



Expanding Access to Dental Care Through California's Community Health Centers

Introduction

Access to dental care for low-income Californians is quite limited. Only 26 percent of the 8.5 million eligible for Medi-Cal dental benefits, commonly known as Denti-Cal, receive treatment every year.¹ Few facilities will offer treatment to patients who rely on publicly funded insurance programs or are uninsured. Low reimbursement rates for Denti-Cal enrollees and the threat of further cuts discourage dentists in private practice from treating such patients.

Federally qualified health centers (FQHCs) offer dental care to a small percentage of low-income Californians and could potentially take on more patients. However, FQHCs, also referred to as community health centers, face numerous obstacles to establishing or expanding dental services.

In an effort to better understand these obstacles, the California HealthCare Foundation commissioned a field survey of FQHC's. Researchers interviewed dental directors, executive directors, clinicians and other staff at six community health centers in California with dental practices that treat a limited number of patients. The researchers also interviewed staff members at organizations that collaborate with and provide support to community health centers in California, Arizona, and Ohio.

The survey findings show that while FQHCs are willing to start or expand dental care for low-income Californians, they face a common set of impediments, ranging from insufficient capital

resources to difficulties in hiring high-quality professional staff and a patient-payer mix that does not allow for adequate reimbursement. The interviews also produced recommendations for overcoming these barriers, including:

- Creation of a peer networking program that would allow clinic dental directors and executives to discuss clinical, operational, administrative, financial, and policy issues;
- Wider dissemination of "best practices" for clinic efficiency and cost savings, such as bulk purchasing of supplies and services;
- Clarification of reimbursement policies for FQHCs on allowable services, billing rules and procedures, and location of services;
- Greater funding for capital funds and start-up costs;
- Support for programs which encourage dental students and professionals to practice in clinic settings, such as externships, residencies, and loan repayment; and
- Further research on the ability of health centers to provide inducements to attract qualified dentists, reduce operating costs through partnerships with other health centers, use expanded-scope dental professionals, and streamline licensing and regulatory requirements for expanding or opening new clinics.

While some clinics that provide dental services have experience in finding ways to solve common problems such as schedule-balancing and

no-shows, all said they could benefit from technical assistance and peer-to-peer networking to address persistent reimbursement and operations issues. In addition, the interviews suggested that the full support of the health center's chief executive appeared crucial to ensuring the success of dental services.

A companion report, *The Good Practice: Treating Underserved Dental Patients While Staying Afloat*, examines the broader problem of how community dental practices—both large and small, public and private—can design or improve the efficiency and effectiveness of the dental services they deliver. The report is available on the California HealthCare Foundation's Web site at www.chcf.org/topics/medi-cal/index.cfm?itemID=133706.

Methodology

To obtain information for this issue brief, a team of researchers made site visits in early 2008 to six California federally qualified health centers which provide a low or moderate volume of dental services and interviewed the dental directors and executive directors. (The researchers defined low-volume clinics as those with fewer than 5,000 dental encounters per year; “moderate” volume as 5,000 to 15,000 per year; and “high” volume as those with over 15,000 annual encounters per clinic site.) Clinics were selected for the diversity of their geographic location, patient mix, and staffing patterns. Additional interviews were conducted with clinics that have yet to provide any dental services, as well as with regional clinic consortia. Lastly, the researchers interviewed people and organizations that collaborate with and provide support to community health centers in the states of California, Arizona, and Ohio. To ensure the maximum degree of candor, interview subjects were offered anonymity both for themselves and their clinics.

The interviews focused on nine key areas:

- Dental capacity and operating model;
- Past, present, or future plans to either expand or scale back dental services;

- Participation in school or community-based services, or other outside activities;
- Competing providers and primary sources for patient referrals;
- Needs of the target population;
- Major impediments for expanding dental capacity;
- Opportunities or incentives to expand dental capacity;
- What has been tried that worked, and what didn't work; and
- How to share best practices data so that clinics can and will use it.

Figure 1 provides general information on the six community health centers that participated in the survey and a visual reference of their geographic locations.

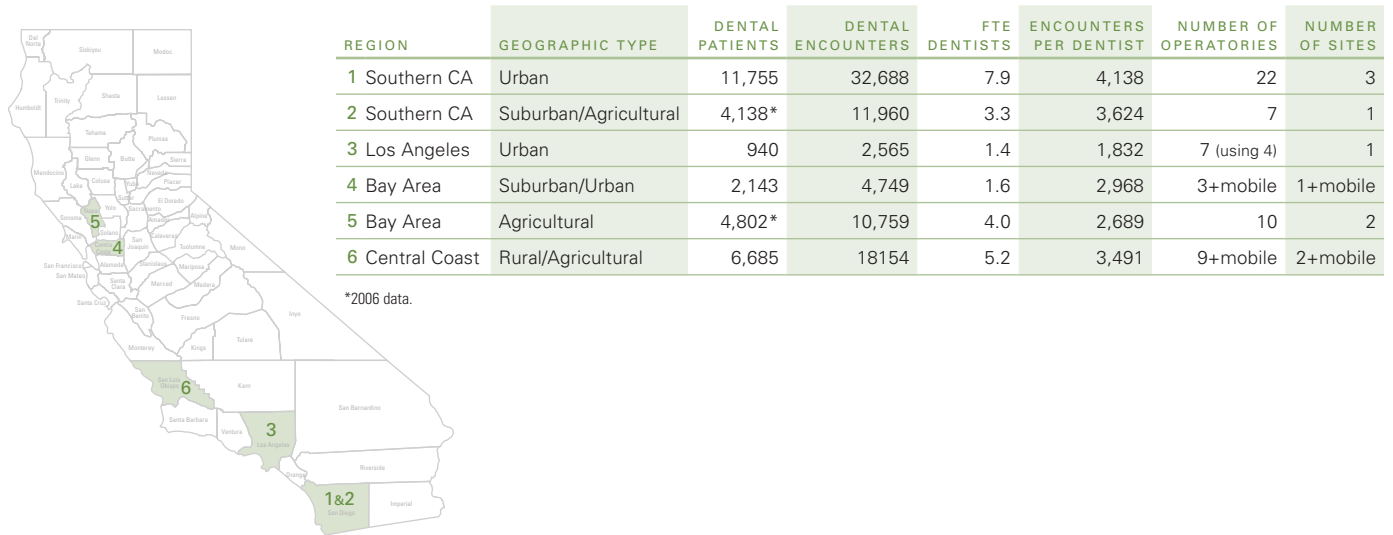
Findings

Although the community health centers interviewed had substantial differences in terms of their location, staffing and patient mix, all agreed on one thing: they do not have the capacity to meet the dental care needs of their patient populations.

Fewer than 2 percent of Denti-Cal services are now provided by community health centers.² Of the 857 licensed community clinics in the state, only 245 (29 percent) reported treating dental patients in 2006. Of these, 34 (14 percent) reported more than 10,000 dental encounters, a volume that accounted for nearly two-thirds (63 percent) of all such visits. By contrast, the 164 clinic sites that provided low volumes of dental care (between 1,000 and 10,000 per year) accounted for an average of 4,200 encounters.

The field research conducted for this issue brief shows that there is no single barrier impeding the expansion of dental care at community clinics; rather there is a set of barriers that proved common to the health centers which participated in this study. These fall into four

Figure 1. Characteristics of Six Participating California Community Health Centers, by Region



main categories: start-up and operating costs; payer mix, reimbursement, and uncompensated care; staff recruitment, retention and training; and issues related to leadership and management, including measures for quality and efficiency.

Start-up and Operating Costs

For a dentist to maximize the number of patients treated per day there needs to be at least two, and preferably three, treatment rooms assigned to each dentist. Because such rooms, formally known as dental operatories, are very specialized and require plumbing for water, compressed air, and suction, the capital cost for a dental clinic (without equipment) is substantially higher than that for a medical clinic. The estimated average capital construction cost for a three-operatory dental clinic is \$375,900, or \$209 per square foot.³ All but one of the clinics interviewed for this issue brief needed to expand their clinic space before they could add additional dental staff. Some were interested in expanding the dental clinic space at their primary location, while others were interested in opening new clinics at additional sites. One clinic had sufficient space but lacked equipment, supplies, and staff.

In addition to construction costs, dental clinics spend \$50,000 to \$75,000 per operatory for large equipment (patient chairs, x-ray units, operating lights, computers, etc.), instruments, non-disposable supplies, and small equipment. In some cases, equipment such as patient chairs and dental units—the chair-side utility station that supplies water, compressed air, electricity, and vacuum—were donated to the clinics. More commonly, money to pay for equipment was obtained through public or private grants, or collected as part of general fundraising.

While construction and equipment costs are a major deterrent to expansion for most clinics, dental directors all voiced greater concern regarding their annual budget for disposable supplies—approximately \$25,000 for a three-operatory clinic. Many pointed out that although grants can be obtained to cover the cost of construction and major equipment, there are few funds available to underwrite daily operations, including disposable supplies.

Payer Mix, Reimbursement, and Uncompensated Care

The sustainability of a dental clinic depends on (1) the mix of payment sources (e.g., Denti-Cal, self-pay), (2) the size of practice, (3) the types of services provided, and

(4) the efficiency of the practice. Managing and deciphering different reimbursement methods, including the process of identifying means of payment for the uninsured, is often overwhelming for management and staff at FQHCs.

For private-pay patients and those enrolled in Healthy Families and Healthy Kids, the clinics bill at a fee-for-service rate. For Medi-Cal patients, reimbursements for each visit are fixed at a rate negotiated with the federal and state government, an arrangement known as the Prospective Payment System (PPS). For these patients, clinics do not bill for individual procedures, but submit a single charge for each visit. The PPS rate is set at a baseline, with annual adjustments tied to the Medicare Economic Index (MEI), which does not necessarily cover the actual increases in costs. A community health center may apply for a rate increase based upon a change in scope of services, e.g., adding a new operatory, adult dental care, or other additional services.

The Prospective Payment System rate for community health centers is an all-inclusive rate designed to reimburse the facility for the overall costs of providing services to Medi-Cal patients, with each visit billed at the average cost. Most FQHCs have a single PPS reimbursement rate which covers both medical and dental visits. Because the size of the PPS rate depends on a community health centers' patient mix and what services they provide, careful attention needs to be paid to these factors if a clinic is to cover its costs.

For the uninsured, FQHCs have sliding-scale fee schedules along with some direct payment funding from public and private sources. They also attempt to determine whether uninsured patients qualify for available programs such as Medi-Cal and Healthy Families, and, if so, help them to enroll. Uninsured patients are advised of the cost of the initial visit. Afterwards, when a treatment plan is developed, clinic staff discuss the costs and payment options with the patient. In interviews, the

clinics reported high success in collecting payments from uninsured patients, due in large part to the fact that the patients recognize that the community health centers' fees are much lower than those of private providers.

Staff Recruitment, Retention, and Training

Dentists

All of the clinics reported problems with recruiting, training, and retaining dentists. One clinic, assuming that it would be unable to recruit a dentist, reported that it had never tried; the others stated that they had difficulty recruiting dentists with the desired qualifications.

Compared to patients seen in private practice, those served by public dental clinics have substantially more complex dental treatment needs, are more likely to be medically compromised, and have poorer compliance to recommended self-care. In addition, public health clinics generally lack the ability to refer patients to specialists, which means that their dentists must be proficient in complex procedures, such as oral surgery and root canals.

The community health centers reported that they pay new dentists between \$52 and \$62 per hour. This is substantially less than the \$84 average hourly net income of a general dentist who owns, or is a partner in, a private practice.⁴ At least one community health center interviewed for this survey has lost dental staff to the California prison system, where annual salaries for dentists have reportedly reached \$180,000, far beyond what clinics can pay. As a result, a large portion of those who apply for FQHC positions are recent dental school graduates, who typically do not have the clinical skills or speed to provide the comprehensive care needed by a clinic's complex patient population.

Hiring such graduates is a long-term investment which requires training in a public health setting. This typically means that the dental director must spend a large portion of clinical time mentoring new dentists, instead of

treating patients. Taking advantage of external training opportunities poses a different sort of problem, since it requires dentists to leave work. The California Dental Association Foundation's Pediatric Oral Health Access Program, which provides free training to general dentists in treating younger children, reports that some clinic dentists find it difficult to attend since they aren't able to secure the necessary time.

Most of the clinic dental directors stated that they look for dentists who (1) are interested in practicing in a community setting, (2) have a strong commitment to public service, and (3) were trained in the United States. Only one U.S. dental school has a teaching model specifically designed to meet the needs of public dental clinics—the Arizona School and Dentistry and Oral Health. During their fourth year, students spend a large portion of time practicing in public clinics throughout the country. For a clinic to host a student, however, it must supply housing and other support, which most FQHCs cannot afford.

Dental Assistants

The community health centers interviewed for this survey reported fewer problems with recruiting and training dental assistants, although retention was sometimes an issue. Relationships with local dental assistant training programs at community colleges were an asset in recruiting qualified dental assistants. Such efforts focus primarily on RDAs—registered dental assistants—rather than the more highly trained registered dental assistants in expanded functions, or RDAEFs, who are authorized to take impressions, apply pit and fissure sealants, remove excess cement from subgingival tooth surfaces, and apply etchant for bonding restorative materials.⁵ Although RADEFs can provide these routine treatments at a lower cost, most of the clinics do not use them, making it necessary for dentists to do such work.

Dental Hygienists

The primary service provided by dental hygienists, which cannot be performed by an expanded-function dental assistant, is the removal of tartar deposits below the gum line as part of the prevention and treatment of periodontal disease in adults. The treatment of periodontal disease, which requires patient compliance with recommended self-care and regular dental visits, is generally not a high priority for FQHCs, for several reasons. Dental hygienist time is expensive (\$45 per hour) and production is low. Only one or two patients can be booked per hour. Double-booking patients to account for no-shows is not feasible because if both patients show up, the hygienist can only treat one. On the other hand, dentist time is only slightly more expensive; dentists can see three or more patients per hour, and they are not limited in the services they can perform. Also, Denti-Cal does not pay for all of the dental hygiene visits required to treat periodontal disease, and the state has not yet implemented independent billing procedures for dental hygienist services.

Leadership and Management

Findings from the survey indicate that two of the elements of a successful clinic are the leadership of a skilled and committed dental director and the support of an engaged chief executive officer (or executive director). The dental director takes on many roles: manager, highly skilled clinician, mentor and trainer, recruiter, office planner, and cheerleader. While the dental directors do not seem to be directly engaged in fundraising, they are responsible for their budgets and act in a cost-efficient manner so as to maximize their available resources.

The support of the chief executive officer cannot be underestimated. With the myriad issues facing clinic CEOs, dental services often take a back seat. They are expensive services with high demand and high overhead. Dental care is new territory for some clinic executives, but with the recent push from the Bureau of Primary Health Care to ensure access to dental services, FQHCs

are taking greater initiative in providing them. The higher-volume clinics were those where the CEO had an understanding of the need for dental services, grasped the operational issues, and was in close contact with the dental director. When the CEO was not paying close attention to the dental component, operations and efficiencies seemed to slip, with a resulting drain on the clinic's operating budget.

Dental directors often work in isolation, both within the operation of the FQHC and from their professional peers. They often lack the opportunity to interact with dental directors from other clinics or the time and resources to attend outside meetings. However, survey results indicated that many of the problems that were raised in one clinic had been solved in another, and that techniques that worked in one clinic could be shared with others. Unfortunately, a statewide venue in which dental directors could discuss clinical, financial, recruitment, and administrative issues does not as yet exist.

Quality of Care

One issue raised by several dental directors was the lack of a consensus on the definition of quality in community clinic settings. FQHCs are rated on the number of visits, both in total and per practitioner, rather than the type of care provided or the clinical outcomes. Based on this metric, the incentive is to perform more exams and preventive services while minimizing restorative services. While a treatment plan should be included in a patient's chart, there is no standard mechanism for reviewing whether the course of treatment is completed. Also, it is difficult to measure outcomes in dentistry, because unlike medical care, there is no dental diagnosis noted on a patient's chart.

The dental directors suggested that one of the purposes of convening clinic dental professionals would be to establish a consensus view on quality standards and develop measures that FQHC's could implement.

Dental Clinic Efficiency

Community health centers' fixed overhead and personnel costs require that they keep patients flowing through their dental clinics. While some of the surveyed clinics had a dentist rotating through three operatories, which is considered the most efficient model, most had two operatories for each dentist, primarily because of space considerations. Due to the significant increase in efficiency when moving from two to three operatories, clinics should make such an expansion a key priority.

Having the right patient mix and flow are key to a successful clinic operation. Patient mix involves the age of patients, their payment sources, and the types of services that are provided. Those clinics that were doing better financially saw many more children than adults, and more Denti-Cal patients than private-pay patients. The financially successful clinics also had a balance of preventive, restorative, and surgical procedures that optimized revenue and clinician time.

Clinic directors were concerned, however, that in focusing on the more profitable exams and preventive services, they were not actually completing treatment plans or providing necessary restorative services. Also, by concentrating on patients with preferred revenue sources, e.g., Denti-Cal, some clinics were not always able to serve their broader patient population, which includes the uninsured. As a condition of their federal status, FQHCs are required to serve the uninsured. Often, due to the lack of preventive and regular care, patients with no insurance have a higher need for complex and costly procedures. While children require substantial preventive and some restorative services, it is the adult population—with its greater proportion of uninsured—that generally accounts for the most expensive treatments. As one clinic director said, "Twenty percent of the patients incur much more than 20 percent of the costs."

Patient scheduling and flow has long been a source of concern for clinics. No-show rates for dental

appointments are often 20 to 40 percent of scheduled patients. Each clinic interviewed for the survey had developed strategies to keep the clinic full. Most double- or even triple-booked their patients. The majority also placed reminder calls to patients at various intervals, as well as keeping a waiting list. Some tried patient contracts to ensure compliance with a treatment plan, but this met with limited success. The most successful strategy proved to be allowing walk-ins to fill the holes left by no-shows.

To maintain good patient flow in clinics with multiple dentists, the dental directors have also worked on managing dentists' schedules. Rather than scheduling individual patients for dentists, they schedule operatories, and the dentist treats whichever patient is ready to be seen. A similar strategy is for all the dentists to take a team approach, continually treating patients as they are ready, sometimes dividing assignments according to their particular skills and expertise.

Recommendations

Startup and Operating Costs

To meet the needs of their patient population and fulfill their public mission, FQHCs need to expand their dental capacity. Grants and low-interest loans for capital and equipment costs were of primary interest to clinics. While the federal government has recently made additional funds available for clinic expansion, these grants are competitive in nature and insufficient to meet the patient needs nationally. Given the high cost of building and equipping a dental clinic, only a small part of the need can be met. Expanded public and philanthropic programs would enhance the ability of clinics to expand.

To reduce the cost of disposable supplies, community health centers recommended that dental clinics adopt bulk or joint ordering and use their non-profit status to obtain discounts and donations from their suppliers.

These approaches are already in use to some degree across California and their expansion to all dental clinics would help offset some costs of operation. One well-established group-purchasing program is organized by the San Diego Council of Community Clinics (www.councilconnections.com). Several clinics suggested the creation of a "340b drug pricing program" for purchasing equipment and supplies at highly reduced costs, using the model of the drug pricing programs FQHCs already use to purchase drugs at the lowest established rate paid by the federal government.

Payer Mix, Reimbursement, and Uncompensated Care

Below is a list of policy issues related to payer mix and reimbursement produced by the interviews. Some may be resolved through clarification for community health center executive directors and dental directors, while others would require a major shift in policy by public and private institutions.

- Clinics' efforts to expand services by using off-site providers are hampered by confusing rules and regulations. For example, it is not clear if school-based services (e.g., sealant programs) or services provided at private dental clinics on behalf of the FQHC (e.g., dental specialists) are reimbursable. There is also confusion concerning the ability to bill for dental hygienists as a separate FQHC-reimbursable visit. Although SB 238 was enacted in 2007 (Chapter 638) to allow for independent billing of hygienist services, it has not yet been implemented. The state and the clinics are working on a mechanism for recalculating clinics' PPS rates for those health centers that use hygienists.
- Payments for oral surgery also are a source of confusion. Some clinics reported that the costs for oral surgery and anesthesia were not reimbursable. For hospital-based cases, Denti-Cal only covers the dentist's charges, while reimbursement for other

services (e.g., operating room and anesthesia) must be sought from the medical side of Medi-Cal.

- Although FQHCs are not reimbursed on a fee-for-service basis, they still must show that they provided a covered service for an eligible patient and met the necessary billing requirements. Clinics complained that adjudication of their Medi-Cal claims was not always clear or consistent. They felt that claim denials or deferrals should be explained by citing specific reasons and include any corrective action that clinics could take.

Community health centers interviewed for this survey also suggested that the reimbursement system be changed so that billing for outside services, such as laboratory work (e.g., for dentures and crowns), can be separated from PPS encounter billing. This would allow a clinic to cover the cost of complex cases requiring outside vendors. FQHCs can apply for a change in their baseline PPS rate under Section 14132.100 of the Welfare and Institutions Code if there has been a change in their scope of services.

Staff Recruitment, Retention, and Training

In the area of professional staffing, clinics underlined the need to create incentives for dentists (particularly new dentists) to practice in community settings. Suggestions included:

- Expand loan repayment programs for new dentists who choose to practice in clinics.
- Increase the availability of general practice residencies in community clinics.
- Train more community oriented, bi-lingual dentists to work in clinics.
- Remove the state board requirement for dentists who have successfully completed a general practice residency. This would provide additional incentives to enter a residency program.

- Allow state institutions (e.g., prisons) to hire dentists with licenses in other states so that they can recruit from a larger national pool and alleviate hiring competition with California clinics.

- Create more opportunities for student externships in clinics through the provision of funds to support training and hosting.

- Amend the California Dental Practice Act to allow FQHCs to operate as a federal facility, similar to Indian Health Service clinics, which would permit expanded-function dental assistants to take on tasks that must now be performed solely by dentists.

- Provide training for dental directors in administrative and financial skills necessary to operate a successful clinic.

- Create mentoring and continuing education programs for dental assistants and front-desk staff geared specifically toward public clinics, rather than private-practice staff.

Leadership and Management

Peer Networking, Technical Assistance

To improve overall management and efficiency of their clinics, dental directors suggested establishing a regular venue for discussing issues with other dental directors. The California Primary Care Association (CPCA) is also interested in regular meetings with community health centers' dental directors, possibly through a joint effort between the regional community clinic consortia and the statewide association. Several regional consortia have periodic meetings of dental directors. The CPCA has a medical clinicians network that meets quarterly to discuss strategic and policy issues and could be a model for a dental directors' network. Another potential partner is the Oral Health Access Council, which already has joint meetings with the CPCA and is attended by a range of people interested in oral health and policy issues.

Some participants in the survey recommended that a network of technical assistance providers work directly with the clinics to improve operational efficiency, and that the network include providers who are independent of FQHCs' funding sources. This approach would avoid any potential conflicts of interest and encourage open communication and the willingness to identify inefficiencies.

Models for this type of technical assistance include:

- **The Dental Pipeline project**, a collaborative of California and U.S. dental schools to reduce oral health disparities by preparing students to work in community settings. As part of its partnerships with community clinics, the Dental Pipeline will provide technical assistance to program clinics on practice management.
- **The Catalyst Institute** (www.catalystinstitute.org), a non-profit Massachusetts-based offshoot of Delta Dental, that provides practice management technical assistance to safety-net clinics. Their Safety Net Solutions program assesses a wide range of operational elements, including financial and productivity data, revenue and expenses, services, payer mix, program leadership, billing, operations, policies, equipment, workflow, and culture.
- **The Dental Clinic Manual** (www.dentalclinicmanual.com) was developed as a collaboration between the Ohio Department of Health, the Indian Health Service, and the Association of State and Territorial Dental Directors. This comprehensive manual highlights all aspects of dental clinic development as well as daily operations. It is designed to assist beginners and includes a series of steps for starting a dental clinic, along with information for those interested in improving an existing dental facility or services.

- **The Arizona Association of Community Health Care** (www.aachc.org), the state's primary care association, convenes its dental directors on a semi-annual basis. These one-day meetings are hosted by various agencies throughout the state and are attended by a majority of the state's 14 FQHCs. Agendas include clinical, administrative, and policy issues. AACHC also hosts an annual Region IX management training conference, which combines the disciplines of health care administration, clinical services, and financial operations.

Interviewees suggested meetings with dental directors that would combine the administrative discussions with clinical education and provide continuing education credits. Quarterly or even semi-annual meetings, perhaps alternating between in-person meetings, video conferences, and Web-based seminars, would provide the opportunity for dental directors to learn from each other, as well as from other outside experts. Given the similar types of issues faced by each of the clinics, which serve similar populations, peer-to-peer networking has the ability to develop solutions from within the clinics and implement them throughout California. Survey participants also recommended that meetings among dentists be coordinated with the clinics' CEOs and CFOs so these executives can share their perspectives on dental services. Funding for travel expenses and time away from work would encourage more participation in clinician meetings.

FQHCs and Dental Clinic Licensure

The amount of red tape involved in licensing dental clinics was identified as a barrier to expanding services. FQHCs cited unclear and inconsistent regulations from multiple agencies at the state and local level, as well as their frustration in obtaining operating licenses in a timely manner. The clinics recommended that efforts be made to standardize and streamline licensing processes. Alternatively, clinics supported the possibility of

developing manuals and checklists that would help them navigate the maze of clinic licensure.

Summary

Field interviews show that California's federally qualified health centers are very interested in expanding their dental clinics. However, clinic directors are cautious about doing so until they have sufficient start up funds, can reasonably expect to attract high quality professional staff, and are able to sustain their operations over the long term with a patient mix that allows for adequate reimbursements.

Some of the barriers to expansion can be overcome with more funding for capital and start-up costs. Staffing issues can be overcome through increased training of community dentists and opportunities for fellowships and loan repayment. Other barriers can be addressed through a more formalized network of technical assistance providers and a peer network of clinic dental and executive directors to share best practices and successful strategies for tackling operational and efficiency issues.

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ABOUT THE FOUNDATION

The California HealthCare Foundation is an independent philanthropy committed to improving the way health care is delivered and financed in California. By promoting innovations in care and broader access to information, our goal is to ensure that all Californians can get the care they need, when they need it, at a price they can afford. For more information on CHCF, visit us online at www.chcf.org.

ENDNOTES

1. California HealthCare Foundation, *Denti-Cal Facts and Figures*, May 2007.
2. Ibid.
3. Safety Net Dental Clinic Manual, Chapter 2 Facilities and Staffing, www.dentalclinicmanual.com, accessed April 14, 2008.
4. According to the American Dental Association the average independent general practitioner's net income from primary private practice in 2002 was about \$175,000 ($\$175,000/\text{year} \div 2,080 \text{ working hours/year} = \$84.13/\text{hour}$).
5. California Code Of Regulations, Title 16. Professional and Vocational Regulations, Division 10. Dental Board of California. Dental Practice Act, Chapter 3, Article 5.