Learning Objectives

• Discuss the characteristics of Health Center patient populations
• Recognize common terms used to reference Health Center oral health programs
• Describe how Health Centers are financed
• List of partners Health Centers collaborate with
• Learn where are Health Centers heading in the future
Health Centers

Public or private not-for-profit organizations that provide primary health services to populations with limited access to health care.

Health Centers were created to increase access to care among underserved and medically disenfranchised populations.
Examples of Health Centers

HRSA 330 grant-supported programs can be:

• Federally Qualified Health Centers (FQHCs)
• Outpatient health programs/facilities operated by tribal organizations
• Hospital-based
• Dental schools
• County public health departments

Sources: U.S. Department of Health and Human Services Health Resources and Services Administration, bphc.hrsa.gov and CDA May 2009
Federally Qualified Health Centers (FQHCs)

• Health care delivery organization must apply to be designated an FQHC by HRSA
• Can be reimbursed for Medicaid visits in a different manner than private practice i.e. by encounter/visit
• Can apply for Federal Torts Claim Act malpractice protection
• Participate in federal student loan repayment programs
Health Center vs. FQHC

• Health Centers that also receive 330-HRSA grants are FQHCs

• FQHC “look-alikes” do NOT receive 330-HRSA grant funding, for example, a county health department or a non-profit clinic, but can apply and also receive alternative Medicaid reimbursement such as the encounter based method
Jordan Valley Community Health Center
Springfield, MO
Health Center Facts
2017 UDS

- Number Health Center programs receiving 330-grant funding: 1,373
- Number HC programs with dental programs: 1,074 or 78%
- Total users: 27,174,372
- Number medical users: 22,866,468
- Number dental users: 6,116,732
- Dental Users: 22.5% all FQHC patients
- Dental Users: 26.7% of all medical patients
Federally Qualified Health Centers (FQHCs)

Source: Centers for Medicare and Medicaid Services; U.S. Department of Health and Human Services; January 2014.

Note: Alaska and Hawaii not shown to scale.
2017 Age Demographics

- 0-17: 30.89%
- 18-64: 60.41%
- 65 and over: 8.69%

Age by %
2017 Demographics: Ethnicity

• 63.36% identify as racial and/or ethnic minorities

• Hispanic/Latino 35.76%
• African-American 22.41%
Percent of Poverty Level – HC users

- 100% and below: 70%
- 101-200%: 22%
- Over 200%: 8%
Common Chronic Conditions

- 22.8 million medical users (2017)
  - 4.5 million: Hypertension
  - 2.4 million: Diabetes
  - 1.2 million: Asthma
Scope of Service

- Each HC has a defined scope of service
  - should be based on assessment of the health care needs of the Health Center service population
- When a new service or a new site is added, a change in scope must be approved
Primary Care Focus

• Health Centers strive to provide community oriented primary care
• Focus on family medicine, pediatrics, general dentistry, pediatric dentistry
Public Health Focus

• Develop policies and plans that support health on individual and community level
• Emphasis is on health care that improves and maintains health
• Focus on prevention, screening, patient self-management of chronic conditions
Health Care Services Integration

- Strength of HC is multiple services available in one location
- Some only provide medical services
- Most provide medical, dental, behavioral and ancillary services (social workers, enabling services, community outreach etc.) at the same site
- Additional services:
  - optometry, pharmacy, lab, imaging, podiatry, WIC
Leadership Launch

Imagine your Health Center mirrors national data, and has capacity for only 1 in 4 medical patients to receive dental care.

• How would you feel about this?
• How would you determine who should access dental care?
• Who else would need to be involved in this decision process?
Ezra Medical Center Brooklyn, NY
Dental Program Scope of Service

• Phase I/Basic/Routine
  • Level I- Emergency care
  • Level II- Diagnostic & preventive care
  • Level III- Expected care: Routine periodontal, restorative (including endodontics) and surgical care

• If not available on site, Level I & II care must be available through contractual arrangement (1998 & later programs)
Dental Program Scope of Service

• Phase II/Rehabilitative/Complex
  • Level IV- Recommended/Rehabilitative care: Complex periodontal, restorative (including endodontics) surgical care and prosthodontics. Other-than-routine specialty care.
Scope of Service

- Scope of service should be determined by the oral health needs of the HC population.
- Most HC dental programs provide a majority of Phase I care services.
- Many Phase II services have up-front fixed costs (i.e. prosthetic lab fees), which must be factored in the costs of delivering services.
2017 Productivity

- 4,882 DDS FTEs across HCs
- 2,497 RDH FTEs across HCs
- 31 Dental Therapists FTEs across HCs
- 2,599 encounters/FTE DDS
- 1,179 encounters/FTE RDH
- 901 encounters/FTE DT
2017 Dental Productivity

- 15,666,112 visits
- 6,116,732 users
- 2.56 visits/user annually

Reasons for dental visits to CHC

- 217,731 had an emergency visit
- 462,117 had sealants
- 1,006,547 had extractions or other surgery
Health Center Financing

• Source of mystery & myth
  • “government pays”
  • “free care”
  • “unfair competition”

• The majority of HC revenues are derived from fees generated from patient care

• In 2017, Federal grants were on average, 20% of revenues
Health Center Revenue – 2017

- Medicaid: 44.4%
- Medicare: 6.6%
- Other public insurance: 1.2%
- Private insurance: 8.6%
- Self Pay: 4.4%
- Federal Grants: 19.8%
- State/Local/Private grants: 11%
- Other revenue: 4%
Prospective Payment System (PPS)

• As FQHCs, Health Centers may be reimbursed for Medicaid visits on an encounter or capitation basis (instead of fee-for-service)

• The process for calculating the PPS rate is determined at the state level and can differ by state

• Rates differ based on scope of HC services, local cost of living, urban vs. rural, etc.
More PPS

- PPS base rate is readjusted yearly based on cost-of-living and whenever a new service is added to the Health Center’s scope of services

- Cost-based reimbursement system
  - For encounter based- rate is the actual cost of delivering services divided by the number of encounters.
  - For capitation, along with monthly rate, at the end of the budget year the difference between the cap rate and the actual cost is determined and reimbursed. This is called the “wrap around.”
Churning

- Churning- systematic, institutionalized practice of maximizing revenues by maximizing visits/encounters

- Each payer method has inherent flaws
  - Encounter based
  - FFS
  - Capitation
Examples of Churning

- Separation of exam & imaging procedures
- Separation of exam, imaging & P&F for children
- Lack of quadrant dentistry
- Separation of sealants
- Lack of definitive treatment of emergencies
Adverse “Churning” Outcomes

• Never finish treatment plans
• Return emergency visits
• Patient dissatisfaction
• Increased clinical risk
• Increased time burden for patients & caregivers
• Below standard of care
• Fraud
Churning I.D. via Quality System

• Chart audit
  • Separation of procedures

• Tracked service use measures
  • Low rates of treatment plan completion

• Patient satisfaction
  • Low because multiple visits
Sliding Scale

• The unique aspect of Health Centers
• Required to offer a sliding fee scale to patients between 100-200% of Federal Poverty Level (FPL)
• Base “nominal fee” that should not impede access to care
• Over 200% of FPL can pay full fee
• In 2017, 22.8% of HC patients were uninsured
Fiscal Sustainability

- Cost per encounter is fixed regardless of reimbursement source
- Sliding scale charges must be subsidized from other sources to balance budget
  - 330 grant
  - Other grants
  - Donations
- What in private practice is considered “profit,” in FQHCs is used to subsidize the sliding scale
2017 Cost Per Dental Visit**

- $200.31/encounter nationally
- Medical visits cost $193.86 each
- Each program should know its costs
- Most basic financial data point needed to develop budget, allocate resources
- Needed to revise PPS rate
Leadership Launch

Do you have regular access to your dental program financial data (encounters, cost, payer mix)?

If so, how do you use the information?

If not, how would you get this information?
Erie Family Health Center
Chicago, IL
Licensure

• Mandatory process by which a governmental agency grants time-limited permission to an individual to engage in a given occupation

• Health Centers must comply with state license requirements for dental staff
Credentialing & Privileging

- Credentialing: assess and confirm qualifications
- Privileging: authorization to provide specific services
- Health Centers must perform both
- Usually Human Resources coordinates
Oversight

• Health Centers experience a level of oversight not always found in the private sector
  • HRSA/BPHC site visits - usually every five years
  • State inspections and Medicaid audits
  • Joint Commission (JC) accreditation visits
IOM Definition Quality- 2001

• “The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”

• Measurement
• Knowledge
Why Assess Quality?

• Section 330 of Public Health Service Act requires every Health Center to have a QI/QA program

• Federal Tort Claim Act deeming application process requires submission of Health Center QI/QA plan and QI/QA committee minutes

• Assures and improves the quality of health care delivery

• NEW UDS Sealant Measure: in 2017 50.71% of patients 6-9 years old with sealants on 1st molars
Leadership Launch

As part of your Dental Director duties, you have to direct your department efforts during Joint Commission (JC) accreditation and state Medicaid audits, as well as develop and implement quality improvement measures.

*How do you get the rest of the dental team to buy into these efforts?*
Academic Collaboration

• Dental assisting programs
• Dental hygiene programs
• Emerging new provider programs (dental therapy)
• Pre-doctoral rotations
• Post-graduate residencies
  • GPR
  • AEGD
  • Pediatric dentistry
Community Collaboration

- As a part of the community, HCs partner with other agencies to facilitate access to health care and/or focus on specific conditions or populations
  - WIC
  - Head Start
  - Title V (maternal & child health programs)
  - County or state health departments
  - School districts
  - Other community based organizations
More Collaboration

- Most Health Centers are members of state Primary Care Associations (PCAs)
  - PCAs provide training, specialized support, advocacy
  - Some have Dental Director peer networks and/or dedicated staff for oral health
- Organized dentistry can be a long-term local partner
The Future

• ???
• Health care reform- newly insured populations
  • Double Health Center capacity
• Meaningful Use/Technology adoption
• Health Home concept
  • Integration of health care disciplines
Workforce Innovation in Health Centers

- Unique characteristics of HC practice provide broad depth of training experience
- HCs train community members for employment
- Opportunities for dental programs to expand capacity
- Ideal locations to pilot innovations
Dental Teaching/Training Centers

- Dental assisting programs/EFDA
- Dental hygiene programs
- Advanced Practice Hygienist/Dental Therapy
- New/emerging dental workforce models
- Pre-doctoral rotations
- Post-graduate residencies
  - GPR
  - AEGD
  - Pediatric dentistry
Practice Scope Innovations

• Expanded scope of practice for public health/Health Center dental hygienists
• Employment for dentist licensure by credential requirements
• Employer of an ADA Community Dental Health Practitioner
• One allowable practice site for the Minnesota Dental Therapist model
• Emerging DT State models i.e. Arizona, Maine, Vermont, Oregon(tribal), & Michigan
The “Triple Aim”

- Improved Health
- Improved Care
- Reduced Cost
Leadership Launch

Who are the external partners you currently work with to expand your Health Center dental workforce or scope of service?

OR

Who are the partners you could potentially work with to expand your Health Center dental workforce or scope of service?
Conclusion

Nearly 27 million people – 1 in 12 people across the United States – rely on a HRSA-funded health center for care, including:

1 in 9 children

1 in 5 rural residents

1 in 3 living in poverty

More than 355,000 veterans

About 3.5 million publicly housed

Nearly 1.4 million homeless

Nearly 1 million agricultural workers

More than 800,000 served at school-based health centers
Oral Health

• Oral health is a vital component of Health Center care and demand for services exceeds capacity

• Good oral health is important to the overall health of the people Health Centers serve

• As a Health Center patient once testified: “How can I have good health when I have bad teeth?”
Thank you!

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