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

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

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

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

All of these listed entities are known as “safety net providers” because they provide health care to underserved patients regardless of their ability to pay. FQHCs are not-for-profit organizations that receive grant funding under the Health Care Program, Section 330 of the Public Health Service Act. FQHCs are community health centers, migrant health centers, health care for the homeless programs and public housing primary care programs.

HRSA states that health centers provide services to the medically underserved or to a special medically underserved group of migrant and seasonal agricultural workers, the homeless, and residents of public housing. The California Primary Care Association describes additional users of health centers as those with language or cultural barriers, those with fear of repercussions on immigration status, and those who are...
HCs will continue to be an important model to serve California’s uninsured.\(^7\)

California has 6.5 million uninsured residents, which is almost one in every five residents, and is 15 percent of the uninsured population in the United States, the largest total of any state.\(^8\)

To meet the needs of the high number of insured residents, HCs have been reported to be one of the federal government’s most successful programs by the Office of Management and Budget.\(^6\) There are many agencies and support organizations for the HC (\(\text{Table 2}\)).

Residents in California face many challenges (\(\text{Table 3}\)). Because of the increasing cost of health insurance, HCs will continue to be an important model to serve California’s uninsured.\(^7\) California has 6.5 million uninsured residents, which is almost one in every five residents, and is 15 percent of the uninsured population in the United States, the largest total of any state.\(^6\)

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**Glossary of Key Terms**

**CHC**

Community health center, also now simply referred by federal regulations as “health center.”

**Health Center**

All-encompassing term. Means an “entity that serves a population that is medically underserved, or a special medically underserved population comprised of migratory and seasonal agricultural workers, the homeless, and residents of public housing; by providing, either through the staff and supporting resources of the center or through contracts or cooperative arrangements” — HRSA. A health center can have any of the following in its organizational system: community health center, migrant health center, health care for the homeless, school-based, or public housing primary care.

**Safety Net Provider**

All community health centers, local county health departments, public hospitals and other health care providers who provide health services to the underserved populations, regardless of their ability to pay.

**FQHC**

Federally qualified health center, a not-for-profit health center organization with one or more clinic sites and receives Section 330 federal grant support under the U.S. Public Health Service Act to provide health services to underserved populations. Uses a sliding fee for eligible patients. There are 376 FQHC sites in California, as of 2005.

**FQHC Look-Alike**

A health center that meets all requirements to be a FQHC but does not receive any Section 330 federal grant support. There are 71 FQHC look-alike sites in California, as of 2005.

**330**

Federally qualified health centers that receive federal grant funding under the Health Center Program, Section 330 of the Public Health Service Act. There are 110 Section 330 grantee organizations in California, as of 2007.

**Sliding Fee**

FQHCs and FQHC look-alikes provide access to services without regard for a person’s ability to pay and provide a sliding fee discount. This discount is based on the patient’s ability to pay, using the patient’s annual income and family size according to the most recent U.S. Department of Health & Human Services Federal Poverty Guidelines — HRSA.

**UDS**

Uniform Data System. Federal system tracks a core set of information appropriate for reviewing the operation and performance of health centers, including patient demographics, services provided, staffing, clinical indicators, utilization rates, costs, and revenues. UDS data are collected at the grantee, state, and national levels.

**Medi-Cal**

California calls its Medicaid program Medi-Cal. It provides health coverage for low-income people and people with disabilities and is funded by federal and state monies.

**CMSP**

The county medical services program provides health coverage for low-income, indigent adults in 34 primarily rural California counties, managed by the CMSP Governing Board administered by Anthem Blue Cross Life & Health Insurance Company. CMSP is not Medi-Cal.

**HPSA**

A health professional shortage area is a geographic area, population group, or medical facility that has been designated by the Secretary of the Department of Health and Human Services as having a shortage of health professionals and is assigned a score based on the level of need.
of uninsured residents, 323 new California HC clinic sites opened their doors from 1995 to 2005, an increase of 68.6 percent, and all California HCs took care of over 3.6 million patients in more than 11 million patient encounter visits in both rural and urban communities in 2005.4 As of 2007, there are 110 Section 330 FQHC clinics operating in 226 rural and urban communities in California.9

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

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

For the purposes of this article, the term CHC will be used as it is the specific type of health center that will be discussed (Table 1). This article will focus on the framework of providing dental care to the underserved at the not-for-profit community health centers in California and will cover the following subjects: licensure and basic services, the CHC dental clinic, administration, dental director, staff dentist, patient care on types of coverage and scope of service, and quality assurance.

Licensure and Basic Services

HCs provide comprehensive health care to many different types of people and areas of need (Table 4). The California Department of Public Health, CDPH, defines the community clinic as “a clinic operated by a tax-exempt non-profit corporation that is supported and maintained in whole or in part by donations, bequests, gifts, grants, government funds or contributions that may be in the
form of money, goods, or services. In a community clinic, any charges to the patient shall be based on the patients ability to pay, utilizing a sliding scale,” pursuant to Section 1204 (a)(4)(A) of the Health and Safety (H&S) Code.”

A CHC must also satisfy the following requirements set by HRSA: be located in or serve a high-need community, be governed by a community board, provide comprehensive primary health care services as well as support services, provide services to all residents regardless of ability to pay, establish a sliding fee schedule based on income, and meet other performance requirements.4,5

All CHCs must also completely follow California code of regulations called Title 22, which provide detailed instructions divided in the following categories: license, basic services, drug distribution, administration, and physical plant.4,14 All applicable laws and regulations of California, including that of the California Dental Board, apply to the private dental office also apply to the CHC. Yet, to ensure the appropriateness of care and the safety of the patient population served, HRSA, Title 22 and other regulations require compliance through routine CHC inspections and audits from the federal, state, and local levels that are not always found in the private sector. This oversight starts with a CDPH licensing and certification officer inspection in order to receive licensure to operate.

For 2008-2009, the CDPH basic licensing fee for a CHC is $600 annually per each site.13 Other individual licenses are required for the dentist and licensed personnel, just as with a private dental office.

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

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

If CHCs provide dental services, it falls under the auspices of the medical department. The CHC must have a licensed physician appointed as the professional director, known as the medical director, who is responsible for all services provided. In cases where no medical services are given, then the professional director is the dentist. The medical director oversees policies and standards, quality, protocols, peer review, credentialing and assigning clinical privileges, and ensuring at least one member of the staff has hospital privileges.4

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**TABLE 3**

**Facts of Life in California**

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

The average total annual cost of care:
- for Medi-Cal patients at HCs: $455
- for Medi-Cal patients at office-based medical providers: $657
- HCs reduced Medicaid spending by 30 percent

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

Source: California Primary Care Association.
mobile vans can be completely self-con-"mote locations or school programs. Dental vans to deliver care at migrant camps, re-
to provide the needed medical or dental
utilized mobile clinics to go to school sites
out to their patients: Urban CHCs have
water at the clinic to ensure patient safety.
and quarterly bacteriological analysis of
equipment must be tested and calibrated
time, a minimum requirement that all
maintained and ready for use at any
dental office. For example, proper standard
precautions and infection control regula-
tions set by the California Dental Board
must be followed in both types of offices.
There are some additional require-
ments set by Title 22 for patient safety.
For example, all autoclaved bags should
be marked with expiration dates. Other
examples of differences include such basic
CHC requirements as having flashlights
maintained and ready for use at any
time, a minimum requirement that all
equipment must be tested and calibrated
monthly with documentation available,
and quarterly bacteriological analysis of
water at the clinic to ensure patient safety.
Some CHCs use mobile vans to reach
out to their patients: Urban CHCs have
utilized mobile clinics to go to school sites
to provide the needed medical or dental
care, and rural clinics have used mobile
cars to deliver care at migrant camps, re-
merge locations or school programs. Dental
mobile vans can be completely self-con-
tained with one or two fully functional,
and could be a financial drain for health
centers. These challenges include the
logistics to bringing the van and staff to
remote locations, transient patients, need
for specialized staffing like the mobile
van driver, and the costs of maintenance
and repair. Of special concern is the cost
of fuel, especially when gasoline had
sold at more than $4 per gallon in 2008.
Since RVs get less than 5 miles per gallon,
it can be quite costly to fill a 75-gallon
tank. Additionally, vans equipped with
gas-powered generators (or diesel) to
run the operators will steadily draw
(fuel from the tank unless the
van is plugged into an electrical grid.

**The CHC Dental Clinic**

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

**Administration**

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

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

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

**Table 4**

<table>
<thead>
<tr>
<th>Patient Profile of the California Health Center</th>
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<tbody>
<tr>
<td>- 70 percent are from ethnic communities</td>
</tr>
<tr>
<td>- 49 percent report English as the secondary language</td>
</tr>
<tr>
<td>- 35 percent are children under 19 years of age, as of 2004</td>
</tr>
<tr>
<td>- About 70 percent of adult women</td>
</tr>
<tr>
<td>- 4 percent are seniors</td>
</tr>
<tr>
<td>Source: California Primary Care Association.</td>
</tr>
</tbody>
</table>
Typically, the dental director performs all dental scopes of services provided at the clinic. The dental director supervises the staff dentists working at the clinic and ensures all follow policies and regulations for the clinic. Just as with the medical director, the dental director is responsible to maintaining quality of care provided at the CHC.

The dental director’s time is allocated to provide direct patient care, often 90 percent or more, leaving the remainder of the usual 40-hour workweek devoted to administration duties. The dental director must be efficient in balancing duties. The dental director can often be found in the middle of performing dental services when asked to address an immediate concern of the dental clinic because administration of the clinic must occur every hour the clinic is open, whether it is during administrative time or not.

**Dental Director**

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

**Table 5**

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

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

**Staff Dentist**

CHCs typically recruit dentists who are interested in working at the community level with a strong commitment to public service. It is difficult to recruit for CHC dentists in California. The No. 1 factor for a dentist to stay employed with a CHC is the desire to take care of the underserved community or an “altruistic motivation.”

There are 309.8 full-time equivalent dentists working at the 110 Section 330 grantee HCs in California (Table 5). The average salary of a dental director is $133,000; the average salary of a staff dentist is $107,000, according to an independent salary survey conducted on 75 primary care dentists in Alaska, Arizona, California, Nevada, and/or the Pacific Territories of the United States in 2007. Another smaller survey in 2008 reported the average staff dentist is paid $52 to $62 per hour, or a full-time average of $118,560 per year. As a frame of reference, the American Dental Association reports the average earnings for a general dentist who owned his/her office is more than $198,000, as of 2005.

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

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

Patient Care: Possible Types of Coverage

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

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

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

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

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

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

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

### Patient Care: Scope of Service

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

No two CHC dental clinics are alike. Some clinics are so inundated with patients and can only provide emergency care and possibly prevention. Others, with different infrastructure or populations, can provide a wider scope of dental care ranging from prevention, comprehensive services from amalgams, composites, root canal therapy and periodontal procedures to reconstructive services such as crown and bridge, and even implant services and cosmetics.

That is why those who have worked in a community clinic say, “If you’ve seen ONE community health center, you’ve seen ONE community health center.”

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

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

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

### Table 6

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

Source: California Office of Statewide Health Planning and Development, compiled by California Primary Care Association.
usually outgrows the new site even before it moves in. California’s HCs continue to grow in numbers of sites, patients seen, and number of patient visits (Table 6).

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

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

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

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

Quality Assurance

Regardless of whether the dental services are provided on site or off site, CHCs are required to have a quality assurance program that follows extensive federal requirements on clinical care standards as a way to monitor the quality of care provided to their patients. Quality assurance starts out at the time of hiring. Providers must go through intensive background and reference checks. This is a very important aspect for CHCs because of the deeming process for Federal Tort Claims Act, FTCA, credentialing, which provides the professional liability for the providers. Most CHCs also pursue additional wraparound malpractice insurance for its dentists, physicians, and other clinical providers. The providers and clinical staffs have to be privileged and credentialed annually to continue practicing at the centers. This process includes, but is not limited to, reviewing dental licenses, DEA licensing, and CPR renewals.

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

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

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

**TABLE 7**

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

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

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

Source: California Primary Care Association.
Conclusion

Health center dental clinics undeniably improve access to care by providing services to patients who do not normally seek dental care in the private sector. The Office of the Surgeon General in 2003 reported, “No one should suffer from oral diseases or conditions that can be effectively prevented and treated. No schoolchild should suffer the stigma of craniofacial birth defects nor be found unable to concentrate because of the pain of untreated oral infections. No rural inhabitant, no homebound adult, no inner city dweller should experience poor oral health because of barriers to access to care and shortages of resources and personnel,” according to the National Call to Action to Promote Oral Health.19

Yet, even with an increase in access available to Californians in need, a common problem expressed by a recent survey of stated that CHCs still believe they do not have the capacity to meet all the dental needs of this underserved population.20

There is good news. Former President George W. Bush made CHCs the centerpiece for his health care plan.8 Under Bush, with bipartisan support from the Congress, federal funding for CHCs doubled and 1,297 health center clinic sites have been created or expanded over the past eight years in the United States.4

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

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

REFERENCES

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