TIMELINE AND TASK ASSIGNMENT

TASK	MONTH	RESPONSIBLE
Initiate data collection	January	Red and Black
Compile results	February	White and Red
Analyze data	March	White
Present results at staff meeting	March	Group
Develop improvement plan	April	Green, Blue and White
Implement plan on pilot basis	May-September	Group
Evaluate plan/collect & analyze data	September	Red, Black and White



7. Third Party Quality Recognition

Many references are available to assist Health Centers with developing or improving their QA/QI programs, including formal resources and review systems supported by government agencies and other organizations. Several are briefly described, such as The Joint Commission. Information about additional partners for the QA/QI process is included in Appendix E.

A. The Joint Commission (TJC)

Formerly known as JCAHO, The Joint Commission (TJC) sets standards for health care organizations, conducts on-site reviews, and accredits those who meet the criteria for continual quality improvement. TJC's mission is "to continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value."[24]

Although Health Centers are not required to meet TJC standards, HRSA widely promotes accreditation. Through the *Accreditation Initiative Update*, described in Program Assistance Letter (PAL) 2009-12, Health Centers are encouraged to participate in the accreditation process, which includes survey-related education, technical assistance, and training.[25]

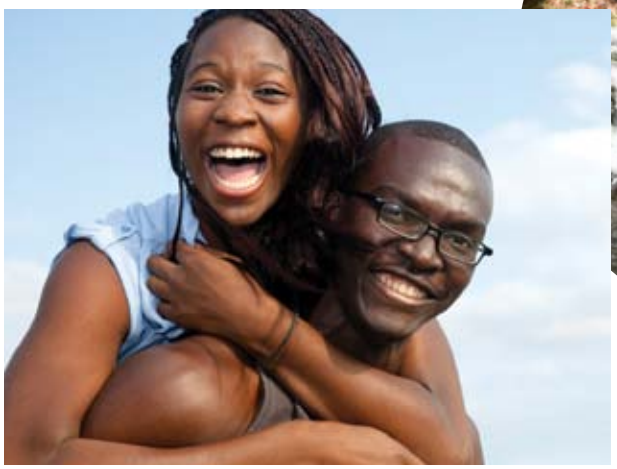
[24] Joint Commission Mission Statement: http://www.jointcommission.org/assets/1/18/Mission_Statement_8_09.pdf
[25] Bureau of Primary Health Care – "Accreditation Initiative Update," PAL 2009-12: http://bphc.hrsa.gov/policiesregulations/policies/pal200912.html

B. Accreditation Association For Ambulatory Health Care (AAAHC)

AAAHC accredits organizations in a wide variety of ambulatory health care settings, including ambulatory and surgery centers, community health centers, medical and dental group practices, medical home, and managed care organizations, as well as Indian and student health centers, among others. All recognized accrediting agencies require certain levels of QA/QI activities, ongoing program evaluation, peer review, and adherence to safety standards. While the accreditation process requires considerable effort, it also provides comprehensive, step-by-step procedures to develop a quality improvement program: http://www.aaahc.org/.

C. NCQA Patient-Centered Centered Medical Home Recognition

Patient-Centered Centered Medical (Health) Home concept is at the core of health care delivery transformation.[26] HRSA actively endorses this concept, citing its many benefits, including improved quality of care, decreased costs, and enhanced integration of care.[27] In Program Assistance Letter 2011-11, HRSA encouraged Health Centers to apply for National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home accreditation and offered technical assistance to Health Centers seeking such accreditation.[28] The integration of health care delivery plays a key role in health care reform at both the federal and state levels. Thus, it is essential for dental providers to understand and embrace the concept during the QI process.



[26] Helpful resources on the medical and dental home concepts include:
- National Maternal and Child Oral Health Resource Center, Georgetown University: http://www.mchoralhealth.org
- American Academy of Pediatric Dentistry: www.aapd.org/

[27] HRSA offers a number of online resources related to PCMHs, including http://www.hrsa.gov/healthit/toolbox/Childrenstoolbox/BuildingMedicalHome/whyimportant.html

[28] Bureau of Primary Health Care – "HRSA Patient-Centered Medical/Health Home Initiative," PAL 2011-11: bphc.hrsa.gov/policiesregulations/policies/pal201101.html; See also National Committee for Quality Assurance: http://ncqa.org/

8. Future Influences On Quality

Research And Technology

New areas of research and discoveries will shape both the clinical practices that constitute quality care as well as the way quality of care is measured in the future. Increased use of information technology (IT) will allow data to be routinely collected and aggregated, enabling more targeted disease management and preventive care. These advances, in turn, will lead to more definitive outcome measurements that ultimately result in higher quality of care for individual patients, as well as communities. Therefore, it is imperative that more effective diagnostic tools and evidenced-based clinical treatment standards are developed to improve the Health Center's ability to collect data and assess quality metrics.

Health Center providers and administrators are encouraged to closely monitor both clinical and technology advancements and incorporate them into their practices. For oral health programs, the transition to electronic dental records (EDR) presents an opportunity to more efficiently and effectively assess patient care. Although implementing an EDR is a long-term process, it can facilitate quality improvements, through easily accessible patient records, and enhanced system wide performance tracking once established. Despite considerable efforts required to establish an EDR, the benefits to the patient, provider, and community continue to propel the future of patient care towards electronic record keeping.

HRSA has developed a resource website for health centers and other safety net providers who are seeking to implement health IT that focuses on pediatric oral health: http://www.hrsa.gov/healthit/toolbox/Childrenstoolbox/PediatricOralHealthIT/index.html

9. Summary

Defined by the Institute of Medicine's six essential domains, quality health care is safe, effective, patient-centered, timely, efficient, and equitable.[29] This chapter was designed to provide information on the fundamentals of quality assurance (QA) and quality improvement (QI) processes. In addition to discussing the importance of quality measurements, the chapter outlined several established improvement methodologies, as well as provided information on quality resources for Health Centers and potential future influences on quality. Although success in achieving quality oral health programs requires considerable effort, it is attainable through small changes over time and staff commitment to ensuring the best possible patient care.

10. Frequently Asked Questions

Q: How can dental department measures link to medical measures?

A: First, it is imperative for the oral health program to be represented within the Health Center Quality Team to ensure it is incorporated into the Health Center's larger QI framework. Although several oral health metrics should be included in the overall Health Center quality measures (e.g., oral health education, preventive health behaviors), oral health clinical and management metrics should be specifically developed for the dental clinic setting.

Collectively working towards common quality measures can be an effective strategy to unite all programs within a Health Center. To further link dental and medical quality measures, consider finding target dental populations within medical populations. For instance, increasing the percentage of children ages 12-24 months receiving medical care at the Health Center who have also had a dental visit within the last year could be an outcome measure for an infant oral health program. Additionally, increasing the percentage of pregnant or diabetic medical patients who are also dental patients is an outcome measure both medical and dental programs could share.

Q: What is a good target number for treatment plan completion?

A: QI is about improving baseline data through small, calculated changes. Because each Health Center faces different challenges, the amount of improvement is variable and depends on the initial baseline number. In general, a 10 to 15 percent increase in the number of completed treatment plans (over baseline data or on an annual basis) can be considered acceptable improvement. While some national efforts have specific targets or benchmarks associated with them (i.e. HEDIS, HP 2020), emphasis should be placed on continual metric improvement rather than on just reaching a specific number. Focus efforts on establishing baseline data, setting goals, and aiming for steady improvement until your Health Center finds its plateau for the metric.

[29] Institute of Medicine – ""Crossing the Quality Chasm: The IOM Health Care Quality Initiative."

Q: Is there a way to use electronic health record (EHR) codes to monitor QI?

A: In most cases, the EHR must be customized to accomplish QI monitoring. Most systems allow for the development of 'dummy codes' to track measures such as treatment plan completion. Sites without an established EHR can track QI measures with internal coding systems.

Q: How can I use diagnostic codes in my practice to track quality?

A: Some QA/QI programs are using ICD-9 codes (which will change to ICD-10 codes on Oct.1, 2013) to track whether or not certain procedures are performed based on particular diagnoses. An example of this would be tracking the number of children ages 0-5 with a diagnosis of 521.01- Dental caries limited to enamel- that also received a fluoride varnish application at the same visit. Although these codes may not perfectly measure all quality metrics within current systems, diagnostic codes could be an important quality tool in the future.

Q: How can I keep staff motivated to continuously improve quality?

A: QI does not just happen. It requires considerable planning, communication, and commitment. NNOHA recommends establishing regular team meetings and instituting goals aligned with QI plans. It is important for staff, patients, and the Health Center Board to be aware of continuous improvements. Consider publishing quality measures on the Health Center's website, newsletters, and wall postings to ensure they are constantly visible. Don't forget to take time to celebrate improvements.

11. Links

HRSA Links

- **BPHC Technical Assistance – Quality:**
  http://bphc.hrsa.gov/technicalassistance/tatopics/qualitymanagementimprovement/index.html#Quality
- **Health Center Operations –**
  Health Center Accreditation: http://bphc.hrsa.gov/policiesregulations/accreditation.html
- **Health Center Operations –**
  Quality Improvement: http://bphc.hrsa.gov/policiesregulations/quality/index.html
- **Health Center Patient Satisfaction Survey:**
  http://bphc.hrsa.gov/policiesregulations/performancemeasures/patientsurvey/satisfactionsurvey.html
- **PAL 2011-01 – HRSA Patient-Centered Medical/Health Home Initiative:**
  http://bphc.hrsa.gov/policiesregulations/policies/pal201101.html
- **Quality Improvement & Risk Management Training:**
  http://www.hrsa.gov/publichealth/guidelines/qualityimprovement.html
- **Quality Improvement:** http://www.hrsa.gov/quality/
- **The Provider's Guide to Quality and Culture:**
  http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English
  (Joint project of Management Sciences for Health, U.S. Department of Health and Human Services, HRSA and BPHC)

Other Links

- **AHRQ Effective Health Care:**
  http://effectivehealthcare.ahrq.gov/
- **American Academy of Pediatric Dentistry:**
  http://www.aapd.org
- **American Academy of Pediatric Dentistry/Dental Home:**
  http://www.aapd.org/dentalhome/

- **American Dental Association Evidence-Based Dentistry Site:**
  http://ebd.ada.org/
- **Association of Maternal & Child Health Programs:**
  http://www.amchp.org
- **Healthy People 2020:**
  www.healthypeople.gov
- **Institute for Healthcare Improvement/Chronic Care Model:**
  http://www.ihi.org/IHI/Topics/ChronicConditions/
- **National Association for Community Health Centers/Clinical Quality:**
  http://nachc.org/clinicalquality.cfm
- **National Maternal and Child Oral Health Resource Center, Georgetown University:**
  http://www.mchoralhealth.org
- **National Quality Forum:**
  http://www.qualityforum.org/
- **NNOHA Website:**
  http://www.nnoha.org/
- **Oral Health Disparities Collaborative Implementation Manual:**
  http://www.nnoha.org/oralhealthcollab.html
- **State Primary Care Associations:**
  http://bphc.hrsa.gov/technicalassistance/partnerlinks/associations.html
- **Worksheet for Assuring a QI/QA Plan meets HRSA Quality Requirements:**
  http://tinyurl.com/HRSA-QIReq

12. Quality Worksheet

True or False? Health Centers are required to have an ongoing quality assurance/ quality improvement program.

TRUE FALSE

Select one measure from the Sample Quality Measures that could be tracked at your site:

_____
_____
_____
_____

List three things this measure might change:

_____
_____
_____
_____

Describe one small-scale PDSA cycle that could be done to affect this change?

_____
_____
_____
_____

Identify one partner you have not utilized in the past who could help you improve your quality program:

_____
_____
_____
_____

My Dental Department is fully engaged in the overall Quality Improvement plans at my Health Center:

TRUE FALSE

Appendix A: Sample Peer Review Form *(Courtesy of Terry Reilly HC, Nampa, ID)*

DENTAL PROVIDER PERFORMANCE REVIEW FROM

Quarterly Chart Review

Date of Review: _____

Reviewing Dentist: _____

Quarter Reviewed _____

Dentist Reviewed: _____

GENERAL CHART INFORMATION	CHART ONE YES	CHART ONE NO	CHART TWO YES	CHART TWO NO	CHART THREE YES	CHART THREE NO	CHART FOUR YES	CHART FOUR NO	CHART FIVE YES	CHART FIVE NO
1. Patient Information complete?										
2. General Consent complete?										
3. Medical History complete?										
4. Medical History update complete?										
5. Are Allergies and Medical conditions documented?										
6. Indicators discussed: caries risk, diabetes, smoking, etc.?										

Comments: _____

CLINCAL EXAM DATA	CHART ONE YES	CHART ONE NO	CHART TWO YES	CHART TWO NO	CHART THREE YES	CHART THREE NO	CHART FOUR YES	CHART FOUR NO	CHART FIVE YES	CHART FIVE NO
1. Soft tissue findings noted?										
2. Occlussal findings noted-carries, missing teeth, dental needs?										
3. Peridontal findings/Classification noted?										

Comments: _____

RADIOGRAPHS	CHART ONE YES	CHART ONE NO	CHART TWO YES	CHART TWO NO	CHART THREE YES	CHART THREE NO	CHART FOUR YES	CHART FOUR NO	CHART FIVE YES	CHART FIVE NO
1. Appropriate Survey, type of Xrays taken?										
2. Adequate Film coverage, all apices covered?										
3. Any image defect: cone cuts, retakes needed?										
4. Number of X-rays taken documented?										

Comments: _____

PROBLEMS / DIAGNOSIS	CHART ONE YES	CHART ONE NO	CHART TWO YES	CHART TWO NO	CHART THREE YES	CHART THREE NO	CHART FOUR YES	CHART FOUR NO	CHART FIVE YES	CHART FIVE NO
1. Appropriate testing done?										
2. Diagnosis documented?										
3. Appropriate consultations made, if needed?										
4. Referrals made if needed?										
5. Findings documented on treatment plan?										

Comments: _____

TREATMENT PLAN / DENTAL RECORD	CHART ONE YES	CHART ONE NO	CHART TWO YES	CHART TWO NO	CHART THREE YES	CHART THREE NO	CHART FOUR YES	CHART FOUR NO	CHART FIVE YES	CHART FIVE NO
1. Does Treatment Plan follow appropriate sequence?										
2. Record is complete and appropriate for treatment rendered?										
3. Follow up appointment is indicated in clinical record?										
4. Documentation is complete, tooth area, anesthetic, procedure and/or materials, signed with Doctor's and Assistant's names, etc.?										

Comments: _____

Director's Comments: _____

_____

Dental Director: _____

Signature: _____ Date: _____

Appendix B: Staff Dental Officer Peer Review Form and Interview Questions

(Courtesy of Federal Bureau of Prisons Dental Program)

STAFF DENTAL OFFICER (SDO) PEER REVIEW

Site: _____

Staff Dental: _____

Date of Review: _____

Reviewing CDO: _____

SECTION 2-KNOWLEDGE SKILLS RELATED TO DIRECT PATIENT CARE	
Knowledge Base Dental Management Strategies for Medically Compromised Patients	**Antibiotic Prophylaxsis:** Discuss the types of patients that need dental prophylaxis. Is the SDO knowledgeable about who should be pre-medicated (The response should be consistent with the AHA guidelines) ☐ ☐ Yes ☐ ☐ No ☐ ☐ Knew most indications Does the SDO know the current guidelines as they relate to prosthetic joints? ☐ ☐ Yes ☐ ☐ No ☐ Does the dentist know the current prophylactic regimen for patients requiring pre-medication? ☐ ☐ Yes ☐ ☐ No ☐ Does the SDO know the alternative regimen for patients allergic to Amoxicillin? ☐ ☐ Yes ☐ ☐ No *If the dentist cannot answer the above questions can the SDO go to a reference for the information? ☐ ☐ Yes ☐ ☐ No
Comments: _____	
Knowledge Base Dental Management Strategies for Medically Compromised Patients	**Hepatitis B and C:** Discuss concerns the SDO has in regard to providing dental care to patients with Hepatitis. Is the SDO aware of problems associated with end stage liver disease? ☐ ☐ Yes ☐ ☐ No ☐ Ask the SDO what type of labs would be ordered for patients with documented liver disease. Is the SDO aware that these labs should be ordered prior to performing dental surgery or exodontia? ☐ ☐ Yes ☐ ☐ No ☐ Does the SDO consult with the Clinical Director or staff physician regarding care for these patients? ☐ ☐ Yes ☐ ☐ No ☐
Comments: _____	

Knowledge Base Dental Management Strategies for Medically Compromised Patients	**Bleeding Disorders and Patients on Anticoagulants:** Discuss various bleeding disorders to include Factor VIII, IX, and X disorders. Also discuss medications and medical conditions that can cause prolonged bleeding or are associated with prolonged bleeding. Is the SDO knowledgeable about illnesses that can contribute to prolonged bleeding? ☐ ☐ Yes ☐ ☐ No ☐ Ask the dentist what medications can cause prolonged bleeding. Was the SDO familiar with some of these? ☐ ☐ Yes ☐ ☐ No ☐ Ask what the normal platelet range is. Did the SDO know the range? ☐ ☐ Yes ☐ ☐ No ☐ Ask the SDO what is an acceptable INR range for patients requiring dental surgery. ☐ ☐ Yes ☐ ☐ No Was the SDO familiar with the INR value? ☐ ☐ Yes ☐ ☐ No
Comments: _____	
Knowledge Base Dental Management Strategies for Medically Compromised Patients	**Diabetes:** Ask the dentist the following questions: What is the relationship between periodontal disease and diabetes? What considerations should be given to patients with diabetes? Is the dentist knowledgeable about Diabetes and the relationship to Oral Health? ☐ ☐ Yes ☐ ☐ No ☐
Comments: _____	
Knowledge Base Dental Management Strategies for Medically Compromised Patients	**Hypertension:** Ask the SDO when is a patient borderline for hypertension (HTN). Did the dentist know this? ☐ ☐ Yes ☐ ☐ No ☐ Ask the dentist to identify problems associated with hypertension and the administration of local anesthetics. Was the Dentist able to discuss and identify potential problems? ☐ ☐ Yes ☐ ☐ No ☐ ☐ Somewhat Familiar Ask the dentist how he/she goes about treating a patient with hypertension. Based on the response provided, did the dentist have a good working knowledge of HTN as it relates to dental care? ☐ ☐ Yes ☐ ☐ No ☐ ☐ Somewhat Familiar Has the dentist reviewed the BOP's HTN guidelines? ☐ ☐ Yes ☐ ☐ No ☐ **If yes can the dentist define Pre Hypertension and discuss the implications? ☐ ☐ Yes ☐ ☐ No ☐ ☐ Somewhat Familiar
Comments: _____	

Knowledge Base Dental Management Strategies for Medically Compromised Patients	**Oral Cancer:** Ask the dentist to discuss the risk factors associated with Oral Cancer. Was the dentist familiar with the risk factors? ☐ ☐ Yes ☐ ☐ No ☐ ☐ Somewhat Familiar Ask the dentist to demonstrate or describe the proper way of performing an oral cancer exam. Was the dentist able to perform an exam and explain what he /she is looking for? ☐ ☐ Yes ☐ ☐ No ☐ ☐ Somewhat Familiar Ask the dentist: What complications are associated with radiotherapy? Was the dentist conversant regarding complications? ☐ ☐ Yes ☐ ☐ No ☐ ☐ Somewhat Familiar ☐ Ask the dentist: What type of post-operative care is routinely provided to patients who have undergone radiotherapy (in maxillofacial complex)? Was the dentist knowledgeable about special care? ☐ ☐ Yes ☐ ☐ No ☐ ☐ Somewhat Familiar Ask the dentist: What past medical history would suggest the patient received bisphosphonate therapy? What complications are associated with dental treatment after bisphosphonate therapy? Was the dentist conversant regarding complications? ☐ ☐ Yes ☐ ☐ No
Comments: _____	
Knowledge Base Dental Management Strategies for Medically Compromised Patients ☐	**HIV Disease:** Ask the dentist to discuss HIV disease and the potential complications. Was the dentist familiar with the oral manifestations? ☐ ☐ Yes ☐ ☐ No ☐ ☐ Somewhat Familiar Ask the SDO how she or he would manage a patient with a CD4 count of 200 cells/mm3? Was the dentist familiar with CD4 values? ☐ ☐ ☐ Yes ☐ ☐ No ☐ ☐ Somewhat Familiar
Comments: _____	

Appendix C: The Oral Health Impact Profile (OHIP-14)[30]

Dimension	Question
Functional limitation	Have you had trouble pronouncing any words because of problems with your teeth, mouth or dentures? Have you felt that your sense of taste has worsened because of problems with your teeth, mouth or dentures?
Physical pain	Have you had painful aching in your mouth? Have you found it uncomfortable to eat any foods because of problems with your teeth, mouth or dentures?
Psychological discomfort	Have you been self-conscious because of your teeth, mouth or dentures? Have you felt tense because of problems with your teeth, mouth or dentures?
Physical disability	Has your diet been unsatisfactory because of problems with your teeth, mouth or dentures? Have you had to interrupt meals because of problems with your teeth, mouth or dentures?
Psychological disability	Have you found it difficult to relax because of problems with your teeth, mouth or dentures? Have you been a bit embarrassed because of problems with your teeth, mouth or dentures?
Social disability	Have you been a bit irritable with other people because of problems with your teeth, mouth or dentures? Have you had difficulty doing your usual jobs because of problems with your teeth, mouth or dentures?
Handicap	Have you felt that life in general was less satisfying because of problems with your teeth, mouth or dentures? Have you been totally unable to function because of problems with your teeth, mouth or dentures?

[30] Slade GD. Derivation and validation of a short-form oral health impact profile. Community Dent Oral Epidemiology 1997, 25:284-290.

Appendix D: The Model for Improvement

THE MODEL FOR IMPROVEMENT IS BASED ON THREE FUNDAMENTAL QUESTIONS:

1 What are we trying to accomplish?

This question is meant to establish an AIM STATEMENT for improvement that focuses the organization's effort. It helps to focus on specific actions or elements of the Care Model, and to define which patients and providers will participate. The AIM STATEMENT should be time- specific, measurable, and as concise as possible – sometimes it takes a few trials of testing an AIM before it becomes truly focused.

2 How will we know that a change is an improvement?

Measures and definitions are necessary to answer this question. Data is needed to assess and understand the impact of changes designed to meet an AIM. When shared AIMS and data are used, learning is further enhanced because it can be shared with other organizations in the Collaborative. In this way, superior performance and best practices are more quickly identified and disseminated through benchmarking.

3 What changes can we make that will result in an improvement?

Testing and learning for the testing is necessary to conclude that a result is an improvement. The PDSA Cycle (PDSA stands for Plan, Do, Study, Act) is a trial-and-learning method to discover effective and efficient ways to change a process. The "study" part of the cycle is the key to learning what change leads to improvement. "Study" compels the team to learn from the data collected, to look at effects on other part of the system and on patients and staff, and under different conditions, such as different practice teams or different sites. Most importantly, the "study" phase is an ideal time to think through how the Chronic Disease Model helps to generate new ideas and approaches to positive change. PDSA cycles are short and quick. Typically, they need only hours, days or at most, a few weeks to complete.

Monitoring Progress

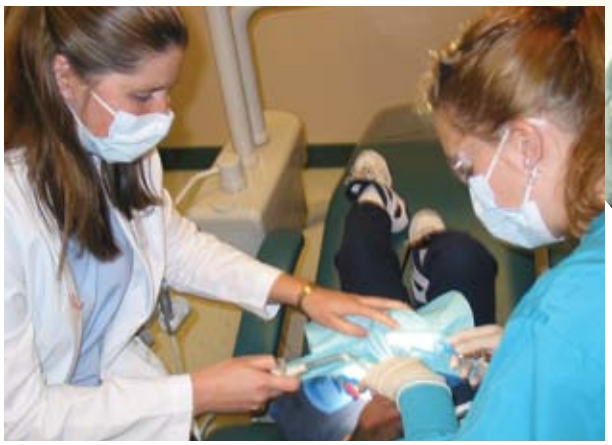
Measurement is essential to be convinced that changes are leading to improvement.

WHY DO WE TEST INSTEAD OF JUST IMPLEMENTING A CHANGE?

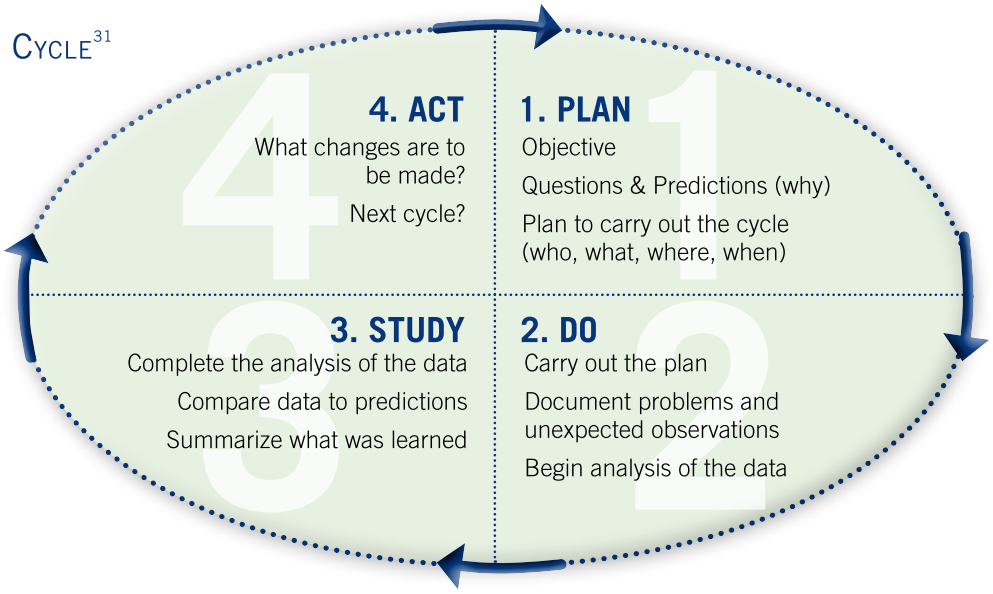
- **To build support** that the change will result in improvement in your environment
- **To better predict** the improvement resulting from a change
- **To learn how** to adapt a change to the conditions within your local environment
- **To determine the costs** and side-effects of the change
- **To minimize resistance** to the change upon implementation

TESTING ON A SMALL SCALE:

- Ask others who are knowledgeable to review the change and comment on its feasibility
- Test the change with team members who are developing it before introducing it to others
- Test the change side-by-side with the existing system to illustrate improvements
- Conduct the test in one facility, with one provider, with one patient
- Test the change over a short period of time
- Test the change on a small group of volunteers
- Try to develop a plan to simulate the change if possible



PDSA Cycle[31]



PLAN: **After studying the assessments. What are the priorities you want to improve?** Elements, such as, cost, increases in FTE, employee satisfaction, stresses to the current system, and the timelines to implement are determined. This is a vital step and needs to be thought out carefully and remember to include the ED and CFO in the planning when necessary.

DO: **Put the plan into motion.** Monitor the impact on staff, patients and the system to see if changes need to be made.

STUDY: **After a reasonable period, revisit the impact of the improvement initiative** to ensure the results are what were desired.

ACT: **Make necessary changes in the plan and cycle through again.** What other improvements can be made? Revisit your assessments and add other metrics you might want to improve.

[31] For the original source of the PDSA model, see Deming WE. The New Economics for Industry, Government, and Education. Cambridge, MA: The MIT Press; 2000.

SAMPLE PDSA SHEET[32]

CENTER:

Date: _____ Initiated by: _____ Cycle Number: _____

CARE MODEL COMPONENT: OrgHC Comm DelSysD DecSupp SelfMgt CIS

PLAN: the change, prediction(s) and data collection	
What change are we testing?	
Who is testing the change?	
When are we testing?	
Where are we testing?	
PREDICTION: What do we expect to happen?	
DATA COLLECTION:	
What data do we need to collect?	
Who will collect the data?	
When will data be collected?	
Where will data be collected?	
DO: carry out the change/test, collect data, and begin analysis	
What was actually tested?	
What happened?	
Unexpected Observations:	
Problems:	
STUDY: complete analysis of data **Summarize what was learned and compare to prediction.**	
ACT:	
What adjustments to the change or method of test should we make before the next cycle?	
Are we ready to implement the change we tested?	
What will the next test cycle be? (use back of form to elaborate)	

[32] National Association for Healthcare Quality: http://www.nahq.org/uploads/apps/files/PDSA%20Template.pdf

Appendix E: Additional Partners/Resources in Developing a QA/QI Plan

- **Indian Health Service (IHS)** is an Agency within the Department of Health and Human Services (HHS) that is responsible for providing federal health services to American Indians and Alaskan Natives. IHS provides a comprehensive health service delivery system for approximately 1.9 million American Indians and Alaskan Natives who belong to 562 federally-recognized tribes in 35 States.[33] The website includes reporting measures on quality, with some related to oral health: http://www.ihs.gov/qualityofcare/index.cfm?module=quality.

- **Department of Veterans Affairs, Veterans Health Administration (VHA)** is a federal department whose mission is to serve America's Veterans and their families with dignity and compassion. The department aims to be Veterans' principal advocate to ensure they receive medical care, benefits, social support, and lasting memorials promoting the health, welfare, and dignity of all veterans in recognition of their service to this Nation: http://www.va.gov/health/.

- **Center for Quality Management in Public Health (CQMPH)** provides information about HIV/AIDS and hepatitis C: http://www.publichealth.va.gov/quality/index.asp

- **Managed Care Organizations (MCOs)** offer health care in a system designed to control costs through managed programs, such as an HMO or PPO, where physicians accept constraints on charges for medical care and the patient's choice of physician is limited. Many States have MCO directories, usually linked from the State's Department of Health website (e.g., www.health.state.ny.us/health_care/managed_care/mcplans.htm).

  Other MCO resources include:

  "Collaboration Among Competing Managed Care Organizations for Quality Improvement," published by IOM (1999): www.nap.edu/catalog.php?record_id=6417

  Continuous Quality Improvement and Managed Care: http://sph2.umdnj.edu/omcweb/1996/ira18.html

  "Evaluations and Comparative Assessments of Managed Care Plans," Oregon Department of Human Services: http://www.oregon.gov/OHA/healthplan/data_pubs/reports/main.shtml#survey-eval

[33] "Indian Health Service Introduction"– http://www.ihs.gov/index.cfm?module=ihsIntro

- **State Quality Assurance Plans** are state-based strategies for Medicaid managed care programs. Examples include: Maryland http://bit.ly/mdqaplan and New York http://www.health.ny.gov/health_care/managed_care/docs/quality_strategy.pdf

- **Contacting Health Center Colleagues** can be a reliable method to obtain information from Health Center programs that have established QI programs. Health Centers implementing or enhancing their current QI program should ask their colleagues for recommendations on programs, measures, successes, and challenges. Other resources and recommendations of model programs can be found at national conferences, such as the National Primary Oral Health Conference, and organizations, such as HRSA, National Association of Community Health Centers (NACHC), and NNOHA.

- **Paid Technical Assistance Providers** specialize in providing guidance to Health Center oral health programs. Many organizations have experienced positive results when working with them. NNOHA recommends that any Health Center considering contracting with paid technical assistance providers, ensure the provider they choose is familiar with the Health Center environment, its mission, and relevant regulations. NNOHA has successfully partnered with DentaQuest Institute's Safety Net Solutions program: http://www.dentaquestinstitute.org/safetynet.

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Thank you to Unity Health Care for generous contribution of some photos used in this publication.

The National Network for Oral Health Access (NNOHA) is a nationwide network of dental providers in safety-net settings. 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.

For more information on NNOHA, visit www.nnoha.org, send an Email to info@nnoha.org, or call 303-957-0635

NNOHA
National Network for Oral Health Access

2012 MEMBERSHIP APPLICATION

For year October 1, 2011 through September 30, 2012

Applicant Contact Information

Name:

Title:

Organization:

Name of Health Center: (if different from Organization name)

Address:

City: State: Zip Code:

Phone: Fax:

E-mail:

NNOHA Membership Category:

- ❑ INDIVIDUAL MEMBER (dues $50)
- ❑ ORGANIZATIONAL MEMBER (dues $350)
- ❑ DENTAL HYGIENIST / DENTAL ASSISTANT (dues $30)
- ❑ ASSOCIATION MEMBER (dues $150)

If you are applying as an Organizational Member, please attach a list of the names, titles, and E-mail addresses of the employees you wish to include in the membership.

If you are applying as an Association Member, please contact NNOHA staff for the criteria for discounted membership.

For more details on the different types of memberships, please visit **www.nnoha.org/membership.html** and click on Membership Levels.

Referred by: (name of NNOHA Member)

Paying by (select one):

- ❑ Check (made payable to NNOHA)
- ❑ Bill Me
- ❑ Credit Card – Card Number:

Security Code: Expiration Date:

Signature

- ❑ Check here If you are interested in receiving information on the current NNOHA committees and opportunities to get involved.
- ❑ Check here if you would like to learn more about the Association of Public Health Dentistry.

Please complete this form and mail it to:

NNOHA, PMB 329, 3700 Quebec Street, Unit 100, Denver, CO 80207-1639

FOR MORE INFORMATION, CONTACT: Jennifer Hein • adminsupport@nnoha.org • Phone: 303-957-0635 / Fax: 866-316-4995

What Is NNOHA?

The National Network for Oral Health Access (NNOHA) is a nationwide network of dental providers who care for patients in safety-net systems. The members of NNOHA recognize the importance of oral health as part of overall health and are committed to improving the health of the country's underserved individuals. NNOHA was founded in 1991 by a group of Health Center Dental Directors who recognized the need for peer-to-peer networking and collaboration to effectively run Health Center oral health programs.

NNOHA's VISION

Individuals and communities are aware of the importance of oral health to overall health, engage in recommended oral health practices, and receive affordable, high quality oral health services.

NNOHA
National Network for Oral Health Access

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