Chapter Three: Health Center Financials
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EXECUTIVE SUMMARY

The familiar saying goes “no money, no mission.” Chapter 3 in NNOHA’s Operations Manual for Health Center Oral Health Programs is all about Financials. The first step towards providing quality care to your patient population is to make sure the dental department is fiscally in order. This does not necessarily mean that the oral health program operates in the black, but that the leadership knows from where their income derives, what the expenses are, and understands all of the crucial legal requirements.

Key points in this chapter include:

■ Understanding the main sources of funding for Health Centers;

■ Adhering to the legal requirements relating to setting of fees and discounts and to patients’ ability to pay;

■ Identifying ways to diversify funding for sustainability;

■ Understanding and making use of the financial benefits of being a Health Center: This Chapter highlights benefits that have a significant financial impact on Health Center operations; and

■ Making use of the tools—such as dashboards, utilizing correct financial terms, and other resources.

Finally, it is important to continue to build your financial communications with your administrative leadership team and to use the resources you have available to develop strong leaders and a solvent program. When the finances are in order, it frees the department and the providers up to spend their time on the most important aspect—providing quality care to those in need.
# FINANCIALS

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1. INTRODUCTION

Perhaps no aspect of the Health Center oral health program engenders more questions than financial management. Externally, there are many myths, assumptions, and opinions about how Health Center oral health programs are funded, from where the operating income originates to how patients are charged for services. There is a common misconception that Health Center oral health programs treat patients “for free,” are “in competition” with private practice dentists, and somehow have an unfair advantage because “they are funded by the government.”

Internally, it is vitally important for Dental Directors, Health Center Management, and the Board of Directors to understand oral health program costs, how clinic revenues are derived, and how to manage payor mix and schedules of discounts to maintain fiscal sustainability while complying with Health Resources and Services Administration (HRSA) program requirements, board mandates, and the organizational mission. This is not always a skill set that Dental Directors start with, but having a strong understanding of how Health Center finances operate can lead to a stronger department, which leads to better patient care.

This chapter will provide a general overview of the Health Center financial structure for oral health programs, explain common fiscal terms, and give some recommendations on how Dental Directors can enhance their financial expertise. This chapter will also illuminate the many financial advantages built into the Health Center system and how those advantages are a part of assuring the ability to continue to serve underserved and vulnerable populations.

2. LEARNING OBJECTIVES

After reading this chapter, one should be able to:

- Explain common Health Center financial terms;
- Understand basic financial tools used in operating a successful oral health program;
- Understand the advantages of working in a Health Center from the financial perspective; and
- Locate helpful resources.
3. Relevant Laws, Regulations and Guidance

The Fundamentals Chapter in this series explains the overarching legislation which authorizes grant funding for development and operations of Health Centers including financials operations. More information can be found in Chapter One: Health Center Fundamentals: http://tinyurl.com/HCBasics.

- Authorizing Legislation–Section 330 of the Public Health Service Act

- Section 330 Implementing Regulations – 42 C.F.R. Parts 51c and 56

- Policy Information Notice 98-23: Health Center Program Requirements
  http://bphc.hrsa.gov/policiesregulations/policies/pin199823.html

There are 19 key program requirements for Health Centers receiving 330 Grant Funds. Many of them impact the Financial Department (staffing, scope of project, etc.) but these three are the most specific regarding financials¹:

**SLIDING FEE DISCOUNTS:**
Health center has a system in place to determine eligibility for patient discounts adjusted on the basis of the patient ability to pay.

- This system must provide a full discount to individuals and families with annual incomes at or below 100% of the poverty guidelines (only nominal fees may be charged) and for those with incomes between 100% and 200% of poverty, fees must be charged in accordance with a sliding discount policy based on family size and income.
- No discounts may be provided to patients with incomes over 200% of the Federal poverty level.

(Section 330(k)(3)(G) of the PHS Act and 42 CFR Part 51c.303(f))

**FINANCIAL MANAGEMENT AND CONTROL POLICIES:**
Health center maintains accounting and internal control systems appropriate to the size and complexity of the organization reflecting Generally Accepted Accounting Principles (GAAP) and separates functions appropriate to organizational size to safeguard assets and maintain financial stability. Health center assures an annual independent financial audit is performed in accordance with Federal audit requirements, including submission of a corrective action plan addressing all findings, questioned costs, reportable conditions, and material weaknesses cited in the Audit Report.

(Section 330(k)(3)(D), Section 330(q) of the PHS Act and 45 CFR Parts 74.14, 74.21 and 74.26)

**BILLING AND COLLECTIONS:**
Health center has systems in place to maximize collections and reimbursement for its costs in providing health services, including written billing, credit and collection policies and procedures.

(Section 330(k)(3)(F) and (G) of the PHS Act)

¹ For the most current information, visit http://bphc.hrsa.gov/about/requirements/index.html
4. Sources of Funding

Sources of funding for Health Centers include, but are not limited to:

- Section 330 grant funding;
- Medicare, Medicaid and CHIP reimbursement;
- Commercial insurance payments;
- Patient payments;
- Private grants and donations; and
- Other public funds, such as tobacco taxes.

This section will focus on the sources that are the most regulated, and are often the most proportionally significant in Health Centers’ mix of funding sources.

A. Section 330 Grant Funding

Section 330 of the Public Health Service Act defines federal grant funding opportunities for organizations to provide care to underserved populations. Types of organizations that may receive 330 grants include: Community Health Centers, Migrant Health Centers, Health Care for the Homeless Programs, and Public Housing Primary Care Programs. Programs that receive grants under section 330 must meet certain requirements and follow specific regulations. The regulations that guide 330 programs are detailed more thoroughly on the Bureau of Primary Health Care (BPHC) website at http://bphc.hrsa.gov/about/requirements/index.html.

The original purpose of section 330 of the Public Health Service Act was to increase access to health care for low income and indigent populations without access to other healthcare resources, as well as individuals facing other barriers to care (e.g., geographic, linguistic, and cultural barriers).

Though Health Centers primarily serve medically underserved populations, anyone can seek care at a Health Center, regardless of insurance or ability to pay, and Health Centers must serve all residents of their service areas who present for services. While Health Centers are nonprofit organizations or public entities, they must be financially viable to continue to provide health care services to the community. As a part of the Health Center, the oral health program is under the same constraints. Just like any private practice or other Health Center departments, an oral health program must be self-sustaining over the long term, or it will not survive. Health Centers must find their own path towards providing services to any members of the patient population while building a viable program.

Grant Allocation

NNOHA recommends that a Health Center oral health program be allocated an equitable portion of the Health Center’s 330 grants. The proportion allocated to the oral health program might be based on a variety of factors, such as percentage of floor space, percentage of uninsured patients utilizing dental services, proportion of total patients who are dental patients, or share of operating expenses etc. Each Health Center can decide what formula the assigned revenue is based upon, but it should be a logical and equitable distribution. An oral health program may also have additional funding sources, such as private grants and donations.
Health Centers are required to assure that services are available to the service population without regard to method of payment or health status. At the same time, Health Centers are expected to maximize revenue from third party payors and from patients to the extent they are able to pay. Any excess revenues (a.k.a revenues over expenses or “profit”) generated by the oral health program can be utilized to provide care for indigent patients who are without resources to pay. The specific requirements are found in the 330 Grant Funding requirements, [3](http://bphc.hrsa.gov/policiesregulations/legislation/index.html), section (k)(3)(G), and HRSA’s Policy Information Notice 98-23: Health Center Program Expectations: [4](http://bphc.hrsa.gov/policiesregulations/policies/pin199823.html). While they are summarized here, readers are encouraged to be familiar the source documents.

**Health Centers**

- Should charge patients whose annual income is above 200 percent of the federal poverty level, without applying any discounts;
- Must apply the sliding fee scale to charges for uninsured and underinsured patients whose annual income is above 100 percent and at or below 200 percent of the federal poverty level; and
- May apply a full discount or collect, nominal fees from uninsured and underinsured patients whose annual income is at or below 100 percent of the federal poverty level.3 It is noted that the government has never defined the parameters of a “nominal fee.”

Health Centers are required to establish “a schedule of fees or payments for the provision of its services consistent with locally prevailing rates or charges and designed to cover its reasonable costs of operation”4. A corresponding schedule of discounts, commonly known as a “sliding fee scale”, is applied to such charges and is adjusted on the basis of the patient’s individual or family income.5

In terms of the schedule of fees, Health Center oral health program costs of operation are the same as those in any private practice, including salaries, supplies, utilities, laboratory costs, and capital equipment. Additionally, the oral health program may be assigned its proportionate share of administrative overhead for the entire Health Center.

The sliding fee scale allows for some revenue to be generated for the program to help cover the cost of providing care while keeping the fees reasonable and affordable for low-income patients. The sliding fee scale must be applied to all oral health services provided by the Health Center that are included within the Health Center’s federally approved scope of project.

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With certain exceptions, Health Centers are not authorized to provide sliding fee scale discounts for services to patients who earn annual incomes greater than 200% of the federal poverty level. Also with certain exceptions, Health Centers are required to charge and use best efforts to collect from such patients the full charges in accordance with their fee schedules, without taking into account any discounts.6

The development of a sliding fee scale for oral health services is both an art and a science. The nominal fee is determined by the Board at an amount that supports the costs of the oral health program, but does not impede access to care. Both the sliding fee scale and the nominal fee in oral health programs can be different from the nominal fee charged for medical services. A small sample of Health Center oral health programs indicated their nominal fees were between $20-$30, but the fees can vary widely based on the decisions of the Board. For more information see the National Association of Community Health Centers (NACHC) document “Establishing and Collecting Fees for Health Center Services” at http://nachc.org/client/documents/Establishing_and_Collecting_Fees.pdf.

There are no specific requirements as to how a Health Center structures its schedule of discounts for patients whose income is within the 101% to 200% of the federal poverty level range. The discount also may vary by type of service, the unifying principle in all cases being that discounts must take into account the patient’s ability to pay so as not to impose a barrier to care.

Even in the context of Health Centers’ schedules of fees and discounts, Health Centers must assure that

- No individual will be denied health care services due to an inability to pay for such services; and
- Any fees or payments required by the Health Center for such services will be reduced or waived to fulfill assurance of access to care.7

To determine whether patients qualify for discounted services, Health Centers should re-verify patients’ income level at least annually. Once a Health Center establishes that a patient qualifies for discounted services, or that the patient has a third party payor source, a Health Center must make “every reasonable effort” to:

- Secure payments from patients in accordance with its fee schedule and corresponding schedule of discounts;
- Collect appropriate reimbursement for services provided to persons covered by third party payors.8

If new schedules of discounts need to be established, NNOHA suggests utilizing the online recommendations located at http://www.dentalclinicmanual.com/ in the finance chapter.

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6 See Section 330, sections h & i
8 See also 42 U.S.C. § 254b(k)(3)(G)(ii).
B. Federal Health Care Programs

To generate program revenue, Health Centers are expected to participate in and collect reimbursement from government health insurance programs, such as: the Medicare program; State Medicaid programs; and CHIP programs.

The Medicare program reimburses Health Centers on a cost-based methodology. Under the Patient Protection and Affordable Care Act, this reimbursement will shift to a Prospective Payment System (PPS). However, it is important to note that Medicare currently does not pay for the basic oral health services that are routinely provided at Health Centers. Medicare will pay for some dental services that are an integral part either of a covered procedure (e.g., reconstruction of the jaw following accidental injury), or for extractions done in preparation for radiation treatment – for more information, see http://www.cms.hhs.gov/MedicareDentalCoverage/.

This section will address Medicaid and CHIP reimbursement.

Medicaid

The major source of health care coverage for 36 percent of the average Health Center population has been Medicaid. Most states report a low participation rate in Medicaid among private practice dentists. As a result, Medicaid revenues provide financial sustainability for most Health Center oral health programs. Oral health programs in Health Centers are often the only treatment option for a community’s uninsured patients. The growing uninsured population can place a strain on the financial viability of Health Center dental departments.

Health Centers are typically reimbursed by Medicaid in a different manner from that offered to private practitioners. In a private practice, Medicaid visits are billed on a fee-for-service or capitation basis.

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) established a PPS for Health Center reimbursement under state Medicaid programs. This system, which has been in place since January 2001, replaced the previous cost-based reimbursement system. The PPS establishes a per visit payment rate for each Health Center. Visits are defined differently, state by state. Generally, a dental visit consists of a face to face encounter between a patient and a doctor of dental surgery (DDS) or a licensed dental hygienist (under the direct supervision of a licensed dentist).

The 2001 payment rate was based on the average of each Health Center’s reasonable costs per visit in FY 1999 and FY 2000. Since FY 2002, payments made under this system have been adjusted annually for inflation using the Medicare Economic Index. Payments also are adjusted based on increases or decreases in change in scope of services provided.

The PPS rate is a floor, not a ceiling on reimbursement for Health Center services. No Federal law prevents, prohibits, or precludes a state from paying Health Centers above the PPS rate. Indeed, Congress explicitly allows states to use an alternative payment methodology so long as it “results in payment to the center or clinic of an amount which is at least equal to the amounts otherwise required to be paid to the center or clinic” under PPS.

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The implementation of the PPS reimbursement is different state by state. There are generally 3 scenarios:

- A Health Center receives the same PPS rate for services rendered in both its medical and dental departments;
- The state has carved dental services out of its PPS reimbursement system, resulting in a different methodology used to reimburse Health Centers for dental services; and
- The state has implemented an Alternative Payment Methodology (APM).

Dental Directors should check in with their CFOs to understand how the rate is determined for each center and contact the state Medicaid agency or Primary Care Association for variations in their state. The 2009 NACHC report, “Update on the Status of Medicaid and CHIP Prospective Payment Systems in the States,” which details variations in each state can be found at http://www.nachc.com/client/2009%20PPS%20Report1.pdf.

People may also hear the term “wrap-around.”

This is a payment mechanism where states reimburse Health Centers if there is a difference between the PPS payment rate and the amount they received under their contracts with Medicaid managed care organizations.


Children’s Health Insurance Program

The Children’s Health Insurance Program Reauthorization Act (CHIPRA) of 2009 reauthorized the Children’s Health Insurance Program (CHIP). CHIPRA finances CHIP through FY 2013, preserving coverage for the millions of children who rely on CHIP and providing the resources for states to reach millions of additional uninsured children.

Under CHIPRA, dental services have become a required benefit as CHIP coverage has been expanded to services necessary to prevent disease and promote oral health, restore oral structures, and treat emergency conditions. CHIPRA allows states the option to provide dental-only supplemental coverage (supplemental dental wrap-around benefit) for children who otherwise qualify for a state’s CHIP program, but have other health insurance without dental benefits. Moreover, under CHIPRA, CHIP programs are required to reimburse Health Centers using the same PPS methodology as that required under the Medicaid program. Additionally, with this legislation, Health Centers are allowed to enter into a contractual relationship with private practice dental providers for the provision of oral health services.

“In order to insure you are receiving the appropriate cost-based reimbursement rate for the levels of care you deliver, it is imperative that you code accurately for all the services you provide. Some providers don’t realize the importance of this since reimbursement is at the same rate for each visit, but this can eventually be reflected during periodic rate adjustments.”

Janet Bozzone, DMD, FAGD, MPH
Open Door Family Medical Centers
C. ADDITIONAL FUNDING OPPORTUNITIES

Equipping and maintaining a dental operatory involves significantly more funding than may be understood by the administration. Dental Directors must be active, as well as creative, in partnering with other community resources that can provide a financial stream to offset losses that occur when treating the uninsured. The opportunities are remarkable if the right parties are involved.

Financial support must come to Health Centers in a variety of ways. In this day and age, Health Centers must be ready to engage any community group, local foundation or civic-minded philanthropist to supplement revenues. Some Health Centers have wine tastings, silent auctions and other creative events to raise awareness and funds for their oral health programs. The relationships formed by these events may become a permanent benefit to the Health Center. Events often have long-term benefits for the community in raising awareness of the importance of oral health as well as raising needed funds. It is the role of the Dental Director to nurture these partnerships for the greater good of the oral health program and the community’s overall health.

Dental Directors must be active, as well as creative, in partnering with other community resources that can provide a financial stream to offset losses that occur when treating the uninsured.

NNOHA cautions Health Centers regarding possible fraud and abuse violations under federal and state laws, including but not limited to the Anti-Kickback and Stark laws and their state equivalents. The federal anti-kickback statute, 42 U.S.C. § 1320a-7b(b), states that individuals who knowingly and willfully receive or pay anything of value to influence the referral of federal health care program business, including Medicare and Medicaid, can be held accountable for a felony. Stark law governs physician self-referral for Medicare and Medicaid patients – the practice of a physician referring a patient to a medical facility in which he has a financial interest, be it ownership, investment, or a structured compensation arrangement.

ALTERNATIVE FUNDING SCENARIOS

- A logical place to begin is with service groups. The Junior Leagues, Rotary, Kiwanis, and Lions clubs are built upon a membership that may include retired dentists dedicated to serving the community. An invitation to present a program on what oral health needs exist in the community may prompt the question, “How much do you need for a new dental chair or mobile dental unit?”

- One Dental Director found herself invited to a prominent social event where 300 women in attendance wanted to hear about children’s oral health in the community. This dentist was pleasantly surprised when they all took out their checkbooks and made a total group contribution of $13,000 to the Health Center’s oral health program.

- One Dental Director initiated a clinical trial where pregnant mothers were shown microscopic slides of their periodontal bacterial flora and given a caries risk test. The patients who were deemed at risk were given an irrigator and an antiseptic plus home care instructions. Both the mom and her baby are being followed to see if their level of disease has been reduced. The trial was presented to a Women’s Foundation to help cover the cost of materials and increase the number of patients seen. They offered the largest gift ($25,000) to the project.

- Private fund raising efforts may include something as simple as pot-luck suppers or bake sales to golf outings and rock concerts. While not all efforts raise funds equally, Health Centers should never miss the opportunity to publicize what they do and their need for additional funding support. In 2009, one New York center successfully raised over $2 million with several events and independent donations from generous benefactors.

- Working with the County Supervisors, the county public health department, a local community college and the City Council, a Health Center was able to open a second site with four operatories without any capital improvement costs to the Health Center. The second clinic is co-located with the dental assistant program on the college campus. Case management is even provided by the county and the equipment maintenance costs are provided for 5 years by the City.

- An engaged Dental Director will consider non-traditional grant funders like the Rural Health Association, or State tobacco restitutions. Keeping involved with the community may lead to new opportunities.

“The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) established a prospective payment system for FQHCs. This system, which has been in place since January 2001, replaced the previous cost-based reimbursement system for Health Centers under Medicaid. The prospective payment system establishes a per visit payment rate for each FQHC in advance. The 2001 payment rate was based on the average of each FQHC’s reasonable costs per visit in FY 1999 and FY 2000. Since FY 2002, payments made under this system have been adjusted annually for inflation using the Medicare Economic Index. Payments also are adjusted based on increases or decreases in change in scope of services provided.”

Dennis Smith
Director, Center for Medicaid and State Operations Centers for Medicare and Medicaid Services
http://www.hhs.gov/asl/testify/t020613.html
5. **Best Practices for Health Care Reimbursement Systems**

Health Centers often use three major types of reimbursement systems which require conformable health care practices to ensure accurate and compliant billing. By closely following the policies outlined for each reimbursement plan, Health Centers avoid billing errors or potential misuses of the system. Auditors look for suspicious billing patterns that may indicate potential cases of provider fraud; the following paragraphs are designed to guide Health Centers with establishing sound billing practices and to avoid a fraud investigation by local, State or federal financial auditors.

Fee-for-Service (FFS) systems are designed to reimburse providers for services and procedures performed for each patient visit. Some centers attempt to redeem financial shortfalls by performing and billing for multiple procedures per visit that may be of questionable value to the patient or not clinically indicated. The practices of over-treating or separating necessary treatment into additional procedures, however, are considered misuses of the system. Any suspicious billing activities expose the Health Center to investigations of its reimbursement practices and discredit the valuable services performed by its providers. When Health Centers adhere to the appropriate fees for reasonable services, they are good stewards of grant funds and ensure the success and continuation of providing care to underserved populations.

Capitation reimbursement systems are designed for pre-paid plans under which the Health Center receives a fixed payment per patient each month. Some providers minimize the number of patient visits to remain within the boundaries of capitation; however, they may jeopardize good health care practices. Providers need to intricately balance fiscal responsibility with quality patient care. If a center does not perform or neglects clinically necessary treatment to minimize the number of patient visits, which allows the practice to retain more of the capitation payment, it is at risk of being investigated for reimbursement misuse and provider fraud. The consequences of a provider fraud investigation, regardless of its outcome, negatively affect the Health Center’s reputation.

Prospective Payment System (PPS) reimbursement systems issue payments of a predetermined, fixed amount based on a classification system of services. The PPS rate is designed to cover 100 percent of the Health Center’s costs of providing Medicaid-covered services while retaining professional and community standards of quality care. Under this type of payment methodology, some Health Centers risk negative legal and financial consequences when providers practice “churning,” which is bringing patients back for more visits than necessary.

The current standard of care is to provide quadrant dentistry, and NNOHA recommends that Health Centers follow this professional standard. There are times when a dentist has to appropriately limit care and additional treatments given the constraints and clinical indicators at the time. Situations may differ, but generally, churning results in poor outcomes for patients, and negative reputations for dentists and oral health programs.

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11 The November 2009 edition of NNOHA News has an article on completed treatment plans, which may be helpful: http://tinyurl.com/NNews08-09

Working in a Health Center presents unique challenges and unique benefits. This section describes 10 benefits that have a significant financial impact on Health Center operations and offers some thoughts on how those benefits impact the Dental Department.

**Benefit One: Cost-Based or PPS Reimbursement for Medicaid Services**

As described earlier in this chapter, Health Centers are reimbursed by state Medicaid and CHIP programs using a PPS methodology or other APM that provides reimbursement equal or greater to that provided under PPS. In states where dental services are included in the Health Center’s PPS or APM, reimbursement for dental visits can be significantly higher than the reimbursement that would be received for similar services under a FFS system.

**Benefit Two: Federal Tort Claims Act Protection (FTCA)**

The FTCA (http://bphc.hrsa.gov/ftca/) provides malpractice liability coverage to Section 330- funded Health Centers that have sought such coverage by submitting a “deeming” application and that have been “deemed” eligible by HRSA. FTCA provides federal malpractice liability coverage for the Health Center organization, as well as its board members and employees, including Health Center employed clinicians and certain contracted clinicians, for activities:

- conducted within the scope of the Health Center’s federally approved scope of project;
- conducted within the particular clinician’s scope of employment/contract; and
- provided to Health Center patients generally served at Health Center sites.
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at no cost to the organization. A Health Center may be deemed eligible to participate in this program by meeting a set of criteria related to credentialing, quality assurance, and other quality performance measures and applying to the Bureau of Primary Health Care (BPHC) to be “deemed” eligible. Contact the BPHC’s FTCA Help Line at (866) FTCA-HELP for more information.

Generally speaking, if deemed eligible for FTCA coverage, a Health Center no longer has to pay for commercial malpractice insurance for services provided within its scope of project and within its clinicians’ scopes of employment/contract. Therefore more dollars go to patient care. Instead their insurance company becomes the United States government, and their legal defense team becomes the U.S. Department of Justice. FTCA coverage is not a license to practice bad medicine. It is quite the contrary, as FTCA comes with additional requirements and oversight.

There are some things to be aware of with FTCA coverage:

- Since it is the U.S. Government that is the named defendant in the case (as opposed to the Health Center or the individual clinician), the U.S. Government can, and frequently does, settle the case without the clinician’s permission. When a payment is made on behalf of a practitioner in settlement of a malpractice case, the entity making the payment is required to make a report regarding the practitioner and the settlement to the National Practitioner Database (NPDB). The NPDB is a database of practitioners whose practice has been limited in any way as a result of disciplinary actions. More information is included in the Risk Management chapter.

- Because the Health Center and its clinicians are replaced by the U.S. Government as the defendant in the case, and thus the Department of Justice’s client is the U.S. Government, it is frequently difficult to get status reports on the case’s processing from the Department of Justice.

- FTCA coverage is only applicable to services provided under the individual Health Center’s scope of project and its clinicians’ scope of employment/contract. It does not cover certain contracted providers or volunteer clinicians as well as certain services provided outside the Health Center’s facility. For some of these reasons, some Health Centers purchase what is sometimes called “Gap” insurance coverage. The “Gap” insurance is backup coverage, intended to cover the center and/or its providers if by some chance the FTCA coverage does not cover a particular event.
FTCA coverage is a valuable service. Dental services have not been as historically high risk as services such as obstetrics, critical care and psychiatric care, but it is comforting to know that Health Centers have this support service in place when needed. More information on FTCA can be found at http://bphc.hrsa.gov/ftca/.

**Benefit Three: Public Health Service Act Discount Pricing (Section 340B) on Pharmaceuticals**

Public Health Service Act Discount Pricing (Section 340B) on Pharmaceuticals Health Centers provide a lot of health care: 67 million encounters and 17 million patients in 2008 alone. An inherent part of health care is the provision of affordable medications. Health Centers can buy pharmaceuticals to be dispensed to Health Center patients at a discount, as required under Section 340B of the Public Health Service Act, also known as Public Health Service (PHS) Act Discount Pricing. Though the average savings achieved through purchasing drugs at 340B discount drug program prices is 19 percent nationally, one Health Center reported pharmaceutical costs decreasing by 60 percent in the first year of purchasing at 340B discount drug program prices, despite dispensing 14 percent more prescriptions than it had under non-PHS pricing the year before. For current information regarding 340b pricing, please visit http://pssc.aphanet.org/what-is-the-340b-program/.

- The average 340B discount is about 19 percent lower than the Medicaid net price and 50 percent lower than the wholesale price.
- States can benefit from the 340B program when Medicaid clients purchase pharmaceuticals through participating Health Centers.
- States have a variety of reimbursement mechanisms for drugs purchased at 340B discount drug program prices. In some states, when Medicaid recipients obtain pharmaceuticals under the 340B program, Medicaid is billed for outpatient drugs at the lower 340B acquisition price, plus a reasonable dispensing fee.

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Eligibility for Section 330 grant funding from HRSA is the single most direct financial benefit of being a Health Center. Obtaining a Section 330 grant is a competitive process. Typical “New Start” grant funding averages $650,000 annually. In some years, there have been inflationary “base adjustments” added to the grant amount. Health Centers also can add to their base grants by applying for and securing “expansion” funding, provided such grant opportunities are available. Health Center 330 grants are generally five years in duration. There are specific requirements to meet and reports to submit as part of the annual continuation of the grant process. The Health Center also must compete in a competitive renewal process to maintain continued federal support.

It is important to establish a dental cost center within the overall Health Center fiscal operation. That perspective began changing in the past 10 years, to the extent that HRSA began dramatically expanding Section 330 grant opportunities in oral health. These expansion opportunities generally expand the entity’s base Section 330 grant by adding targeted funding for specific oral health projects by up to $250,000 per year. Given that all Section 330 grant application opportunities are extremely competitive, the savvy Dental Department leadership team prepares for Section 330 oral health expansion grant opportunities months, if not a year, in advance of the application cycle being announced. The 330 grant is a great means of support for serving underserved patients.

What is a Cost Center?

Setting up a separate “dental cost center” means having an accounting structure where the dental department can track all of its own income, revenues, and expenses separately from the rest of the Health Center. This enables a Dental Director to understand their own expenses and budget and to have a knowledgeable financial picture of the costs of running a dental department. This may prove to be challenging at Health Centers that work on a “total budget” and submit financial reports based on that total budget. NNOHA advocates for Dental Directors to better understand their costs per patient and to monitor expenditures. Creating the dental cost center affords a Dental Director to work collectively with the CFO and CEO in keeping costs low and providing more services to the community.

Have one or more members of the Health Center’s leadership team enroll as HRSA grant reviewers, and gain as much experience as is possible serving on the review panels for the various Section 330 grant opportunities.

To sign up to become a candidate for grant reviews, visit https://grants.hrsa.gov/webReview/
**Benefit Five: National Health Service Corps Resources**

National Health Service Corps (NHSC) resources, through scholarship and loan repayment programs, encourages medical, dental and mental health providers to work in Health Professional Shortage Areas (HPSAs).\(^{17}\)

The scholarship program is one in which students pursuing careers in primary health care—medical, oral health, or mental health—may apply for a NHSC scholarship to pay their health profession education tuition and fees and receive a living stipend (wage). In exchange for a scholarship, the student agrees to practice primary care in an approved site within a high-need HPSA for a number of years proportionate to how many years they have the scholarship (minimum of two years service).

The NHSC Loan Repayment Program (LRP) is one in which primary health care providers serving in an underserved area can apply to NHSC for tax-free loan repayment awards. The initial commitment is for two years for the full-time option, in which the clinician will receive up to $60,000 towards educational debt repayment, or two to four years for part-time options, where the clinician is eligible for an award of $30,000 or $60,000 respectively. This award is above and beyond whatever compensation the center pays the provider and is available to scholars that have completed their scholar obligation term. It is the expectation of the NHSC that the employing Health Center pay a fully competitive salary for the services of the health care provider. The NHSC encourages clinicians in the LRP to apply for additional years of service in exchange for additional loan repayment. Providers willing to stay for a longer time period may receive up to $170,000 in loan repayment for completing a five-year service commitment and, with continued service, may be able to pay off all eligible student loans.

All Health Center facilities are automatically deemed “facility HPSAs” for the particular Health Center site by virtue of their Health Center status. However, Health Centers must still compete for NHSC scholars and LRP participants based on the specified scoring procedure. Once a site is determined to be eligible to participate in the NHSC, appropriate job opportunities are posted on the NHSC scholarship and/or loan repayment vacancy lists.

NNOHA’s suggested reading is *Community Health Centers, a Movement and the People Who Made It Happen*, by Bonnie Lefkowitz.

More information on the NHSC can be found at http://nhsc.hrsa.gov/ or by calling the NHSC Call Center at 1-800-221-9393.

\(^{17}\) More information on HPSAs can be found at http://bhpr.hrsa.gov/shortage/hpsadesignation.htm

\(^{18}\) HRSA Factsheet – Clinician Recruitment and Service: http://www.hrsa.gov/ourStories/factSheets/scholarships.shtml

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“More than 78 percent of National Health Service Corps clinicians continue to work in underserved communities beyond their service commitment to the Corps.”

“52 percent of NHSC alumni remain in service to underserved communities between 1 to 15 years after fulfilling the service commitment.”\(^{18}\)
**Benefit Six: National Network for Oral Health Access (NNOHA)**

NNOHA is a nationwide network of dental providers who care for patients in the safety net, including Health Centers. The benefits of NNOHA to a Health Center oral health program include mentoring for new Dental Directors, a job bank for posting safety-net dental vacancies, online practice management resources, a discussion forum devoted to the unique concerns of safety-net oral health programs, and sponsorship of the annual National Primary Oral Health Conference. Through HRSA support for NNOHA’s services, NNOHA is able to provide support to Health Center oral health programs for minimal membership fees. NNOHA’s mission is to improve the oral health of underserved populations and contribute to overall health through leadership, advocacy, and support to oral health providers in safety-net systems. NNOHA provides resources, support and a network of dental providers to help Health Centers run the most effective oral health programs possible.

**Benefit Seven: National Association of Community Health Centers Resources (NACHC)**

NACHC is the primary national, non-profit, professional membership and advocacy organization that represents federally-funded Health Centers and Federally Qualified Health Center (FQHC) look-alike entities. NACHC’s mission is to promote the provision of high quality, comprehensive health care that is accessible, coordinated, culturally and linguistically competent, and community directed for all medically underserved people. NACHC’s advocacy efforts include, but are not limited to, a congressional advocacy website and a Washington D.C.-based team of advocates. NACHC also provides educational opportunities and serves as a source of information, analysis, research, and training regarding medically underserved individuals and communities. Visit their website for more information at www.nachc.com.

**Benefit Eight: State and Regional Primary Care Associations**

Primary Care Associations (PCAs) are non-profit organizations representing Health Centers and other primary care (safety-net) providers at state or regional levels. PCAs provide a variety of services in support of community-based primary care. Such services may include centralized clinician recruitment, technical assistance in a variety of clinical, management and governance areas, training, conferences and more. PCAs are actively involved in health policy reform at the state level. Some associations oversee a pooled program of liability or group health/medical insurance for their members; some manage statewide information systems or practice management networks. PCAs are a valuable resource for assistance and advice. PCAs have been incredibly important in the development and expansion of Health Centers. Many PCAs have accepted the notion of oral health care being an integral aspect of overall health, and they have made remarkable progress on a statewide basis in gaining more equal funding for oral health services, especially from state Medicaid programs. PCAs have been integral in driving the development of state oral health coalitions and being strong advocates for oral health issues within each state. A savvy Dental Director would take note of the importance of working with his or her state’s Dental Director, PCA leadership, and state coalitions in furthering efforts that support oral health issues.
**Benefit Nine: Benevolent Support**

Many Health Centers have traditionally received a tremendous amount of charitable support. The good that Health Centers do—phenomenal amounts of high-quality, low-cost primary care to the most vulnerable of our nation—has not gone unnoticed by those with resources to share. The area of oral health services is a growing charitable focus for many Health Center benefactors. Their benevolence has resulted in Health Centers receiving millions of dollars dedicated to constructing and operating dental clinics, especially those focused on serving pregnant women and children. Dental Directors should work with their executive team and development department to plan and develop funding proposals to address oral health in their community.

**Benefit Ten: Academic Affiliations**

Health Centers and graduate dental education programs may establish collaborations whereby a Health Center serves as a residency rotation site (and/or as a site for other educational/training activities). Such collaborations often enable Health Centers to expand clinical provider capacity, while allowing the dental residency program to offer dental residents a unique opportunity to hone their clinical skills in community-based settings serving diverse, underserved patient populations across all life cycles. Although residency program models vary, graduate dental education programs are typically limited to third and fourth year dental residents that have month-long rotations at the Health Center under the supervision of the Health Center’s dentists.

The Health Center must retain responsibility and control over activities related to provision of direct patient care services and service delivery, including decisions regarding the scope, location and scheduling of services. It is also critical that the Health Center provide the necessary operatories to accommodate the residents. Health Center dentists often serve as the faculty preceptors (subject to their appointment to the training program), and are accordingly charged with supervising and evaluating the residents’ involvement in the provision of dental services to Health Center patients. The residents must provide services in accordance with the Health Center’s oral health policies and procedures to ensure quality of care for the patient and the safety for the resident.

The dental residency program retains responsibility for the planning, administration and execution of teaching/training activities at the Health Center’s site, and for otherwise operating the residency program in a manner that satisfies applicable accreditation requirements. Teaching/training activities for which the residency program has primary responsibility and control include activities such as classroom teaching, retreats, orientation programs, undergraduate training, faculty/program meetings, curriculum development, resident/program evaluation, resident/student recruitment and selection, and general teaching program administration.

Each Health Center that enters into an arrangement with a dental residency program should execute a formal written agreement to define the responsibilities and duties of each party and to formally document the proper allocation of graduate medical education (GME) teaching/training costs to the GME recipient. Such agreement should specify that the residency program, as the party receiving GME, will be responsible for the payment of residents’/students’ salaries and benefits, as well as a fair allocation of overhead costs directly attributable to any teaching activities, and the purchase of sufficient malpractice/professional liability insurance for the residents.
In addition, the agreement should specify that the cost of space and/or equipment which is used primarily or exclusively for teaching activities would be covered by the residency program. Under most Health Center-dental teaching program partnerships, revenues produced by the students have been retained by the site and faculty training and continuing dental education associated with that training are generally provided at no cost or reduced fees to the dentists or to the organization.

State licensure laws vary with regard to the requirements for allowing dental residents to provide dental services. In order to allow dental residents to provide care, under most states’ licensure laws, a fully licensed employed or contracted Health Center dentist must directly supervise the care that is provided. The standard for such supervision varies among states. Similarly, payors have set varying standards of supervision required for services rendered by residents to be billable. Assuming proper supervision is provided, the services rendered by residents may be billable by the Health Center. Billing for services performed by residents under appropriate supervision is often done using the teaching physician, not the resident, as the rendering provider. Health Centers should seek the advice of qualified counsel to determine what level of supervision is necessary to meet state licensure and scope of practice requirements as well as to ensure that the services are billable to federal, state, and commercial payors.

Health Centers should not enter into a residency agreement expecting the program to be a revenue generator—there are resources required to run a successful program and they do not always increase productivity. However, in the long run, academic affiliations can be good for the residents, the Health Center, and the patients.

Financially, the Health Center is generally barred from assuming the costs of true teaching/training activities not directly related to the provision of oral health services. Accordingly, such costs must be incurred by the educational program or another third party. If a collaboration involves a residency program for which a hospital is receiving federal graduate medical education (GME) reimbursement for the time spent by the resident at the Health Center, that hospital must ultimately incur the related training costs, including the residents salaries and benefits, incurred at the Health Center.

“For over a decade, the Department of Dental Medicine has strengthened its commitment to care for underserved communities by pioneering and forging collaborative alliances and partnerships with Health Centers and other public agencies that serve as catalysts for developing exciting models for dental residency training.”

—Dr. Neal Demby, LMC Dental Director and NNOHA Board Member
The benefits to having an affiliation with an academic institution include, but are not limited to, the following:

- Having more people to provide care to the most vulnerable populations in the community;
- Exposing students to the Health Center model and available career opportunities;
- Helping recruitment for the involved programs; and
- Engaging Health Centers as part of the teaching community.

Post-graduate dental residencies at Health Centers are becoming more common. Lutheran Medical Center (LMC) places dental residents at Health Centers for their advanced clinical training. These dental residents practice under the supervision of Health Center dentists, who are also residency trained, and focus on providing care relevant to their residency training. Lutheran Medical Center dental residents are matched to a Health Center within the Lutheran Healthcare Network for an entire year or two of clinical training. Distance Learning technologies link residents and faculty in a live, interactive advanced education didactic curriculum on a weekly basis and online forums are utilized for literature review and educational discussions of dental disciplines.

The Arizona School of Dentistry and Oral Health (ASDOH), a school of A.T. Still University, has developed a very innovative program: ASDOH’s Integrated Community Service Partnerships (ICSP) place students in community settings to complete a portion of their clinical training during their third and fourth years. ASDOH is unique, in that it searches for dental student applicants with strong community service backgrounds, integrates and emphasizes community and public health principles in their didactic curriculum graduating dentists with a unique understanding of, and desire to serve communities in need. “Our mutual goal is to make a difference in the oral health of those we serve. By becoming partners in the education of the future of the dental profession we can change the face of dental education, and in the process, improve access to oral health care across the nation.”

— Wayne Cottam, ASDOH Associate Dean of Community Partnerships, and NNOHA Board Member
7. THE BALANCING ACT – FUNDING AND COSTS

Health Centers must develop a sound business plan for oral health delivery. The principle elements of a business plan include:

- a linkage between the budget and the goals and objectives specified in the clinical plan and overall Health Center plan; and
- specific costs such as salaries, equipment, supplies, rent, etc.

The program should operate and be tracked as a Cost Center for analysis of cash flow, revenue generation, program costs, and utilization. A Cost Center is a department or unit that is accountable for their expenditures and expenses. This analysis should reflect the degree to which the budget and financial plan assures the appropriate utilization of resources, meets service objectives, and projects the likelihood that the program will remain viable.

Some experts who have been working for a long time with Health Centers suggest that sources of funding for a sustainable oral health program should be equally divided among federal grants, patient revenues and other sources. The ideal revenue mix will be based on the needs assessment and the resources available to address those needs. However, as stated above, a Health Center cannot control or establish a set payor mix if it means closing the Health Center doors to certain groups based on payor source. For example, a Health Center may not state that no more appointments are available for uninsured or medical assistance program patients because the anticipated payor mix is skewed from the ideal. This has become an even more difficult task in certain states with limited or no dental benefits for adult Medicaid patients. Health Centers may have to make certain strategic priorities in order to continue to provide essential dental services with shrinking third party revenue. A Dental Director may need to request additional grant support from their organization in order to insure that patients can continue to access oral health care and at the same time insure that their fee structure does not become a barrier to obtaining dental care.

A Health Center which was once providing a full range of comprehensive adult services may need to look closely at limiting their scope of care in order to remain financially viable if their Medicaid revenues are being severely cut. Expansion of care for those with continued coverage, usually children, may need to be prioritized so that sufficient revenue can be generated to help insure that those without coverage can continue to receive care.

It is important remember that one of HRSA’s expectations is to “maximize revenue from non-federal sources.” Sources of funding aside from the 330 Grant include: Medicaid and CHIP reimbursement; private third party insurance reimbursement, patient payments; private grants and donations; and other public funds, such as tobacco, liquor or sweetened beverage taxes. Patients need to understand that oral health services are not free and Health Centers are obligated to show “due diligence” in attempting to collect fees for services rendered. Each organization must develop a fee structure based on the federal poverty level which does not present an undue burden for their patients to pay. It is important to revisit funding sources often to maximize the diversity of a Health Center’s revenue stream in order to insulate the program from unexpected loss of funding from any one source.
8. **Dental Clinic Costs**

**A. Dental Clinic Start-Up Costs**

There are some basic costs associated with starting up an oral health program. Here is a sample of start-up costs based on real-life data from a rural site in Colorado. Please be aware that costs vary by region and each center’s final costs will likely be different. Note that this sample does not include IT costs that may be included with electronic dental records or digital radiography. Additional information on what is included in the categories below can be found in Appendix A. Additional samples can also be found in the online Safety Net Dental Clinic Manual at www.dentalclinicmanual.com.

### DENTAL COST BASICS SAMPLE

<table>
<thead>
<tr>
<th><strong>Building/Leasehold Costs</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Central Costs</strong></td>
<td></td>
</tr>
<tr>
<td>Central Equipment, Instrument/Supply Costs</td>
<td>$76,234.00</td>
</tr>
<tr>
<td>Central Cabinetry Costs</td>
<td>$42,000.00</td>
</tr>
<tr>
<td>Office Equipment and Computers</td>
<td>$11,785.00</td>
</tr>
<tr>
<td><strong>Total Estimated Central Costs</strong></td>
<td>$130,019.00</td>
</tr>
<tr>
<td><strong>Operatory Costs</strong></td>
<td></td>
</tr>
<tr>
<td>Operatory Equipment Supply Costs</td>
<td>$46,917.00</td>
</tr>
<tr>
<td>Cabinetry Costs</td>
<td>$4,200.00</td>
</tr>
<tr>
<td>Central Equipment (compressor, vacuum, sterilization, etc.)</td>
<td>$20,000</td>
</tr>
<tr>
<td><strong>Total Estimated per Operatory Costs</strong></td>
<td>$51,117.00</td>
</tr>
</tbody>
</table>

Leasehold Improvements $85 / Sq Ft.
Build $165 / Sq Ft.

**Example – 3 Operatory Facility**

- 2000 Sq. Ft.
- Central Costs $130,019.00
- 3 Operatories $153,351.00
- Leasehold $170,000.00
- Build $330,000.00
- **Total 3 Operatory Facility Costs – Leasehold $453,370.00**
- **Total 3 Operatory Facility Costs – Build $613,370.00**

**Example – 6 Operatory Facility**

- 3000 Sq. Ft.
- Central Costs $130,019.00
- 6 Operatories $306,702.00
- Leasehold $255,000.00
- Build $495,000.00
- **Total 6 Operatory Facility Costs – Leasehold $691,721.00**
- **Total 6 Operatory Facility Costs – Build $931,721.00**
## OPERATING COSTS

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentist Salary</td>
<td>$125,000</td>
</tr>
<tr>
<td>Dental Hygienist Salary</td>
<td>$68,000</td>
</tr>
<tr>
<td>Dental Assistant Salary</td>
<td>$30,000</td>
</tr>
<tr>
<td>Fringe</td>
<td>$55,440</td>
</tr>
</tbody>
</table>

### COSTS FOR A 3-OPERATORY FACILITY

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Supply costs – 3 Operatory</td>
<td>$40,000</td>
</tr>
<tr>
<td>Operating costs (rent @ 27/Sq Ft – for 2000Sq Ft)</td>
<td>$54,000</td>
</tr>
<tr>
<td>Contractual costs (mainly dental lab)</td>
<td>$10,000</td>
</tr>
<tr>
<td>Education, Training, Conferences</td>
<td>$8,000</td>
</tr>
<tr>
<td>Maintenance and Repair</td>
<td>$5,000</td>
</tr>
<tr>
<td>Dues</td>
<td>$3,000</td>
</tr>
<tr>
<td>Recruitment</td>
<td>$10,000</td>
</tr>
<tr>
<td>Contractual (specialty care)</td>
<td>$10,000</td>
</tr>
<tr>
<td>Administrative costs</td>
<td>$47,213</td>
</tr>
</tbody>
</table>

### Example 1 Dentist, 1 Dental Hygienist Health Center Practice

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentist</td>
<td>$125,000</td>
</tr>
<tr>
<td>Dental Hygienist</td>
<td>$68,000</td>
</tr>
<tr>
<td>Three Dental Assistants</td>
<td>$90,000</td>
</tr>
<tr>
<td>Fringe of 24% for $283,000</td>
<td>$67,920</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$350,920</strong></td>
</tr>
<tr>
<td>Annual Supply Costs–3 Operatories</td>
<td>$40,000</td>
</tr>
<tr>
<td>Operating Costs (rent $27/ft)</td>
<td>$54,000</td>
</tr>
<tr>
<td>Contractual costs (dental lab)</td>
<td>$10,000</td>
</tr>
<tr>
<td>Education, Training, Conferences</td>
<td>$8,000</td>
</tr>
<tr>
<td>Maintenance and Repair</td>
<td>$5,000</td>
</tr>
<tr>
<td>Dues</td>
<td>$3,000</td>
</tr>
<tr>
<td>Recruitment</td>
<td>$10,000</td>
</tr>
<tr>
<td>Contractual (specialty care)</td>
<td>$10,000</td>
</tr>
<tr>
<td>Administrative costs (12%)</td>
<td>$96,058</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$236,058</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$586,978</strong></td>
</tr>
</tbody>
</table>

B. Salaries

Salaries are generally the largest portion of the budget. A Health Center administration’s responsibility is to pay Health Center employees an equitable salary for the skills they offer based on competitive and comparative rates in the area. When benefits and bonuses are factored into salaries, they can be comparable to compensation offered in private practice. NNOHA and the Baylor College of Dentistry conducted a salary survey in 2009-2010. The final results are available on NNOHA’s website. http://www.nnoha.org/workforce.html.

All dentists participating in the survey were grouped into five salary categories for statistical purposes. The category of $95,000-$110,000 had the highest percentage of respondents at 26.7%. Next was the category of $110,001-$125,000 (24.6%), followed by >$140,000 (19.0%). Similarly, dental hygienists were grouped into five salary categories. The $50,001-$60,000 category (35.5%) was the largest category chosen by respondents. This was followed by $40,000-$50,000 (25.2%), then by $60,001-$70,000 (15.0%). In contrast, non-salaried or part-time dentists reported a mean hourly wage of $63.17 with a median of $60/hour. According to the American Dental Association, the reported mean income for private practice General Practitioners surveyed in 2009 was $207,210. Dental hygienists reported a mean hourly wage of $29.64 with a median of $30/hour. According to data it released in 2009, the Bureau of Labor Statistics (BLS) states that Dental Hygienists in the U.S. earn an average annual salary of $67,860 or $32.63 per hour. Salaries will be covered more in depth in the Workforce & Staffing chapter.

The benefits of working at a Health Center can be substantial. When a prospective employee compares straight starting salaries, they may not realize how all of the benefits of working in a Health Center can add up. An Employer Compensation Analysis allows for a side-by-side comparison of the value of working in a Health Center. One example can be found on NNOHA’s website: http://www.nnoha.org/?page_id=46011. This tool is useful to illustrate to prospective job applicants or current staff the value of employer provided benefits.

**SOME EMPLOYER-PROVIDED BENEFITS COULD INCLUDE:**

- Vacation Time
- Continuing Education Time & Costs paid
- Personal Time
- Paid Sick Leave
- Paid Holidays
- Other days off with pay
- Professional Organization Dues
- Malpractice premiums
- Employer contribution towards health benefits
- Life Insurance
- Disability benefits
- Pension plans
- Other fringe benefits

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19 American Dental Association, Survey Center, Surveys of Dental Practice
9. **Dashboards**

A dashboard is a brief, easy-to-read report that gives a director highlights of the financial status of the department. Whether this data is readily available may be a good indicator of the status of the oral health program in a Health Center. Frequently, the financial aspects of an oral health program are not well understood by Health Center administration. Data that may be routinely provided for the medical program is either not determined for the oral health program or it is not made available to the Dental Director for review. It is important for the Dental Director to request and review this data on a regular basis.

The first step to managing the fiscal status of an oral health program is to ascertain if the information in the sample dashboard is being produced on a monthly basis. If not, the CEO/CFO and/or IT staff should be approached to begin developing a system to produce this key data. It is important to develop a collaborative relationship with the CFO and IT staff of the Health Center, to work together on the oral health program data requirements, which may change over time.

The following is a sample dashboard that has some basic information that a Dental Director may want to track:

![Sample Dashboard](image-url)

Data checklist adapted from The Good Practice: Treating Underserved Dental Patients While Staying Afloat. Published by the California HealthCare Foundation August 2008.
10. Monitoring an Oral Health Program

Very few dentists have received formal training in finance or accounting. To most effectively manage an oral health program and serve the largest number of individuals, it is essential to understand the terms and financial reports that are being used to discuss the program. The Dental Director should be able to identify and have timely access to the necessary financial data that will assist in the evaluation of the fiscal status of the oral health program. The previous sample dashboard can be used by a clinical leader who is interested in understanding fiscal management of the oral health program. It includes key fiscally related information that a Dental Director should have available on a monthly and yearly basis to evaluate their oral health program. Readers of this chapter are encouraged to attempt to fill in the information to test how much is readily known or available. Please note that this sample only includes financial measures. The vitality of a Health Center is not measured by finances alone – a complete dashboard must include clinical quality measures appropriate to the individual center’s setting and treatment modalities provided. Sample quality measures will be included in a subsequent chapter on Quality.

Knowledgeable staff should understand the terms and accounting language that may be used to discuss the program. It may be a new skill set for some staff. Not all of the following terms will be necessary to know, but they may be useful in discussing oral health programs with the CFO.
BASIC ACCOUNTING TERMS

Accounts Payable – Money owed by an organization to its suppliers and/or vendors for goods or services purchased.

Accounts (or Grants) Receivable – Money owed to an organization by its suppliers and/or vendors for goods and services sold (or money committed to an organization through a grant or donation).

Accrued Expenses – Expenses incurred, but not yet paid for, during an accounting period. Generally recorded as a current liability on the balance sheet. Examples include: accrued wages payable, accrued sales tax payable, and accrued rent payable.

Administrative Overhead – Costs that cannot be identified with a program activity but are needed for the general administration of the organization. This expense is often distributed among programs based on a formula.

Balance Sheet – Statement showing an organization’s financial position (i.e., the magnitude, distribution and nature of assets, liabilities and net assets) at the close of business on a particular date. Also known as statement of financial position.

Budget – Detailed breakdown of estimated income and expenses that can be used as a tool for projecting revenue and expenditures for the ensuing fiscal year.

Cost Center – Organizational unit headed by a manager or a group of managers that are accountable for costs/expenses.

Direct Expenses – Expenses that can be traced directly to cost for the oral health services. It includes expenses for labor, material, etc. Also called “direct costs.”

Financial Statement – Written report that quantitatively describes the financial health of an organization. A complete financial statement includes a balance sheet, income statement, statement of cash flows, and often a statement of functional expenses. Financial statements are usually compiled on a quarterly and annual basis.

Indirect Expenses or Indirect Costs – Costs that are shared by many services concurrently, for example, maintenance, administration, advertisement, equipment, electricity, water. Also referred to as overhead costs.

Income Statement – Summary of the revenue and expenses of an organization during an accounting period. Also known as statement of activities or profit and loss statement.
**BASIC ACCOUNTING TERMS (cont.)**

**Liabilities** – Items owed by an organization or claims against its assets. Examples include: accounts payable, accrued salaries and benefits, accrued payroll taxes, deferred revenue, lines of credit, construction loans, current portion of long-term debt, short-term notes payable, and long-term debt. See assets and net assets.*

**Net Assets** – Difference between total assets and total liabilities. In for-profit accounting, known as the net worth or equity of an organization. Net assets can be categorized as unrestricted, temporarily restricted, or permanently restricted.*

**Payor (Payer) Mix** – Combination of reimbursement sources (payers) that pay for patients’ dental care [or other services].****

**Revenue per Encounter** – Total revenue divided by total number of encounters.

**Revenue Sources** – Sources of income for an organization. For Health Centers, they include federal, state or foundation grants, contracts, Medicaid, CHIP, Medicare, Insurance and Patient Payment.

**Statement of Cash Flows** – Summary of the sources and uses of cash that reconciles cash at the beginning of the year with cash at the end of the year. Organized into the following three categories:

- **Cash flows from operating activities** – Cash changes in working capital items, such as accounts and grants receivable, inventory, accounts payable, accrued liabilities and deferred revenue.
- **Cash flows from financing activities** – Payments and receipts from lines of credit, notes payable, term loans, etc.
- **Cash flows from investing activities** – Payments and receipts from acquisitions or sales of marketable securities, as well as from fixed assets, such as plant, property, and equipment.*

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* Nonprofit Finance Fund’s Glossary of Financial Terms

** NACHC Information Bulletin #8: Financial Information Needed by Health Center Boards for Effective Oversight

*** Nonprofits Assistance Fund Glossary of Financial Terms
  http://www.nonprofitsassistancefund.org/pages/glossary

**** Nonprofit Good Practice Guide: Glossary

***** Safety Net Dental Clinic Manual
11. Resources for Self-Learning

NNOHA has compiled five recommendations for how Dental Directors can maximize their understanding of the fiscal management of oral health programs:

a) Partner with the CFO, Executive Director and IT Staff

It is strongly recommended that each Health Center Dental Director develop and nurture a relationship with their Health Center’s Chief Financial Officer (CFO), and the Executive Director (ED). Health Center CFOs generally know little about clinical dentistry; but they have an outstanding understanding of the intricacies of Health Center finances. This includes the financial benefits that Health Centers have (explained in an earlier section of this chapter) and their expertise can be invaluable in the development and success of the Dental Director and Dental Department. The most successful Health Center Dental Directors have a great working relationship with their CFO. In many cases, the Dental Director and CFO have regularly scheduled (weekly, semi-weekly or monthly) meetings, and assist each other in the achievement of the Health Center’s and the Dental Department’s respective mission and goals.

b) Attend NNOHA’s National Primary Oral Health Conference

The conference is a unique gathering of Health Center dental providers and the resources, education, networking, and support opportunities. The Dental Director should bring his/her Health Center’s CFO and ED to the National Network for Oral Health Access’ (NNOHA) annual National Primary Oral Health Conference. CFO attendance at NNOHA’s annual conferences with the Health Center’s Dental Director can be a sentinel event in the development of successful Dental Directors and Dental Departments.

c) Consult the Online “Safety-Net Dental Clinic Manual”


The DCM was developed and is maintained by the Indian Health Service; the Ohio Department of Health, Bureau of Oral Health Services; the Association of State and Territorial Dental Directors, and NNOHA. The website is hosted by National Maternal and Child Oral Health Resource Center. The DCM has a user’s guide, introduction, and five content chapters:

1. Partnerships and Planning
2. Facilities and Staffing
3. Financing
4. Clinic Operations
5. Quality Assurance/ Improvement
The User’s Guide, chapters, and appendices are downloadable.

Chapters 1 and 2 are particularly useful in the planning phases for developing a new Health Center oral health program. Chapter 3 has useful information on revenue sources, payer mixes, and financial feasibility. Chapter 4 covers staffing and how to establish policies and procedures, and Chapter 5 covers quality assurance and accreditation. The manual was not designed for Health Center programs, but for safety-net dental programs, so some advice may not be a perfect fit for Health Centers; however, acquiring and carefully reading the DCM will improve the learner’s knowledge on how to lead a successful Health Center oral health program.

d) Attend the National Association of Community Health Centers’ Two-Day Seminar on Health Center Financial and Operations Management

As mentioned in the NNOHA Health Center Fundamentals publication, http://tinyurl.com/HCFundamentals, the Dental Director should be considered an integral part of the overall Health Center leadership/management team. This training is received by new Health Center EDs, CFOs, and Chief Operating Officers (COOs). There are three levels of training (Beginning, Intermediate and Advanced) that the Dental Director should attend in sequence. Overall course content ranges from what are the distinguishing characteristics of a Health Center to understanding and negotiating managed care contracts. Ideally, the Dental Director would attend all three sessions with his/her CFO and Executive Director to facilitate better dialogue and understanding between that leadership team. This would be true even if the CFO and Executive Director had attended the sessions before and perhaps even multiple times. Their attendance with the Dental Director will help immeasurably in the subsequent application of the coursework. Information about course offerings and other information that supports Health Center dental services are available at www.nachc.com.

e) Attend Commercially-Focused Dental Practice Conferences

The Dental Director and CFO should attend commercially focused dental practice seminars together. While it is true that Health Center oral health operations have some unique aspects, and a commercially-focused dental practice seminar simply would not be an appropriate first step in gaining an understanding of successful Health Center oral health operations, it is also true that Health Center dentistry can learn a lot from the private, commercially focused dental practice world. One example would be to have a private practice dentist sitting on the Health Center’s Board. Another outstanding conference held annually is called the Business of Dentistry (www.businessofdentistry.com). Focus areas include maximizing practice income; learning effective leadership skills; increasing practice productivity; strengthening practice management software knowledge; and continually developing and improving the practice environment – all worthy goals of both Health Center and other dental practices.

There are additional sources available for support, but NNOHA believes that if a new Dental Director were to follow these five recommendations, it could improve Health Center Dental Directors’ knowledge base and their oral health programs for the better.
12. Resources for Starting an Oral Health Program

The number of Health Centers initiating or expanding their oral health programs is at an all-time high. Oral health is clearly a service option that has a need, momentum, and opportunities. If a center’s administration finds that they are ready to pursue a new start or an expansion of oral health services, the first recommendation is to review the BPHC/HRSA regulations and guidance found in section 3 of this chapter, then, the following may be helpful resources for the developmental phases of a program:

- The Online Safety Net Dental Clinic Manual, particularly Chapter 1, Partnerships & Planning and Chapter 2, Facility Design & Staffing. The manual is not geared specifically towards Health Center programs, but provides valuable recommendations for safety-net programs: http://www.dentalclinicmanual.com/.

- Safety Net Solutions offers support services for new start Federally Qualified Health Center programs. The staff is highly respected and experienced, though centers should be aware it is a paid service: http://www.dentaquestinstitute.org/safetynetsolutions/new-dental-startup/.

- Capital Link is an organization that assists Health Centers and primary care associations in accessing capital for building and equipment purchases. They provide extensive technical assistance throughout the entire capital development process, from initial idea through completion of the new facility or implementation of new equipment. Capital Link is partially supported by a HRSA Cooperative Agreement: http://caplink.org/.

- The Clinical Directors Network (CDN) has a variety of resources including a series of webinars related to oral health, some coordinated by NNOHA: http://www.cdnetwork.org/NewCDN/LibrarySearch.aspx

- NNOHA’s website has compiled some resources on How to Start a New Dental Clinic on the website at http://www.nnoha.org/practicemanagement/startclinic.html. Some resources include equipment recommendations, staffing guidelines, and information on mobile/portable programs. Successive chapters of this operations manual series are also recommended.

- Peer to Peer support may be the most valuable resource as few learning opportunities compare to learning from someone who has already gone through the same challenges. Staff of proposed new starts are highly encouraged to contact their peers either through the state Primary Care Association, state oral health networks, national oral health conferences (such as NNNOHA’s National Primary Oral Health Conference), or through NNOHA.
13. **Summary**

Health Center Dental Directors have a unique opportunity to provide needed health care to underserved populations and to be strong leaders by participating in the financial decisions that are made for the Health Center’s oral health program. This chapter summarized basic financial terms and tools to support Dental Directors in running a high-quality oral health program. There are a number of financial benefits that help Health Centers along the path of providing health care to those in need. There are differences in the way Health Center oral health programs are funded compared to private practice, but ultimately both private and public entities must achieve fiscal balance and viability to continue to be able to serve patients. Health Centers and their dental clinics are providing needed oral health care services to millions of Americans who could not otherwise access care – becoming knowledgeable about the financial aspects of the Health Center will help the program become more efficient, productive, and ultimately able to provide more care to the patients in the community.

“So let us summon a new spirit of patriotism, of responsibility, where each of us resolves to pitch in and work harder and look after not only ourselves but each other.”

~President Barack Obama
14. **Frequently Asked Questions**

**Q:** Does a Health Center’s fee schedule and sliding fee scale for dental services have to be the same as that used for medical services?

**A:** No.

**Q:** Can a Health Center implement a different nominal fee for dental services from that charged for medical services?

**A:** Yes. The Health Center management team, in conjunction with the Health Center’s Board of Directors, can determine what nominal fee makes the most sense for each department (e.g., medical, dental, behavioral health).

**Q:** Should some portion of a Health Center’s Federal (Section 330) grant be allocated to dental services?

**A:** Yes. 330 funds are not provided for “medical” or “dental.” They are provided to support the provision of all services rendered within the Health Center’s scope of project to underserved clients who are at or below 200 percent of the federal poverty level. The funds are to be used to supplement the nominal fee charged to patients at or below 100 percent of poverty, and the schedule of discounts charged to patients between 101-200 percent of poverty.

**Q:** Can a Health Center charge a co-pay (down payment) for the next dental appointment to prevent no-shows? For instance, can we charge a $15 payment for a patient to schedule an appointment for treatment?

**A:** There are numerous reasons why charging a co-pay for a service not yet rendered would not be appropriate or pass legal muster, including, but not limited to the prohibition on Health Centers’ allowing the patient’s inability to pay to become a barrier to care. In the circumstance you describe, requiring payment before care (or an appointment for care) is given can be interpreted as an improper barrier to care based on ability to pay. Additionally, a co-pay is a payment made in exchange for medical/dental services rendered, not as compensation for an agreement to schedule such services. This situation is different from common fiscally prudent practices, such as not initiating a rehabilitative service that involves a laboratory fee (e.g. crown or denture) until the patient has paid a certain percentage of the sliding scale fee (usually enough to cover the lab expense).
Q: If my Health Center doesn’t receive any 330 funds targeted for dental services, can’t we do whatever we want in regards to services?

A: No. It is not uncommon to think that because a center does not have 330 funds targeted to dental that they don’t have to abide by scope of project & scope of practice regulations; however, 330 funds are supporting the entire Health Center, regardless of whether a portion of the funds were awarded to target specific services.

Q: What are the average and starting salaries of staff dentists, dental hygienists and Dental Directors at Health Centers?

A: Based upon surveys done in 2009 by NNOHA in partnership with Texas A&M’s Baylor College of Dentistry, the average salaries for staff dentists are $110K-$125K. The average salaries for hygienists are $50K-$60K. More information on adequate salary and benefits will be included in the subsequent Workforce & Staffing chapter of this manual.

Q: Are dental hygienists financially viable providers?

A: Dental hygienists are an integral part of the oral health team, and for the purposes of this chapter, we examine only the financial aspects. Historically, dental hygiene programs have been net revenue producers: the revenue they generated exceeded the costs of running the program. And if nothing else, these programs precluded having to use a dentist’s time to do work a dental hygienist could perform at a lower cost. What has changed, and continues to change, is what dental hygienists are legally allowed to do. Health Center dental hygienists should work to the full scope of practice allowed in their particular state. Note that dental hygienists are reimbursed differently by Medicaid in different states: http://www.adha.org/governmental_affairs/downloads/medicaid.pdf

Q: How do you establish starting salaries?

A: Reasonable salaries are determined by several factors. “It is important to know the market in which you are competing for staff, and to determine what you can afford to pay and sustain relative to the market. Higher compensation generally will attract more experienced people who may be more productive.” To get some ideas, you may check regional salary surveys (http://www.dentalclinicmanual.com/chapt3/1_16.html). In addition to experience, you have to account for benefits you are including in the package. It should be noted that salaries could be about 60-70% of your overall budget.

Q: How do I set up a schedule of discounts?

A: First, make sure the overall fee schedule is consistent with locally prevailing rates and covers the reasonable costs of operation. e.g.: Do not charge $60 per extraction as a full fee when the market rate is $125. Then, set the sliding fee scale for patients with annual incomes between 101-200% of the federal poverty level appropriately, such as 25 percent of a $125 fee, instead of 50 percent of a $60 fee. This way you won’t devalue the services provided, and if someone has insurance, you will collect the actual charge of providing care. Set a nominal fee that does not create a barrier to care for patients with incomes at or below 100% of the federal poverty level. Update your fee schedule, sliding fee scale, and nominal fee annually.

Q: Can you limit your program for Medicaid-only patients?

A: No. Health Center programs may not limit access to their services based on ability to pay, financial status, or payor source. Health Centers may give priorities to populations of focus such as pregnant women or children, which in turn could affect payor mix, but only if the Health Center needs assessment clearly demonstrates a need for these populations.

Q: Can I get paid on a fee-for-service basis for Medicaid dental services?

A: Each state has different nuances in dealing with the PPS rate. Contacting your State Medicaid Office is the best way to get your answer. Find a list of state contacts at http://www.medicaiddental.org/index.html.

Q: How do I provide service to everyone without regard for payment and still be able to operate my program?

A: Not all programs can have the “ideal” patient mix and must maintain a close eye on their bottom line. Each program needs to analyze their sources of revenue and develop strategies to maximize collections from all sources. Although Health Centers are not permitted to deny services based on a patient’s inability to pay, no one states that the need for payment should be totally disregarded. If a program does not generate and collect sufficient revenue, it may cease to be sustainable. No margin... no mission! Patients should be encouraged to pay what they can at the time of service and efforts should be taken to collect the balance. Remember, the chances of collecting the fees generated by your providers diminish significantly once the patient has left your office, and selecting the right individuals for collecting this payment is crucial. More information is included in the section of this chapter entitled “The Balancing Act.”

Q: Are Health centers “free clinics?”

A: No. Health Center dental clinics do not see patients “for free.” They cannot deny services to any individual because of an individual’s ability to pay. This means that, occasionally, individuals who receive care may not pay their bills, but this is no different than private practice. Patients receiving routine comprehensive care are expected to make payment, based on the Health Center’s sliding fee schedule and corresponding schedule of discounts, at the time of their visit, or they will be billed for services, as they would be at a private practice.
Do Health Center oral health programs create unfair competition with private practice?

A: Health Center oral health programs may indeed be “in competition” with private practice dentists in some cases. As in real estate, location is everything. In a rural area, the Health Center oral health program may be the only dental provider in the area and there is no competition. In other locations, the Health Center may be the only dental provider in the area that accepts government sponsored insurance plans, such as Medicaid. Again, there may be little to no competition for patients covered by those particular plans.

Certainly, in some areas where private practice providers accept government sponsored insurance plans, there may be competition between private practices and Health Centers. In those instances, private practices and Health Centers compete for patients based on traditional criteria, such as accessibility, office appearance, staff friendliness and perceived quality of care.

Generally, Health Center oral health programs are not in competition with private practice for indigent patients. As mentioned previously, 200 percent of the 2009 federal poverty level is an annual income of $21,660 for an individual. Individual indigent patients with incomes of $21,660 a year or less will most likely not be able to afford full-fee dental care and will most likely not be covered for dental services by commercial health insurance.

Do Health Center oral health programs have an unfair advantage because “they are funded by the government?”

A: The idea that clinics somehow have an unfair advantage because “they are funded by the government” is not true. As has been seen, the amount of a Health Center’s total 330 grant allocated to the oral health program covers only a portion of total expenses.

Section 330 grants are intended to support costs of care provided to low-income and indigent patients, typically defined as at or below 200% of the federal poverty level. Therefore, as stated above, Section 330 grant funds are not helping Health Centers compete for patients seen by private practices—insured patients and self-pay patients with resources.

Health Centers may also serve as a referral base to private practice. NNOHA encourages private practice providers to serve Medicaid and uninsured patients and encourages its members to partner with their private practice counterparts to benefit the health of their communities.
15. Links

The following resources may be beneficial for a Health Center developing a new start oral health program or for centers looking for guidance on Financials as they relate to dental clinics.

- 340b Program: http://www.hrsa.gov/opa/
- American Academy of Pediatric Dentistry: www.aapd.org
- American Dental Association: www.ada.org
- Association of State and Territorial Dental Directors: www.astdd.org
- Business of Dentistry Conferences: www.businessofdentistry.com
- California Dental Association: http://www.cda.org/
  Thank you to the California Dental Association – portions of this chapter were original published in the May 2009 CDA journal focused on Health Center dental practice. http://cda.org/page/Library/cda_member/pubs/journal/jour0509/index.html
- Capital Link: http://caplink.org/
- Children’s Dental Health Project: www.cdhp.org
- Dental Pipeline Program: http://www.dentalpipeline.org/
- Environmental Drift in Health Center Dental Practice Management: http://www.cda.org/library/cda_member/pubs/journal/jour0509/russell.pdf
- Hometown Partnerships for Oral Health: http://www.atsu.edu/asdoh/community/hometown.htm
- Lutheran Medical Center: http://www.lutheranmedicalcenter.com/
- Medicaid/SCHIP Dental Association: www.medicaiddental.org
- National Association of Community Health Centers, Inc.: www.nachc.org
- Health Center Financial and Operations Management Seminars
- National Center for Health in Public Housing: www.healthandpublichousing.org
- National Health Care for the Homeless Council: www.nhchc.org
- National Health Service Corps: http://nhsc.hrsa.gov/
- National Network for Oral Health Access: www.nnoha.org
- Safety Net Dental Clinic Manual: www.dentalclinicmanual.com
- Sliding Fee Scale Requirements: http://www.bphc.hrsa.gov/technicalassistance/taresources/slidingrequirements.html
16. HEALTH CENTER FINANCIALS WORKSHEET

1. Should a Health Center oral health program be assigned a reasonable portion of the total Health Center 330 grant?
   a. Yes
   b. No
   c. Depends on the situation

2. Are Health Centers obligated to apply a sliding fee scale to charges for services provided to patients with annual incomes between 101 and 200 percent of the federal poverty level (FPL), and, at most, charge a nominal fee for patients at or below 100% of FPL?
   a. Yes
   b. No

3. How many of the “Top 10” financial benefits of working in a Health Center can you name:
   1. ____________  5. ____________  8. ____________
   2. ____________  6. ____________  9. ____________
   3. ____________  7. ____________ 10. ____________
   4. ____________

4. What service(s) does the National Health Service Corps provide?
   a. Scholarship program  b. Job Board
   c. Loan repayment program  d. All of the above

5. What area(s) of the financial operations of your Health Center are the most challenging for you? What is one thing you could do to become savvier about financials?

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

6. What three things can you provide to your Executive Team or CFO to help them better understand the business of dentistry?

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
**Appendix A**

**Dental Cost Basics Category Details:**

<table>
<thead>
<tr>
<th>Central Equipment Costs</th>
<th>Equipment/Instrument Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Asistina Handpiece Station</td>
<td>• ADEC Cabinets</td>
</tr>
<tr>
<td>• Miele dishwasher</td>
<td>• Cavitron</td>
</tr>
<tr>
<td>• Processor, X-Ray</td>
<td>• Patient Chair</td>
</tr>
<tr>
<td>• X-Ray Daylight Loader</td>
<td>• Doctor’s Stool</td>
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<tr>
<td>• Dark-Room Light</td>
<td>• Assistant’s Stool</td>
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<tr>
<td>• N20 Manifold Alarm</td>
<td>• Doctor’s Mount Tubing</td>
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<tr>
<td>• Autoclave X 2</td>
<td>• Track Light</td>
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<tr>
<td>• Sterilization Items</td>
<td>• View Box</td>
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<tr>
<td>• Lab</td>
<td>• Slow Speed Motor</td>
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<tr>
<td>• Vacuum Pumps</td>
<td>• X-Ray Unit</td>
</tr>
<tr>
<td>• Compression</td>
<td>• N20 Flow Meter</td>
</tr>
<tr>
<td>• Rotary Equipment</td>
<td>• Hoses for N20</td>
</tr>
<tr>
<td>• X-Ray Duplicator</td>
<td>• Curing Light</td>
</tr>
<tr>
<td>• Vitality Scanner</td>
<td>• Wig L Bug</td>
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<tr>
<td>• Panorex, X-Ray</td>
<td>• Instrument Cassettes</td>
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<td></td>
<td>• X-Ray Holder</td>
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<td></td>
<td>• X-Ray Apron</td>
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<td></td>
<td>• Floss Dispenser</td>
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<td></td>
<td>• Gauze/Etc for Tubs</td>
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<td></td>
<td>• Amalgam Instruments/3 Cassettes</td>
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<td></td>
<td>• Composite Instruments</td>
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<td></td>
<td>• Endo Instruments/Sm and Lg</td>
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<td></td>
<td>• Crown Instruments</td>
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<tr>
<td></td>
<td>• Tubs, Probs, Mirrors, Explorers</td>
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<td></td>
<td>• Rubber Dam Forceps, Frames,</td>
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<tr>
<td></td>
<td>• Mouth Props, Snap a Rays, Etc.</td>
</tr>
<tr>
<td></td>
<td>• Handpieces</td>
</tr>
</tbody>
</table>
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The National Network for Oral Health Access (NNOHA) is a nationwide network of Health Center dental providers. These providers understand that oral disease can affect a person’s speech, appearance, health, and quality of life and that inadequate access to oral health services is a significant problem for low-income individuals. The members of NNOHA are committed to improving the overall health of the country’s underserved individuals through increased access to oral health services.
MEMBERSHIP APPLICATION
For calendar year 2011 (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 MEMBERSHIP ($50.00) ☐ ASSOCIATION MEMBERSHIP ($350.00/$150.00)
☐ DENTAL HYGIENIST / DENTAL ASSISTANT ($30.00) ☐ STUDENT MEMBERSHIP (Free)
☐ ORGANIZATIONAL MEMBERSHIP ($350.00)

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

For more information, contact:
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The National Network for Oral Health Access (NNOHA) is a nationwide network of dental providers who care for patients in safety-net systems. The members of NNOHA recognize the importance of oral health as part of overall health and are committed to improving the health of the country’s underserved individuals. NNOHA was founded in 1991 by a group of Health Center Dental Directors who recognized the need for peer-to-peer networking and collaboration to effectively run Health Center oral health programs.

NNOHA’s VISION

Individuals and communities are aware of the importance of oral health to overall health, engage in recommended oral health practices, and receive affordable, high quality oral health services.