Chapter One: Health Center Fundamentals
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Version 1.1

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The mission of the National Network for Oral Health Access (NNOHA) is to improve the oral health status of the underserved through advocacy and support for Health Centers.

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Executive Summary

Health Center Dental Directors, Chief Executive Officers, and other Health Center leaders have a need for operations resources that are specific to the populations they serve and the unique challenges of running a Health Center oral health program. New Health Center Dental Directors are sometimes overwhelmed by a learning curve that includes productivity standards, training issues, program management, Federal Tort Claims Act questions, quality management and other issues specific to serving low-income, vulnerable populations that are unique to Health Centers. The National Network for Oral Health Access (NNOHA) consistently heard from its membership of the need to share information and experiences among Health Center Dental Directors and their teams. This manual strives to share information among Health Center oral health teams so that no one has to ‘reinvent the wheel’ when it comes to operating strong oral health programs with high quality dental services for underserved populations.

Health Center oral health programs serve a unique need that the private practice dental community generally is unable to meet. Health Center patients typically have more oral disease than their more affluent counterparts. Most private practice dentists are inadequately trained to handle patients who have unique cultural, linguistic or health care needs. In many ways, dedicating a career as a dentist or dental hygienist to serve underserved populations is a calling that requires peer support, specific information and training. NNOHA has been charged with developing the resources to support the unique needs of Health Centers.

In 2008, the National Network for Oral Health Access received a Cooperative Agreement from the Health Resources Services Administration. One of the main objectives of the Agreement is to develop Practice Management resources that meet the specific needs of a Health Center oral health program. This Fundamentals Chapter is the first in an ongoing series of chapters in a “Health Center Oral Health Program Manual.” In the future, the manual will include information on Financials, Risk Management, Leadership, Best Practices, Workforce, and Quality Management among other topics.
**ORAL HEALTH IN HEALTH CENTERS**

With more than 40 years of experience, Health Centers have evolved as a primary source of care for America’s underserved population. Their success in providing affordable, culturally competent, high quality services is well recognized. They have proven to be a valuable asset in reducing medical inefficiencies, such as overuse of emergency rooms and lowering health care costs.  

Health Centers are at the core of a new health care movement to further reduce health care costs by shifting emphasis from treatment to prevention or “total body health.” Concepts such as “Health Homes” are developing primary care “gatekeepers” that direct patients with health risks to proper care managers before the risks develop into disease states. Quality systems are being developed that include the patient as a partner in health management.

Research clearly demonstrates that dental must be an integral part of this team. Oral bacteria, which cause local infections can enter the bloodstream and travel throughout the body. Oral pathogens or their antigens have been isolated in blood vessels, arterial plaque and placental tissue. These oral pathogens have been associated with blood proteins, such as C-Reactive Protein, which is a risk factor for heart disease and Tumor Necrosing Factor, which adversely affects insulin efficiency. Although research has not defined the actual level of risk or exact biological mechanism, it is generally accepted that oral disease enhances the risk of heart disease, stroke, and adverse birth outcomes. It is well documented that a relationship exists between diabetes and periodontal disease. The Surgeon-General has recognized that we cannot have total health without oral health.

This poses a perplexing problem for Health Center oral health programs. The population served has an overwhelming disease burden with multiple complex treatment needs, such as extractions, restorations, and replacing missing teeth as well as periodontal infections. Balancing this with the call for initiating oral health by 12 months of age is daunting. Since the only way to reduce the disease burden is through prevention and disease management, Health Center oral health programs must develop meaningful preventive programs. Many oral health programs have targeted the most vulnerable population – children, as well as educating mothers to the transmissibility of oral pathogens and other causative factors. The future is an integrated “dental home” into the health home model with prevention being a primary focus. All Health Center oral health programs are deeply encouraged to seek innovative ways to improve their preventive and disease management efforts.

Many oral health programs have extended their scope of practice to include conscious sedation, implants, hospital dentistry and oral surgery. There has been a significant increase in Dental Residency programs throughout the country and the Health Center is becoming a more attractive venue for providers with post-graduate residency certificates as they can better utilize their skill with a close relationship with the medical team. This expands Health Centers’ abilities to expand their scope of practice.

The Health Center oral health team is in a unique position to lead the practice of dentistry into the next dimension. The quality of leadership from Health Center providers and administrators will determine whether this actually occurs.

2 A list of multiple citations for the research referencing oral health’s relationship with overall health can be found on NNOHA’s website at http://www.nnoha.org/goopages/pages_downloadgallery/download.php?filename=8584.pdf&orig_name=citations_for_oral_health10_09.pdf&cdpath=/citations_for_oral_health10_09.pdf
October 1, 2009

Some of you are probably new to the Health Center world or possibly new to your career in dentistry, and some of you are skilled Dental Directors that could be looking for some advice. NNOHA’s Practice Management Committee is writing this Health Center Oral Health Program Manual with Dental Directors in mind, but we hope it will be a valuable resource for CEOs or Executive Directors looking to expand, Financial Officers looking for more information on what it means to finance an oral health program, dental clinic managers who want to better understand the Health Center world, or other oral health providers looking to enhance their leadership skills. This document is based on available guidelines, research, and the experience of your peers.

Having a leadership role in a Health Center oral health program has the potential to be the most rewarding thing you’ll ever do in your career. NNOHA also recognizes that to be successful, there are a lot of questions that you have to address:

- How do I provide quality care with limited resources?
- What makes a Health Center different from private practice?
- What are the federal regulations that guide my program?
- How can I meet the needs of my whole community?

What we have tried to do is cover the most relevant issues for Health Centers – where there are legal requirements or guidelines, we include those references, where there are gray areas, we’ve tried to give you the recommended best practices from the wealth of Health Center providers and leaders that have gone through this before you. This manual is a developing resource, and we expect that it will continue to evolve and be updated through at least 2011. Please give us feedback on what has helped your program and areas where you still look for guidance.

You are not in this alone. We hope that this manual will be a valuable resource for you in developing your oral health program. The common adage goes, “If you’ve seen one Health Center, you’ve seen one Health Center.” Here’s to making your ‘one Health Center’ the most efficient, productive and high-quality center it can be.

Sincerely,

Colleen Lampron, MPH
NNOHA Executive Director

John McFarland, DDS
NNOHA President

Martin Lieberman, DDS
Practice Management Committee Co-Chair

Janet Bozzone, DMD, FAGD, MPH
Practice Management Committee Co-Chair
1. INTRODUCTION

For more than 40 years, Health Centers in the United States have provided comprehensive health care to medically underserved populations and patients in underserved areas, regardless of their ability to pay. Health Centers are known as a growing source of care for America’s underserved population, and they are also venues that provide high-quality, innovative care using the latest in evidence-based research, new technologies and multidisciplinary health care. This section provides the fundamentals for anyone interested in having a successful oral health program. This manual will emphasize that comprehensive health care includes oral health services. One of the goals of this training manual is to remind Health Center staff about the core competencies required to effectively manage an oral health program within a Health Center, consistent with standards and guidelines established by HRSA’s Bureau of Primary Health Care, which sets policies for all Health Center programs. Where there are legal requirements or guidelines, references are included. Where there are gray areas, there are recommendations from the available wealth of experienced Health Center providers.

2. LEARNING OBJECTIVES

After reading this chapter, one should be able to:

- Understand the regulations that govern Health Centers;
- Understand how Health Centers fit in a larger system of health care;
- Recognize the importance of oral health as an integral part of primary care; and
- Understand common terms used to reference Health Center oral health programs.
3. **History of Health Centers**

The 1964 Economic Opportunity Act established the first grant program that supported Community Health Centers (CHCs), a model that combined local community resources with federal funds to reduce health disparities. The Health Center Consolidation Act of 1996 combined authority for various Health Center grant programs, such as Migrant, Healthcare for the Homeless, Public Housing Primary Care, and Community Health Centers, under Section 330 of the Public Health Service Act (PHSA). This act firmly established Health Center programs as an extension of public health grant programs administered by the Health Resources and Services Administration’s (HRSA) Bureau of Primary Health Care (BPHC). Section 330 of the Public Health Service Act will be referenced frequently throughout this document.

Health Centers have grown to serve people in communities that otherwise confront financial, geographic, language, cultural and other barriers. Though Health Centers primarily serve medically underserved populations, anyone can seek health care at a Health Center, regardless of insurance or ability to pay. Health Center oral health programs are an integral part of the Health Center and, must follow the same regulations and requirements as the medical program and the entire Health Center program. Being a part of the key management team as a Dental Director is important to understanding the big picture of the Health Center program as it relates to users, encounters, productivity, medical capacity and sliding fee discounts. Health Center oral health programs have seen a large increase in services in the last 10 years due in part to President Bush’s Health Center Initiative in 2002 and more recently to the capital expansion projects supported by President Obama’s American Recovery and Reinvestment Act (ARRA) of 2009.


**Talking Terminology**

“Health Center” is the term commonly used to refer to Community Health Centers, migrant and seasonal worker health centers, health centers that treat the homeless, and centers that treat residents of public housing.

“Federally Qualified Health Center” or FQHC is a Medicare/Medicaid/SCHIP term related to reimbursement, which includes Section 330 funded centers, sub-recipients (e.g. sub-grantees) and look-alikes.

Authorizing Section 330 legislation has officially changed the term “Community Health Center” to the accepted term “Health Center” and that is the term used throughout this manual to refer to the above listed types of grant-supported entities.

*Dental Health vs. Oral Health – NNOHA uses the term “oral health” throughout this manual to encompass health aspects of the mouth beyond dentition. It is important to note that BPHC does not distinguish between oral health and dental health in their writings so both terms may be found interchangeably in linked documents.*

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4 The Bureau of Primary Health Care was called the Bureau of Health Care Delivery and Assistance (BH/CD) until 1996, when the Health Care Consolidation Act took effect.
Health Centers are part of a larger system of interrelated federal entities designed to improve the overall health of Americans. The following chart is a limited organizational chart to show some of the key players involved in the Health Center world and their influence on oral health programs in Health Centers. Additional entities in the Department of Health and Human Services are not listed here but can be found online at www.hrsa.gov/about/orgchart/default.htm. Descriptions of each of these entities follow the chart.

For more a more detailed flow chart, please visit: http://www.hrsa.gov/about/orgchart/default.htm
**DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS)** — The principal federal agency responsible for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. HHS includes more than 300 programs, covering a wide spectrum of activities. [http://www.hhs.gov/](http://www.hhs.gov/)

**HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)** — Agency within HHS charged with increasing access to health care for those who are medically underserved. HRSA's programmatic portfolio includes a range of programs or initiatives designed to increase access to care, improve quality, and safeguard the health and well-being of the nation's most vulnerable populations. [http://hrsa.gov/](http://hrsa.gov/)

**BUREAU OF PRIMARY HEALTH CARE (BPHC)** — One of the six Bureaus of HRSA. This bureau works to improve health outcomes, and eliminate health disparities for underserved populations. [http://bphc.hrsa.gov/](http://bphc.hrsa.gov/)

**NATIONAL NETWORK FOR ORAL HEALTH ACCESS (NNOHA)** — Membership network of Health Center oral health providers committed to improving the oral health status of the underserved. [http://www.nnoha.org/](http://www.nnoha.org/)

**CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)** — A part of the HHS, the CDC conducts and supports public health activities in the United States. The Center's mission is to use collaborative process to create the expertise, information, and tools that people and communities need to protect their health – through health promotion, prevention of disease, injury and disability, and preparedness for new health threats. [http://www.cdc.gov/](http://www.cdc.gov/)

**CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)** — Formerly the Health Care Financing Administration (HCFA), the CMS, administers Medicare, Medicaid, related quality assurance programs, and other programs. It also makes certain that its beneficiaries are aware of the services for which they are eligible, that services are accessible, and that they are provided in an effective manner. [http://www.cms.hhs.gov/](http://www.cms.hhs.gov/)

**HEALTHCARE SYSTEMS BUREAU, OFFICE OF PHARMACY AFFAIRS** — Bureau under HRSA which administers the 340B Drug Pricing Program, through which certain federally funded grantees (including Health Centers) and other safety-net health care providers may purchase prescription medication at significantly reduced prices. [http://www.hrsa.gov/opa/](http://www.hrsa.gov/opa/)

**HIV/AIDS BUREAU** — One of the six Bureaus of HRSA, it oversees the Ryan White HIV/AIDS Program which provides primary care, support services and antiretroviral drugs for approximately 530,000 low-income people. The program also funds training, technical assistance and demonstration projects designed to slow the spread of the epidemic in high-risk populations. [http://hab.hrsa.gov/](http://hab.hrsa.gov/)

**THE INDIAN HEALTH SERVICE (IHS)** — Agency within HHS responsible for providing federal health services to American Indians and Alaska Natives. The IHS provides a comprehensive health service delivery system for approximately 1.9 million American Indians and Alaska Natives who belong to 562 federally recognized tribes in 35 states. [http://www.ihs.gov/](http://www.ihs.gov/)

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5 IHS – Indian Health Service Introduction: [http://www.ihs.gov/PublicInfo/PublicAffairs/Welcome_Info/IHSintro.asp](http://www.ihs.gov/PublicInfo/PublicAffairs/Welcome_Info/IHSintro.asp).
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<tr>
<th>Organization</th>
<th>Description</th>
<th>Website</th>
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<tr>
<td>MATERNAL AND CHILD HEALTH BUREAU (MCHB)</td>
<td>Bureau within HRSA that provides national leadership, in partnership with key stakeholders, to improve the physical and mental health, safety and well-being of the maternal and child health population. This includes women, infants, children, adolescents, and their families, including fathers and children with special health care needs.</td>
<td><a href="http://mchb.hrsa.gov/">http://mchb.hrsa.gov/</a></td>
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<td>NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS (NACHC)</td>
<td>Primary national, non-profit, professional membership and advocacy organization that represents Health Centers.</td>
<td><a href="http://nachc.org/">http://nachc.org/</a></td>
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<tr>
<td>THE NATIONAL HEALTH SERVICE CORPS (NHSC)</td>
<td>Through scholarship and loan repayment programs, NHSC helps Health Professional Shortage Areas (HPSAs) in the U.S. get the medical, dental, and mental health providers they need to meet their desperate need for health care. Approximately 3,800 physicians, dentists and other NHSC primary health care clinicians are currently working in underserved communities nationwide — in small towns in the frontier west and in the most distressed inner-city neighborhoods.</td>
<td><a href="http://nhsc.hrsa.gov/">http://nhsc.hrsa.gov/</a></td>
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<td>OFFICE OF HEALTH INFORMATION TECHNOLOGY (OHIT)</td>
<td>An office of HRSA, the OHIT promotes the adoption and effective use of health information technology (HIT) in the safety net community.</td>
<td><a href="http://www.hrsa.gov/healthit/">http://www.hrsa.gov/healthit/</a></td>
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<td>OFFICE OF RURAL HEALTH POLICY (ORHP)</td>
<td>Office within HRSA, works with federal, state and local levels of government and with the private sector, associations, foundations, providers and community leaders – to find solutions to rural health care problems.</td>
<td><a href="http://ruralhealth.hrsa.gov/">http://ruralhealth.hrsa.gov/</a></td>
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<td>STATE PRIMARY CARE OFFICES (PCOs)</td>
<td>Assist in the coordination of local, state, territorial and federal resources that contribute to improving primary care service delivery and workforce availability in the state or territory to meet the needs of underserved populations. PCOs work with Health Centers, professional organizations, public and private entities and other community-based providers of comprehensive primary care.</td>
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<tr>
<td>STATE/REGIONAL PRIMARY CARE ASSOCIATIONS (PCAs)</td>
<td>Private, non-profit organizations that provide training and technical assistance to Health Centers and other safety-net providers, support the development of Health Centers in their states, and enhance the operations and performance of Health Centers.</td>
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4. **What is a Health Center?**

Health Centers are public or private not-for-profit organizations that provide preventive and primary health care services to populations with limited access to health care. Health Centers are located in all 50 states, in rural and urban areas, and include centers large and small. The defining attributes that make them different from other types of health care providers are: 1) the designation is available only to programs that meet the five requirements of what used to be called Community/Migrant Health Centers (C/MHCs) or Community Health Centers (CHCs), listed below, and 2) Health Centers receive federal grant funds under Section 330 of the Public Health Service Act. There are additional requirements that Health Centers must adhere to, but these five are fundamentals. 7

The Five Program Fundamentals dictate that all Health Centers must be:

1) **Located in or serve a high need community** (designated Medically Underserved Area or Population).

2) **Governed by a community board** of which 51 percent or more must be Health Center patients who represent the population served. No more than 25% of the board can make more than 10% of their income from health care.

3) **Provide comprehensive primary health care services**, as well as supportive services (education, translation, transportation, etc.) that promote access to health care.

4) **Provide services available to all** with fees adjusted based on ability to pay.

5) **Meet other performance and accountability requirements** regarding administrative, clinical and financial operations.

Because of the increasing cost of health insurance and serious access point shortages, Health Centers will continue to be an important model to serve uninsured and underinsured people. The mission of Health Centers makes them a valuable part of addressing access to oral health care.

5. **Other Types of Health Centers**

In addition to grant-supported Health Centers receiving funding under Section 330, federal law identifies two other types of Health Centers:

- **Federally Qualified Health Center Look-alikes** are Health Centers that have been identified by HRSA and certified by the Centers for Medicare and Medicaid Services as meeting the definition of “Health Center” under Section 330 of the PHS Act, although they do not receive grant funding under Section 330 or FTCA coverage.

- **Outpatient health programs/facilities operated by tribal organizations** (under the Indian Self-Determination Act, P.L. 96-638) or urban Indian organizations (under the Indian Health Care Improvement Act, P.L. 94-437).

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7 HRSA – What is a Health Center? http://bphc.hrsa.gov/about/
HEALTH CENTER SNAPSHOT

- In 2008, there were 1,087 Health Center Program grantees receiving funding under Section 330 of the Public Health Service Act nationwide.

- In 2008, Health Centers employed 113,000 Full-time Equivalent (FTE) employees.

- Health Centers provided services to approximately 17 million medical and dental patients in 2008.

- Between 1998 and 2008, the total number of patients at Health Centers increased by 96%.

- 36% of patients at Health Centers are on Medicaid.

- There were 6.6 million uninsured patients in 2008 (38% of all patients).

ORAL HEALTH SNAPSHOT

- Nationwide in 2008, Health Centers employed 2,300 (FTE) dentists and 900 dental hygienists.

- More than 850 Health Centers (80%) across the country offered on-site dental services as of 2008.

- In 2008, Health Centers provided dental care to 3.1 million patients with 7.3 million visits. During that same year, Health Centers provided medical care to 14.9 million patients.

- Between 1998 and 2008, the number of dental patients at Health Centers increased by 158% (from more than 1.2 million in 1998 to 3.1 million in 2008).

- NNOHA estimates that more than 12 million Health Center patients do not have access to dental services.

- There are an estimated 40 million Americans without Medical Insurance and an estimated 120 million without dental insurance.

*2007 and 2008 UDS Data

6. RELEVANT REGULATIONS

One of the main differences between private practice dentistry and Health Center oral health programs is the requirement to adhere to additional federal regulations. The following are the main regulations related to Health Center oral health program operations. These regulations date back to 1976 and said little about oral health. Most of what is included in the regulations regarding oral health services is not mandated, but is highly encouraged. Requirements under statute and regulation are limited, but they have become key criteria for grant applications. It is important to note that whenever HRSA documents reference ‘clinical’ services, dental is included without being specifically mentioned.8 The requirements for oral health services contained in these documents are summarized in a table in the “Scope of Services” section of this chapter.

8 This statement reflects in-person discussions held by HRSA in developing its Program Expectations. NNOHA supports this interpretation.
<table>
<thead>
<tr>
<th>a. Authorizing Legislation - Section 330 of the Public Health Service (PHS) Act</th>
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<tr>
<td><a href="http://bphc.hrsa.gov/about/legislation/section330.htm">http://bphc.hrsa.gov/about/legislation/section330.htm</a></td>
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<tr>
<td>Section 330 is the main authorizing legislation for Health Centers. This document provides definitions, information on grants, population focus, audits and other general information. The entire text can be found by following the link above.</td>
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<th>b. Implementing Regulations</th>
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<tr>
<td><a href="http://law.justia.com/us/cfr/title42.html">http://law.justia.com/us/cfr/title42.html</a></td>
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<td>42 CFR Part 51c</td>
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<td>42 CFR Part 56.201-56.604</td>
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<td>42 CFR Part 491 - Medicare regulations</td>
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<td>45 CFR Part 74 - Grants administration regulations</td>
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<th>c. Migrant Health Program Regulations</th>
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<tr>
<td><a href="http://tinyurl.com/MigrantRegs">http://tinyurl.com/MigrantRegs</a></td>
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<tr>
<td>These provisions include the requirements specific to Migrant Health Center programs. Follow the link above for the full documentation.</td>
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<th>d. Federal Tort Claims Act</th>
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<tr>
<td><a href="http://bphc.hrsa.gov/FTCA/">http://bphc.hrsa.gov/FTCA/</a></td>
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<tr>
<td>Under this Act, Health Centers are considered Federal employees and are immune from lawsuits, with the Federal government acting as their primary insurer.</td>
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<tr>
<th>e. Policy Information Notice 2008-01: Defining Scope of Project and Policy for Requesting Changes</th>
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<tr>
<td><a href="http://bphc.hrsa.gov/policy/pin0801/">http://bphc.hrsa.gov/policy/pin0801/</a></td>
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<tr>
<td>This document describes policy for an approved scope of project for Health Centers funded under section 330 of the Public Health Service (PHS) Act, the five components of an approved scope of project, and the policy and process for Health Centers seeking prior approval to make changes in the approved scope of project.</td>
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<tr>
<td><a href="http://bphc.hrsa.gov/policy/pin9823/default.htm">http://bphc.hrsa.gov/policy/pin9823/default.htm</a></td>
</tr>
<tr>
<td>This document describes expectations of entities funded by the Bureau of Primary Health Care (BPHC) under section 330 of the Public Health Service Act as amended by the Health Centers Consolidation Act of 1996.</td>
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<th>g. 1987 Regional Program Guidance</th>
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<tr>
<td><a href="http://tinyurl.com/1987-RPG">http://tinyurl.com/1987-RPG</a></td>
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<tr>
<td>This guidance on dental policy was published by HRSA’s Bureau of Health Care Delivery and Assistance in March of 1987. An updated guidance is in development.</td>
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7. FUNDING

Health Centers, including oral health programs, receive much of their funding from traditional reimbursement sources, such as third-party payor revenues from insurance plans and patient fees. What makes Health Centers unique is the funding they receive under Section 330 of the Public Health Service Act. Ideally, oral health programs will have a cost center that utilizes Section 330 funds. A Health Center and its oral health program can also have additional funding sources, such as private grants and donations. Health Centers are designed to serve the health care needs of a community – Section 330 funding covers services for all members of the community (or special populations), not just the financially or medically underserved - they are not entitlement programs. More information on the revenue sources, definitions, as well as the benefits of working in a Health Center are included in the Financials chapter of this manual.

8. FEDERAL TORT CLAIMS ACT COVERAGE

The Federal Tort Claims Act (FTCA) is the federal legislation that provides coverage for Health Centers, their employees, and certain contractors against parties claiming to have been injured by negligent actions. FTCA considers Health Center employees to be employees of the United States, subsequently, any claims would be brought against the federal government.

For FTCA coverage, Health Centers must apply to HHS for the coverage and go through a deeming process which focuses on risk management and credentialing. If deemed, FTCA then protects Health Centers, their employees, and certain contractors, but does not provide coverage with respect to claims for malpractice involving services that are out of scope of project, volunteers, or moonlighting employees.

More details on FTCA are included in the “Risk Management” chapter of this manual and at http://bphc.hrsa.gov/FTCA/.

9. 340B DRUG PRICING PROGRAM

The 340B Drug Pricing Program resulted from enactment of Public Law 102-585, the Veterans Health Care Act of 1992. Section 340B requires drug manufacturers to provide covered outpatient drugs to certain federal grantees, including Health Centers, at reduced prices. Eligible entities must submit a request to participate to the Office of Pharmacy Affairs (OPA) with their Medicaid billing information.

The 340B price defined in the statute is a ceiling price, meaning it is the highest price a covered entity would have to pay for a given outpatient drug. As a result, 340B prices have been found to be roughly 50% of the Average Wholesale Price.9

There are some risk management issues associated with the 340B program that oral health programs need to be aware of. 340B drugs are to be sold only to patients whose treatment is within a Health Center’s scope of project. Fees for outpatient drugs, including drugs acquired at 340B pricing, should be set at or close to the prevailing rate or

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charge in the community for the drug. Simply passing on the Health Center’s acquisition costs for a drug (plus, presumably, a dispensing or administrative fee) is not consistent with Section 330 requirements in two respects: (1) with regard to the fee structure itself, and (2) insofar as it provides a discount off of locally prevailing rates to patients who are not entitled to a discount, i.e., patients who are insured or are beneficiaries of a health program and uninsured or underinsured patients with annual incomes exceeding 200% of the poverty guidelines. Moreover, this approach fails to maximize a health center’s revenue, as required by Section 330 regulations.

As part of the original 340B legislation, the government was also required to establish a Prime Vendor Program (PVP). The program currently provides access to 340B sub-ceiling prices for over 2,800 drug products, access to multiple wholesale distributors at favorable rates, and access to other related value-added products. The PVP is free to all 340B covered entities, but the covered entity must enroll in the PVP.

For more information on requirements and regulations, visit: http://www.hrsa.gov/opa/.

10. Administration

Board of Directors: Health Centers 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 include holding monthly meetings, approval of a Health Center’s grant application and budget, selection of services to be provided and hours of operation, and establishment of general policies for the Health Center. The volunteer board composed of professionals and patients must have at least nine members, but no more than 25.10

To help ensure the Health Center is meeting the needs of the patients it serves, the majority of the board (51% or more) must be patients who are utilizing its services. Board members customarily have different professions by day. Whether they are attorneys, farm workers, stay-at-home parents or community leaders, they all should share a commitment to leading a not-for-profit organization. Non-consumer Board members 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.” 11

Executive Director: In order to oversee the day-to-day operations of a Health Center, HRSA requires the board to be responsible for hiring an administrator or Executive Director (ED). An ED manages the daily functions of the Health Center and oversees the performance of health care given to the patients with Medical and Dental Directors. The ED is responsible to lead the center and work with the board. The board sets the qualifications needed for the job, sets the parameters, and monitors the performance of the ED. The ED hires and evaluates the rest of the Health Center staff. 12

Key Management Team: “Health Centers are most effectively managed by a team of individuals with the skills to provide leadership, fiscal management, clinical direction and management information system expertise.”13 In addition to the ED, 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. The functions associated with some positions might be combined and performed by the same person.

10 The Health Center Program: Requirements, http://bphc.hrsa.gov/about/requirements.htm
11. **Health Center Staffing**

Health Centers’ staffing patterns will depend on the mix of services they offer. Many Health Centers benefit from an interdisciplinary team of providers. Types of providers employed by Health Centers include, but are not limited to: Physicians, Nurse Practitioners, Physician Assistants, Nurses, Midwives, Dentists, Dental Hygienists, Psychiatrists, Case Workers, and Outreach Workers.

All Health Centers are expected to maintain a core staff of primary care providers with training and experience appropriate to the culture and identified needs of the community. It is preferable that the Health Center directly employs the core clinical staff, or at least the majority of the providers. Health Centers should also hire culturally and linguistically competent staff, according to the needs of the community they serve.

Current program guidance dictates the following: “Applicants are also expected to demonstrate that the proposal will address the major health care needs of the target population and will ensure the availability and accessibility of essential primary and preventive health services, including oral health, mental health and substance abuse services, to all individuals in the service area.”

The Bureau of Primary Health Care, which directly funds Health Centers under HRSA, requires that any Health Center with an oral health program provide preventive and emergency dental care and screening for all children.

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If the Health Center does not have an oral health program on site, it is required to make arrangements for referrals to a private practice or other clinics through a contractual agreement.\(^{15}\)

The training and the mix of providers at the Health Center can also influence the types of care provided. Most Health Center oral health programs employ general dentists, who, in order to successfully take care of their patients’ needs, must have experience or develop competency in all aspects of general dentistry, including pediatric and geriatric care, oral surgery, and endodontics. Some Health Centers are able to recruit specialists, which allow them to provide more specialty services to their patients. (More information on this topic can be found in a successive chapter on hospital-based pediatrics as one example). Demand for oral health services typically far exceeds a Health Center’s capacity to provide care. It is not uncommon to see a new clinic reach its capacity shortly after it opens. A wait of three months or longer for an appointment is not unusual, even though the number of Health Centers with oral health programs continue to grow.

Because some Health Center patients may be receiving dental care for the first time in their lives, patient education on disease prevention is extremely important. The staff must be skilled in explaining the etiology, treatment and prevention of common oral diseases and providing the patients with tools to encourage self-management of disease.

### 12. Licensure, Credentialing and Privileging

A Health Center’s oral health professionals must be licensed in accordance with applicable statutes and/or licensing regulations for each state. Professional staff must maintain necessary, professional certification and licensure, which may vary depending on the state where their Health Center is located. Dental providers at Health Centers are no different from private practitioners in that they must abide by the same licensing requirements dictated by each state. A list of links to individual state practice acts can be found on NNOHA’s Website at: http://tinyurl.com/StPracticeActs. The American Dental Association also has a link to its national registry for state regulations that apply to dentists who were trained outside of the United States: http://www.ada.org/prof/prac/licensure/index.asp.

HRSA PIN 01-16 (http://bphc.hrsa.gov/policy/pin0116.htm) coordinates policies on credentialing and privileging. Credentialing is the process of assessing and confirming the qualifications of a health care practitioner. HRSA requires that all Health Centers assess the credentials of each licensed or certified provider to determine if they meet Health Center standards. Privileging is the process that health care organizations employ to authorize practitioners to provide specific services to their patients.\(^{16}\) A Health Center must verify that its providers possess the requisite skills and expertise to manage and treat patients and to perform the medical procedures that are required to provide the authorized services.

To ensure the appropriateness of care and the safety of the patient population served, HRSA, other regulators, and accrediting bodies conduct inspections, audits, and other reviews of Health Centers that are not always found in the private sector. This oversight may start with a state-specific licensing of the facility and the individual providers.

Assuring that care providers have the proper credentials and licensure is a direct responsibility of the Health Center Board of Directors. Generally, the Executive Director develops policies and procedures for credentialing all staff.

\(^{16}\) PIN 01-16 Credentialing and Privileging of Health Center Practitioners, http://bphc.hrsa.gov/policy/pin0116.htm
providers, which are then approved by the Board. All providers must have graduated from an accredited educational institution or met requirements that recognize graduates from a foreign educational institution. Graduation must be verified through copies of diplomas and institutional documents. It is also imperative to obtain professional letters of recommendation from colleagues, professors or previous institutions of employment. Most Health Centers require three professional recommendations.

Health Center oral health programs must also comply with State Licensure regulations. Before dentists are allowed to treat patients, they must pass a state or regional examination and be properly credentialed and licensed through a State Dental Board of Examiners. Some states will recognize licensure from other states. Most state Medicaid programs also require a registration process that includes obtaining a provider number. In addition, a Controlled Substance Registration Certificate is needed and many Medicaid programs will not issue a provider number until the provider obtains a Controlled Substance Certificate. If a provider begins work before obtaining the Controlled Substance Certificate, Medicaid may refuse to pay for any services rendered by the provider until after approval. Sample Human Resources forms and checklists can be found on NNOHA’s website at http://www.nnoha.org/dentallibrary.html.

Almost all states require a minimum number of Continuing Education (CE) credits annually. CE is necessary to maintain an ongoing level of competency and is critical to quality of services. Providers generally are on the honor system, but are required to maintain copies of course credits. These are checked through random audits by the State Board of Dental Examiners. The number of credits varies among states; therefore, it is necessary to check state requirements.

13. **Patient Population**

Health Centers are designed to serve the community. Some examples of the populations Health Centers serve are: medically underserved and low income people, migrant and seasonal agricultural workers and their families, homeless adults, families and children, and residents of public housing; however, Health Centers are available to everyone in the community regardless of personal resources or lack of resources. Health Center patients generally have more rampant disease, fewer resources, and greater barriers to getting the care they need, such as transportation, language, and child care. Health Center patients should receive care that is at least as good as that in private practice and follows the latest evidence for the best health outcomes.

“**We have to be better dentists, because our patients can least afford any mistakes.**”

_Janet Bozzone, DMD, FAGD, MPH, Director of Dentistry at Open Door Family Medical Centers in New York_
14. **Developing Cultural Competency**

Cultural competency is developed by acquiring and integrating knowledge, awareness and skills about cultures and their differences. This will enable health care professionals to provide optimal care to patients of various racial, ethnic and cultural backgrounds.\(^{17}\)

Culture is the integration of patterns of human behavior that include language, thoughts, communications, actions, customs, beliefs, values and institutions of different racial, ethnic, religious and social groups. The easiest way for Health Centers to obtain cultural background data is by participating in community stakeholder coalitions to obtain community survey data. Health Centers should assess the communities they serve by conducting regular target population surveys.

Health Centers should seek to engage and become part of community organizations representing cultural, racial and ethnic groups in order to regularly evaluate the various groups that make up the target population. This information should be stored in a database and updated and shared with staff regularly. Clinical and educational materials should be developed with cultural relevance for the target community. Cultural characteristics are dynamic and subject to change. Information on cultures should be specific to the target community, not limited to generalizations from broad-based national data. This level of sensitivity can only be obtained through community-based stakeholders directly associated with the target population. Regular sensitivity surveys of providers and staff should be conducted to determine areas of weakness that may need improvement.

15. **Community Health Needs Assessment**

Each Health Center must conduct a needs assessment of their community.\(^{18}\) This assessment will be used to justify project plans, prevention and treatment needs, service mix, organization of care, and staffing requirements. The recommended elements of an oral health program needs/demand assessment include:

1. Estimated number of users, specifying the critical mass of dental patients for the program.
2. Description of existing providers and resources in the community, as well as an assessment of unmet need.
3. Predominant characteristics of service population, such as race, sex, age, ethnicity, primary language, income, etc.
4. Oral health status, prevention, and treatment needs of the population. If this data is unavailable, Health Centers should conduct a small scale assessment of the oral health status of community members.
5. Barriers to access/availability to comprehensive oral health care services.
6. Description of needs and treatment of special populations, such as people living with HIV, the homeless or migrants.

\(^{17}\) Cultural Competence in Cancer Care: A Health Care Professional Passport, HRSA Office of Minority Affairs, Rockville Maryland

Health Centers use this assessment to develop a primary oral health care plan that addresses those needs listed in the assessment. This needs assessment also identifies resources and providers in the community to provide necessary services. The primary oral health care plan is an integral component of the overall primary health care plan, based upon what is feasible, taking into consideration the programs, projected revenue, other resources and grant support.

Since oral health care needs in underserved communities are extensive and cannot be fully addressed by any one organization, it is important that programs actively solicit the collaboration and linkages with dentists, dental schools, dental societies and other health care providers in the community.

16. **PATIENT CARE: SCOPE OF SERVICE**

A. Required Services

Section 330 of the Public Health Service Act (Section 330) requires Health Centers to provide “required primary health services” to all residents of the area served by the center. (Section 330 legislation can be referenced at http://bphc.hrsa.gov/about/legislation/section330.htm) See 42 U.S.C. § 254b(a)(1). Primary health services are defined in the statute to include “dental screenings for children” and “preventive dental services.” See 42 U.S.C. § 254 (b)(1)(A)(i)(III) (ff) & (hh). The Section 330 statute, itself, does not define the scope of “preventive dental services.” However, the implementing regulations define “preventive dental services” to include services provided by a licensed dentist or other qualified personnel, including (i) oral hygiene instruction; (ii) oral prophylaxis, as necessary; and (iii) topical application of fluorides, and the prescription of fluorides for systematic use when not available in the community water supply.

See 42 C.F.R. § 51c.102(h)(6). In addition, BPHC Program Expectations express BPHC’s expectations that Health Centers will provide emergency dental services as well as preventive dental services listed in the statute and regulations. See BPHC Policy Information Notice (PIN) #98-23, Section II.B.1.a, at p.13. (PIN 98-23 can be viewed at http://bphc.hrsa.gov/policy/pin9823/default.htm).

If the Health Center does not directly provide required oral health services, it is required to make these minimal services accessible through referral or other contractual arrangements with other community dental providers. See BPHC Policy Information Notice (PIN) #98-23, Section II.B.1.a, at p.13.

B. Additional / Recommended Services

In addition, Health Centers can obtain approval from the Department of Health and Human Services (HHS) to provide “supplemental health services,” which can include “dental services other than those provided as primary health services,” within their Scope of Project. See 42 C.F.R. § 51c.102(j)(6).19 However, in order to include additional services as part of its Scope of Project (which is a pre-requisite to accessing the related reimbursement and other benefits for such services), the Health Center is obligated to offer such care to all residents of its service

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19 A fundamental concept impacting Health Center operations is its federally-approved “Scope of Project.” As explained in the Health Center Fundamentals chapter, “scope of project” involves five key elements: (1) service delivery sites/locations; (2) scope of services provided; (3) service providers; (4) geographic service area; and (5) target population served. With respect to (2), the scope of dental services made available to Health Center patients are formally set by the Health Center’s Board of Directors and must meet the minimum statutory and regulatory standards and should relate back to the Health Center’s community needs assessment. The inclusion of the Health Center’s oral health services in its Scope of Project is a prerequisite to accessing unique FQHC benefits (e.g., cost-related Medicare, Medicaid, and S-CHIP reimbursement, FTCA, 340B drug discount program) available to the Health Center with respect to such oral health services.
area, including those persons who are publicly or privately insured and those who are uninsured, regardless of ability to pay or payor source, and subject to Section 330 discount and sliding fee schedule requirements. As is the case with the required services described above, any supplemental services brought into the Health Center's Scope of Project that cannot be provided directly by the Health Center must be made accessible through referral or other contractual arrangements with other community dental providers. See BPHC Policy Information Notice (PIN) #98-23, Section II.B.1.a, at p.13. The inclusion of additional services in a Health Center's Scope of Project is necessary to access reimbursement, FTCA coverage and other FQHC benefits for the provision of such services.

NNOHA encourages all Health Centers to provide comprehensive oral health services that improve the health of the community, whether or not required by Section 330, regulations or agency guidance, and wants to emphasize the flexibility (as additional or supplemental services) that the law affords each Health Center in determining its appropriate scope. The type of treatment and scope of service provided by a Health Center's oral health program should be no different from services provided by the private sector. Health Center patients are encouraged to become regular patients who have comprehensive exams and follow-up treatment. The concept of having a "health home" is the recommendation for all community oral health programs.

Primary oral health care is personal oral health care, delivered in the context of family, culture and community including a range of services that meet all but the most specialized oral health needs of the individuals and families being served. Primary oral health care integrates those services that promote and preserve oral health; prevent oral disease, injury and dysfunction; and provide a regular source of care for acute and chronic oral diseases and disabilities.

The primary oral health care provider incorporates community needs, risks, strengths, resources and cultures into clinical practice. The primary oral health care provider shares with the primary care team an ongoing responsibility for oral health care.
Phase 1 = Prevention, maintenance and/or elimination of oral pathology that results from dental caries or periodontal disease. This includes: oral cancer prevention and early diagnosis; prevention education and services; emergency treatment; diagnostic services and treatment planning; restorative treatment; basic periodontal therapy (non surgical); basic oral surgery that includes simple extractions and biopsy; non-surgical endodontic therapy; and space maintenance and tooth eruption guidance for transitional dentition. Phase I includes the various levels of services described below:

- **Level I - Emergency Dental Services** include diagnosis and treatment of acute episode of pain, infection, swelling, hemorrhage or trauma. Keep in mind, if a center does not have the ability to offer Level I and II services on site, they must be available through contractual arrangements with other providers (for programs developed since 1998).20

- **Level II - Preventive Dental Care and Diagnosis** Include oral health education; oral hygiene instructions; dietary counseling; trauma prevention; fluoridation; periodontal prophylaxis and self-prophylaxis; topical application of fluoride; supplemental fluoride therapy (tablets and drops); community and school water fluoridation assessment; oral cancer detection and prevention principles; and pit and fissure sealants as appropriate.

- **Level III - Expected Services** include basic dental care and those services related primarily to the disease process. Examples include restorative dental services, basic endodontic, periodontal and oral surgery (routine extractions) services; occasional single crowns; and space maintenance.

Phase 2 = rehabilitative services, such as dentures, partials, crown and bridge, elective oral surgical procedures, periodontal surgery, and orthodontics (Elective dental procedures.) Phase 2 includes the services described below:

- **Level IV - Recommended Services** are those generally designated as rehabilitative dental services, which primarily restore oral structure. If a Health Center can find low cost solutions to replace dentition, their patients may be assisted in obtaining employment, education or enhancing self esteem. Examples include: removable prosthetic services; fixed prosthetic services (bridges and multiple crowns); oral surgery services (elective or complicated); and other-than-routine specialty services. NNOHA recommends Health Centers offer as many of these listed services as possible to meet the needs of their patients and community.
No two Health Center oral health programs are alike. Because each Health Center responds to the specific needs within a community, it is nearly impossible to compare one Health Center to another. The common saying goes: “If you’ve seen ONE Health Center, you’ve seen ONE Health Center.”

As with patients in the private sector, oral disease prevention is often a difficult concept for Health Center patients. Many patients may opt for no treatment due to limited financial resources, a common reality that sometimes frustrates providers. In private practice and Health Centers alike, every treatment has to be explained to patients very clearly to ensure the patients are making well-informed decisions.

Literature supports the link between an individual’s oral and general health status, so it’s critical that a Health Center’s dental staff form strong relationships with their medical counterparts. Dental Directors must take the lead in fostering improved communication among departments, as well as greater respect and understanding of their counterparts’ contributions. The unique Health Center model demonstrates that collaboration between medical and dental entities is possible and will benefit the organization, staff and patients.

The goal is to arrest and control disease in the community.

17. Contracting with Outside Providers

As stated previously, Health Centers are required under Section 330 to provide primary health services to all patients. In addition, Health Centers may provide additional services based on the needs of the community, by including those services in their “scope of project.” Services can be provided by the Health Centers directly, or through a written referral or contract.

When Health Centers lack the structural capacity to provide on-site required services, they may choose to contract with outside, private dentists. It is important to note that Health Centers cannot just contract to serve CHIP or Medicaid patients. Dentists provide services on behalf of the Health Center under the terms and conditions of their joint contract, not under the Medicaid Program, therefore, contracted services must be accessible to the whole patient population, regardless of the individual’s or family’s ability to pay or of payor source. Health Centers must allocate funds to pay for required services for the uninsured patients.

For more information about contracting, including how to define and change scope, payment and billing mechanisms, and a model contract, refer to Increasing Access to Dental Care Through Public/Private Partnerships: Contracting Between Private Dentists and Federally Qualified Health Centers available at http://www.cthealth.org/matriarch/documents/handbook.pdf.

18. Quality Management

Regardless of whether the dental services are provided on or off site, under section 330, Health Centers 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. Health Centers are expected to establish a quality
management program for oral health care service delivery that is integrated within and coordinated with the overall Health Center quality management system. The system should be an ongoing evaluation of processes and outcomes of oral health care delivery for patients and populations served by the center. The goals of the quality management system should be to:

- assure and improve the quality of oral health care delivery,
- improve oral health care status of the community, and
- integrate quality into the long term operational planning and management of the center.

Health Centers are expected to establish oral health care clinical protocols and practices that reflect accepted standards of care and best practices reflecting the needs and demands of the populations served. These protocols must meet or exceed accepted therapeutics and clinical guidelines of the American Dental Association, as well as other professional guidelines, federal program regulations, and program expectations. Protocols must be reviewed and revised periodically. Chart audits by key professional staff at the Health Center and external audits by consultants or clinical networks should be done periodically to evaluate quality and appropriateness of care, as well as to plan for improvement of care to meet the needs of the populations served.

In the spirit of continuous improvement, NNOHA recommends that Dental Directors have an ongoing conversation with the quality improvement staff at their Health Center to monitor the quality and effectiveness of the services provided to the community. Additional details and sample outcome measures will be available in successive chapters of this manual. Sample quality measures related to prenatal care and young children can be found in the Oral Health Collaborative Pilot work on NNOHA's Website:


~ Scott Wolpin, DMD
Choptank Community Health System
Chief Dental Officer

\[21 \text{ http://bphc.hrsa.gov/policy/pin9823/default.htm}\]
19. **The Health Center Primary Care Advantage**

Health Center oral health programs have a unique and important partner in their Medical and Behavioral Health Program counterparts. Ideal health care integrates all aspects of overall health, and Health Centers are primed to reinforce this concept by collaborations between medical, mental, and dental departments and often co-located services as well. Interdepartmental collaboration between clinics can be beneficial in a number of ways:

- Mutual education and training between staff;
- Sharing of resources, including case management, nurse assistance in emergency triage, medical consultation services, anticipatory guidance by medical providers to parents of infants and young children, and cross-practice referrals;
- More eyes to monitor the oral health status of mutual patients; and
- The oral health program also gains effective advocates to support its need for increased oral health resources.

More information on the Oral Health Collaborative Pilot, which emphasized medical and dental integration, can be found at: http://www.nnoha.org/oralhealthcollab.html.

20. **Health Centers – Key Components of Dental Public Health**

Health Centers are a critical component of the dental public health infrastructure. Public health dentistry in Health Centers is primarily focused on the collective oral health status of the communities they serve. This perspective is not always adequately taught in schools of dentistry, leaving many Health Center dentists unprepared to address it.

“Dental public health is the science and art of preventing and controlling dental disease and promoting dental health through organized community effort. It is that form of dental practice which serves the community as a patient rather than the individual: It is concerned with dental education of the public, applied dental research, and administration of group dental care programs, as well as the prevention and control of dental disease in the community.”

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22 Definition developed by the American Board of Public Health Dentists, and accepted by the American Dental Association, Dental Health Section of the American Public Health Association, and the American Association of Public Health Dentists
21. **Basic Dental Public Health Concepts:**

A Health Center oral health program is built upon the foundation of public health principles. These principles should be engrained in the dental provider undertaking the challenge of a Health Center-based “safety net” oral health program.

There are two essential principles:

- Public health is “people health,” and
- Public health’s focus is on the collective health status of a group of people.

Traditional dental training and practice focus on the oral health of a particular patient, not the community as a whole. The public health dental practitioner must focus on the community environment and conditions that impact the dental health of the community. The goal of a public health oral health program is to maintain or restore the public’s oral health by eliminating environmental causes of disease and restoring oral health to the population. Below are concepts a provider should consider in the practice of Health Center dentistry.

- Services provided should be based on the disease pattern of the target population, rather than the individual patient.
- The target population demand and the resources available to address that demand should be considered.
- Continuous surveillance of the target population should assess the dental disease rate, perceived need for services, actual demand for services, and projected need for future services.
- While individual patients pay for private practice dental services, Health Centers and public health oral health programs are financed through a graduated patient payment structure and partially via a budget approved by a public or private funding agency.
- Both individual patient treatment planning and surveillance of total population needs should be part of an efficient Health Center oral health program.
- Service and treatment option priorities should be based on availability of resources, size of the target population, disease pattern and demand of the population, and a reasonable definition of oral health verses ideal restoration.
- The patient population is the community.
22. **Summary**

These are the basics of the Health Center world. This chapter was designed to provide the fundamentals on the structure, regulations, and concepts related to Health Center oral health programs. To fully understand the Health Center world will require additional research, and there are many ways to go beyond the minimum and create a program that excels. Successive chapters in this manual will include discussions on Risk Management, Financials, Best Practices, and Leadership. NNOHA aims to provide the necessary tools to assist providers, patients, oral health programs, Health Centers, and communities.

23. **Basic Contact Information**

| **National Network for Oral Health Access (NNOHA)** | **Address:** PMB 329, 3700 Quebec Street, Unit 100 Denver, CO 80207-1639  
**Phone:** 303-957-0635  
**Website:** www.nnoha.org |
| **Health Resources and Services Administration (HRSA)** | **Headquarters**  
**Address:** 5600 Fishers Lane, Rockville, MD 20857  
**Phone:** 1-888-275-4772  
**Email:** ask@hrsa.gov  
**Website:** http://www.hrsa.gov/  
**Regional Offices**  
http://www.hrsa.gov/about/staff/oprstaff.htm |
| **Bureau of Primary Health Care (BPHC)** | **Address:** 5600 Fishers Lane, Rockville, MD 20857  
**Phone:** 301-594-4110  
**Website:** http://bphc.hrsa.gov/ |
| **State Primary Care Offices (PCO)** | http://bhpr.hrsa.gov/Shortage/pcos.htm |
| **American Dental Association (ADA)** | **Main Site:** www.ada.org  
National Registry for state regulations for dentists trained outside of the United States:  
http://www.ada.org/prof/prac/licensure/index.asp/ |
| **Primary Care Associations (PCAs)** | http://nachc.com/nachc-pca-listing.cfm  
**Address:** 7200 Wisconsin Ave, Suite 210, Bethesda, MD 20814  
**Phone:** 301-347-0400  
**Website:** http://nachc.org/ |
| **National Association of Community Health Centers (NACHC)** | **Address:** 604 Gallatin Avenue, Suite 106, Nashville TN 37206  
**Mailing Address:** PO Box 60427, Nashville, TN 37206-0427  
**Phone:** 615-226-2292  
**Website:** http://www.nhchc.org/ |
24. GLOSSARY OF KEY TERMS

1. **330 Grantees** – Another name for Health Centers taken from the Health Center Program, Section 330 of the Public Health Service Act.

2. **CHC - Community Health Center**, now simply referred to by federal regulations as “Health Center.”

3. **Entitlement Program** - A federal program that guarantees a certain level of benefits to persons or other entities who meet requirements set by law, such as Social Security, farm price supports, or unemployment benefits.

4. **FQHC – Federally Qualified Health Center.** This is a term that was developed for Medicare/Medicaid billing purposes and refers to organizations that receive Section 330 funds to operate Health Centers. FQHCs include Health Centers that receive 330 funds, sub-recipients of such funds, and look-alikes. Although FQHC is often used as a general term for Health Centers, it was originally a billing term and NNOHA recommends using the term Health Center. All 330 grantee Health Centers are FQHC’s, but not all FQHC’s are 330 grantees.

5. **FQHC Look-alike** - A Health Center that meets all requirements to be a FQHC, but does not receive any Section 330 federal grant support.

6. **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 services, 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 health centers, or centers that treat residents of public housing (refer to 330-legislation).

7. **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. Each area is assigned a score based on the level of need.


10. **Nominal Fee** – A Health Center can charge a small fee, approved by the Board of Directors to all patients, providing it is not a barrier to care for any patient.

11. **Public Health Service (PHS) Act** – The Public Health Service Act of July 1, 1944 (42 U.S.C. 201), consolidated and revised, sets forth all existing legislation relating to Public Health Service, including a variety of PHS-administered grant programs including section 330 which regulates Health Centers.
13. **Safety Net** - All Health Centers, local county health departments, public hospitals, non-profit clinics, and other health-care entities that provide health services to underserved populations, regardless of their ability to pay.

14. **Sliding Fee** – Health Centers provide access to services regardless of a person’s ability to pay. After establishing a schedule of charges consistent with locally-prevailing charges designed to cover the Health Center’s costs, a corresponding schedule of discounts of charges establishes the amount patients who are uninsured or underinsured with annual incomes at or below 200% of the Federal poverty level can afford to pay; no more than a “nominal fee may be charged for services provided to uninsured or underinsured patients with income at or below 100% of the Federal poverty level.”

15. **UDS - Uniform Data System.** UDS is a federal system used to track 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 is collected annually.
25. **Frequently Asked Questions**

**Q: What is a FQHC Look-alike?**

A: A FQHC Look-alike is an organization that meets all of the eligibility requirements to receive a PHS Section 330 grant, but does not receive grant funding.

**Q: Are Health Center dental providers licensed?**

A: Yes. Health Center dental providers must meet the criteria for licensure in the state where the Health Center is located.

**Q: Are there location requirements for Health Centers?**

A: It depends. Each Health Center that receives PHS 330 grant funding must meet the requirements of that grant. Health Centers must serve a Medically Underserved Area (MUA) or Medically Underserved Population (MUP). To determine if your area qualifies, you can search the MUA/MUP database at http://bhpr.hrsa.gov/shortage/muaguide.htm. Migrant Health Centers, Health Care for the Homeless and Public Housing Primary Care Programs do not need to meet the MUA/MUP restriction. Health Centers may be located in both rural and urban areas.

**Q: Is a sliding fee scale required?**

A: Yes, Health Centers must use a sliding fee scale for all services included in their scope of project for patients between 100%-200% of the Federal Poverty Level (FPL). A sliding fee discount cannot be applied to anyone above 200% of the FPL or below 100% of the FPL. The sliding fee scale includes discounts based on patient family size and income in accordance with federal poverty guidelines. Health Centers must be open to all, regardless of their ability to pay. If you provide services outside of your scope of project, you must bill separately, but are not required to slide the fee.

**Q: Are Health Centers “free clinics?”**

A: No. Health Centers do not provide free care to patients. Health Centers are required to serve all people regardless of their ability to pay. When a patient falls below 100% of the poverty guidelines, a nominal fee or no fee is charged. Most Health Centers have a nominal payment that is expected from the patient, regardless of the percentage of sliding fee discount for which one qualifies. If a patient cannot afford to pay even the nominal fee, the Health Center may not refuse to provide services.
26. Links

- National Network for Oral Health Access: www.nnoha.org

- American Association of State & Territorial Dental Directors: www.astdd.org.

- The American Dental Association link to the national registry for state regulations for dentists who were trained outside of the United States: http://www.ada.org/prof/prac/licensure/index.asp.

- Authorizing Legislation (Section 330 of the Public Health Service Act): http://bphc.hrsa.gov/about/legislation/section330.htm

- Community Health Center Program Regulations: http://tinyurl.com/HCRegulations

- Health Resources and Services Administration, Bureau of Primary Health Care website: www.bphc.hrsa.gov


- Indian Health Service: http://www.ihs.gov/

- Migrant Health Program Regulations: http://tinyurl.com/MigrantRegs


- Ohio Dental Safety Net Information Center: www.ohiodentalclinics.com


- State practice acts can be found on NNOHA’s Website at: http://tinyurl.com/StPracticeActs.
HEALTH CENTER BASICS WORKSHEET

1. Which term has its origins as a Medicaid billing term?
   a. Health Center
   b. Community Health Center
   c. Safety-net
   d. Federally Qualified Health Center (FQHC)

2. Can a for-profit clinic be a Health Center?
   a. Yes
   b. No
   c. Depends on other factors

3. Which of these services is not required, by legislation or regulation, to be part of your Health Center’s services?
   a. Preventive Dental Care
   b. Emergency Dental Services
   c. Treatment of Disease
   d. Pediatric Dental Screenings

4. What governmental office oversees Health Centers?
   a. Center for Disease Control
   b. Health Resources Services Administration
   c. Office of Management and Budget
   d. American Dental Association

5. What are the highest oral health needs in your community?

6. What populations in your community have the highest oral health needs?

7. Write your elevator speech for why you chose to work at a Health Center:
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http://cda.org/page/Library/cda_member/pubs/journal/jour0509/index.html
MEMBERSHIP APPLICATION
For calendar year 2010 (January 1st through December 31st)

APPLICANT CONTACT INFORMATION

Name:
Title:
Organization:
Name of Health Center: (if different from Organization name)
Address:
City: State: Zip Code:
Phone: Fax:
E-mail:

NNOHA MEMBERSHIP CATEGORY:

❑ Individual Member (dues $25)  ❑ Organizational Member (dues $250)

If you are applying as an Organizational Member, please attach a list of the names, titles, and E-mail addresses of the employees you wish to include in the membership.

Referred by: (name of NNOHA Member)

Paying by (select one):

❑ Check (made payable to NNOHA)  ❑ Bill Me
❑ Credit Card – Card Number:

Security Code: Expiration Date:

Signature

❑ Check here If you are interested in receiving information on the current NNOHA committees and opportunities to get involved.

Please complete this form and mail it to:
NNOHA, PMB 329, 3700 Quebec Street, Unit 100, Denver, CO 80207-1639
An online application is also available at http://www.nnoha.org/membership.html

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The mission of the National Network for Oral Health Access (NNOHA) is to improve the oral health status of the underserved through advocacy and support for Health Centers.