Health Center Fundamentals 101: Lifelong Learning

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Learning Objectives

✓ Describe the 5 defining characteristics of Health Centers
✓ Understand the Health Center role in delivering health care
✓ Learn the expected scope of oral health care services in Health Centers
✓ Understand how public health concepts relate to oral health care in Health Centers
NNOHA’s Practice Management Resources

Operations Manual for Health Center Oral Health Programs:

- Health Center Fundamentals – Published!
- Leadership (under review)
- Financials (under review)
- Quality (in progress)
- Risk Management
- Integrating Specialty Care Services
- Workforce and Staffing
- Understanding Reimbursements
History of Health Centers

- **Economic Opportunity Act** (1964)
  - Established Community Health Centers (CHCs)

- **Health Center Consolidation Act** (1996)
  - Combined under Section 330 of the Public Health Service Act
  - Accepted Term: Health Centers
    - Community Health Centers
    - Migrant Health Centers
    - Homeless Health
    - Public Housing

- **Tremendous Growth** (last 10 years)
FQHC vs. Health Center

• Federally Qualified Health Center: relates to the way encounters are reimbursed
• All 330 Health Centers are FQHC’s
• Rates are determined at the state level
• Not all FQHC’s are 330 Health Centers
  ▪ County Health Departments, IHS clinics
What is a Health Center?

- Public or private not-for-profit organization that provides primary health services to populations with limited access
Health Center
Five Program Fundamentals

1. Located in or serve a high need community

1. **Governed by a community board** composed of a majority of HC patients

1. Provide comprehensive primary health care services as well as supportive services

1. Provide services available to all with fees adjusted based on ability to pay.

2. Meet other performance and accountability requirements
Role of Health Centers

• Entry point for low-income populations
  ▪ 20% of Medicaid visits nationwide

• Elimination of traditional barriers to accessing health care
  ▪ Cost
  ▪ Geography
  ▪ Culture/Language
Future Roles

• Created an infrastructure for delivering health care

• Key component in health care reform
  - Capacity for newly insured?
  - 2008- 12 million Health Center medical patients do not have access to dental services (15M-3M)
Funding

• Traditional reimbursement sources
  ▪ Third-party payer revenues from insurance plans including FQHC Medicaid
  ▪ Patient fees
• 330 Grant
• Private grants and donations
Future Role

- Incubator for innovation in payment methodologies
- Pay 4 Performance
  - Measures
  - IT capability
HC Administration

- **Board of Directors**
  - Approve grant application and budget
  - Approve scope of service and general policies for HC operations
  - Approve changes

- **Executive Director**
  - Manages the daily functions of the HC and oversees the performance of health care

- **Management Team**
  - In addition to the Executive Director, the team typically consists of a Chief Financial Officer (CFO), Chief Information Officer, Clinical / Medical Director, and a Dental Director, who usually report to the ED.
Why a Dental Director Should Report to the ED

- Medical Director may not understand dental any more than the ED
- Medical Director may not understand the differences between medical practice and dental practice
- Medical director already very busy
- Dental can have tight financial margins - need immediate access to information and decision makers
Role of Dental Director

- Willing to lead, advocate for dental
- Willing to learn skills needed
- Logical, common sense points
- You are the expert about dental...after all you are delivering the care!
Role of Dental Director

• Increased collaboration
  ▪ Medical
  ▪ IT
• Data/evidence based decisions
• Appreciation of financials
Basic Dental Public Health Concepts

- Public health is “people health”
- Focus is on the collective health status of a group of people
  - Health center population
  - Community
Basic Dental Public Health Concepts

- Concepts HC dental provider must consider:
  - Disease pattern of the target population
  - Demand & resources available
  - Payment structure
  - Providing both individual patient treatment planning & surveillance of total population
  - Prioritize service & treatment based on availability of resources, size of the target population, disease pattern, demand and a reasonable definition of dental health verses ideal
Community Health Needs Assessment

- Estimated number of users.
- Existing providers and resources, assessment of unmet need.
- Demographics of service population
- **Oral health status, prevention, and treatment needs.**
- Barriers to access/availability
Form Dictates Function

• Needs assessment defines characteristics of dental program
  ▪ Capacity
  ▪ Location
  ▪ Culture/language
  ▪ Scope of Service
**Patient Care: Scope of Service**

- **PHASE I**: Prevention, maintenance and/or elimination of oral pathology that results from dental caries or periodontal disease
  - Level I - Emergency Dental Services
  - Level II - Preventive Dental Care
  - Level III - Expected Services - basic

- *If not available on site Level I & II must be available through contractual arrangement (1998 & later programs)*
Patient Care: Scope of Service

- **PHASE II**: Rehabilitative services, such as dentures, partials, crown and bridge, elective oral surgical procedures, periodontal surgery, and orthodontics.
  - Level IV - Recommended Services- If a Health Center can find low cost solutions to replace dentition, patients may be assisted in obtaining employment, education or enhancing self esteem.
Staffing

• Staffing pattern depends on the mix of services offered
  ▪ Most efficient for maximized encounters & revenues
  ▪ State practice acts
• Training and experience appropriate to the culture and needs of the community
Licensure, Credentialing and Privileging

• Professional staff must maintain necessary, professional certification, licensure and credentialing.
• Requirements dictated by each state.
  ▪ Exemptions
• JCACHO
Quality Management

- Goals of the Quality Management System:
  - Assure and improve the quality of oral health care delivery
  - Improve oral health care status of the community
  - Integrate quality into the long term operational planning and management of the center
Quality Assessment

- Objective periodic chart audit/peer review
- Objective tracked service use measures
- Subjective patient satisfaction/outcomes survey
Quality Improvement

- A process that is both prospective and retrospective

- Improve quality of the system and therefore the health status of the target population.
  - PDSA
Risk Management

- **Risk management** is the identification, assessment, and prioritization of **risks** (*effect of uncertainty*) followed by coordinated and economical application of resources to minimize, monitor, and control the probability and/or impact of adverse events.

- In tandem with Quality Improvement System.
FTCA Coverage

• The Federal Tort Claims Act (FTCA) provides coverage for all deemed Health Center employees against parties claiming to have been injured by negligent actions.
• HC employees considered employees of the United States- claims would be brought against federal government.
• Volunteers not covered.
Quality & Churning

• Churning- systematic, institutionalized practice of maximizing revenues by maximizing visits/encounters
• Each payer method has inherent flaw
  • Encounter based
  • FFS
  • Capitation
Examples of Churning

- Separation of exam & imaging procedures
- Separation of exam, imaging & P&F for children
- Lack of quadrant dentistry especially if small restorations
- Separation of sealants
- Lack of definitive treatment of emergencies
Adverse Outcomes

- Lack of comp/preventive care
- Return emergency visits
- Patient dissatisfaction
- Increased clinical risk
- Increased time burden for patients & caregivers
- Below standard of care as taught in dental schools
- Fraud
- Never finish Tx plans
I.D. via Quality System

- Chart audit
  - Separation of procedures

- Tracked service use measures
  - Low rates of Tx plan completion

- Patient satisfaction
  - Low because multiple visits
Strategies to Counter

• KNOW YOUR BASELINE DATA
• Clear policies
  • Scope of service and population served
  • Control emergencies & N/S
• Sufficient clinical resources
• Quality management system
• More than “no money, no mission”
  • What is the Mission?
  • Optimal health outcomes
Health Center Advantages

• Co-location of primary health care services
  ▪ Established, accepted model (40 years)
• Efficiencies of scale in the total system
• Facilitates improved health outcomes IF there is cross department collaboration
  ▪ Untapped potential
Health Center Advantages

• Benefits of Collaboration
  ▪ Important ally and bridge to patients and the community
  ▪ Gain effective advocates to support oral health resources

• Oral Health Collaborative Pilot
  http://www.nnoha.org/oralhealthcollab.html
For More Information...

- Order a printed copy, or download the PDF version of the **Fundamentals Chapter** at: http://www.nnoha.org/practicemanagement/manual.html

Attend other Practice Management Sessions at the Conference!

**Tuesday, October 26**
- 9:00-10:00 - **Understanding Health Center Dental Program Financials**
  Allen Patterson, CPA, FACMPE, MHA
- 2:00-3:30 - **Becoming an Outstanding Leader**
  Dan Watt, DDS

**Wednesday, October 27**
- 9:00-10:00 - **Quality Assessment, Quality Improvement & HRSA’s Oral Health Measures**
  Dan Watt, DDS and Marty Lieberman, DDS
- 1:00-2:00 - **Integrating Specialty Care Services**
  Scott Wolpin, DMD
- 1:00-2:00 - **HRSA FTCA Program and Risk Management**
  Jay Anderson, DMD, MHSA
- 3:00-4:30 - **Best Practices Roundtable**
  Janet Bozzone DMD, MPH
THANK YOU!

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