

Toward a Stronger Oral Health Safety Net

Oral Health Care in Massachusetts Community Health Centers

October 2007

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About the Catalyst Institute

The Catalyst Institute is committed to improving the effectiveness, efficiency and quality of oral health care. Through direct research, demonstration projects, education and training, the Institute is transforming oral health.

Catalyst Institute

2400 Computer Drive
Westborough, MA 01581
508-329-2280
www.catalystinstitute.org

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Background

For millions of Americans, access to dental care is difficult, especially for those who are unable to afford such care, who are behaviorally or physically disabled, or who reside in rural areas.¹ In 2004, for example, 58% of persons from a high-income family had one or more dental visits during the year while only 30% of persons from a family with low income had at least one dental visit during the year. In addition, while 57% of those with private dental coverage had a visit during 2004, 32% with public dental coverage only and 27% with no dental coverage had a dental visit.²

“Safety net providers of oral health care play a critical role in ensuring timely access and improving individual and community oral health for many Americans,” says James W. Hunt, Jr., President and CEO of the Massachusetts League of Community Health Centers. The Institute of Medicine defines safety net providers as **those providers that organize and deliver a significant level of health care and other health-related services to uninsured, Medicaid, and other vulnerable patients.**³ Community health centers (CHCs) are a major component of America’s health care safety

net, which also includes, for example, public hospital systems; local health departments; and, in some communities, school-based health clinics, teaching and community hospitals, academic institutions, and some private practitioners. Many CHCs offer primary and preventive dental services to their patients regardless of their ability to pay. For example, among 1,002 health centers that received support from the Health Resources and Services Administration in 2006, about 73% provided preventive dental services while about 69% provided restorative or emergency dental services.⁴ More than 2.5 million patients received dental services from these CHCs, representing about 6.1 million dental encounters. In Massachusetts, more than 92,000 patients had more than 263,500 dental encounters at CHCs.⁵

Maintaining a stable, effective, and efficient dental safety net is critical to ensure access to primary and preventive oral health services for millions of Americans who are unable to afford such care. Because of the financial, workforce, and programmatic challenges faced by safety net providers, however, both individual community health dental practices and the entire oral health safety net are at risk.



Safety net providers of oral health care play a critical role in ensuring timely access and improving individual and community oral health for many Americans.

–James W. Hunt, Jr., President and CEO of the Massachusetts League of Community Health Centers

1. U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Dental and Craniofacial Research; 2000. <http://www.surgeongeneral.gov/library/oralhealth/>

2. Manski RJ and Brown E. Dental Use, Expenses, *Dental Coverage, and Changes, 1996 and 2004*. Agency for Healthcare Research and Quality, Chartbook 17, Medical Expenditure Panel Survey, 2007. http://www.meps.ahrq.gov/mepsweb/data_files/publications/cb17/cb17.pdf

3. *America’s Health Care Safety Net: Intact but Endangered*. Marion Ein Lewin and Stuart Altman, Editors; Committee on the Changing Market, Managed Care, and the Future Viability of Safety Net Providers, Institute of Medicine, 2000, page 3. http://www.nap.edu/catalog.php?record_id=9612

4. US Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care Section 330 Grantees Uniform Data System (UDS), Calendar Year 2006 Data. <http://bphc.hrsa.gov/uds/2006data/national/nationaltable2.htm>

5. US Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care Section 330 Grantees Uniform Data System (UDS), Calendar Year 2006 Data Massachusetts Rollup Report.

Aim

The purpose of this survey was to collect general information about CHC dental programs in Massachusetts and more specific information about CHC dental directors. In particular, we were interested in identifying the challenges CHC dental directors face in leading such programs and factors that impede timely and effective patient care. Such knowledge will contribute to a better understanding of the current status of CHC dental programs and will guide efforts to provide appropriate program support and leadership development.



Methods

The project was undertaken jointly by the Catalyst Institute and Massachusetts League of Community Health Centers. A survey questionnaire was designed and posted by using an online commercial web-based product, *SurveyMonkey*.⁶ Items were designed to collect information in three areas: general characteristics and profiles of the CHC dental programs; background information about the CHC dental director and his or her experiences in that role; and interest in a variety of continuing dental education topics. Where possible and appropriate, questions were taken from existing surveys.⁷ Additional questions were developed as necessary. Prior to distribution, the survey instrument was reviewed by two regional CHC dental directors, two dental public health professionals, and representatives from the Massachusetts League of Community Health Centers. Items were revised based on their input.

We obtained contact information for all existing Massachusetts CHC dental programs (n=33) and sent the final survey to the dental director at each of these sites. (A list of these programs is included on the back cover.) In March 2007, a letter from the President of the Massachusetts League of Community Health Centers was sent via email to each dental director that included a Web link to the online questionnaire. CHC dental directors were asked to respond within three weeks. Two weeks from the initial emailing, non-responders were contacted through reminder phone calls, and a second email was sent out. For those who did not respond within one week of the second reminder, the CHC's chief executive officer was contacted to encourage participation. The final response rate was 100%. The survey instrument and data tables are available at www.catalystinstitute.org.

6. <http://www.surveymonkey.com/>

7. Bolin KA and Shulman JD. National survey of work environment perceptions and dentists' salaries in community health centers. *J Amer Dent Assoc* 2005;136:214-220.

Capacity and Access

CHC dental programs alone do not have the capacity to meet current demand, especially given reported oral health disparities among residents of Massachusetts. In general, CHC dental programs were open longer hours and on more days than most private dental offices. In addition, most had more dental operatories per site than most private dental offices. Most CHC dental programs scheduled more patients per provider per day than those providers actually saw. In about three-fourths of CHC dental programs, patients did not keep more than one-in-five scheduled dental appointments. Waiting times for new appointments and for ongoing treatment were significant, although the reason(s) for such delays were unclear. In 67% of CHCs, new dental patients waited more than one month to be seen for their first dental appointment, and, in more than 33% of CHCs, the wait time was three months or longer.

Key Findings:

1. On average, CHC dental clinics were open 51 hours per week (range = 29.5 to 71 hours per week).
2. An equal number of CHCs were open five days (48.5%) or six days (48.5%) per week. One CHC dental program was open seven days per week.
3. The 33 CHC dental programs included 47 unique dental clinic sites with a total of 234 operatories (dental chairs). The mean number of dental operatories per CHC was 7.1 (range = 2 to 15 dental operatories).
4. On average, 15.8 dental appointments per provider in CHC dental programs were scheduled on a typical, full-working day (range = 9 to 20). On average, an individual provider saw 13.4 patients on a typical, full-working day (range = 8 to 20).

Figure 1. Percentage distribution of Massachusetts CHC dental programs by average waiting times for a new patient to be seen for first dental appointment, 2007 (n=33)

In 33% of CHC dental programs, new patients waited three months or more to be seen for their first appointment.

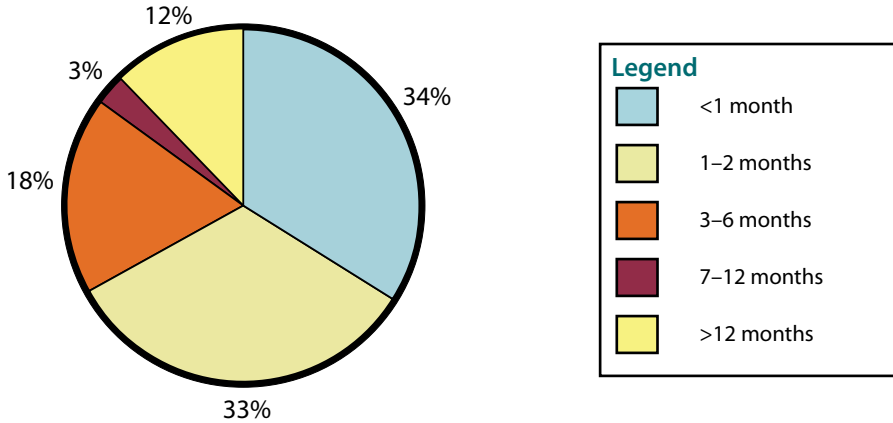


Figure 2. Percentage distribution of Massachusetts CHC dental programs by average waiting times for an existing patient to receive his/her next dental appointment, 2007 (n=33)

In about one-half of CHC dental programs, existing patients waited five weeks or more to be seen for their next appointment.

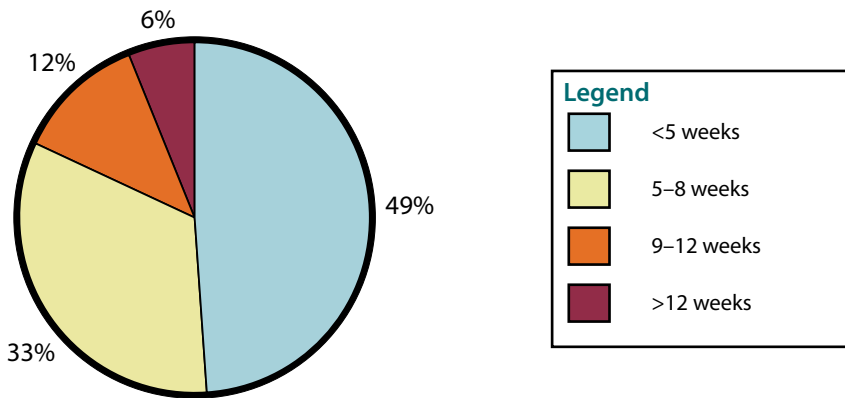
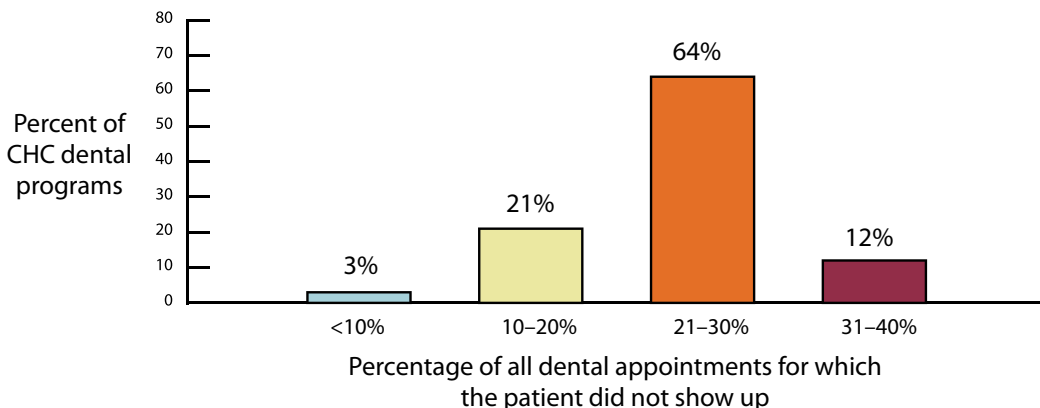


Figure 3. Frequency distribution of CHC dental programs in Massachusetts by no show rates, 2007 (n=33)

76% of CHC dental programs had a no show rate of greater than 20 percent. Only one CHC dental program reported a no show rate of less than 10%.



Workforce

Staffing patterns in CHC dental programs were different than those seen in private dental offices. Dental hygienists represented a much lower proportion of the total dental workforce. Limited-licensed general dentists are key providers within the community health center dental workforce. Two-in-five general dentists practiced with a limited registration dental license⁸ and were required to work under the direction of a registered dentist employed by the CHC. Two-thirds of CHC dental programs had one or more open dental staff positions. The number of open positions for general dentists (30 FTEs) and dental assistants (19.5 FTEs) and the turnover rate for these staff categories reduces capacity and income, limits access, increases waiting times, and presents staffing challenges for CHC dental directors.

Key Findings:

1. A total of about 429 full-time equivalents (FTE) staff were employed in CHC dental programs in Massachusetts. The average number of FTE staff per CHC dental program was 12 (range = 3.0 to 31.8 FTEs).
2. Dental hygienists represented about 7% of the dental workforce in CHCs in Massachusetts.
3. General dentists and dental assistants represented about 31% and 35% of the dental workforce in CHCs, respectively.
4. There were 70 open dental positions in CHCs in Massachusetts. About 43% of the open positions were for general dentists, 28% were for dental assistants, and about 19% were for dental hygienists.
5. Twenty-two CHCs were recruiting for one or more positions. On average, they were recruiting for 1.7 general dentists, 1.6 dental assistants, and 1.0 dental hygienist.
6. During the 24 months prior to the survey, CHC dental directors reported a net increase in dental staff: 75 FTE dental staff had left their position while 122 FTE had been hired. Among those leaving the CHC, general dentists and dental assistants represented about 47% and 33%, respectively. Among those who were hired, general dentists and dental assistants accounted for 36% and 42%, respectively.

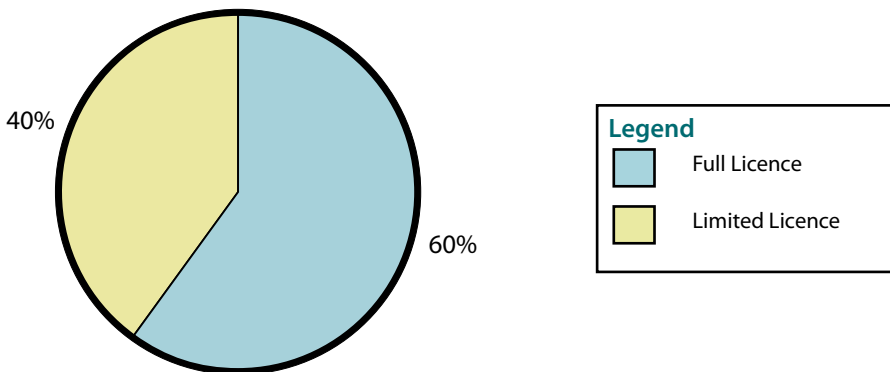
8. A limited registration may be granted to an individual who provides proof of receiving a diploma from a reputable dental school, other than one accredited by the Commission on Dental Accreditation, or has been employed as a faculty member of a school accredited by the Commission on Dental Accreditation, or, has been appointed as a dental intern in a hospital or other institution maintained by the commonwealth or by a county or municipality, or in a hospital or dental infirmary incorporated under the laws of the commonwealth. This limited registration allows the applicant to practice dentistry only in the hospital or other institution designated on his registration and under the direction of a registered dentist employed therein. The limited registration is issued for one year and may be renewed for up to five years. The only exception to this rule is if the individual is a full time faculty member. http://www.mass.gov/?pageID=eohhs2terminal&L=6&L0=Home&L1=Provider&L2=Certification%2c+Licensure%2c+and+Registration&L3=Occupational+and+Professional&L4=Dentistry&L5=Licensing&sid=Eeohhs2&b=terminalcontent&f=dph_quality_boards_p_dentist_foreign_trained&csid=Eeohhs2



The management of a Community Health Center Dental Clinic is a complex task that requires expertise above and beyond the technical skills of a competent dentist. I think it is imperative that a well-qualified dentist be the one to oversee this task.
–Survey Respondent

Figure 4. Distribution of general dentists by type of dental license among CHC dental programs in Massachusetts, 2007 (n=33)

Among the 131.8 general dentist FTEs employed at CHCs, limited registration licensed dentists represented about 40% of the workforce.



Services

All CHC dental programs in Massachusetts provided diagnostic, preventive, and restorative dental services. More complex services, including specialty services, were less available, although not uncommon. Community health centers were challenged by limited funding for complex services, such as oral surgery, endodontic, and fixed prosthodontic services. Emergency visits represented a significant proportion of total visits and presented significant challenges in a program's ability to balance the ongoing needs of its patients. While most CHC dental programs participated in oral health activities outside the existing clinic, most often these activities involved screening programs, health fairs, and oral health education and did not involve the provision of dental care.

Figure 5. Percent distribution of type of dental services provided among CHC dental programs in Massachusetts, 2007 (n=32)

Diagnostic, preventive, and restorative care were provided by all Massachusetts CHC dental programs. About 75% of the programs provided oral surgery, endodontic, and fixed prosthodontic services. Only one program provided orthodontic services.

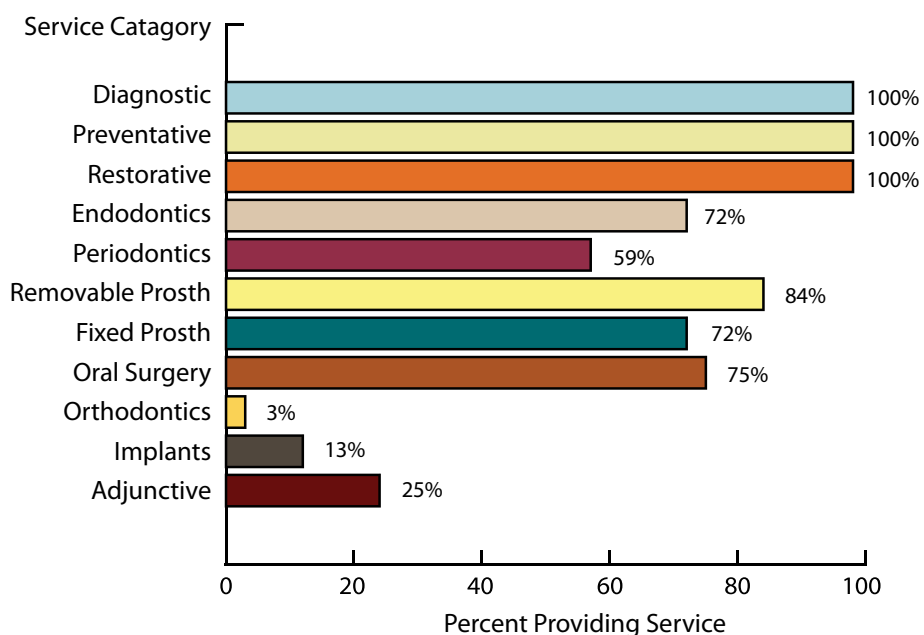


Figure 6. Percentage distribution of all dental visits for emergency/urgent care among CHC dental programs in Massachusetts, 2007 (n=33)

In 80% of CHC dental programs, emergency visits represented 10% or more of total patient visits. A large number of emergency visits can cause challenges in scheduling timely follow-up visits.

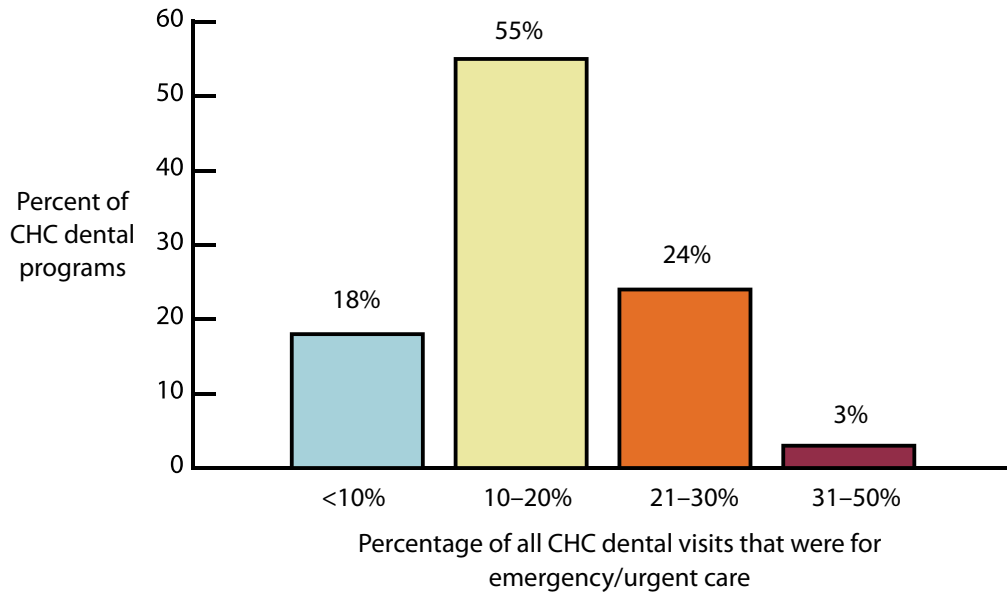
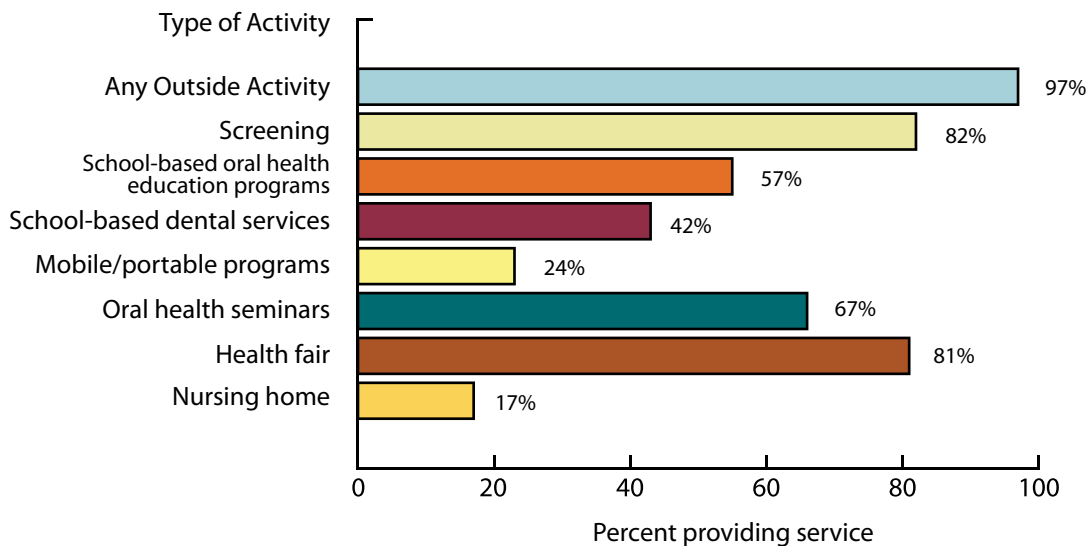


Figure 7. Frequency distribution of oral health activities offered by CHC dental programs in Massachusetts outside of CHC's dental clinic, 2007

Nearly all (97.0%) CHC dental programs offered outreach dental services in their communities. Screening programs (82%) and health fairs (81%) were the most common types of outside activities in which these programs participated.



Leadership Profile

Nearly one-half of current CHC dental directors were 50 years of age or older, and nearly one-quarter were 60 years of age or older. More than one-half of current CHC dental directors were women, and there was greater racial and ethnic diversity among current CHC dental directors than in the general dentist population in Massachusetts.

When asked about why they chose to work in a CHC, dental directors reported that they were motivated by a sense of mission to the dentally underserved population and a desire to practice in a community setting. A large proportion of CHC dental directors were previously employed as CHC dentists. Nearly all were satisfied with their CHC as a place to work, and about two-thirds of dental directors intended to always practice in a CHC setting. Most CHC dental directors reported either to their CHC's Executive Director or Medical Director and felt that they had the support they needed to be an effective dental director. Most CHC dental directors were members of one or more professional organizations, and more than half had a university or college faculty appointment.

On average, CHC dental directors were involved in providing direct patient care or supervising clinical activities for about three-quarters of their time.

Nearly all dental directors felt that they could benefit from additional continuing education that is relevant for dentists whose practice is in CHCs. Examples of such content included methods for increasing best practices in quality assurance, strategic scheduling designed to maximize efficiency and increase revenues, retaining qualified dental staff, and budgeting and strategic planning.

Key Findings:

1. Women represented about 55% of CHC dental directors.
2. About 33% of CHC dental directors had a master-level graduate degree in addition to their dental degree.
3. Over half (55%) of CHC dental directors had a university or college faculty appointment.
4. About 80% of CHC dental directors reported being members of the American Dental Association and the Massachusetts Dental Society. About 16% reported being members of the National Dental Association, and about 8% reported being members of the Hispanic Dental Association.
5. Prior to their current position, about 43% percent of CHC dental directors reported that they were previously employed as a CHC dentist. About one-third reported that they had been in private practice as an associate or employee.
6. About 25% of CHC dental directors had been in that role for one year or less, and about 33% had been in that role for one to four years. About 10% had been in that role for more than 10 years.

Figure 8. Frequency distribution of CHC dental directors by age group in Massachusetts, 2007 (n=31)

Nearly 50% of CHC dental directors were 50 years of age and older, about 25% were 60 years of age and older, and about 40% were under 40 years of age.

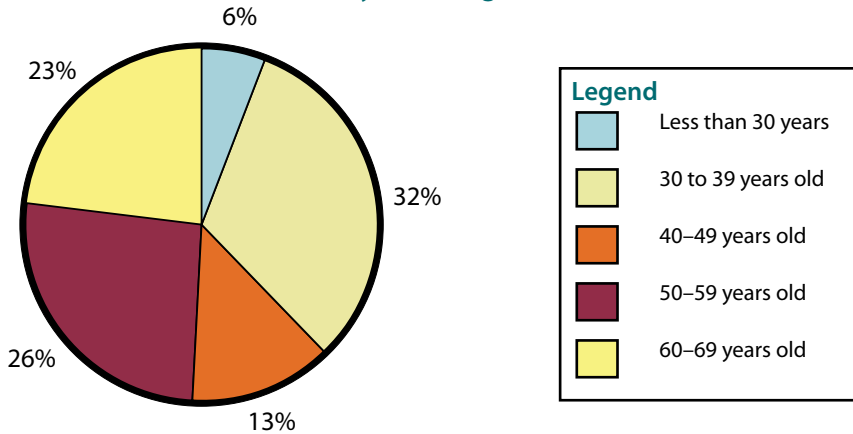


Figure 9. Frequency distribution of CHC dental directors by race and ethnicity among CHC dental programs in Massachusetts, 2007 (n=31)

When asked to report their race and ethnicity, about 44 percent of CHC dental directors described themselves as non-Hispanic white. About 23 percent reported being non-Hispanic Black or African American, and about 20 percent were Asian. About 10 percent characterized themselves as Hispanic whites.

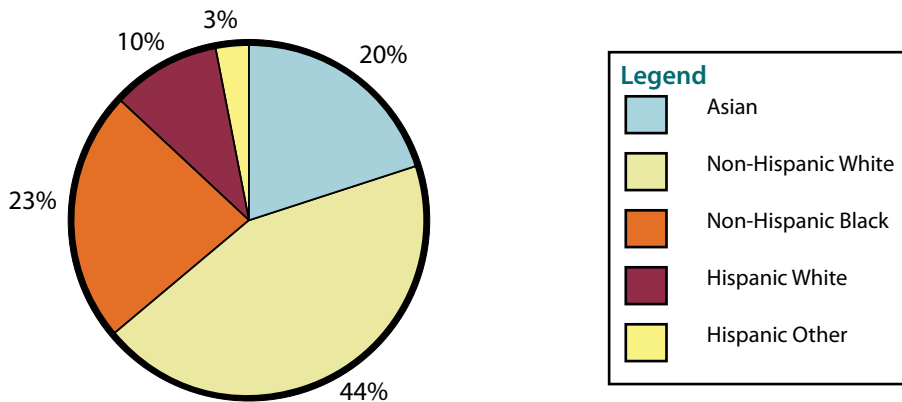
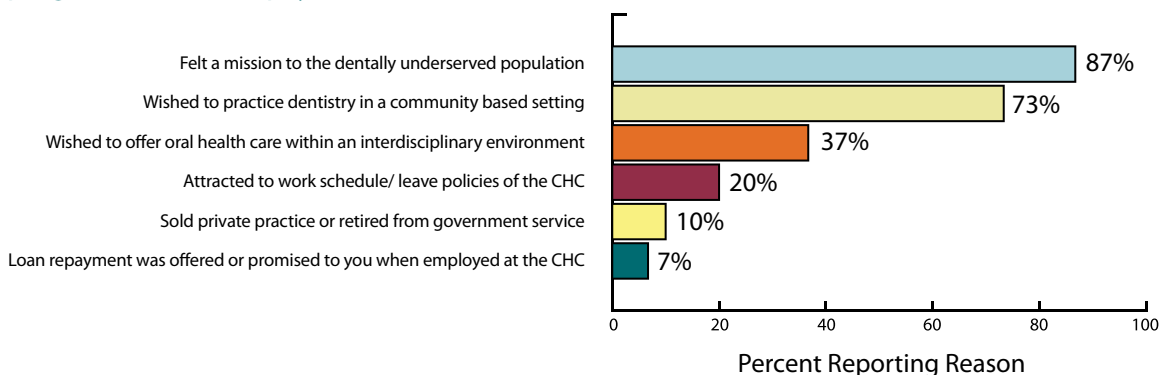


Figure 10. Frequency distribution of top reasons CHC dental directors report for choosing to practice in a CHC dental program among CHC dental programs in Massachusetts, 2007 (n=30)

When asked to list their top three reasons for choosing to practice dentistry in a CHC setting, an overwhelming majority (87%) of respondents felt a mission to the dentally underserved. About 7% worked in CHC dental programs for loan repayment.



Leadership Experience

Nearly one-half of CHC dental directors reported their annual gross salary to be less than \$100,000, and many were dissatisfied with their compensation.

According to the American Dental Association, in 2004, the average net income for an independent general private practitioner who owned all or part of his or her practice was \$185,940.

Key Findings:

1. Most CHC dental directors in Massachusetts did not live in the communities in which they practiced. On average, dental directors commuted about 22 miles each way to work (range = 2.3 to 100 miles).
2. CHC dental directors indicated that they reported mainly to the CHC Executive Director (60%) or the Medical Director (26%).
3. On average, community health center dental directors spent about 60% of their time providing direct patient care (range = 0% to 97%), 17% supervising clinical activities (range = 0% to 90%), and 23% on administrative duties (range = 3% to 100%).
4. Nearly all CHC dental directors (97%) in Massachusetts reported that they were satisfied with their community health center as a place to work and had the support needed from their CHC leadership to be an effective dental director.
5. About 67% of dental directors reported that they intended to always practice in a community health center dental program.
6. About 41% of survey respondents reported being dissatisfied with their current compensation package.
7. About 75% of dental directors felt that their dental program could do more to reach out to the community.

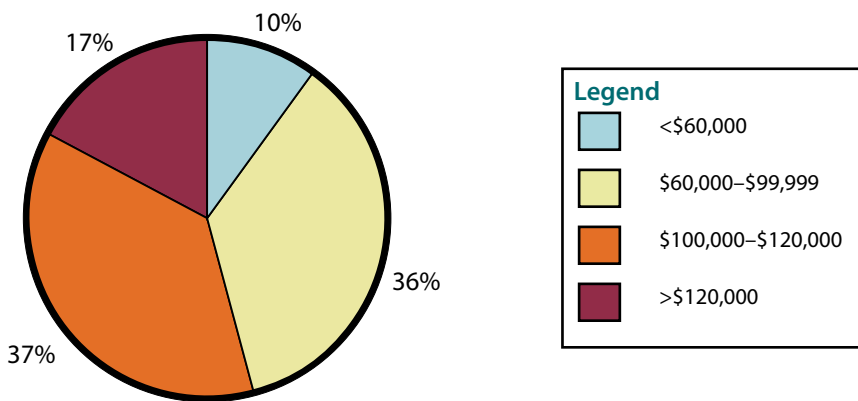
What I like most about my position as a community health center dental director is the ability to give something back to underserved populations as it relates to dental services and quality care.

–Survey Respondent



Figure 11. Frequency distribution of CHC dental directors by annual gross salary among CHC dental programs in Massachusetts, 2007 (n=30)

About 46% of CHC dental directors reported earning less than \$100,000 per year, while about 17% earned more than \$120,000, a salary more comparable to private practicing dentists.



Community Health Centers Participating in the Massachusetts Community Health Center Dental Director Survey (n=33)

Boston Health Care for the Homeless Program
Boston, MA

Brockton Neighborhood Health Center
Brockton, MA

Brookside Community Health Center
Jamaica Plain, MA

Cambridge Health Alliance Health Centers
Cambridge, MA

Caring Health Center
Springfield, MA

Codman Square Health Center
Dorchester, MA

Community Health Connections Family Health Center
Fitchburg, MA

Desmond Callan Community Health Center
(Formerly Community Health Center of Franklin County)
Turner Falls and Orange, MA

Dimock Community Health Center
Roxbury, MA

Dorchester House Multi-Service Center
Dorchester, MA

East Boston Neighborhood Health Center
East Boston, MA

Family Health Center of Worcester
Worcester, MA

Geiger-Gibson Community Health Center
Dorchester, MA

Great Brook Valley Health Center
Worcester, MA

Greater New Bedford Community Health Center
New Bedford, MA

Greater Roslindale Medical & Dental Center
Roslindale, MA

Harvard Street Neighborhood Health Center
Dorchester, MA

Healthfirst Family Care Center
Fall River, MA

Hilltown Community Health Centers
Huntington and Worthington, MA

Holyoke Health Center
Holyoke and Chicopee, MA

Joseph M. Smith Community Health Center
Allston and Waltham, MA

Lynn Community Health Center
Lynn, MA

Mattapan Community Health Center
Mattapan, MA

Mid-Upper Cape Community Health Center
Hyannis, MA

No Tooth Left Behind Dental Clinic [Brightwood]
(at German Gerena Elementary School in Springfield, MA)

North End Community Health Center
Boston, MA

North Shore Community Health
Peabody and Salem, MA

Roxbury Comprehensive Community Health Center
Roxbury, MA

South Boston Community Health Center
South Boston, MA

South Cove Community Health Center
Boston and Quincy, MA

South End Community Health Center
Boston, MA

Upham's Corner Health Center
Dorchester, MA

Whittier Street Health Center
Roxbury, MA