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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.

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

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

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

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

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

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TABLE 1

Glossary of Key Terms

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

not able to use traditional health services.[4]

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

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

To meet the needs of the high number

TABLE 2

Agencies and Support Organizations for the HC

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

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

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

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

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

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

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

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

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

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

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

Licensure and Basic Services

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

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

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

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

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

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

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

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

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

TABLE 3

Facts of Life in California

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

The average total annual cost of care:

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

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

Source: California Primary Care Association.

TABLE 4

Patient Profile of the California Health Center

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

Source: California Primary Care Association.

The CHC Dental Clinic

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

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

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

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

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Administration

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

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

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

TABLE 5

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

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

Source: HRSA Uniform Data System for California, 2007.

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

Dental Director

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

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

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

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

Staff Dentist

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

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

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

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

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

Patient Care: Possible Types of Coverage

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

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

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

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

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

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

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

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

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

TABLE 6

California Health Center Data

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

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

Patient Care: Scope of Service

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

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

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

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

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

TABLE 7

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

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

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

Source[4]: California Primary Care Association.

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

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

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

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

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

Quality Assurance

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

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

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

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

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

Conclusion

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

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

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

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

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

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