The mission of the National Network for Oral Health Access (NNOHA) 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.
**Executive Summary**

Workforce issues are a primary concern for Health Center oral health programs that are struggling with recruitment, retention, training, salary and benefit packages and high turnover rates. NNOHA recognizes that a well-trained and committed workforce is required for Health Centers to manage the growing needs for dental services, and to enable the Health Center to fulfill its mission of providing excellent oral health care to its patients while improving the overall health of the community.

This chapter provides helpful tools and resources for tackling the issues related to workforce, and addresses the following questions:

- What are the recommended staffing and equipment ratios?
- What staffing models are applicable for Health Center oral health programs?
- What are some recruitment strategies for Health Center oral health programs?
- What should be included in oral health job descriptions?
- How can Health Center oral health programs retain their staff?
- How can oral health providers work effectively and efficiently as part of the Health Center team?

Health Center oral health programs face the vital task of serving a growing number of patients in the years to come. To meet this growth in demand, the number of oral health providers needs to increase at an unprecedented rate. By adopting creative workforce strategies, Health Centers can view this challenge as an opportunity to increase their capacity and address disparities in care.
# WORKFORCE AND STAFFING

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1. INTRODUCTION

Health Center oral health programs have grown significantly over the past decade. In 2010, more than 800 Health Centers (72 percent of all Health Centers) offered dental services on-site, compared to 430 in 1999. Health Care Reform will provide access to government health care programs to an estimated 32 million Americans, in addition to 7 million children. This will present extraordinary challenges and opportunities for Health Centers in meeting the needs of the underserved in coming years. As Health Centers add more dental programs, the need for quality providers committed to caring for underserved patients will grow as well.

Health Center oral health providers have the challenging mission of eliminating oral health disparities in underserved communities where patients generally exhibit greater degrees of dental disease due to lack of access and awareness. Health Centers have provided care for over 3.75 million dental patients (approximately 1.2% of the total population of the US) in 2010 and employed or contracted with approximately 1.5% of 186,000 professionally active dentists in the country. While on the surface, this may seem appropriate, the greater needs of the underserved vastly increase the workload of the Health Center dentists. Effectively managing and expanding the Health Center oral health workforce could be one piece of the puzzle in addressing the ever-increasing needs in underserved communities.

This chapter provides helpful tools and resources related to workforce, one of the top concerns for Health Center oral health programs. It offers insights on the subjects of frequently asked questions such as productivity standards, nontraditional staffing, recruitment strategies, and salaries.

2. LEARNING OBJECTIVES

Upon completing this chapter, the reader will gain a better understanding to:

- Identify recruitment and retention strategies for the Health Center oral health program
- Work effectively and efficiently with the Health Center team
- Create a collaborative working environment
- Develop an ideal staffing ratio for their program
- Develop ideas and strategies for training and evaluating staff
- Locate beneficial resources

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1 Terminology: “Health Center” is the term commonly used to refer to programs funded through Section 330 of the Public Health Service Act. It includes 330(e) Community Health Centers, 330(g) migrant health centers, 330(h) healthcare for the homeless and 330(i) healthcare for residents of public housing.

2 Uniform Data System – Health Resources and Services Administration (2010).

3 Under the Affordable Care Act, more than 32 million uninsured Americans will have access to coverage options (http://www.healthcare.gov/lawinfocus/providers/index.html) and CHIP will double the number of children enrolled from 7 million to 14 million.

3. **Relevant Authorities**

**A. SECTION 330 OF THE PUBLIC HEALTH SERVICE (PHS) ACT**

Section 330 of the Public Health Service (PHS) Act (Section 330) is the main authorizing legislation for Health Centers. It provides definitions, information on grants, population focus, audits and other general information. The entire text is available at the link above.

**B. FEDERAL TORT CLAIMS ACT (FTCA)**
Medical Malpractice Program for Health Centers

FTCA is the federal legislation that allows parties claiming to have been injured by negligent actions of employees of the United States to file claims against the federal government for the harm they suffered. The FTCA also provides authority for the federal government to defend against such claims. For these purposes, health centers that have been deemed covered by the Health Resources and Services Administration, as well as their directors, officers, employees, and certain contractors are considered employees of the United States for claims alleging injury resulting from the performance of medical, surgical, dental, or related functions.

**C. POLICY INFORMATION NOTICE 2008-01: DEFINING SCOPE OF PROJECT AND POLICY FOR REQUESTING CHANGES**

This document describes policy for an approved scope of project for Health Centers funded under Section 330, the five components of an approved scope of project, and the policy and process for Health Centers seeking prior approval to make changes in the approved scope of project.

**D. HEALTH CENTER PROGRAM REQUIREMENTS**
[http://bphc.hrsa.gov/about/requirements/index.html](http://bphc.hrsa.gov/about/requirements/index.html)

This page contains a summary of Health Center program requirements on the need, services (including staffing), management and finance, and governance, based on the statute and regulations.

**E. P.L. 111-148: PATIENT PROTECTION AND AFFORDABLE CARE ACT**
**P.L. 111-152: HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010**


These Public Laws comprise the Health Reform Law, which contains several provisions related to oral health workforce, such as establishment of the Title VII Training Program for dental separate from medicine, National Health Service Corps (NHSC) improvements, and primary care residency funding. Most of the provisions stand as amendments to the Public Health Service Act mentioned above.
4. Recruiting and Hiring Oral Health Professionals

Delivery of quality oral health care services requires well-trained providers and support staff who are dedicated and motivated to support the mission of the program. Recruiting qualified and experienced team members can be challenging when confronted by urgent oral health needs of a community; however, taking time to carefully screen and select appropriate candidates provides long-term benefits for the oral health program. Doing so can build support and collaboration among partners, patients, board members, the community, and current team members, as well as reduce turnover and recruitment costs.

An important consideration when hiring providers is their understanding of the program’s mission. New graduates and others unfamiliar with Health Centers should be trained through orientation, mentoring, and observation. Studies showed that when a provider does not understand a Health Center’s purpose or does not demonstrate an interest in furthering its mission, the provider is less dedicated to the patients or the center and more likely to leave the program. The Survey of Health Center Oral Health Providers: Dental Salaries, Provider Satisfaction, and Recruitment and Retention Strategies published by NNOHA in 2010, identified 39.1 percent of current Health Center dentists chose a career in a Health Center because of their commitment to the dentally underserved. Those providers are less likely to leave the Health Center because of their dedication to the program’s mission. The same principle applies to support staff and dental auxiliaries.

Other factors to consider when hiring providers include the program’s scope of services, productivity expectations, cultural competency and sensitivity, language considerations and the ability to function in an interdisciplinary team environment. It is important to select qualified providers with the appropriate skills to meet the oral health needs of the population served by the Health Center. The comfort level of the providers in delivering services expected by the community should also be considered. For example, if a Health Center provides a large number of endodontic oral surgery procedures or pediatric dental services, recruitment should focus on providers comfortable with delivering those services. Community-based practice can differ from private practice in that Health Centers

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6 Ibid.
may be more likely to have patients with extensive, untreated dental disease, which requires providers skilled in oral surgery, treatment of acute dental conditions and oral medicine.

It is equally important that care be delivered in a manner that is both appropriate and acceptable to the patient population. Cultural sensitivity, experience and comfort with treating a diverse patient population are essential.

New providers should be offered support and training by the Health Center on these and other topics so they can acquire the specific competencies needed to serve the community and grow professionally. Health Centers, like any other employer, should be cautious to avoid violating any employment laws, such as prohibitions on discrimination, through their hiring practices.

**SAMPLE STRATEGIES & RESOURCES FOR SUPPORT & TRAINING**

There are several ways to improve a provider’s clinical skills including observation and mentoring with an experienced provider, as well as online and in person continuing education courses. It is important for new providers to meet with the Dental Director and develop a plan for acquiring and/or developing the specific clinical skills with periodic assessment to monitor progress.

Resources for enhancing cultural competency including the U.S. Department of Health & Human Services, Office of Minority Health sponsored website (https://cccm.thinkculturalhealth.hhs.gov/) which contains an online practical guide to culturally competent care. The website will soon be adding content specifically targeted towards oral health providers. In addition, the National Primary Oral Health Conference also offers clinical and practice management sessions relevant to Health Center oral health programs: http://www.nnoha.org/conference/npohc.html.

**A. RECRUITMENT STRATEGIES**

In the *Survey of Health Center Oral Health Providers*, Executive Directors reported that advertising in local and national dental journals and recruiting from local dental societies are some of the most frequently-used methods. Alternative methods may be more effective for other Health Centers, depending on their individual requirements.

There are similarities in recruitment strategies for urban versus rural Health Center locations. A candidate who grew up in a rural area is not necessarily interested in living in a rural community. Relocation to a different environment may be one of the candidate’s goals. These examples illustrate the need for a Health Center to research and provide potential candidates with a wide range of information about the service area, such as housing opportunities, school districts, child care, and taxes. If the Health Center is in a rural community, know the distance to the nearest city that provides larger department stores, major concerts, sporting events, and the closest airport. When recruiting candidates, it helps to promote the social aspects of living in the community that align with the interests.

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of both the candidates and their families, such as local attractions, entertainment, and cultural events. Schools and quality of life are major factors in recruiting.

It is also helpful to inform potential candidates that Health Center careers often provide benefits that are unavailable to those in private practice. Such benefits may include: malpractice coverage; guaranteed salary; continuing education options; paid vacations; paid membership dues; retirement programs; and the ability to collaborate with multidiscipline health providers for the complete and comprehensive management of patients' needs.

There are specific channels through which Health Centers may recruit oral health providers:

i. Scholarship and Loan Repayment Programs

In the NNOHA Survey of Health Center Oral Health Providers: Dental Salaries, Provider Satisfaction, and Recruitment and Retention Strategies, currently-employed Health Center dentists ranked their primary reasons for being attracted to a Health Center dental career. Second to felt a mission to the dentally underserved population was that loan repayment was available. Many individual states offer loan repayment programs, but the largest and most well-known program available to Health Centers is through the National Health Service Corps (NHSC – http://nhsc.hrsa.gov).

Established in the early 1970s, the NHSC is a program of the U.S. Department of Health and Human Services (DHHS), Health Resources and Services Administration (HRSA). NHSC helps facilities and organizations located within Health Professional Shortage Areas (HPSAs)8 recruit and retain medical, dental, and mental health providers through scholarship and loan repayment programs. Relationships with Dental Pipeline programs, student externships, and residency programs are viable pathways to recruit providers who understand the mission of the Health Center.

NHSC Scholarships (http://nhsc.hrsa.gov/scholarship/) are competitive, and pay for tuition, fees, and a living stipend to students enrolled in accredited dental and other selected clinical training programs. Upon graduation, scholarship recipients serve as primary care providers between two and four years in a community-based site in a high-need HPSA that has applied to and been approved by the NHSC as a service site.

As of November 2010, the NHSC Loan Repayment Program (http://nhsc.hrsa.gov/loanrepayment/) offers dentists, dental hygienists, and selected other clinicians up to $60,000 to repay student loans in exchange for two years serving in a community-based site in a high-need HPSA that is a NHSC-approved service site. After completing their two years of service, loan repayors may apply for additional years of support, up to $170,000 for five years of service commitment. In addition, NHSC now offers flexible options for completing service, including a two-year full-time contract, a four-year half-time contract, and a two-year half-time contract.

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8 A Health Professional Shortage Area (HPSA) is a geographic area, population group or medical facility that has been designated by the Secretary of the Department of Health and Human Services as having a shortage of health professionals. Each area is assigned a score based on the level of need. For more information, visit: http://bhpr.hrsa.gov/shortage/
Health Centers, rural health clinics, and other sites that care for low-income and uninsured people can become NHSC-approved sites where dentists, dental hygienists, and other clinicians who are eligible for loan repayment funding or have received scholarships can fulfill their service obligation. In order to be approved as a qualifying service site, organizations must be located in a HPSA, provide services on a discounted-fee schedule, and fulfill other obligations. To continue participation in the NHSC programs, it is important for Health Centers to update and maintain their HPSA scores through the appropriate state agency or organization.9

The responsibility for applying for and regularly updating HPSAs can lie in various state government or associated organizations. It should also be noted that updated HPSAs are not an automatic, regular occurrence in every state. In some states, re-application must occur with ample time for processing prior to the expiration of the current HPSA.

For more information about NHSC opportunities and requirements, please visit http://nhsc.hrsa.gov/.

Health Centers can also utilize state loan repayment programs. The amount offered and years of commitment vary from state to state.10 Additionally, some state dental associations offer special loan repayment programs. For example, California Dental Association Foundation has a loan repayment program that pays up to $120,000 for a three-year commitment for dentists who work in underserved areas.

ii. Community Involvement

When recruiting a new dentist or dental hygienist, going outside of the Health Center to involve members of the local community can increase the likelihood to gain buy-in and support. Before approaching stakeholders within the community, as described below, consider conducting a needs assessment and economic impact analysis to prove the value of hiring the new provider. Then, contact these stakeholders, preferably in person, to discuss the benefits of their involvement:

- **Other medical/dental staff in the community**, and other healthcare organizations (e.g., nursing homes, home health agencies, pharmacists, etc.). These groups provide a base of cooperative co-workers, peers for consultation, and friendships for the provider and the family. By being involved, the community members are more likely to feel reassured that the new provider is not a threat to their businesses, may help with their workloads, and can help the economy of the entire community.

- **Community businesses** (e.g., bankers, grocers, schools, chambers of commerce, real estate agents, etc.) and local citizens (e.g., parents, senior citizens, civic groups, public information meetings, etc.). These contacts help the provider and family feel welcomed, help build the provider’s patient base, and provide job networking opportunities for the new employee’s significant other or spouse. These collaborators influence the attitudes of the community and can effectively communicate that the new hire will boost the local economy, may bring other new employees to the job market, and is an integral player in the health and wellbeing of the community at large.

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9 For more information regarding HPSA designation and its process, visit: http://bhpr.hrsa.gov/shortage/hpsas/index.html

10 For more information, visit http://www.ada.org/sections/educationAndCareers/pdfs/loan_repayment.pdf, or contact the state loan repayment programs directly.
When Health Centers include one or more of these community members on the recruitment team, it can illustrate to candidates that the entire community is interested in their success and creates a welcoming atmosphere. Connecting new providers to other community members helps them feel integrated into the community, a key to both recruitment and retention. Having community members on the team is also a way to share the recruitment work load, provide candidates with easy access to information about the area, and spearhead networking options for the spouse and other family members.

iii. Utilizing Dental Schools, Residencies, and Dental Hygiene Schools

Dental schools, residencies, and dental hygiene schools are excellent sources of providers. Most have alumni departments and job placement or posting services for their outgoing students and alumni. Many allow a Health Center to advertise its openings at no charge. Many dental schools and universities have regularly scheduled recruitment fairs, while others allow Health Centers to present a “lunch-and-learn” or brown bag session to present available opportunities. These recruitment options are especially beneficial if information about Health Center careers is presented concurrently with the NHSC loan repayment option. NNOHA has developed a white paper with more specific information and recommendations regarding successful partnerships with students and residents. Please visit http://www.nnoha.org/generalpage.html for more information.

iv. Private Practices and Provider Associations

The results from the Survey of Health Center Oral Health Providers (2010) showed that more than half of dentists and dental hygienists that are currently working in Health Center practices are experienced, having come from private practice settings. Among the dentists, 31.9 percent (179 out of 561 respondents) were previously a private practice owner, partner, or associate dentist, while 18.5 percent (104 respondents) were a private practice dentist prior to their Health Center employment.11

For dental hygienists, 70.4 percent were previously private practice associates or employees. These results indicate this particular labor force is a viable recruitment source. Recruiting efforts can be directed to popular professional journals, ADA, ADHA, state/local dental associations, or other venues that private practice dentists and dental hygienists are exposed to on a regular basis.

Health Centers benefit when their dentists and Dental Directors are active members of the local dental society. In the Survey of Health Center Oral Health Providers, 69 percent of Health Center dentists reported being members of organized dentistry.\textsuperscript{12} Being an active member greatly increases the familiarity of private dentists with Health Centers and opens up numerous avenues for potential recruitment for providers and potential volunteers.

\textit{v. Primary Care Associations}

Primary Care Associations (PCAs) provide training and technical assistance to Health Centers and other safety-net providers, support the development of Health Centers in their states, and enhance the operations and performance of Health Centers. As part of their services, PCAs often provide recruitment and retention resource programs, such as candidate sourcing and hosting of job postings. Many PCAs utilize NNOHA’s job bank (http://www.nnoha.org/dentalcareers.html) to recruit candidates for Health Centers they represent. Others maintain their own listing of state-specific vacancies upon their own website. For a complete listing of state and regional PCAs, visit: http://www.nachc.com/nachc-pca-listing.cfm. A majority of the PCAs also host job banks, and the list of links may be found on the NNOHA website: http://www.nnoha.org/otherbanks.html.

\textit{vi. Health Center Controlled Networks}

A Health Center Controlled Network (HCCN) is defined as: “A group of safety net providers (a minimum of three collaborators/members) collaborating horizontally or vertically to improve access to care, enhance quality of care, and achieve cost efficiencies through the redesign of practices to integrate services, optimize patient outcomes, or negotiate managed care contracts on behalf of the participating members.”\textsuperscript{13}

HCCNs have come together to exchange information and establish collaborative mechanisms to meet administrative, IT and clinical quality objectives. Some networks have collaborated on both hiring and sharing of staff, including oral health staff. They have also collaborated on establishment of HIT systems, which could be of immense assistance to oral health programs that are embarking on an EHR selection and implementation process. The concept of sharing, collaborating and integrating in terms of workforce should be considered.

\begin{quote}
\textbf{NNOHA’S JOB BANK}

NNOHA coordinates a job bank to help connect Health Center dental openings with candidates looking for a career in service to underserved patients. NNOHA members and students looking for career opportunities at Health Centers may also submit an “Opportunity Wanted” ad. For more information, please visit: http://www.nnoha.org/dentalcareers.html
\end{quote}

\textsuperscript{12} National Network for Oral Health Access (NNOHA) – “Survey of Health Center Oral Health Providers: Dental Salaries, Provider Satisfaction, and Recruitment and Retention Strategies” (2010).
\textsuperscript{13} HRSA – What Is a Health Center Controlled Network?: www.hrsa.gov/healthit/toolbox/HealthITAdoptiontoolbox/OpportunitiesCollaborations/abouthccns.html
B. The Hiring Process

i. Creating Job Descriptions

A detailed job description that is specific in terms of program expectations, qualifications, and roles and responsibilities is an essential tool for attracting the right person for any position. There are many online resources that provide guidelines for constructing an effective job description. NNOHA’s website provides examples of job descriptions for oral health providers that were developed in partnership with the National Association of Community Health Centers (http://www.nnoha.org/dentallibrary.html). These templates offer an outline of the expectations of many oral health positions. Health Centers may add details that are specific to their programs. In addition, many Health Centers have human resource officers who can assist with creating job descriptions. At a minimum, a job description should contain:

- Job title
- Goals of the organization
- Description of reporting relationship
- General job purpose or function
- Major job duties – daily, periodic, and occasional
- Job responsibilities, including:
  - Nature of supervision, if any
  - Handling of physical or financial resources
  - Judgment- or decision-making requirements
  - Reporting requirements
  - Managing emergencies or on-call responsibilities
  - Education, training, skills or specialized knowledge needed for the position
  - Expected participation in, and compliance with, the compliance program
  - Amount of experience needed for the position
  - Personal characteristics or traits needed
  - Description of physical demands of the position
ii. Qualifications of a Dental Director

Dental Directors need to have a unique set of skills to direct the Health Center oral health team and serve as the liaison with the Executive Team. With their clinical background, they understand how to design and deliver oral health services. It may require additional skills to serve underserved patients. Qualified Dental Directors should also have administrative and management skills to successfully operate oral health programs. While they are often familiar with issues relevant to Health Centers, such as policy and advocacy, financial management, leadership, and public health, Qualified Dental Directors should also know how to work effectively with multidisciplinary teams at the clinical, administrative, and executive levels. Since they are the leaders of their Dental Departments, Dental Directors are responsible for resolving any conflicts that may arise in their programs.

The duties of Dental Directors vary from one Health Center to another depending on the level of responsibility. Because qualified Dental Directors possess clinical skills based on their knowledge and training, enabling them to establish fundamental clinical protocols for their dental departments, this document does not provide details on preventive, primary, and comprehensive treatments. However, the position does involve financial implications affecting Health Centers; therefore, Dental Directors are advised to engage with the Leadership Team for setting these guidelines.

Organizational responsibilities for Dental Directors may include:

- Develop a service delivery model
- Establish standards of performance and quality control
- Establish scheduling and patient flow guidelines
- Coordinate staff recruitment, development and training
- Establish priorities and develop budget
- Complete provider reviews
- Resolve conflicts
- Manage utilization
- Allocate resources
- Assist with the planning for expansion of services
- Ensure completion of customer service and patient satisfaction surveys
- Maintain internal and external communications related to mission and vision
- Develop and update policies and procedures
- Monitor and manage financial viability of the oral health program
- Participate in Senior Administration management team meetings and discussion
- Serve as member on the Continuous Quality Improvement Team for the Health Center
- Participate in annual meetings with the Health Center Board to present the State of Affairs in the oral health program
NNOHA has developed various resources to support the work of Dental Directors at Health Centers. Chapter 2 of this Operations Manual, *Leadership – Becoming an Outstanding Dental Director*, found on the NNOHA website at http://www.nnoha.org/practicemanagement/manual.htm, is particularly helpful. *The Safety Net Dental Clinic Manual* (www.dentalclinicmanual.com) is another useful resource for Dental Directors.

### iii. Orientations

Immediately upon employment, new staff members should receive a thorough orientation. The Human Resources Department of the Health Center usually assumes responsibility for providing the orientation, especially with issues pertaining to Health Center administration and workforce regulations. However, Dental Directors or other supervisors should play a key role in providing a quality orientation to the dental aspects. In some smaller organizations, the Dental Directors may need to assume both roles.

**Key elements of a good new-hire orientation could include:**

- Introduction to the oral health program, office, and working area
- Description of the organization, including mission, history, administrative structure, Board makeup and functions, and funding mechanisms and departments
- Introduction to co-workers and supervisors
- Introduction to the compliance program
- Orientation to relevant Federal, State and local workplace regulations
- Comprehensive training on Occupational Safety and Health Administration (OSHA) Infection Control and Biohazardous Materials, Safety, and the Health Insurance Portability and Accountability Act (HIPAA)
- Explanation of benefits and enrollment
- Orientation to the schedule and scheduling practices
- Health Center’s operational policies and procedures, including credentialing and privileging
- Description of the reporting and management structure
- Description of various committees an employee may join to participate in process improvement (i.e., quality assurance, infection control, and safety committees)
5. Staffing

Getting the right people to staff a Health Center is one of the key elements of a successful program. This section covers many of the different staffing models being used across the country, and also presents some of NNOHA’s recommendations for a strong oral health team.

A. Staffing Models

Many staffing models are available for Health Centers to operate their oral health programs and meet the needs of their communities. Health Centers can consider their available workforce options and decide which ones to employ for providing the most efficient and effective oral health services within the scope of their practices.

i. Effectively Utilizing Dental Hygienists

Dental hygienists are an important part of the dental team; they provide preventive care and education for the patients. With changes in regulations, dental hygienists can “now practice in at least one setting under general supervision – a less restrictive arrangement than indirect or direct – in 45 states, compared to only 30 states in 1993.”

Permissions and supervision levels vary from state to state, depending on the state’s Dental Practice Act, or similar legal and regulatory scheme (State Practice Act). For more detailed information, review the Dental Hygiene Practice Act Overview, provided by the American Dental Hygienists’ Association: http://www.adha.org/governmental_affairs/downloads/fiftyone.pdf.

As of 2010:

- Fifteen states allow dental hygienists to receive direct reimbursement from Medicaid for prevention services provided by them. Oregon also pays for services provided by a person under the supervision of a limited-access permit dental hygienist.

- Thirty-two states allow for direct access in some settings outside of the dental office.

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In 2008, ten states signed bills into law that expanded the functions of dental hygienists that directly support the types of programs identified by the Department of Health and Human Services Oral Health Initiatives. These changes in regulations mean that dental hygienists are allowed to perform certain functions with varying degrees of supervision by the dentist, thereby increasing the number of patients Health Centers can see. Health Centers should use all of their employees to the extent of their capabilities and authority. Expanding the functions of dental hygienists is a major step forward in lowering the incidence of oral disease in underserved populations. Health Centers need to consult appropriate state regulating bodies to determine the permitted functions in their states.

**ii. Expanded Function Dental Assistants**

In some states, dental assistants who are authorized to perform certain activities involving intra-oral manipulation, such as the exposure of dental radiographs, may have specialized titles, such as expanded function dental assistants (EFDAs). The range of functions that EFDAs are authorized to perform varies from state to state. In some states, dental assistants with appropriate professional training may perform all preventive procedures allowable, in addition to other procedures. The dental assistant’s job title also differs depending on the state in which the dental assistant is employed, even if he or she is allowed to perform the same duties. The different job titles of EFDAs are listed by the Dental Assisting National Board (DANB) at: http://www.danb.org/PDFs/JobTitles.pdf. DANB also compiles state-specific information on dental assistants at: http://www.danb.org/main/statespecificinfo.asp. Health Centers that utilize EFDAs, following the regulations of the State Practice Acts, increase the efficiency of their oral health programs. Links to state dental boards can be found at: http://new.dentalboards.org/states/index.htm. Health Centers should consult appropriate state regulating bodies to determine the permitted functions in their states. Alternative workforce models may eventually be a beneficial option, but EFDAs can be utilized now.

**iii. Contract and Short-Term Workers**

Health Centers are permitted under Section 330 to provide required dental services through staff and supporting resources of the center or through contracts or cooperative agreements. Furthermore, Section 503(d) of the 2009 Children’s Health Insurance Program Reauthorization Act (CHIPRA) amended federal law to provide that states may not prevent a Health Center from entering into contractual relationships with private practice dental providers in the provision of Health Center services.

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Nonetheless, there are several factors a Health Center should consider before contracting for dental services.

For example, one factor to consider is the consequence that providing services at a location other than the Health Center may have on the Health Center’s scope of project. Health Centers also should note that FTCA coverage is not available to all contracted dental providers. More details and clarification of the requirements for FTCA coverage can be found in Chapter 4: Risk Management of the Operations Manual for Health Center Oral Health Programs, as well as applicable HRSA policies.21

Contracting with dental specialists is becoming more common in Health Centers and provides access pathways for services that are often unavailable at the Health Center. Exploring pathways for contracting with private practitioners is an opportunity for education and collaboration that can increase access and further HRSA objectives for oral health. Ideally, the contracted dentists should be oriented to the mission of the Health Center so they understand the importance of their work and the environment in which the Health Center operates. This concept is further explored in NNOHA’s white paper on Health Centers and Hospital Based-Dentistry.22

As contracting with dental providers is still a new practice for many Health Centers, there are many areas for which clarifications are needed. Children’s Dental Health Project (CDHP) published and updates a helpful resource, Increasing Access to Dental Care Through Public/Private Partnerships: Contracting Between Private Dentists and Federally Qualified Health Centers (http://www.cdhp.org/resource/FQHC_Handbook), which answers questions regarding this topic. It also includes a chart for Health Centers to use in determining whether or not they should establish offsite specialty services, as well as a model contract for Health Centers to use when deciding if contracting is a viable option. More details and clarification of the requirements for FTCA coverage for contractors can be found in the FTCA Health Center Policy Manual, PIN 2011-01 (http://www.bphc.hrsa.gov/policiesregulations/policies/pin201101.html) as well as, Chapter 4: Risk Management of the Operations Manual for Health Center Oral Health Programs.23

iv. Volunteers

Health Centers may utilize volunteers, such as retired dentists or private practice providers who have additional availability. As with contractors and short-term workers, the factors a Health Center should consider before accepting volunteer work include any implications on scope of project and FTCA coverage. At the time of this writing, volunteers are ineligible for FTCA coverage. Volunteers usually carry their own insurances, and Health Centers should require that they do, unless private malpractice coverage is otherwise provided by the Health Center. A Health Center’s emergency preparedness plan should address volunteers and their insurance needs. Like paid staff, volunteers also need to have an orientation to the health center so that they understand the organization’s mission, policies, and processes.

21 The chapter is available at: http://www.nnoha.org/generalpage.html. For more details on HRSA policies related to FTCA, refer to: http://bphc.hrsa.gov/policiesregulations/policies/pin201101.html
22 The whitepaper is available at: http://www.nnoha.org/generalpage.html
23 The chapter is available at: http://www.nnoha.org/generalpage.html
v. Private Sector Practitioners

A number of Health Centers utilize the part-time services of local retired private practitioners who can mentor younger dentists in both the clinical and business aspects of managing a dental program as their Dental Directors. Semi-retired local practitioners can strengthen a dental program through their contributions, be they one day per week or per month. It is an added bonus if these local practitioners happen to be specialists. NNOHA recommends that a local dentist be represented on the Health Center’s board of directors to provide oral health expertise to the rest of the board. This local practitioner can provide links to community resources that keep a Health Center’s oral health program strong and resilient.

As there are similarities and distinct differences between the business models of a private practice and a Health Center operation, it is important for the private practitioner working for a Health Center to have a clear understanding of the mission, clinical policies, and business principles of the Health Center, and an awareness of how Health Centers operate.

vi. New Dental Team Members

Currently, multiple types of alternative dental practitioners are in development to address unmet needs of the communities and improve access to care. The educational requirements and the scope of practice vary from one practitioner type to another. Some types only need training two years post high school, while others require a Masters level education. The list of alternative dental practitioners includes:

- **Advanced Dental Hygiene Practitioners** – are “proposed as case managers and primary dental care providers who could assess risk, educate, provide preventive services and basic restorations, refer patients for more complex services and do follow-up.” This model was proposed by the American Dental Hygienists’ Association (ADHA) and the background and FAQs can be found at: http://www.adha.org/media/backgrounders/adhp.htm.

- **Community Dental Health Coordinators (CDHC)** – were proposed by the American Dental Association (ADA) as “community health workers with dental skills focusing on education and prevention.” The use of this type of practitioner targets improving access to care in underserved communities. A pilot program in Oklahoma, organized by ADA and modeled on the community health worker, was completed in November 2010. The program has graduated 5 coordinators.

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Dental Therapists – are “primary dental care providers focused on delivering basic preventive and restorative care to children, and in some places, adults”.26 In addition to the dental health aid therapists (DHAT) in Alaska, the University of Minnesota introduced both Bachelors and Masters degree programs in dental therapy in Fall 2009.

Patient Navigators and other Community Health Workers – serve as “member[s] of the healthcare team who help patients ‘navigate’ the healthcare system and get timely care. Navigators work with patients to identify their barriers to healthcare and connect them to the resources they may need such as financial assistance, counseling, language translation or transportation.”27 Dental patient navigators may work with other oral health providers, such as dental hygienists and dentists, to identify appropriate dental care and resources for patients. Patient navigators do not provide care and may not be considered part of the “dental team” to some, but they can be an important member of the team that ensures the patient receives the best possible care.

While it is too early to evaluate the effectiveness of these new team members, NNOHA is committed to providing updates in future revisions of this chapter and other publications. More information on the alternative dental workforce models can be found at the following:


- Commissioned from Children’s Dental Health Project by the WK Kellogg Foundation, *Training New Dental Health Providers in the US* (http://www.cdhp.org/resource/training_new_dental_health_providers_us) was published in December 2009. This report provides information on training, scope of services, supervision and deployment of both conventional and alternative dental workforce models in the U.S and abroad.

NNOHA’s position statement on alternative workforce model, voted by the NNOHA Board of Directors in March 2010, is included in the Appendix.

27 Colorado Patient Navigator Training website: http://patientnavigatortraining.org/
B. Health Center Oral Health Team

Health Center oral health programs that maintain sufficient staffing and equipment ratios can maximize their efficiency and productivity. Utilization of staff members depends on different definitions of direct supervision and indirect supervision and can vary state-by-state. Health Centers need to stay up-to-date with their own state regulations.

i. Staffing Requirements

Staffing a Health Center oral health program involves a number of considerations, including:

- Mission, vision and values of the program
- Service area and demographic knowledge
- Estimated number of expected patients
- Growth expectations
- Scope of services
- Patient demographic and payor mix
- Efficient productivity and maximal use of available facilities
- Cash flow needs
- State practice regulations and flexibility of dental workforce
- Patient satisfaction
- Quality management
- Clinic patient flow
- Unexpected needs beyond existing capacity

While there are no current evidence-based models that fit all situations, NNOHA recommends the following strategies:

DENTAL ASSISTANT-TO-DENTIST RATIO:

For Health Centers, NNOHA recommends **2.0 or more** full-time dental assistants per 1 full-time dentist for optimum service. This ratio usually can provide between 2,500 and 3,000 visits annually.

If there are fewer than 2.0 assistants available per dentist, the program is likely to experience difficulty in maintaining a smooth patient flow. An insufficient number of dental assistants can result in multiple operatories used inefficiently, because, under such circumstances, dentists will be working alone when it is more productive to have a chair-side assistant.  

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Some practice experts even recommend a minimum of 3.0 full-time dental assistants for 1 full-time dentist. This higher ratio is especially desirable if the state’s Practice Act allows the use of Expanded Function Dental Assistants (EFDAs) or similar practitioners. When a Health Center utilizes the maximum number of dental assistants and employs a flexible dental assistant support system that allows extra functions normally performed by dentists, it usually becomes more efficient and increases its patient capacity. Importantly, studies suggest that the higher dental assistant-to-dentist ratio comparably improves the efficiency and productivity of the dentist, whether measured in services provided, visits, or revenue generated.

**DENTAL HYGIENISTS:**

Preferably, dental hygienists should have a separate and dedicated operatory. One dental hygienist generally can provide 1,300 to 1,500 visits annually, depending on the level of clinical periodontal needs and the emphasis placed on health promotion and disease prevention.

Dental hygienists are best added after a practice develops a sufficient recall list for preventive services, typically after the first 6 to 12 months of operation. A general guideline is that six months of operation establishes a recall volume that fully employs and validates the expense of a dental hygienist. This is highly dependent on the management expertise available within each facility. In situations where the State Practice Act allows dental hygienists to perform services with indirect supervision (without the physical presence of a dentist), NNOHA recommends having a full-time dental hygienist start with the dentists upon opening of the site. This allows school-based prevention programs, wherein the dental hygienist works part-time offsite providing preventive services and refers children to the clinic for treatment—an effective strategy for recruiting patients. Since children of low-income families are often covered by State Medicaid or CHIP programs, this strategy can also increase a Health Center’s revenue while promoting prevention within the community.

**SUPPORT STAFF:**

When resources allow, it is desirable to have a front desk staff dedicated to the oral health program because of the intricacies of scheduling and billing for oral health procedures. There are benefits if the front desk person has dental assistance experience, but it could be counterproductive for a Health Center’s dental assistant to assume the duties of a receptionist or billing clerk in addition to his or her responsibilities as a dental assistant. Other clinic staff may include a site/office manager, patient care coordinator, and interpreter.

Complying with these recommendations, however, does not automatically guarantee a cost-effective and productive oral health program. An efficient and effective program requires capable Dental Directors who allocate and manage resources effectively, ensuring that programs operate smoothly. When Dental Directors manage their oral health program operations with sustained income and productivity, they can advocate higher staffing ratios while demonstrating support for their staff at the same time.

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29 Dental Assistants that are authorized to perform activities involving intra-oral manipulation, such as the exposure of dental radiographs, may be called “expanded function dental assistants” (EFDAs) or other similar titles. For more information, see Sub-Section e of the Section 6, Staffing Models.
30 According to the 2010 UDS data, average encounter rate for dental hygienists was 1,337.7 encounters per FTE annually. In addition, each operatory could produce 1,500 visits per year, including dental hygienist, if the patient mix is 50% adults and 50% children.
31 Please note that the addition of these types of programs to a Health Center project would require prior approval via a change in scope request. As with all project changes, the Health Center should consult with its Project Officer regarding the need for a Change in Scope of Project before adding any sites or services.

**ii. Equipment Ratios**

NNOHA recommends having two dental operatories per 1 full-time dentist as a minimum, excluding those used primarily by the dental hygienist. If the ratio of dental operatories to full-time dentists is less than 2:1, the program is likely to experience bottlenecks in patient flow. A ratio of three operatories per full-time dentist enables the program to function at peak efficiency. If expanded functions and EFDA restorative services are available in the program, a minimum of three chairs should be available per 1 full-time dentist. For Health Centers that have students and residents, the ratio may vary, because providers spend time supervising and checking the work of their students and residents. The number or ratio of operatories, however, can remain the same if the provider and students are counted together as a dental team unit.

Studies such as “Differences in Characteristics of California Dentists Who Employ Dental Hygienists and Those Who Do Not” by Pourat (http://jada.ada.org/content/140/8/1027.full) show that dental hygienists greatly improve their efficiency and are able to see more patients if a dedicated dental assistant plus another operatory chair are added; i.e., two operatories per full-time dental hygienist.

Increased chair capacity provides significant benefits for Health Center oral health programs. When an extra chair is available, beyond what is needed for the daily scheduled patients, the Health Center can accommodate unexpected emergencies and short procedures, and it also enjoys less-crowded waiting rooms and increased patient satisfaction. In addition, there is opportunity for more daily encounters.

### 6. WORKING WITH A HEALTH CENTER ORAL HEALTH TEAM

#### A. REPORTING STRUCTURES

By virtue of the federal requirements, Health Centers are all similar, yet each is unique and has varying administrative structures. Each Health Center is governed by a Board of Directors that is representative of the community served. The Board hires an Executive Director to oversee and ensure the appropriate operations of the Center. The Executive Director, who reports to the Board, usually forms a Key Management Team to oversee the operational units of the Health Center, which may include the Chief Financial Officer (CFO), Chief Information Officer, Clinical/Medical Director, and Dental Director.

With Board oversight, the Key Management Team typically implements the Health Center’s strategic plan; develops policies and procedures for daily operations; and establishes priorities for funding, space allocation, patient prioritization, and other resource allocations. These important discussions should be conducted on regular and ongoing basis.
Although other reporting structures are successful for different programs, NNOHA’s recommendation is for the Dental Director to report directly to the Executive Director. This structure provides several advantages for the Dental Director, including:

- Assuring unfiltered and direct participation in the decision-making process
- Helping the Dental Director to determine the priorities and strategic direction of the Health Center
- Giving the oral health program organizational parity in relation to the other programs or departments of the Health Center
- Offering the Dental Director access to budget and finance information and allowing the Dental Director to determine if sufficient funds are allocated to effectively operate the oral health program. Ideally, the Dental Director should have such access and should determine if sufficient funds are allocated regardless of the reporting structure
- Providing a better perspective of the oral health needs of the community based on clinical experience

The Survey of Health Center Oral Health Providers,\textsuperscript{32} showed a significant association with the title of the Dental Director’s supervisor (i.e., CEO/Executive Director versus CMO/Medical Director) and intent to leave the Health Center practice. Dental Directors who reported to a CMO/Medical Director were 2.2 times more likely to indicate intent to leave the Health Center practice than those Dental Directors who reported to a CEO/Executive Director.

\textbf{B. MANAGING & MOTIVATING AN EFFECTIVE STAFF}

It is the Dental Director’s responsibility to continually work on building a strong dental team. There are several key points to managing and motivating an effective team:

- **Clear mission of the practice:** When every person on the team understands the mission of the practice and its primary goals, the practice operates more smoothly. If the Dental Director outlines the priorities and explains the benefits of achieving these goals, increased buy-in from the staff occurs.

- **Precise and detailed job descriptions:** When staff and providers know exactly what their responsibilities are, clear lines of communication can be established. The Dental Director can pinpoint the source of issues quickly to mitigate risk, and conversely, staff knows where and from whom to seek assistance. The Dental Director and employees assume ownership of their responsibilities, which leads to improved job satisfaction and pride in their work.

\textsuperscript{32} National Network for Oral Health Access (NNOHA) – “Survey of Health Center Oral Health Providers: Dental Salaries, Provider Satisfaction, and Recruitment and Retention Strategies” (2010).
■ **Well-defined organizational charts:** When organization charts are well-defined, everyone understands where they fit into the overall organization, which allows employees to clearly visualize they are an integral part of the Health Center. Organization charts demonstrate where and how decisions are made, which often helps employees to buy into decisions and changes that affect their day-to-day jobs.

■ **Open and clear channels of communication:** All employees need an opportunity to ask questions. Staff meetings are an important venue for communicating information to the staff, engaging in an open dialogue, and listening to questions or concerns. Periodic meetings with the entire organization improve communication and relationships between departments.

■ **Ensure all members of the dental team feel valued:** Positive feedback from the Dental Director provides intangible benefits for the Health Center, such as increased productivity, job satisfaction, and achievement of goals. Whether it is an individual contributor or team effort, recognition from the Dental Director is a powerful motivator.

■ **Create a positive work environment.** All the factors above are important in creating a positive work environment, where staff feels satisfied and motivated. Having a supportive environment where colleagues have positive relationships with each other can have a great impact on the staff performance and productivity.

C. **Encounter Rates and Productivity Standards**

Dental Directors should be aware of the benchmark values available for Health Centers across the country. Based on the 2010 Uniform Data System (UDS) results, the average annual visit rates are 2,672 per dentist and 1,337 for dental hygienists.\(^\text{33}\) The productivity of a Health Center is dependent on multiple factors, such as the scope of service allowed in each state, the number of support staff, equipment, patient mix, patient needs, and a multitude of other factors. Each facility should consider all of those factors and develop a goal that is appropriate and allows the program to be sustainable. Too few or too many visits\(^\text{34}\) can signal possible poor patient outcomes or a failed business plan. These numbers are not quality indicators; however, they are simply averages to help in business planning.

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\(^{34}\) For UDS reporting purposes, visits are defined as “documented, face-to-face contacts between a patient and a provider who exercises independent professional judgment in the provision of services to the patient.” A dental hygienist is credited with a dental visit when the visit is independent from and not combined with the dentist encounter. Only one visit may be counted during a patient visit to the dental clinic in one day. For more information, see the 2010 UDS Reporting Manual ([http://www.hrsa.gov/data-statistics/health-center-data/reporting/2010manual.pdf](http://www.hrsa.gov/data-statistics/health-center-data/reporting/2010manual.pdf)). Health Centers should note that some encounters that are “visits” for UDS reporting purposes may not be considered billable visits for purposes of billing Medicare, Medicaid, CHIP or other health care programs.

—I’ve been in private practice 17 years, managed care clinics 4 years, and for the past year in a CHC. This past year has been the best, most satisfying and most rewarding.”

—National Primary Oral Health Conference Participant
In addition to tracking encounter rates, two commonly used methods for tracking productivity are Relative Value Units (RVUs) and gross charge dollar value. Both systems have their attributes.

- Some Health Centers use the RVU system as a standard for productivity, as it enables a director to quantify the output of services performed by the provider. The RVU is a time-based measure that can serve as a common reference among providers and different programs to evaluate and compare dental performance. This time measurement remains constant over time, whereas a dollar or visit measurement may vary under different conditions. There are a number of successful uses of this measurement system, and there are several publications and presentations on the use of this system found in the literature.35

- Some Health Centers use the dollar value system because patients do not pay in RVUs nor are providers compensated in RVUs. It keeps the language for comparison the same from the CFO's office to the Dental Director's office.

One critical factor for productivity is retention of staff. It is difficult for a Health Center to maintain high productivity levels and quality service with new dentists or frequent staff changes. Retention, recruitment, pay, working conditions, quality assurance, productivity, and patient satisfaction are viewed as interdependent.

For more information about various productive measures, as well as their strengths and weaknesses, visit: http://www.dentalclinicmanual.com/docs/Productivity_measures.pdf.

35 More information about the RVU system can be found in Appendix C.
D. Administrative vs. Clinical Time

In addition to providing patient services, Dental Directors perform administrative functions to operate and manage the oral health programs. Successful Dental Directors manage to balance the two responsibilities, as both are critically important. Some Dental Directors feel insufficient time is allotted for their assigned administrative duties. Juggling the needs for clinical productivity with administrative, development, and advocacy activities can be a source of tension between the administration of the Center and the Dental Directors. In the Survey of Health Center Oral Health Providers, 71 percent of respondents indicated there was not enough or no time allocated for assigned administrative duties.36

Each Health Center is unique, and many factors contribute to the amount of administrative time that is needed for its Dental Director, which makes it challenging to develop a general rule that defines sufficient administrative time. However, the following guidelines may be helpful:

- A general suggestion is that most programs with four to seven professional providers require at least one fifth of the Dental Director’s time for administrative duties.
- If the Health Center provides oral health services at one site and all the dentists are in the same location, one hour per dentist per week is probably adequate.
- If there are multiple offices providing oral health services, 1.5 hours per dentist per week is realistic, given the need to travel between sites.
- Another variable is the number of meetings. If the Dental Director is on the senior corporate leadership team, more administrative time may be needed to accommodate the meetings he or she attends.
- If there are five or more dentists at the Health Center, it is ideal to have a business manager.
- A business manager and a lead dental assistant can handle many of the clerical duties, such as scheduling staff, ordering supplies, payroll, monitoring time off, running production, and producing other reports. If the Dental Director performs any of these functions, it adds to the needed administrative time.
- If staff dentists have additional administrative duties, they may need administrative time as well.

Executive Directors should carefully consider the expectations they have for their Dental Directors and in what activities they should be engaged. If the Dental Director is expected to participate and contribute to the discussions on development and strategic planning of the Health Center, be involved in advocacy on the local, state or national level, be involved in community outreach, oversee budgets and supervise support staff, adequate time is required for the participation and completion of these activities. Dental Directors, who are not allowed adequate time for these duties, may feel stressed, overwhelmed and dissatisfied. Retention and long-term cost savings can be realized by either reducing the administrative duties or allowing sufficient time to complete them.

7. **Retention of Staff**

Retention is a workforce issue that many Health Centers find challenging once qualified candidates are recruited and hired. This section explores strategies for retaining the Health Center’s qualified dental providers.

**A. Salaries**

Competitive compensation is a key strategy, which requires Health Centers to know what their competitors, including private practice, are paying, and offer a compensation package that is comparable. When presenting a compensation offer, it is recommended to focus on all of its elements and their values, which may include base salary, benefits, sign-on bonus, potential loan repayment, vacation days, and annual and incentive bonuses. Salaries should be presented in writing with allowance for negotiations by an authorized official to negotiate and approve salary adjustments.

In the Survey of Health Center Oral Health Providers (2010), 26.7 percent of the dentists indicated their salaries were within the range of $95,000 to $110,000 (not including benefits, which typically is about 20 percent of salary), and 35.5 percent of the dental hygienists stated their salaries were within the $50,001 to $60,000 category. Salaries should be adjusted based on the local market rates. For more information, visit the website of the Bureau of Labor Statistics: http://www.bls.gov/oes/current/oes291021.htm.

**B. Incentive Programs**

Incentive programs motivate staff members and improve productivity by rewarding them for their performance. Income is not the only measure of good performance, but is one detailed here. Designing an incentive program involves certain components. First and foremost, the plan should be linked to performance rather than to events (e.g., giving bonuses during the holidays), or the length of the staff’s employment. A Health Center should establish well-defined and objective standards to evaluate its staff performance and how their work is contributing to the mission and goals of the Health Center. Other decisions to make when developing an incentive program include the amount of bonus, how it is calculated, and who is included in the program.

There are four attributes to an effective incentive program:

1. Simple, easy to understand and manage.
2. Based on a target ‘goal’ that directly influences the organization’s income.
3. Achievable and attractive
4. Frequent (e.g. monthly or quarterly, rather than annually)
Designing an incentive program involves participation and decisions of the Leadership Team. Factors, such as prior bonus amounts, financial performance and overall budget of the oral health program, economic conditions, and competition, affect the mechanisms of the incentive program. For Health Centers, other elements such as participation in community outreach programs or quality assurance programs may be involved in the criteria. When used effectively, incentive programs benefit both Health Center oral health programs and their employees.

C. Combating Burnout

Similar to strategies used for retention, there are recommendations to avoid burnout of the Health Center’s dental providers, which may result in turnover of qualified staff. Frequent communication with providers and allowing their participation in policy decisions, their contract negotiations, and position descriptions help to establish solid relationships and show they are valued contributors to the mission of the Health Center. Maintaining commitments made to providers, such as awarding incentives on time is another way to demonstrate their value. The Health Center can mitigate burnout by ensuring the program has adequate resources with support staff, equipment and workspace. Above all, it is the responsibility of the Dental Director to ensure adequate coverage so providers may appropriately use their paid time off for vacation and sick days. Some Health Centers include stress management days and sabbaticals after 5, 10, and 20 years of service. In these situations, it may be necessary to bring in Locum clinicians to ensure adequate coverage.

D. Continuing Education (CE) and Training

Allowing for quality CE and training for providers has two benefits. First, it helps to ensure that patients are receiving the most recent standards of care, which benefits patients and serves as an effective recruitment tool. Second, it allows providers to continue their professional development – a necessity for provider satisfaction and continued licensure. Health Centers may consider providing time off for CE opportunities and having a monetary allowance for travel and conference registration as part of their benefits package. On average, dentists receive $2,000 for CE reimbursement and dental hygienists receive $800. Much of this CE can be obtained at conferences that also emphasize the particular needs of Health Centers and Public Health. Conferences, such as the National Primary Oral Health Conference (NPOHC – http://www.nnoha.org/conference/npohc.html) or the National Oral Health Conference (NOHC – http://www.nationaloralhealthconference.com) provide many of these opportunities.

37 Locum clinicians (or locum tenens) most commonly refer to temporary clinicians who contract with recruitment agencies to perform medical services for a healthcare organization over a certain period of time.

A variety of opportunities also exist online, through video conferences or programs sponsored and hosted by Primary Care Associations and local and state health departments. It should be noted that while CE delivered electronically has the advantage of eliminating travel and lodging costs, it does not provide opportunities for networking and interaction with providers in similar situations. This type of networking helps reduce feelings of isolation while offering support and camaraderie among Health Center providers, which is known to influence long-term retention. Networking through CE opportunities encourages sharing of evidenced-based practices and models, lessons learned, and resolutions to relevant issues.

E. Staff Evaluation

Evaluation is an integral part of Health Center operations. Similar to incentive programs, it is a tool used to shape performance, increase productivity, and strengthen commitment to the mission of the program. It can also be an informational tool to increase retention. At the same time, the Health Center can ensure that the staff is a good fit for the organization, discuss provider satisfaction, and implement improvement plans. An effective evaluation is a two-way dialogue between the Dental Director and the provider being evaluated. A prearranged time should be scheduled for the provider and his or her supervisor to meet, after the provider has had the opportunity to read the criteria. A period of 2 to 3 weeks prior to the scheduled evaluation should be reserved for the provider and the supervisor to complete their separate portions of the evaluation. The evaluation meeting should focus on positive elements first, followed by areas for improvement, then reinforced with positive feedback again. A sample provider evaluation is attached as Appendix A.

8. Summary

Effective workforce planning and implementation are required for Health Center oral health programs to fulfill their mission and improve access to care. For many Health Centers, workforce issues are their primary concerns, as recruitment and retention of competent providers remain a challenge.

With the expected increase in dental patients under Health Care Reform, as well as the recent development of alternative dental workforce models, the environment in which Health Centers operate is constantly changing. These changes pose both opportunities and challenges for Health Centers. Health Center oral health programs are now required to be more innovative in their workforce-related strategies, and address workforce needs from multiple viewpoints to ensure the health of their community is improved by committed and qualified oral health providers.

This chapter described several models for structuring an oral health workforce, identified sources for potential recruitment, and discussed strategies and methods that Dental Directors and the Executive Team can employ to promote job satisfaction of their providers at the Health Center, thereby improving retention.
9. Frequently Asked Questions

**Q:** What are the recommended staffing and equipment ratios?

**A:** NNOHA recommends an optimal ratio of 2.0 or more full-time dental assistants per 1 full-time dentist. A ratio of 2.0 to 3.0 operatories per dentist will enable the program to function at peak efficiency. If expanded functions and EFDA restorative services are available in the clinic, 3.0 chairs should be available per dentist. In addition, a dental hygienist should have a separate, dedicated operatory.

**Q:** How do I convince my administrative team to hire more support staff?

**A:** Make your case by compiling the numbers. Run a test cycle using additional staff (for instance, if one provider is out for the day, have his or her support staff work with another provider). Prove that the additional staff will be productive and efficient and will enable you to provide high-quality care to the patients while not doing damage to the budget.

**Q:** Where can I find a sample contract form?

**A:** The Children’s Dental Health Project has a Health Center Model Services Agreement available online: http://www.cdhp.org/resource/FQHC_contract

**Q:** What is the recommended annual visit rate?

**A:** According to the 2009 Uniform Data System (UDS) results, average annual visit rates are 2,726 per dentist and 1,352 per dental hygienist. The productivity rate of a Health Center is dependent on multiple factors, such as the scope of service allowed in each state, the number of support staff, equipment, patient mix, patient needs, and a multitude of other factors. Each facility should consider all of those factors be to make a goal that is appropriate for the organization and allows for the program to be sustainable.
10. Links


- National Health Service Corps: http://nhsc.hrsa.gov/


- NNOHA’s Workforce Resources: http://www.nnoha.org/workforce.html

- New Mexico Health Resources, Inc. (NMHR): http://www.nmhr.org


- Safety Net Dental Clinic Manual: http://www.dentalclinicmanual.com

- 3RNet: https://www.3rnet.org
## 11. Worksheet

1. **How much administrative time do you need per week?**

2. **What are your Dental Department’s productivity standards?**

3. **What factors affect your productivity?**

4. **Check the areas in which you have challenges:**
   - ☐ Recruitment (e.g., dental vacancies unfilled for a long duration)
   - ☐ Retention (e.g., high turnover rate)
   - ☐ Low productivity
   - ☐ Low staff motivation
   - ☐ Communication with staff
   - ☐ Clinical vs. Administrative time

5. **What are your strategies to address the issues above? What resources can you draw from?**

6. **What staffing models can be utilized more effectively in your program?**
Appendix A: Sample Evaluation Form

[Health Center Name]
Provider Performance Evaluation with Goals

Employee Name: ____________________________________________________________

Department: ___________________________________ Site: __________________________

Job Title: ___________________________________ Date: ____________________________

Last Review Date: ___________________________ Next Review Date: ________________

PERFORMANCE STANDARDS:

1. Performs duties as outlined in job description and contract:
   _______ Performing satisfactorily _______ Needs remediation

2. Achieves productivity expectations:
   _______ Performing satisfactorily _______ Needs remediation

3. Patient/consumer/client satisfaction:
   _______ Performing satisfactorily _______ Needs remediation

SELF REVIEW:

1. Accomplishments for performance review time period: __________________________________________
   ___________________________________________________________________________________
   ___________________________________________________________________________________
   ___________________________________________________________________________________

2. List involvement in community activities related to the Health Center’s mission: _________________
   ___________________________________________________________________________________
   ___________________________________________________________________________________

3. List participation in professional development activities: _________________________________
   ___________________________________________________________________________________
GOALS AND OBJECTIVES:

1. Supervisor-guided expectations for the next performance review time period:

   In the spaces provided below, list two development goals, indicating key actions and milestones for each. Goals should be job/performance development related. The goals and objectives are considered a “living document” and should be reviewed and updated on a regular basis.

   Remember that well-written goals are “SMART” — Specific, Measurable, Attainable, Relevant, Time-bounded

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Employee signature: ______________________________________________________ Date:  ____________________

Supervisor signature: ______________________________________________________ Date:   ____________________

HR Review: ______________________________________________________________Date: _____________________
Appendix B: 2008 NNOHA Position Statement on New Dental Workforce Models

NNOHA Position Statement on New Dental Workforce Models

Health Centers provide oral health services for underserved populations at dental clinics throughout the United States. Between 1998 and 2008, the number of Health Centers offering on-site dental services increased from 411 to 850, and the number of dental patients went up by 158%. As dental capacity grows, the need for a dental workforce committed to caring for underserved patients is growing as well.

Given the growing demand, new types of dental providers, such as dental health therapists and advanced dental hygiene practitioners – sometimes called mid-level providers – have been proposed as a way to strengthen the dental safety net and to address unmet needs for dental services. If successful, such programs can not only facilitate a division of labor that allows dentists to manage and treat more acute and complex issues, but also can contribute to primary prevention of severe and expensive problems.

NNOHA EXPRESSES ITS POSITION ON NEW DENTAL WORKFORCE MODELS AS FOLLOWS:

■ **NNOHA supports access to high quality oral health services.** NNOHA welcomes initiatives that help to improve the oral health status of the underserved, which is the mission of our organization. We believe that everyone should have access to quality care, regardless of his or her ability to pay.

■ **NNOHA supports development and implementation of pilot dental workforce programs,** including, but not limited to, Dental Therapists, Community Dental Health Coordinators, Oral Preventive Assistants, and Advanced Dental Hygiene Practitioners. Several programs are currently in development and should be supported to determine if they can be successful.

■ **NNOHA wants to see evaluation and ongoing monitoring of new dental workforce models.** To provide high quality services, comprehensive evaluation and ongoing monitoring of new dental workforce models are needed. We believe that new types of dental providers should go through performance evaluation, certification and other procedures to ensure that their experience and skills are sufficient to treat patients with complicated oral health problems, which are often seen at Health Centers.

■ **NNOHA supports new dental workforce models working in partnership and collaboration with dentists and other medical providers.** New dental workforce models should complement the work of conventional dental providers, such as dentists and dental hygienists, rather than replace them. It is important to NNOHA that any new types of dental providers do not work in isolation and that they perform their tasks within an established system of supervision.
Appendix C: Relative Value Units

NNOHA WEBSITE

NNOHA website (http://www.nnoha.org/practicemgmt.html) has a fee schedule based on RVUs and calculated costs per RVU. You can enter your own cost per RVU ($45 is used for illustration) and your lab and/or supply costs for certain services. The Excel formulas will calculate the rest.

Dr. Janet Bozzone, Dental Director at Open Door Family Medical Centers and NNOHA Board Member, developed this resource. Please note that this uses Region II RVU values for known procedures. Since the Region II RVUs have not been updated recently, Dr. Bozzone extrapolated a guessimate indicated by an “E” in the first column. If you want to use the RVS data, you have to buy a copy of their PDF file and manually override the values that are already in there. Please check the latest version of the CDT if you have any questions.

The Dental Evaluation System which Region II implemented in the early 1980s to provide useful data on the management of Health Center oral health programs might offer some insights. The eight indicators used in the system were:

- RVU per Staff Personnel Equivalent Dentist
- Prevention and Diagnosis RVU as a Percent of All RVU
- RVU per Dental User
- Dental Users Age 5-19 as a Percent of Medical Users Age 5-19
- Direct Cost per RVU
- Users per Staff Personnel Equivalent Dentist
- The Ratio of Staff Personnel Equivalent Dental Assistant to One Staff Personnel Equivalent Dentist
- The Ratio of Operatories to One Staff Personnel Equivalent Dentist
The National Network for Oral Health Access (NNOHA) is a nationwide network of dental providers in safety-net settings. 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.

For more information on NNOHA, visit www.nnoha.org, send an Email to info@nnoha.org, or call 303-957-0635.

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**MEMBERSHIP APPLICATION**

For calendar year 2012 (October 1, 2011 through September 30, 2012)

<table>
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<tr>
<th>Applicant Contact Information</th>
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<td>Name:</td>
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NNOHA Membership Category:
- Individual Member (dues $50)
- Dental Hygienist/Dental Assistant (dues $30)
- Organizational Member (dues $350)
- Association Member (dues $150)

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.

If you are applying as an Association Member, please contact NNOHA staff for the criteria for discounted membership.

For more details on the different types of memberships, please visit www.nnoha.org/membership.html and click on Membership Levels.

- Additional Donation $______
  - $25
  - $50
  - $100
  - $500
  - $1000

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.

Check here if you would like to learn more about the Association of Public Health Dentistry.

Please complete this form and mail it to:

**NNOHA, PMB 329, 3700 Quebec Street, Unit 100, Denver, CO 80207-1639**

For more information, contact:
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adminsupport@nnoha.org
Phone: 303-957-0635 / Fax: 866-316-4995

**NATIONAL NETWORK FOR ORAL HEALTH ACCESS**

WWW.NNOHA.ORG
What Is NNOHA?

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.

NNOHA
National Network for Oral Health Access

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