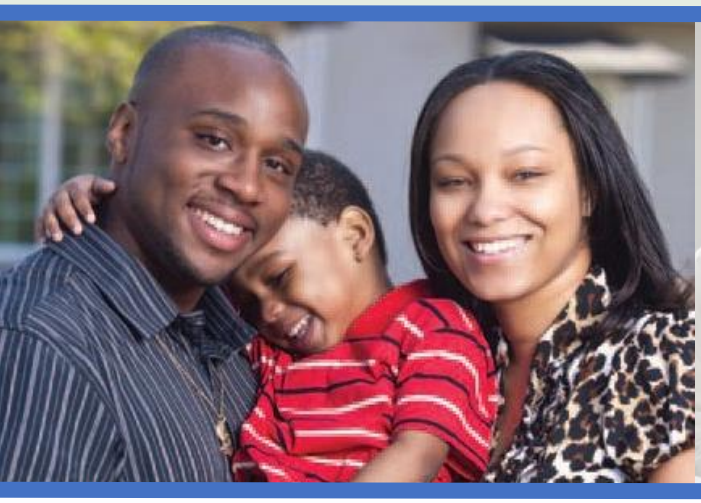
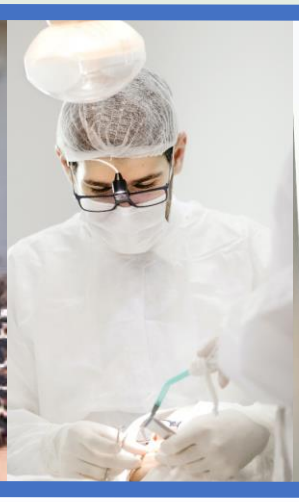
Chapter Five: Workforce

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Operations Manual

Chapter Five: Workforce

Version 2.0

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Note: The information in this document was accurate at the time of this printing. As regulations and information regarding Health Centers are not static, NNOHA recommends readers verify any critical information with different state/federal regulations and changes that may have occurred since printing.

Chapter Five: Workforce

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Executive Summary

Health centers are one of the primary sources of oral health care for people in the United States. Health centers must be equipped to provide quality care by having an established and competent workforce. Workforce issues are often a critical concern for health center oral health programs that are struggling with recruitment, retention, training, salary, and high turnover rates. NNOHA recognizes that a well-trained and committed oral health workforce is required for health centers to manage the growing needs for dental care, and to enable health centers to fulfill their mission of providing quality oral health care to its patients. This chapter of the NNOHA Operations Manual will provide helpful tools and resources for tackling the issues related to workforce for health center oral health programs. Topics discussed in this chapter include recruitment and retention strategies, successful staffing models, recommendations for staffing and equipment ratios, and effective use of dental team members. Health center oral health programs face the vital task of serving a growing number of patients. To meet this growth in demand, health centers need to be prepared to recruit and retain more oral health providers. By adopting creative workforce strategies, health centers can view this challenge as an opportunity to increase their capacity and address disparities in health care.





1. Introduction

Health Center oral health programs have grown significantly over the past decade. In 2018, more than 1,000 health centers (80% of all health centers)[1] had a dental program, compared to 800 in 2010.[2] Health centers serve nearly 28.4 million patients in the U.S. and its territories.[1] The number of people served by health centers continues to increase since 2000. This is also due in part to the Affordable Care Act which provided access to government health care programs for an estimated 32 million adults and 7 million children in 2010.[3] It is critical that health centers meet the needs of this growing patient population. As health centers add more dental programs, the need for quality staff committed to caring for underserved patients will grow as well. Health center dental staff 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. In 2018, health center dental programs served over 6.4 million people with 5,099 full time dentists.[1] Effectively managing and expanding the health center oral health workforce is an important piece of the puzzle in addressing the ever-increasing needs of underserved communities. This chapter of the NNOHA Operations Manual provides helpful tools and resources related to workforce, one of the top concerns for health center oral health programs. It offers insights on frequently asked questions such as productivity standards, nontraditional staffing, recruitment strategies, and salaries. In addition, this chapter of the NNOHA Operations Manual discusses emerging models of dental professionals for health centers.

2. Learning Objectives

Upon completing this chapter, the reader should be able 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 the health center dental program.
- Develop ideas and strategies for training and evaluating staff.
- Locate beneficial resources about workforce for dental programs.

3. Relevant Authorities

Public Health Service Act

Section 330 of the Public Health Service (PHS) Act is the main authorizing legislation for health centers. The PHS Act provides definitions, information on grants, population focus, audit information, and other general information. The entire text is available in Section 9 of this manual, Helpful Links.

Federal Tort Claims Act

The Federal Tort Claims Act (FTCA) is the federal legislation that allows parties claiming to have been injured by negligent actions of employees of the United State to file claims against the federal government for the harm they suffered. 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 (HRSA), as well as their directors, officers, employees, and certain contractors. These individuals` are considered employees of the United States for claims alleging injury resulting from the performance of medical, surgical, dental, or related functions. For more information about FTCA, follow the link in Section 9, Helpful Links.

Health Center Scope of Project

Information regarding health centers' scope of project can be found using the link in Section 9, Helpful Links. HRSA describes the policy for an approved scope of project for health centers funded under Section 330, 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.

Health Center Program Compliance Manual

Health Center Program Compliance Manual provides a consolidated resource to assist health centers in understanding and demonstrating compliance with Health Center Program requirements, based on the statute and regulations. For more information about the Compliance Manual and Health Center Program requirements, follow the link in Section 9, Helpful Links.

Health Care and Education Reconciliation Act of 2010

Public Law No: 111-152 and Public Law No: 111-148 comprise the Health Reform Law (Section 9, Helpful Links), 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 the 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. According to previous NNOHA Health Center Workforce Surveys, 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 health center and more likely to leave the program. The *NNOHA Health Center Workforce Survey Analysis of 2018 Results* identified 51.6 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.[5] The same principle applies to support staff and dental auxiliaries. Follow the link in Section 9 of this manual for the full *NNOHA Health Center Workforce Survey Analysis of 2018 Results.*

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 quantity 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 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 and attention should be paid to recruit applicants that understand the population and its cultural nuances.

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 ensure they comply with all employment laws, such as prohibitions on discrimination, through their hiring practices.

A. Recruitment Strategies

In the *NNOHA Health Center Workforce Survey Analysis of 2018 Results*, Executive Directors reported that advertising positions on online recruitment websites (i.e. Indeed, Monster Jobs, Ziprecruiter) was the most common recruitment method for dentists and dental hygienist vacancies. Other methods for recruitment included the NNOHA Job Bank, community health center website postings, and primary care associations.[4] The NNOHA Job Bank can be accessed in Section 9, Helpful Links. Other recruitment methods may be more effective for 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 may not necessarily be interested in living in an urban community. On the other hand, 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, it is important to know the distance to the nearest city that provides larger department stores, major cultural entertainment and 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 of both the candidates and their families. Schools and quality of life are major factors in recruiting. It is also important to communicate opportunities within the community for the candidate's spouses, partners, and family. All the members of the recruited providers support structure should be engaged in the recruitment process. It is also helpful to inform potential candidates that health center careers often provide benefits that may be unavailable to those in private practice. Such benefits may include: malpractice coverage, guaranteed salary, continuing education options, paid time off, paid membership dues, retirement programs, and the ability to collaborate with multidisciplinary health providers for the complete and comprehensive management of patients' needs.



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

Scholarship and Loan Repayment Programs

In the *NNOHA Health Center Workforce Survey Analysis of 2018 Results*, health center dentists ranked their primary reasons for being attracted to a health center dental career. The primary reason was that they felt a mission to provide care to the dentally underserved population. The second major reason was the availability of loan repayment.[4]

- **National Health Service Corps (NHSC)**
  Established in the early 1970s, the NHSC is a program of the U.S. Department of Health and Human Services' (HHS), HRSA. NHSC helps facilities and organizations located within Health Professional Shortage Areas (HPSAs)[6] recruit and retain medical, dental, and mental health providers through scholarship and loan repayment programs. HPSAs are used to identify areas and population groups in the United States that are experiencing a shortage of health care professionals. 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 are competitive, pay for tuition fees, and a living stipend to students enrolled in accredited dental and other selected clinical training programs. Upon graduation, scholarship recipients apply to serve as primary care providers between two and four years in a community-based site in a high-need HPSA that has been approved as a service site by the NHSC.

  As of the July 2020, the NHSC Loan Repayment Program offers dentists, dental hygienists, and selected other clinicians up to $50,000 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 $20,000 for the third and fourth years of service and $10,000 for the fifth year and beyond. 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.

  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.[6]

  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, refer to Section 9 Helpful Links.

- **State Loan Repayment Programs**
  Health centers can also utilize state loan repayment programs. The amount offered and years of commitment vary from state to state. HRSA maintains a list of state loan repayment programs, including award amounts and contact information for applications. For more information about state loan repayment programs, reference the link in Section 9, Helpful Links.

- **Other Loan Repayment Options**
  In addition to state loan repayment programs, some state dental associations offer special loan repayment programs. For example, California Dental Association Foundation has a loan repayment program that pays up to $105,000 for a three-year commitment for dentists who work in underserved areas.[7]

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 of gaining buy-in and support. Directly engaging these community members during a candidate's interview can help the candidate feel more comfortable in the community. 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 and 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.

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 workload, provide candidates with easy access to information about the area, and spearhead networking options for the spouse and other family members.

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. PCAs may utilize outside resources like the NNOHA Job Bank to help health centers recruit staff and providers. Others may maintain their own listing of state-specific vacancies upon their own website. For a complete listing of state and regional PCAs, visit the National Association of Community Health Centers (NACHC) State Regional PCA Listing webpage in the Helpful Links section.

Dental Schools, Residencies, and Dental Hygiene Schools

Dental schools, dental hygiene schools, and dental residencies including those supported by HRSA 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.[8] This white paper can be accessed in Section 9, Helpful Links.

Private Practices and Provider Associations

The NNOHA *Health Center Workforce Survey Analysis of 2018 Results* showed that nearly 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, 27.7 percent (51 out of 184 respondents) were previously a private practice owner, partner, or associate dentist, while 16.3 percent (30 respondents) were a private practice dentist prior to their health center employment.[4]



For dental hygienists, 70 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, American Dental Association (ADA), American Dental Hygienists Association (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 *NNOHA Health Center Workforce Survey Analysis of 2018 Results*, the ADA and NNOHA were the top two professional organizations joined by both dentists and dental directors. The top organization for dental hygienists was the ADHA. Dental professionals reported additional memberships in organizations such as the Academy of General Dentistry, Special Care Dentistry Association, and Primary Care Associations.[4] Being an active member of organized dentistry greatly increases the familiarity of private dentists with health centers and opens up numerous avenues for potential recruitment of providers and potential volunteers.

The NNOHA Job Bank

NNOHA coordinates a job bank to help connect health center dental programs with candidates looking for a career to serve underserved populations. NNOHA members and students looking for career opportunities may also submit an "Opportunity Wanted" ad. Job listings are posted on NNOHA's website as well as in NNOHA's biweekly newsletter.

For more information, please visit http://www.nnoha.org/resources/jobbank

B. The Hiring Process

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. These job descriptions are available in NNOHA's Dental Forms Library (Section 9, Helpful Links). 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 purposes or functions
- 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 the compliance program
    - Amount of experience needed for the position
    - Personal characteristics or traits needed
    - Description of physical demands of the position

Qualifications of a Dental Directors

Dental Directors, or Chief Dental Officers, 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. Additional skills may be required 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. In addition to clinical care, the Dental Director position does involve financial implications affecting health centers; therefore, it is essential that Dental Directors are active participants with the Leadership Team in the budget process and setting financial guidelines.

NNOHA has developed various resources to support the work of health center Dental Directors. Chapter 2 of this Operations Manual, *Leadership – Becoming an Outstanding Dental Director* is particularly helpful. The NNOHA Operations Manual can be found using the link in Section 9, Helpful Links. NNOHA also accepts applications for an annual cohort of Dental Directors and other leaders in oral health programs for their National Oral Health Learning Institute. *The Safety Net Dental Clinic Manual* is another useful resource for Dental Directors (Helpful Links section).

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.
- Complete provider reviews.
- Resolve conflicts.
- Allocate resources.
- Participate in Senior Administration management team meetings and discussion.
- Participate in annual meetings with the health center Board of Directors to present the state of affairs in the oral health program.
- Assist with the planning for expansion of services.
- Establish priorities and develop budget.
- 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.
- Serve as a member on the Quality Improvement team for the health center.

Credentialing and Privileging

Credentialing and privileging are the processes by which health centers ensure that their health care practitioners are competent and properly qualified to provide care to patients. Both credentialing and privileging are ongoing processes and should be reviewed and updated at least every two years. They are vitally important to protect patient safety, provide high-quality health care services, reduce medical errors, and avoid potential legal liabilities. The Federally Supported Health Centers Assistance Act of 1992 requires all health centers that participate in the FTCA program to credential all practitioners and other licensed or certified health care practitioners. For more information about FTCA, follow the link in Section 9, Helpful Links. The HRSA Compliance Manual also provides requirements for health centers in credentialing, privileging, and fitness for duty.

It is important that health centers understand their responsibilities with respect to credentialing and privileging and implement operating procedures for the initial and recurring reviews of credentials for clinical staff members (licensed independent practitioners (LIPs), other licensed or certified practitioners (OLCPs) and other clinical staff providing services on behalf of the health center) who are health center employees, individual contractors, or volunteers.

Specific credentialing procedures should ensure verification, as applicable, of current licensure, registration, or certification using a primary source; education and training for initial credentialing, using primary sources for LIPs, primary or other sources (as determined by the health center) for OLCPs and any other clinical staff; completion of a query through the National Practitioner Data Bank (NPDB); clinical staff member's identity for initial credentialing using a government-issued picture identification; Drug Enforcement Administration (DEA) registration; current documentation of basic life support training. Procedures for privileging should address the following: verification of fitness for duty, immunization, and communicable disease status. Initial privileging requires verification of current clinical competence via training, education, and reference reviews. For renewal of privileges, verify current clinical competence via peer review or other methods such as supervisory performance reviews; and establish process for denying, modifying or removing privileges based on assessments of clinical competence and/or fitness for duty. The health center needs to maintain files or records for its clinical staff, other employees, and contractors. These files include documentation of licensure, credentialing verification, and applicable privileges, consistent with operating procedures.

Credentialing and privileging is discussed in more detail in the NNOHA Operations Manual, Chapter 4: Risk Management.

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 of the oral health program, office, and working area.
    - Description of the health center, including mission, history, administrative structure, Board makeup and functions, funding mechanisms and departments.
- Introduction to co-workers and supervisors.
- Description of the compliance program.
- Orientation to relevant Federal, State, and local workplace regulations.
    - Comprehensive training on Occupational Safety and Health Administration (OHSA) 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.
- Best practices for documentation, treatment planning, and referral policies.
- 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.

Effectively Using Dental Hygienists

Dental hygienists are an important part of the dental team; they provide preventive care and education for patients. With changes in regulations, many states allow dental hygienists to practice under general supervision. Permitted functions and supervision levels of dental hygienists vary from state to state, depending on the state's dental practice act, or similar legal and regulatory scheme.

As of 2019:

- Eighteen states allow dental hygienists to receive direct reimbursement from Medicaid for prevention services rendered.[9]
- Forty-two states allow for direct access in at least some settings outside of the dental office.[10]

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 receiving care in health centers. Health centers should use all of their employees to the top of their licenses and 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.



For more information about states that allow direct access to dental hygienists or an overview of dental hygiene practice acts by state, visit the American Dental Hygienists' Association (ADHA) resources in the Helpful Links Section.

Expanded Function Dental Assistants

In some states, dental assistants who are authorized to perform certain activities involving intra-oral manipulation, for example the restoration of prepared teeth, may have specialized titles, such as expanded function dental assistants (EFDAs) or expanded duty dental assistants (EDDAs). The range of functions that EFDAs and EDDAs 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.[11] 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. Health centers should consult appropriate state regulating bodies to determine the permitted functions in their states. For more information about EFDAs, follow the Dental Assisting National Board link in the Helpful Links section.

Contract and Short-Term Employees

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*.[12] 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.[13]

Nonetheless, there are several factors a health center should consider before contracting for dental services. For example, one factor to consider is the consequence of providing services at a location other than the health center and the impact that 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 the Risk Management Chapter of the NNOHA Operations Manual and on the HRSA website (Helpful Links section).

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, operation, policies and procedures of the health center so that they understand the importance of their work and the environment in which the Health Center operates and how to effectively interact with your organization. This concept is further explored in NNOHA's white paper, *Contracting for Dental Services in Health Centers: Implementation Strategies* (Helpful Links section).

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) created a Federally Qualified Health Center (FQHC) Handbook for contracting with private dentists. This link is available in the Helpful Links section.



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. Semi-retired local practitioners can strengthen a dental program through their contributions, either 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, business principles of the health center, and an awareness of how health centers operate.

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 table below lists examples of alternative dental practitioners.

Alternative Dental Practitioners

Advanced Dental Hygiene Practitioners

- "Proposed as case managers and primary dental care providers who could assess risk, educate, provide preventive services and basic restorations, refer patients for complex services, and do follow-up."[14] This model was proposed by the ADHA. For more information about dental hygiene based dental workforce models, visit: https://www.adha.org/resources-docs/75112_Hygiene_Based_Workforce_Models.pdf.

Community Dental Health Coordinators (CDHC)

- Proposed by the American Dental Association (ADA) as "community health workers with dental skills focusing on education and prevention.[15] The use of this type of practitioner targets improving access to care in underserved communities.

Dental Therapists

- "Primary dental care providers focused on delivering basic preventive and restorative care to children, and in some places, adults."[14] Many states have sought legislation to include dental therapists as part of their dental care teams. As of 2019, according to ADHA, 13 states recognize dental therapists as a potential model to address access to care challenges.[16]

Patient Navigators and other Community Health Workers

- "Members of the health care team who helps patients navigate the health care system and get timely care. Navigators work with patients to identify barriers to health care and connect them to the resources they may need such as financial assistance, counseling, language translation, or transportation."[17] Patient navigators do not provide care, but they can be an important member of the team that ensures the patient receives the best possible care.

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 that can vary state-by-state. Health centers need to stay up to date with their own state regulations.

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 payer 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.[16]

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 EFDAs or similar practitioners. A health center becomes more efficient and increases its patient capacity if it utilizes the maximum number of dental assistants and employs a flexible dental assistant support system that allows extra functions normally performed by dentists. 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 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. According to the HRSA Uniform Data System (UDS), health center dental hygienists provided an average of 1,150 visits annually.[1]
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 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 for 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 Children's Health Insurance Programs (CHIP), this strategy can also increase a health center's revenue while promoting prevention within the community. It is important to remember that the addition of these types of programs to a health center project requires prior approval via a change in scope request. As with all project changes, the health center should consult with its HRSA project officer regarding the need for a Change in Scope of Project before adding any sites or services.

Support staff
Depending on the size of the program, it is essential 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 assisting 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. For more information on staffing ratios, refer to the Safety Net Dental Clinic Manual in the Helpful Links section.

Responding to National Emergencies
Staffing ratios may need to be adjusted in the event of national emergencies such as the 2020 COVID-19 pandemic. Health centers should be prepared to adapt to the continuously changing environments during national emergencies. This includes changes in roles for dental team members such as redeploying dental team members to assist in other areas of the health centers and reduction in the number of dental team members in the dental clinic.

NNOHA recommends health centers consider the following factors for staffing ratios in the event of a national emergency versus the traditional ratios described above:

- Number of dental operatories per dentist.
- Number of dental residents.



- New infection prevention and control protocols as a result of the national emergency (more dental team members may be required to accommodate changes in sterilization and enhanced personal protective equipment (PPE)).

Health centers may consider a staffing ratio of one dental assistant for each scheduled operatory in the dental clinic instead of a dental assistant to provider ratio. Additionally, health centers should consider the number of support staff needed to accommodate increased infection prevention and control.

C. 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.



There are studies that 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.[19]

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, the opportunity increases 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/Chief Executive Officer (CEO) to oversee and ensure the appropriate operations of the Center. The Executive Director/CEO, 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, Chief Operating Officer (COO) and Chief Dental Officer (CDO) or 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 a 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/CEO. NNOHA's *Survey of Health Center Oral Health Providers* showed a significant association with the title of the Dental Director's supervisor (i.e. CEO/Executive Director versus EMO/Medical Director) and their job satisfaction as indicated by the length of time they intend to stay at their health center.[5] An example organizational chart is available in Appendix B.

Having the Dental Director report directly to the Executive Director/CEO 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.

B. Managing and 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 smoother. 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.
- **Well-defined organizational charts:** When organizational charts are well-defined, everyone understands where they fit into the overall organization, which allows employees to clearly visualize that they are an integral part of the health center. Organizational 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 (i.e.



monthly 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 tremendous impact on staff performance and productivity.
- **Create and perform annual competencies for each clinic staff member:** It is essential that all team members display competency in various aspects of their work. Annual competencies are a way to engage with staff members to ensure quality oral health care is delivered to patients.

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 2018 UDS results, the average annual visit rates are 2,630 per dentist, 1,150 per dental hygienist, and 783 per dental therapist.[1] On average, there were 2.58 visits per patient each year. On average, the cost per dental visit was $200.31.[1] 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, and patient needs. 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 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. Health centers should note that some encounters that are considered "visits" for UDS reporting purposes may not be considered billable visits for Medicaid, CHIP, or other health care programs.

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.

1. **RVU System** enables a director to quantify the output of services performed by the provider. RVUs help determine if fees reflect the relative value of one procedure as compared with another procedure and provide a mechanism for establishing a baseline set of fees. This baseline should be used as a starting point for developing an appropriate fee schedule. A set of RVUs for the procedures your clinic provides may be obtained from a company or organization that studies and analyzes dental procedure RVUs, or may be developed internally, based on the value the clinic's health professionals and administration place on the specific set of procedures performed in the clinic.
2. **Dollar Value System** is often used by health centers because patients do not pay in RVUs nor are providers compensated in RVUs. It keeps the language for comparison the same from the chief financial officer'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. More information about productivity measures can be found in the Safety Net Dental Clinic Manual in the Helpful Links section.



D. Administrative and 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 health center and the Dental Director. In the *NNOHA Health Center Workforce Survey Analysis of 2018 Results*, about 53 percent of respondents indicated there was not enough or no time allocated for assigned administrative duties. There was an average of 11.7 hours per week allocated for Dental Directors to perform administrative work.[4]

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 likely adequate for administrative duties.
- 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, then 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. To improve provider satisfaction, especially among less-experienced staff and relatively recent hires, health centers should consider implementing robust orientation programs, lunch and learns, or other continuing education and training opportunities to help medical providers and oral health providers better understand each other's work and build stronger relationships, and mentorship programs where experienced oral health staff help guide new staff. Dental directors, oral health program managers, and the entire administrative team should also instill a culture of daily dedication to the health center's mission to help build a sense of community purpose.



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 effective dental providers and supporting staff such as, dental assistants and front desk personnel.

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. According to the ADA's 2018 Health Policy Institute data, the average annual net income for a general dentist in private practice is close to $200,000 per year. When presenting a compensation offer, health centers should include all benefits and their values, which may include base salary, sign-on bonus, loan repayment, vacation, holiday and sick days, continued education allowance, retirement plans, health, disability and life insurance, and annual and incentive bonuses. Benefit packages in health centers tend to be more robust than those offered in private practice, and this can give health centers a competitive advantage over private practice, where base salaries may be higher. Salaries should be presented in writing with allowance for negotiations by an authorized official to negotiate and approve salary adjustments. Health centers should not include loan repayment in the dental salaries.

In the *NNOHA Health Center Workforce Survey Analysis of 2018 Results,* nearly 39% of dentists indicated that their salaries were over $140,000 (not including benefits), 23.7% had salaries between $125,000 and $140,000, 23.7% had salaries between $110,000 and $125,000, 11.9% between $95,000 and $110,000 and 1.7% had salaries at or below $95,000.

Approximately 38.2% of hygienists had salaries over $70,000, 27.3% between $60,000 and $70,000, 21.8% between $50,000 and $60,000, 10.9% between $40,000 and $50,000 and 1.8% below $30,000.

Salaries should reflect market rates for the local areas in which each health center operates. There are a variety of resources available to help determine salaries for various dental staff positions. For more information on salaries for dental professionals, visit the ADA Health Policy Institute website or the Bureau of Labor Statistics website in the Helpful Links section.

B. Incentive Programs

Incentive programs may be helpful in retaining and motivating dental staff by rewarding them for their performance. Incentive plans should supplement rather than take the place of annual performance evaluations of all dental staff and merit-based pay increases. While many health centers only provide incentive programs to dentists (and possibly hygienists), an incentive program that rewards all members of the dental staff fosters teamwork and shared accountability. In developing an incentive program, consider what results you are trying to encourage, and be aware of the potential for unintended consequences. For example, an incentive program that rewards dental staff only for meeting or exceeding encounter goals might encourage the team to achieve lots of visits without much meaningful care being provided in each visit. An incentive program based on gross charges might result in lots of costly or unwarranted procedures (that may or may not be covered by insurance or could pose a financial burden to uninsured patients).

Incentive programs should be easy to administer and easy for staff to understand. A successful incentive program depends on the ability to gather accurate and timely data on the performance measures. A strategic incentive plan includes both individual provider goals and team goals. Goals should be meaningful (i.e. support program success) but also realistic and achievable. Individual provider goals can include several metrics such as access (number of encounters), revenue (net not gross), productivity (number or types of services and/or relative value units) and quality (such as percentage of completed Phase I treatments, patient satisfaction scores and/or compliance with documentation requirements). Team incentives are usually based on important overall program goals such as net revenue.

One basic rule of incentive programs should be that they don't kick in unless the dental program reaches at least break even for the incentive period (which could be monthly, quarterly or annual). It doesn't make sense to reward staff if the dental program is operating in the red. Money to fund the incentive program should be built into the dental budget as a direct operating cost.

Staff should only be eligible for the incentive program once they are past any probationary periods for new hires. Incentives should be pro-rated for part-time staff. In formulating its incentive program, the health center should decide how it will manage incentives for staff with performance or disciplinary issues (such as chronic tardiness or excessive use of sick time).

Incentive programs should be developed in collaboration with the Executive Leadership team. Many factors can impact how incentive programs are structured. The goal, however, is to design a program that is a win for the staff, a win for patients and a win for the health center. Examples for different Incentive Programs can be seen in Appendix A.

C. Combating Burnout

The *NNOHA Health Center Workforce Survey Analysis of 2018 Results* showed that burnout was the #1 reason why respondents indicated they might leave their health center. Preventing burnout among all members of the dental staff is paramount, as the negative impact of frequent turnover is significant. Workforce turnover may result in lost productivity, loss of institutional knowledge, and incurred costs of



recruiting and training qualified staff. Staff burnout is also discussed in the Quality Chapter of the NNOHA Operations Manual (Helpful Links section).

The best way to retain staff and combat burnout is to create a positive and rewarding work environment. The list below provides some important strategies. More specific guidance on creating a productive work environment and leading a dental team is available in the Leadership Chapter of the NNOHA Operations Manual (Helpful Links section).

1. Set realistic and achievable goals (especially the number of encounters). Asking staff to treat more patients than they can realistically accommodate on a regular basis is a sure path to burnout. Determine the potential daily visit capacity based on program structure and manage to that capacity.
2. Make sure staff has the tools and resources they need to do their jobs. Having enough support staff prevents frustration of providers trying to maintain a good patient flow.
3. Provide opportunities for career growth and development such as career ladders, opportunities to learn new skills and promotion from within.
4. Actively seek out staff feedback and ideas—employees want to have a say in decisions that impact them and their patients.
5. Recognize staff for their hard work and dedication—everyone wants to feel valued and appreciated. Engage in team-building activities to strengthen the bonds between staff.
6. Give staff regular feedback on program performance. Seek their input in problem-solving barriers to success. Develop and maintain open channels of communication—employees who feel like they have a voice are more likely to stay
7. If you are the dental leader, you should have adequate time to perform your administrative work. The amount of time depends on the size and complexity of the dental program and could range from a few hours a week to full-time.

D. Continuing Education and Training

Allowing time and funds for quality continuing education (CE) and training for providers has two benefits. First, it helps to ensure that patients are receiving care that is up-to-date and meets or exceeds the community standards. Second, it allows providers to continue their professional development—a necessity for provider satisfaction and continued licensure.

The scope of treatment of health centers may not always satisfy a provider's needs for professional growth and quality CE allows for professional development beyond the current scope in a health center. This is very important for provider satisfaction and retention. 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.

According to the *NNOHA Health Center Workforce Survey Analysis of 2018 Results*, dentists average $1,916 per year in CE reimbursement and hygienists average $1,208. CE credits can be obtained at conferences that also emphasize the particular needs of health centers and public health.

A variety of CE opportunities also exist through online webinars, programs, or conferences. While CE delivered electronically has the advantage of eliminating travel and lodging costs, it does not provide opportunities for networking and interaction with dental providers in similar situations. This type of networking helps to reduce feelings of isolation while offering support and camaraderie among health center providers, managers, and staff, which is known to influence long-term retention. Networking



through CE opportunities encourages sharing of evidence-based practices and models, lessons learned and resolutions to relevant issues.

Continuing Education Options for Health Center Dental Professionals

Annual Conferences

- NNOHA Annual Conference
  http://www.nnoha.org/event/nnoha-annual-conference/
- National Oral Health Conference
  http://www.nationaloralhealthconference.com

Online Continuing Education

- NNOHA webinars
  https://www.nnoha.org/calendar/
- HRSA Bureau of Primary Health Care
- Primary Care Associations
- National Association of Community Health Centers
- Local dental and dental hygiene associations
- National organizations

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.

In addition to clinical training, other training for oral health providers in a community health setting may include cultural competency, motivational interviewing, behavioral health, substance use disorders, trauma-informed care, narcan training, and oral health care for people with special health care needs. Here are some resources for online trainings:

- Cultural Competency for Oral Health Professionals
- Special Care: An Oral Health Professional's Guide to Serving Children with Special Health Care Needs
- Effective Communication for Oral Health Professionals
- Trauma Informed Care and Resilience
- Caries Management
- Clinical Training

E. Staff Evaluation

Evaluation of performance is an integral part of health center operations. Like incentive programs, it is a way to motivate employees to do their best, recognize and reward excellence, and strengthen commitment to the mission of the program. Performance evaluations can also be an informational tool to increase retention as feedback obtained through staff performance evaluations can be used to improve the work environment. Performance evaluation enables the health center to make sure the staff is a good fit for the organization, discuss staff satisfaction, career development opportunities, and performance improvement needs if warranted. An effective evaluation is a two-way dialogue between



the program leader(s) and each staff member who reports to them. Most health centers have formal performance evaluation processes that need to be followed to ensure consistency of content and delivery. In addition to the annual performance evaluation, dental program leaders should see employee performance assessments as an ongoing process of seeking and providing feedback around individual and program goals. Effective leaders are continually looking for constructive ways to develop and improve staff performance and job satisfaction. A satisfying and rewarding work environment is one where program leaders and staff can question, challenge and discuss goals and objectives to gain clarity on an ongoing basis. A sample provider evaluation form is available in the Helpful Links section.

F. Internal Staff Development

Internal promotions for existing staff members are an additional way to motivate performance and may help prevent burn out. For example: a good front desk staff member could be promoted to become a dental assistant and be trained for the new position within the organization. This provides a new and exciting role for a person which may include a pay raise and also contribute to the important cross training among staff. Another example could be encouraging and paying for a dental assistant to pass the registered dental assistant exam. A dentist who has proven to be an excellent team member could be promoted to lead clinician. These are just a few examples that can help prevent burn out, bring new excitement to the workplace, and possibly encourage capable people to stay with the health center rather than considering other opportunities.

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 remains a challenge.

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 need to evolve and be more innovative in their workforce-related strategies in order to address their workforce needs. By addressing workforce needs from multiple viewpoints, health centers will ensure that they have the qualified oral health providers that they need in order to improve the health of their community.

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 improved retention through job satisfaction of their providers at the health center.



9. Helpful Links

NNOHA Links

- NNOHA Job Bank: https://www.nnoha.org/resources/jobbank/
- NNOHA Partnerships with Academic Institutions and Residency Programs to Develop Service Learning Programs: https://www.nnoha.org/nnoha-content/uploads/2016/07/Academic-Partnerships-Paper-revised-7.12.16.pdf
- NNOHA Dental Forms Library: https://www.nnoha.org/resources/dental-program-management/dental-forms-library/
- NNOHA Operations Manuals: https://www.nnoha.org/resources/operations-manual/
- NNOHA Contracting for Dental Services in Health Centers: Implementation Strategies http://www.nnoha.org/nnoha-content/uploads/2017/07/Contracting-Implementing-Strategies-FINAL-July-2017.pdf
- NNOHA Sample Performance Evaluation Form: http://www.nnoha.org/nnoha-content/uploads/2013/08/Miscellaneous-Performance-Appraisals-English.pdf
- NNOHA Health Center Workforce Survey Analysis of 2018 Results http://www.nnoha.org/nnoha-content/uploads/2018/10/Workforce-Survey-2018_Final-report.pdf

HRSA Links

- Public Health Service Act: https://www.hrsa.gov/about/legislation/bphc.html
- Federal Tort Claims Act: http://bphc.hrsa.gov/ftca/index.html
- HRSA BPHC Scope of Project: https://bphc.hrsa.gov/programrequirements/scope.html
- HRSA Health Workforce Connector: https://connector.hrsa.gov/connector/
- HRSA THCGME: https://bhw.hrsa.gov/grants/medicine/thcgme
- HRSA Health Center Compliance Manual: https://bphc.hrsa.gov/programrequirements/compliancemanual/index.html
- Health Care and Education Reconciliation Act of 2010: https://www.govinfo.gov/content/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf http://www.gpo.gov/fdsys/pkg/PLAW-111publ152/pdf/PLAW-111publ152.pdf

Other Helpful Links

- Children's Dental Health Project: Increasing Access to Dental Care through Public Private Partnerships: http://www.nnoha.org/nnoha-content/uploads/2019/09/FQHC_Handbook_March_2011_0.pdf
- National Health Service Corps (NHSC): http://nhsc.hrsa.gov
- NHSC scholarship: http://nhsc.hrsa.gov/scholarship/
- NHSC loan repayment: http://nhsc.hrsa.gov/loanrepayment
- State Loan Repayment programs: https://nhsc.hrsa.gov/loanrepayment/stateloanrepaymentprogram/contacts.html
- National Association of Community Health Centers (NACHC) State Regional PCA Listings: http://www.nachc.org/about-nachc/state-affiliates/state-regional-pca-listing/
- American Dental Hygiene Association (ADHA) Direct Access to Dental Hygienists: https://www.adha.org/resources-docs/7513_Direct_Access_to_Care_from_DH.pdf
- ADHA Scope of Practice for Dental Hygienists: https://www.adha.org/scope-of-practice
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11. Appendices

Appendix A – Dentist Incentive Programs

The resource below was provided by Dr. Mark Koday and DentaQuest.

What are the parameters to be met?

- Dental program reaches sustainability first
- Financial goals designed to generate at least enough revenue to meet direct and indirect expenses
- Productivity goals designed to increase access AND foster completion of treatment plans
- Contains quality goals

Reward all staff or only those who meet individual financial/productivity goals?

- Rewarding all staff fosters teamwork and accountability
- If wide variability exists among providers, consider basing bonuses on individual performance AND attainment of departmental goals

How to make it work



- Profit forms “incentive pool” from which bonuses are distributed
- Support staff can receive either:
    - Fixed dollar amount bonus or
    - Flat rate percentage of available incentive pool
- For providers, % of incentive pool received should be based at least in part on attainment of individual goals set
- Bonus amount given should be pro-rated based on number of hours worked

Metric to Measure

- Access (visits, priority populations)
- Productivity (gross charges, net revenue, number of procedures)
- Quality (completed treatments, other outcomes, compliance with documentation, etc.)

Setting Goals

- Know your costs (direct and indirect)
- Know your potential capacity
- Define realistic capacity
- Define your quality measures (HRSA, Healthy People 2020)
- Use benchmarks as guides

Provider Goals

- Number of visits per day
- Number of procedures per visit
- Gross charges/day
- Gross charges/visit
- Projected net revenue/day (based on practice’s overall collection rate)
- Number/percentage of completed treatments
- Other outcomes measures, if applicable
- Compliance with documentation (target: zero variance with quarterly chart audits)

Practice Goals

- Failed Appointment Rate <15-18%
- Gross Charges (based on expected collection rate)
- Net Patient-Generated Revenue
- Total Visits
- Payer Mix
- Patient Mix (percentage of priority populations)

Residency programs

- For clinics with dental residents or student, staff dentists who precept get full credit for whatever revenue their residents or students generate

Dentist Incentive Examples

Example 1: Commission based

- Providers’ salaries are 100% based on a percentage of their productivity (typical range is 30-35%)



- Productivity = the net revenue collected for the dentistry each provider performs
- Review the market rates for providers and offer a competitive and fair commission that your dental program can afford
- The provider receives fringe benefits in addition to the commission
- Providers who elect not to receive benefits may receive a higher commission
- For each 2-week pay period, run reports by provider to determine payments posted to patient accounts for services provided by that provider
- Multiply that amount x commission percentage to determine gross pay for payroll
- Payroll taxes and employee benefit contributions are subtracted just like they would if the provider were salaried
- For example, for two-week pay period, payments totaling $24,000 were posted to patient accounts for services provided by Dr. A
- $24,000 x 35% = $8,400 in commissions owed to Dr. A
- Payroll taxes and employee deductions = $2,100
- Total paid out to Dr. A as "salary" = $6,300
- After taxes and other withholdings, Dr. A net $163,800 per year

Pros & Cons

- Providers are highly motivated to be productive
- Potential for providers to abuse system by over treating—need to monitor to ensure quality
- Potential for providers to abuse system by cherry-picking patients—need equitable scheduling process and controls on who schedules appointments
- Establish quality assurance indicators to ensure ethical work
- Monitor completed treatment plans, patient outcomes and patient satisfaction

Example 2: Base Plus Commission

- Providers are guaranteed a base salary plus ability to receive commissions on revenue above a pre-determined threshold
- For example, base salary of $110,000/year
- Dentist generates net productivity of $24,000 each two-week pay period and receives 35% of productivity above $18,000
- $6,000 x 35% = $2,100
- $1,575 after taxes/deductions x 26 pay periods = $40,950 in additional net take home pay for total salary of $150,950
- But potential to increase take home salary by increasing productivity

Example 3: Incentive Bonus

- Provider receives a market rate salary
- Provider is eligible for periodic bonuses based on the attainment of defined goals
- Goals should cover access, productivity and quality goals
- Not strategic to base bonuses solely on number of visits
- Crucial to have good systems to generate reliable data to track and share performance
- A full-time dentist gets an annual salary of $150,000 plus benefits
- On a quarterly basis, the dentist's performance in meeting practice goals is reviewed
- If the dentist meets or exceeds practice goals, he or she receives a bonus
- Available bonus is $1,500-$3,000 per quarter



- $1,500 awarded for meeting goals with higher awards for exceeding goals (e.g., $2,000 for exceeding goals by 25%, $2,500 for exceeding goals by 50%, $3,000 for exceeding goals by 75% or more)

Staff Bonus Programs

Many dental practices have incentive programs in place to reward dentists for meeting or exceeding productivity goals. Financial rewards can be a powerful tool to motivate providers to work harder and achieve key practice goals. But what about the rest of the dental staff—what is being done to reward them? Practices that reward only the dentists (or dentists and hygienists) are missing an important opportunity to create overall teamwork and shared accountability by investing each member of the dental practice in rewards based on the successful attainment of key strategic goals.
Bonuses can be awarded monthly, quarterly, semi-annually or annually. We recommend quarterly as that keeps the reward program fresh in everyone's minds.

For any given quarter, **a net revenue** threshold must be met for the bonus program to be activated. Net revenue should be used as this figure represents **actual** revenue collected for patient care provided—staff should not be rewarded for anticipated or expected revenue (e.g. **adjusted production**) because of the risk that the practice won't collect enough of the expected revenue to cover its direct and indirect operating expenses.

The quarterly net revenue threshold needs to be determined for each individual dental program as one-fourth of the total net revenue needed to at least break even (that is, generate enough net revenue to cover all of the direct and indirect expenses for the dental program). For example, if the dental program needs to collect $1,000,000 in net patient revenue to break even, the quarterly net revenue threshold to be met for the bonus program to kick in will be $250,000. If the practice collects $250,000 or more in net patient revenue, each staff members receives a bonus. If the practice falls below the $250,000 threshold, bonuses are not awarded for that quarter.

The projected cost of the bonus program needs to be identified on an annual basis and included as a line item expense in the annual operating budget. Dental staff can be broken up into reward categories based on job functions:

1. Dental assistants and reception/registration staff
2. Expanded Function Dental Assistants
3. Dental hygienists
4. Clinic manager(s)
5. Dental billers

Quarterly bonus amounts can be the same for each staff member or be different for each job category. In the following example, dental assistants and reception/registration staff receive the same amount ($350 per quarter). Expanded function dental assistants get $400 per quarter, and hygienists and the hygienists and the practice manager get $500 per quarter.

Example - Quarter 1: Net revenue threshold is met

Staff Type	Quantity	Bonus Amount	Total
Full-time dental assistant	2	$350	$700
Part-time dental assistant	2	$175	$350



Full-time reception	2	$350	$700
Part-time reception	1	$175	$175
Expanded function dental assistant	2	$400	$800
Full-time dental hygienist	1	$500	$500
Part-time dental hygienist	1	$250	$250
Practice manager	1	$500	$500
		Total	$3,975

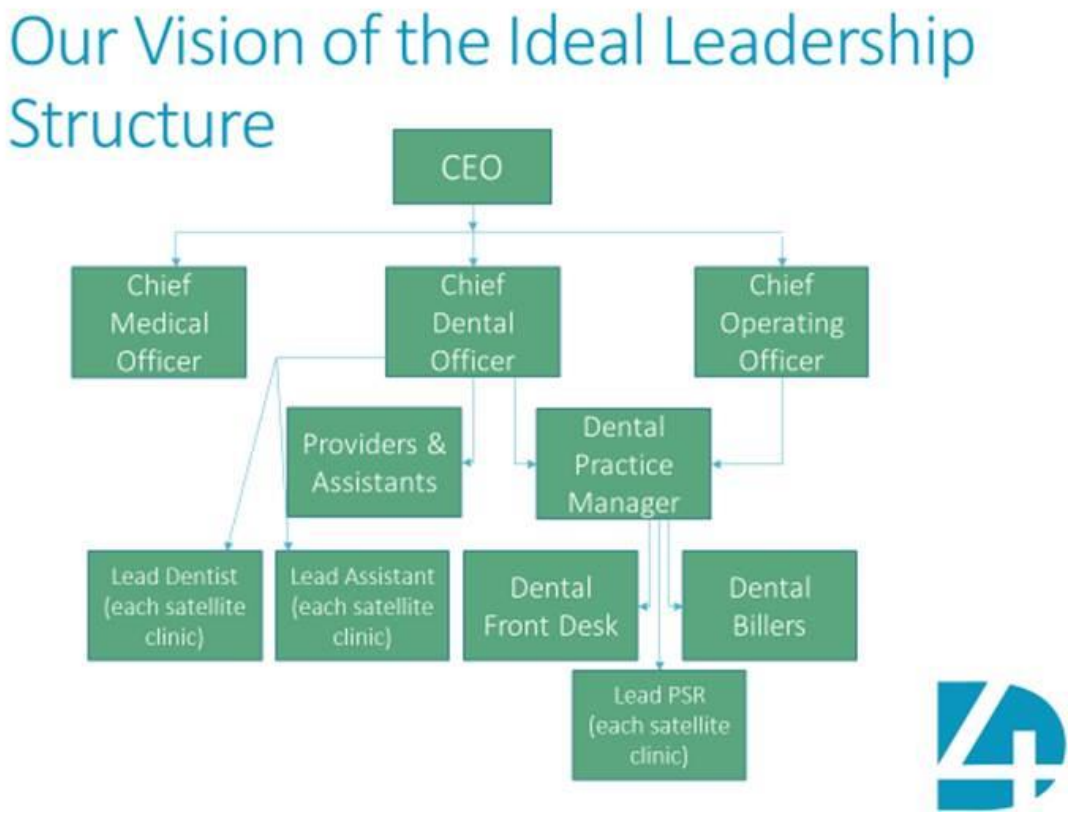
In determining the annual bonus line item expense for the year, the dental program should plan for the possibility that the dental practice will meet the quarterly threshold four times to ensure that sufficient funds are allocated in the operating budget for the bonus program. In the sample above, the dental practice will budget $15,900 for the annual bonus program.

In the event the net revenue threshold is not met for a particular quarter, practice leadership should assemble the entire dental team to evaluate program performance for the quarter against practice goals and discuss barriers to success and potential strategies for overcoming those barriers.
Some additional components of the bonus program dental practices can consider:

- New staff members do not qualify for the bonus program until after the first 90 days of their employment.
- Staff who have more than a defined number of unscheduled absences (e.g. 3 or more) in the quarter forfeit their bonus for that quarter.

Appendix B – Organizational Chart Example

Organizational chart example provided by D4 Practice Solutions.



Appendix C – NNOHA Position Statement on New Dental Workforce Models – November 2011



Health centers provide oral health services for underserved populations at dental clinics throughout the United States. As dental capacity grows, the need for a dental workforce committed to caring for underserved patients is growing as well.

Given the growing demand for dental services, new types of dental providers, such as dental health therapists and advanced dental hygiene practitioners 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.



12. Credits

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The National Network for Oral Health Access (NNOHA) is a nationwide network of dental professionals and supporters 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, email info@nnoha.org, or call 303-957-0635.