Central Valley Health Policy Institute
California State University, Fresno

Central Valley Health Network

Oral Health Survey of Federally Qualified Health Centers in the Central Valley

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CENTRAL VALLEY HEALTH POLICY INSTITUTE

The Central Valley Health Policy Institute improves equity in health and health care by developing the region's capacity for policy analysis and program development through integrating the resources of California State University, Fresno and the institutions and communities of the San Joaquin Valley. The Institute was funded in July 2003 by The California Endowment, in partnership with the university, to promote health policy and planning in the region.

Additional information about the Central Valley Health Policy Institute, its programs and activities (including this report), can be found at: www.cvhpi.org

CENTRAL VALLEY HEALTH NETWORK

Incorporated in 1998, the Central Valley Health Network (CVHN) is a consortium of 13 Federally Qualified Health Center corporations that provide comprehensive preventive primary care services and advocate on behalf of low-income and medically underserved families throughout the northern, Central Valley and Inland Empire areas of California. In most Central Valley communities, CVHN members are the only safety net provider.

CVHN has 116 sites in 20 counties that provide 2.1 million encounters to 530,000 patients annually of whom 77% are at or below 100% of federal poverty level, 49% Medi-Cal, 35% uninsured, 74% Latino, and 40% farm workers. CVHN members provide services in urban disadvantaged areas and rural and remote areas throughout California and are active at the local, state, and federal level advocacy for low-income.

The Mission of CVHN is to facilitate community health centers' strength in the marketplace and to support member community health centers' effective delivery of high quality accessible health care to residents of their respective communities with special focus on advocacy for attaining optimal health for the medically underserved.

Additional information about the CVHN, its programs and activities, can be found at: www.cvhnclinics.org

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TABLE OF CONTENTS

List of Figures

List of Tables

EXECUTIVE SUMMARY

Low-income residents of the Central Valley face limited access to oral health care due to barriers, including a shortage of dental health professionals, a maldistribution of services, and a lack of providers willing to accept uninsured or publicly insured patients. Federally Qualified Health Centers (FQHCs) ease access barriers by providing oral care to underserved populations. In an effort to respond to regional concerns regarding the shortage of oral health professionals, a survey was conducted to evaluate the impact of these shortages in the Central Valley.

This report presents findings from an oral health survey of FQHCs that offer dental services onsite. The 12 FQHCs surveyed were members of the Central Valley Health Network. Survey participants included chief dental officers, dental supervisors, dental services managers, directors of operations, and an executive assistant. The survey included 34 qualitative and quantitative questions that described clinic operations, staffing, patient visits, referrals, and future plans to expand services.

Findings from the survey demonstrate that FQHCs face a common set of challenges in providing access to oral health care. One of the challenges of the FQHCs is the limited capacity to provide care. Only half of the FQHCs reported having enough operatories to provide services to patients. In addition, more than half of the FQHCs stated that the number of operatories was a barrier to providing care. Of the FQHCs planning to expand dental services, nearly all reported that capital for facilities will be a factor in their future expansion efforts.

The FQHCs also reported that patients have difficulty accessing oral health specialty care due to the limited providers who accept uninsured or Medi-Cal patients, the expensive costs of specialty care, and traveling long distances to obtain care. All of the FQHCs stated that financial difficulty of patients was a barrier to receiving care. Other barriers to accessing care were lack of insurance, transportation, childcare, and social services support. All FQHCs also reported experiencing barriers to providing services. The main barriers include a lack of specialists, insufficient operatories, and low reimbursement rates.

The survey respondents were asked to identify possible solutions to access concerns resulting from dental professional and support staff shortages. The most common solution reported was the expansion of loan repayment programs for dentists and support staff. Others reported incentives and the use of different recruiting strategies as solutions. The FQHCs also suggested higher base pay salaries for dentists.

Oral health policy recommendations are presented based on findings from this study as well as consulting with FQHC leadership. The proposed policy recommendations based on the findings of the survey include: 1) The protection, expansion, and enhancement of government funded oral health care programs for underserved and uninsured populations; 2) Increasing reimbursement rates for oral health care services at FQHCs; and 3) Establishing a permanent and continuing revenue source to fund the state's loan repayment program for providers willing to serve in medically underserved areas. The policy recommendations based on FQHCs long-term capacity to provide oral health care include: 1) Establishing a select and/or sub-committee in the state legislature that focuses specifically on health care issues in the Central Valley, including oral health; 2) Extending hours of intermittent clinics, which may also contain dental operatories, from 20 operational hours to 40; 3) Having an administrative change in FQHCs being treated as non-institutional providers; 4) Monitor and pursue the implementation of SB 564, which requires the State Department of Public Health to extend funds appropriated for implementation of the Public School Health Center Support Program; and 5) Licensing reform for community health centers in order to streamline the licensing process for community health centers.

Introduction

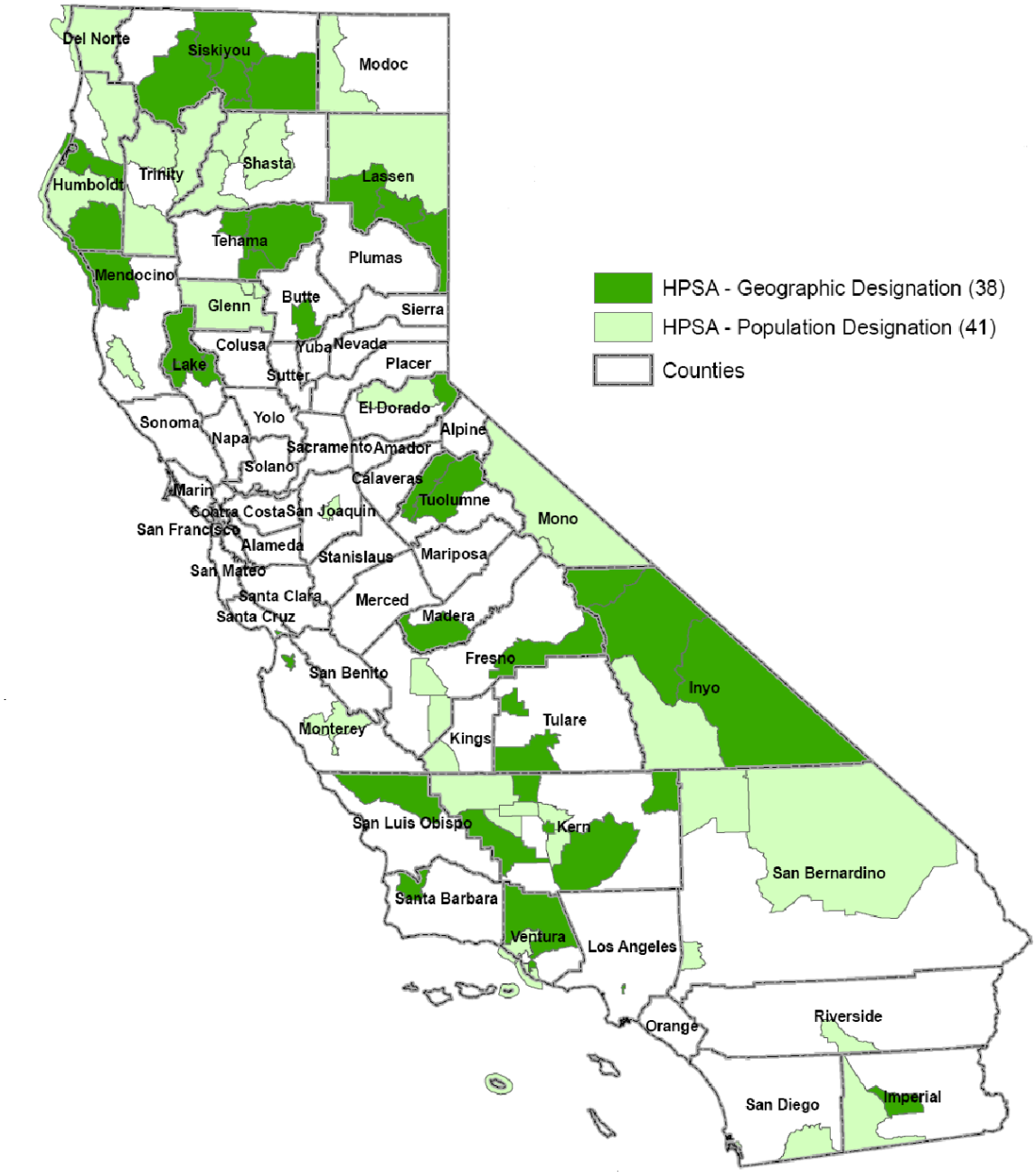
Access to oral health care for low-income and uninsured populations in the Central Valley is very limited. However, Federally Qualified Health Clinics (FQHCs) play an important role in easing access to oral care for these underserved populations. The FQHC dental clinics serve to improve oral care for these vulnerable groups who face various access barriers, including a shortage of dental health professionals, a maldistribution of services, and a lack of providers willing to accept uninsured or publicly insured patients. In an effort to address these concerns, a survey was conducted to evaluate the impact of these shortages in the San Joaquin Valley.[1] This report presents findings from an oral health survey of FQHCs that offer dental services onsite. The FQHCs were all members of the Central Valley Health Network (CVHN). The purpose of this project was to describe the shortage of oral health professionals in the San Joaquin Valley, and how the shortages impact the provision of oral health care services at FQHCs.

Background

California's Central Valley is a particularly challenged region that faces health professional shortages. There is a geographic and socio-economic maldistribution of health professionals as well as an absolute lack of providers in areas of the region (Figure 1). Rural and low-income residents are disproportionately affected by the health professional shortages. Rural residents lack ready access to primary care, and must travel long distances to obtain services. Low-income residents face access barriers such as limited providers who offer treatment to the uninsured or publicly insured.

[1] Clinics that serve counties in Northern California (Butte, Colusa, Glenn, Sutter, Yuba) and Southern California (San Bernardino) were also included in the survey

Figure 1. Designated Dental Health Professional Shortage Areas in California



U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Bureau of Health Professions, 2008

The shortage of oral health professionals in the Valley is of particular concern because it contributes to the disparities in oral health. Since 2000, researchers have documented the relationship between negative oral health outcomes and inadequate access to oral care. Platt and Cabezas found that more than one-third of California preschoolers have poor dental outcomes and these poor results can be attributed to issues with the major programs in funding oral health services, including Denti-Cal, Child Health and Disability Prevention (CHDP) program, Healthy Families, California Children's Dental Disease Prevention program, and some First 5 programs. Funding levels of these programs and restrictions on access were viewed as primary causes of poor outcomes.[2] According to findings from oral health surveys from the Health Consumer Alliance and Health Rights Hotlines, Denti-Cal participants are frequently denied oral health services that should be covered and access to oral health care is particularly problematic for non-English speakers and rural residents.[3]

The same people with the most unmet oral health needs, namely low-income families, minorities, and rural residents, rely on community health centers for oral health services.[4] FQHCs remove multiple barriers to health care for the vulnerable and underserved populations. The clinics are often located in high-need, medically underserved areas and serve all patients regardless of insurance status or income. The services provided are offered in a culturally and linguistically appropriate setting, which means staff members are often bi-lingual and sensitive to the needs and beliefs of their patients. Although FQHCs have limited resources and capacity to provide dental services, they play a key role in improving the oral health of the most vulnerable and underserved populations.[5]

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[2] Platt, L. and Cabezas, M. (2000) *Early Childhood Dental Carrie,* UCLA Center for Healthier Children, Families, and Communities, Los Angeles.
[3] Jones, L. (2002) *Denti-Cal Denied: Consumer Experiences Accessing Services in California's MediCal Program.* Health Consumer Alliance, Los Angeles.
[4] Ruddy, G. (2007) *Health Centers' Role in Addressing the Oral Health Needs of the Medically Underserved*, National Association of Community Health Centers, Inc., Washington, D.C.
[5] Byck, G. R., et al. (2005). *Safety-Net Dental Clinics: A Viable Model for Access to Dental Care*. Journal of American Dental Association, 136, 1013-1021.

Methodology

The twelve FQHCs that participated in the survey provide oral health services to residents of Butte, Colusa, Fresno, Glenn, Kern, Kings, Madera, Merced, San Bernardino, San Joaquin, Stanislaus, Sutter, Tulare, and Yuba counties. The dental clinics serve more than 75,000 patients, and provide over 30,000 dental visits per month. The surveys were conducted by the Oral Health Director of CVHN. The survey participants were chief dental officers, dental supervisors, dental services managers, directors of operations, and an executive assistant.

Both qualitative and quantitative questions were asked to gain insights of the impact of dental health professional shortages in the region. The survey included 34 questions that described clinic operations, staffing, patient visits, referrals, and future plans to expand services. See Appendix A for the survey instrument.

Results

The survey results show that FQHCs face a common set of challenges in providing access to oral health care. These challenges are summarized and presented in the following sections: capacity to provide care; diversity of dentists; scheduling appointments; referrals to specialists; patient barriers to accessing care; barriers to providing care; dental staff recruitment strategies; and expanding services.

Capacity

Findings from this survey suggest that the FQHC dental clinics operate with modest capacity. There were a total of 45 dental clinic sites at the 12 FQHCs. The number of dental clinic sites at each FQHC ranged from 1 to 8. Eleven out of the 12 FQHCs had at least one full time dentist. There were about 74 full-time equivalent (FTE) general dentists and no specialists at the dental clinic sites. All FQHCs had at least one dental assistant on staff. Ten of the 12 FQHCs had receptionists; half of the FQHCs had at least one dental hygienist; five FQHCs had expanded function dental assistants; one-third of the FQHCs had dental educators; and two FQHCs had dental records staff. Dental support staff at the clinics included

a total of 148 dental assistants, 57 receptionists, 23 dental records staff, 16 expanded function dental assistants, 14 dental hygienists, and 3 dental educators.

The number of dental operatories per FQHC ranged from 2 to 46, with a total of 236. Six of the FQHCs had 20 or more operatories. Half of the FQHCs reported having enough operatories to provide services to patients. One of the clinics stated that their sites would benefit by expanding their facilities to add more operatories. Another clinic said they would be able to serve more patients if they had more operatories.

All of the FQHCs use interpreters at their clinics. Every FQHC reported using staff to interpret for their patients. Half of the FQHCs use an interpreter service such as AT&T or Health Net Language Center. Family and friends also interpret for patients who have difficulty communicating with providers. The majority of clinics expressed they were not experiencing any problems in providing quality care as a result of a shortage of dental staff fluent in patients' languages. One-third of the FQHCs reported a lack of qualified interpreters limited the ability to provide quality care in the areas of appropriate follow-up, long-term effects, treatment options, and understanding of dental disease. Five of the 12 FQHCs did not have issues with a lack of qualified interpreters and providing care in these areas.

Diversity of Dentists

Despite having greater numbers of Latinos and Hmong in the Central Valley compared to other areas of the state, this study found that only 12 percent of dentists at the FQHCs are Latino and 3 percent are Hmong.

Scheduling

Eleven of the 12 FQHCs have dental clinics that accept walk-in patients, and only one FQHC accepts patients who have scheduled appointments. Across all FQHCs the office wait time for scheduled appointments averages between 15 to 30 minutes. Patients who do not have a scheduled appointment wait between 30 to 60 minutes to obtain care. Eight of the 12 FQHCs schedule appointments for new

patients within two weeks or less. One-fourth of the FQHCs schedule appointments for new patients within three weeks or more. The challenges reported by FQHCs in scheduling appointments for new patients are limited appointment slots, lack of operatories, and availability of providers due to the lengthy dental procedures. Another challenge in scheduling appointments for new patients is accommodating their preferences in appointment times. Patients prefer appointment times outside of business hours due to school or work hours. Table 1 describes the wait times and scheduling appointments.

Table 1a. Waiting Times, by number of clinics responding

Average office wait times	15 minutes	30 minutes	60 minutes
Scheduled appointments	8	4	0
Walk-in appointment	0	8	4

Table 1b. Length of Time New Patients Wait for an Appointment, by number of clinics responding

Less than 1 week	3
1 – 2 weeks	5
2 – 3 weeks	1
More than 3 weeks	3

The FQHCs were asked about the impact of staff shortages on scheduling appointments, the clinics' capacity to accept walk-ins, and patient follow-up on missed appointments. One-fourth of the FQHCs reported staff shortages are either "most of the time" or "always" a factor in scheduling appointments. The clinics are especially impacted by shortages when staff takes time off for vacation or sick leave. One FQHC reported that staff shortages are "always" a factor in the clinic's capacity to accept walk-in patients. One-fourth of the clinics responded "most of the time" or "always" to the question about staff shortages limiting the clinic's ability to follow-up on patients who do not return for scheduled visits.

Ten of the 12 FQHCs overbook patients, while only two do not overbook. Clinics overbook times to compensate for the patients who miss appointments. Several clinics stated that they experience a high rate of missed appointments and must overbook so that "provider and chair time are not wasted." Despite the majority of clinics who overbook, only 25 percent have a policy on overbooking patients. Some examples of policies on overbooking include: "no more than double booking," "20 percent is allowed," and "overbook as time and patient flow allows."

Dental Referrals

All FQHCs refer patients to dental specialists. Referrals are made to pediatric dentists (12 FQHCs), oral surgeons (11 FQHCs), orthodontists (11 FQHCs), endodontists (10 FQHCs), periodontists (9 FQHCs), and prothodontists (5 FQHCs). Ten FQHCs reported that patients experience difficulty obtaining specialty care because the limited specialty providers who accept Medi-Cal, the high costs of specialty care, and traveling long distances to obtain care. One of the FQHCs stated that their patients are not having difficulty in obtaining specialty care because they rarely make referrals. Another FQHC said referral is not an issue at the present time because their dental clinic recently opened.

Table 2 summarizes the FQHCs that experience difficulty completing referrals for adults, children (0-18 years old), and according to types of insurance.

Barriers to Accessing Care and Providing Services

Respondents were asked about the barriers patients face to accessing care. All of the clinics stated that financial issues were a barrier for patients. Other barriers to accessing care were lack of insurance (11 FQHCs), transportation (11 FQHCs), childcare (9 FQHCs), and social services support (6 FQHCs). One clinic reported an access barrier is that patients do not perceive oral health as a priority.

All FQHCs reported experiencing barriers to providing services. The barriers to providing services identified were the number of specialists (8 FQHCs), number of operatories (7 FQHCs), reimbursement rates (7 FQHCs), funding (6 FQHCs), site limitation such as size, location, etc. (4 FQHCs), number of

general dentists (3 FQHCs), shortage of support staff (2 FQHCs), clinic hours (1 FQHC), and supplies (1 FQHC).

Table 2. Difficulty of Completing Referrals, by number of FQHC responses

	Rarely/ Never or Sometimes	Half of the time, Most of the time, or Always
Endodontist		
Adults	6	7
Children	7	5
General Dentist		
Adults	10	1
Children	11	1
Oral Surgeon		
Adults	6	8
Children	8	5
Orthodontist		
Adults	5	9
Children	5	7
Periodontist		
Adults	4	10
Children	6	6
Prothodontist		
Adults	6	6
Children	5	6
Insurance		
Medi-Cal	6	5
Healthy Families	7	3
Healthy Kids	7	3
Private Insurance	11	1
Uninsured	3	8

Recruitment Strategies

The FQHCs use various recruitment strategies to fill open positions. Table 3 describes the recruiting strategies.

Table 3. Recruitment Strategies, by number of FQHC responses

Recruitment Strategy	**Number of FQHC responses**
Websites	11
Newspapers	10
Schools	7
Associations	6
Job fairs	6
Other	4
Referrals, internal job posting, word of mouth, CVS career line	

Fifty-eight percent of FQHCs employ dentists and/or dental support staff who participate in federal/state loan repayment programs. The programs are offered through the Office of Statewide Health Planning and Development, California Dental Association Foundation, National Health Services Corps, and American Educational Services. Half of the FQHCs have a relationship/partnership with an academic health center. The academic health centers include A.T. Still University, Concord for Dental Assistants, Galan College, Reedley College, Riverside Community College, San Joaquin College, Tulare Tech Prep for Support Staffing, University of California Los Angeles, and University of California San Francisco.

Expanding Services

Seventy-five percent of FQHCs plan to expand dental services in one to three years by either adding more operatories or dental clinic sites. The factors to be considered include capital for facilities (11 FQHCs), provider availability (7 FQHCs), and support staff availability (3 FQHCs).

Respondents' Recommendations

The FQHCs were asked to identify possible solutions to access concerns resulting from dental professional and support staff shortages. The most common solution reported was the expansion of loan repayment programs for dentists and support staff. Loan repayment programs are available for dentists and dental hygienists willing to practice in underserved areas. These loan repayment programs may be attractive to dentists with high student debt.

Sixty-five percent (8 FQHCs) reported incentives as a solution and fifty-eight percent (7 FQHCs) reported the use of different recruiting strategies as another possible solution. The FQHCs also suggested higher base pay salaries for dentists. One clinic explained, "The correctional institution system has a very high base salary and retirement benefits. Community health centers offer competitive salary, benefits, and retirement. However, the correctional institution far exceeds the ability of community health centers."

Policy Recommendations

Oral health policy recommendations are presented based on findings from this study as well as consulting with FQHC leadership. In addition to three recommendations that follow directly from the findings presented here, FQHCs have called for examining policies to improve oral care access issues in the context of broader initiatives to ensure that long-term capacity of FQHCs to meet the full spectrum of health care needs.

Recommendations Based on Findings

1.) The protection, expansion, and enhancement of government funded oral health care programs targeted specifically to meet the needs of the underserved and uninsured populations, such as Denti-Cal, Child Health and Disability Prevention (CHDP), Healthy Families, California Children's Dental Disease Prevention program and various First 5 programs, is a key element to continue to meet the needs of the underserved populations.

By securing ongoing funding for these programs and expanding the eligibility it will allow FQHCs the opportunity to obtain funding for services to a wider scope of individuals that may not have before qualified for a given program. Funding for these programs is critical given this time of severe cuts to government funded health programs. By eliminating and cutting back on much-needed health programs and services, access is reduced rather than expanded.

2.) Increasing reimbursement rates for oral health care services will also help FQHCs meet the continued rising cost associated with providing oral health care services and securing the necessary equipment.

Since FQHCs offer dental services as part of their single pre-negotiated per-visit Medi-Cal rate, the addition of offering dental care is inadequate to support capital costs associated with opening new and/or maintaining current operatories. If a change to per-visit rate is not feasible, an alternative would be funding capital costs for these services directly.

3.) Establish a permanent and continuing revenue source to fund the state's loan repayment program for health care providers, which include oral health care providers, who are willing to serve a designated amount of time in medically underserved areas to pay down student loans. Specifically, the state loan repayment program would be amended to meet the particular needs of the state and region. Designated amounts of funding for loan repayment would be allotted to specific regions that correlate with its needs. This will help in creating a pipeline of oral health care providers that will provide vital services in the Central Valley.

During the 2007-2008 legislative session, precedent was set for a continuing revenue source when the California Medical Association was successful in sponsoring and passing Senate Bill 1379 (Ducheny), which appropriates $1,000,000 annually into Medically Underserved Account for the purpose of the Steven Thompson Physician Corps. The monies allotted to this particular program are from fines and administrative penalties gathered and deposited into the Manage Care Fund from administrative violations.

Recommendations Based on Long-term Capacity to Provide Care

1.) Establish a select and/or sub-committee in the state legislature that focuses specifically on health care issues, such as oral health and/or the provider shortage in the Central Valley. It is of the interest to the whole state to discuss, address, and try to find health care solutions in the Central Valley, as its residents are a valued asset to the state and the region is a vast agriculture and economic engine that fuels California's economy.

An established sub-committee will help ensure that continuing education of our state policy-makers will take place in the proper forum to explore and discuss evolving and urgent health care issues in the region that will have a statewide impact. A sub-committee dedicated to explore the health care challenges of the area will also provide a forum in which to demonstrate that the FQHC model of care is both an effective and efficient use of government funding, as the President's Office of Management and Budget has already noted. This would help fortify the argument and provide additional opportunity to solidify ongoing funding for EAPC, SAMW, RHSD, and funding for construction to expansion of existing FQHC facilities.

2.) Extend hours of intermittent clinics, which may also contain dental operatories, from 20 operational hours to 40 will not only increase hours of access but help create the opportunity to see additional dental patients. Increased hours make it more viable to maintain dental operations in certain health centers and geographic regions.

3.) Have an administrative change in FQHCs being treated as non-institutional providers, specifically during our state's current economic environment. It is critical in ensuring that FQHCs continue to receive their Medi-Cal reimbursement during a state budget impasse.

With extended delays in Medi-Cal reimbursements, maintaining operational hours is difficult. Reimbursement delays negatively impacts access and capacity to make payroll which could lead to the loss of providers, such as dentist, hygienist and other dental staff, who are difficult to recruit in a region that suffers from a larger shortage of providers than the rest of the state.

4.) Monitor and pursue (if needed) the implementation of Senate Bill 564 (Ridley- Thomas), which requires the State Department of Public Health (DPH) to extend funds appropriated for implementation of the Public School Health Center Support Program to establish a grant program to provide technical assistance and funding for the expansion, renovation, and retrofitting of existing school health centers and the development of new school health centers. This is critical as specific oral health care services are provided in these school-based health centers.

5.) Licensing reform for community health centers in order to streamline the licensing process will help alleviate a number of administrative costs and obstacles that delay the opening of community health centers. By allowing health center corporations to open additional sites under their current provider number, it would ease bureaucratic barriers that create costly delays.

Conclusion

Although the FQHCs varied by number of sites, patient visits, and staffing levels, they all face common challenges in providing access to oral health care. There are no specialty providers at the FQHCs and clinics must refer patients to outside providers. Most clinics reported that patients are having difficulty accessing specialty care due to the limited providers who accept uninsured or Medi-Cal patients, the expensive costs of specialty care, and traveling long distances to obtain care. Dentistry is among the least diverse health professions and this is shown by the lack of African American and Hispanic dentists at the clinics. This was not a main concern among the FQHCs that were interviewed, and clinics seem to be filling the need through a very diverse support staff.

Findings from this survey also demonstrate the lack of adequate resources to meet the oral health needs of patients at FQHCs. Half of the FQHCs reported having sufficient operatories, while the other half needed more operatories to serve a higher volume of patients. In order to add operatories, some clinics must physically expand their offices and others stated they had to add more dental clinic sites. Adding operatories or new dental clinic sites will require capital for facilities. Nearly all of the clinics reported that

capital for facilities will be a factor to be considered for expanding services in the future. Furthermore, oral health professional shortages may be exacerbated as a result of expansion.

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APPENDIX

CENTRAL VALLEY HEALTH NETWORK
ORAL HEALTH PROGRAM SURVEY

1. **Please enter your contact information.**

   Name: _____

   Position/Title: _____

   Health Center: _____

   Address: _____

   Contact #: _____

   Email address: _____

2. **What counties do you serve? Please circle all that apply.**

   Butte
   Calaveras
   Colusa
   Fresno
   Glenn
   Inyo
   Kern
   Kings
   Madera
   Merced
   San Bernardino
   San Joaquin
   Solano
   Stanislaus
   Sutter
   Tehama
   Tulare
   Yolo
   Yuba
   Other: _____

3. **How many dental patients do you see?**

	Total # of dental patients in you organization	Total # of dental patient visits/month
Adults		
Children		
Total		

4. **How many dental sites do you have?**

   # of dental sites: _____

5. **How many operatories do you have throughout the organization?**

   # of operatories: _____

6. **Do you have enough operatories to provide services to your patients?**

   _____ Yes
   _____ No

   Comments:

7. **How many dental providers do you have?**

	# of Providers	FTE	Open FTE
Endodontist			
General Dentist			
Oral Surgeon			
Orthodontist			
Pediatric Dentist			
Periodontist			
Prothodontist			

Other. Please Specify. _____

8. How many dental support staff do you have?

	# of Staff	FTE	Open FTE
Dental Assistant/s			
Dental Assistant/s EF			
Dental Hygienist/s			
Dental Hygienist/s EF			
Dental Records			
Educator/s			
Receptionist/s			

Other. Please Specify. _____

9. Race/Ethnicity of you dental staff:

	Dentist/s	DH	DHEF	DA	DAEF	DR	EDUC	RECEP
African American								
American Indian/Alaska Native								
Hmong								
Laotian								
Latino								
Native Hawaiian/Pacific Islander								
Punjabi								
Vietnamese								
White								

Other. Please Specify. _____

10. What recruiting strategies do you use to fill open positions?

_____ Associations
_____ Job Fairs
_____ Newspapers
_____ Schools
_____ Websites
_____ Other
Please Specify:

11. Are any of your dental providers and/or dental support staff committed through a federal/state loan repayment program?

_____ Yes
_____ No

If yes, what program? What provider type? How many are in that program?

12. How often does a shortage of dental staff fluent in your patients' languages limit your ability to provide quality care to your patients? Please check N/A if none of your patients speak the language.

	Rarely or Never	Sometimes	Half of the time	Most of the time	Always	N/A
English						
Hmong						
Laotian						
Mien						
Mixteca						
Punjabi						
Sign Language						
Spanish						
Tagalog						
Thai						
Vietnamese						

Other. Please specify. _____

13. Do you use interpreters?

_____ Yes
_____ No

If yes, who interprets? Or what interpreter services do you use?

14. In what areas does the lack of qualified interpreters/staff limit your ability to communicate/provide quality dental care at your site/s?

	Yes	No
Appropriate follow-up	_____	_____
Long-term effects	_____	_____
Treatment options	_____	_____
Understanding of dental disease	_____	_____

Other. Please specify. _____

15. What dental specialties do you refer to? Circle all that apply.

Endodontist
Oral surgery
Orthodontist
Pediatric dentist
Periodontist
Prothodontist
Other. Please specify. _____

16. Are your patients experiencing difficulties obtaining specialty care?

_____ Yes
_____ No

Please explain.

17. How long does a new patient have to wait for an appointment at your clinic?

_____ less than a week
_____ 1-2 weeks
_____ 2-3 weeks
_____ more than 3 weeks

What are your challenges in scheduling patient appointments?

18. How often are dental professional/support staff shortages a factor in scheduling appointments?

_____ rarely of never
_____ sometimes
_____ half of the time
_____ most of the time
_____ always

Please explain.

19. Are you an appointment only site or do you accept walk-in patients (other than for emergency care)?

_____ appointments only
_____ accept walk-ins

20. How often are dental professionals/support staff shortages a factor in your clinic's capacity to accept walk-ins?

_____ rarely or never
_____ sometimes
_____ half of the time
_____ most of the time
_____ always

Please explain.

21. What is the average office wait time for patients to be seen at your clinic? (From the time a patient registers to the time they see the dentist).

	15mins	30mins	60mins
For scheduled appointments			
For walk-in appointments			

Please explain.

22. Do you overbook patients?

_____ Yes
_____ No

Comments.

23. Do you have a policy for overbooking?

_____ Yes
_____ No

If so, describe how many and how often.

24. About what percentage of no-shows/missed appointments do you have each week?

	Medi-Cal	Healthy Families	Healthy Kids	Private Insurance	Uninsured
0-10					
11-25					
26-50					
50+					

How does that negatively affect your practice?

25. What are the barriers patients face to accessing care? Circle all that apply.

Childcare
Financial issues
Lack of insurance
Social services support
Transportation
Other. Please specify. _____

26. What barriers are you experiencing in providing services? Circle all that apply.

# of General dentist/s
# of operatories
# of Specialist/s
Clinic hours
Funding
Reimbursement rate
Site limitation (size, location, etc.)
Supplies
Support staff shortage
Other. Please specify. _____

27. How often is it difficult to complete a referral for the following services for adult patients?

	Rarely or never	Sometimes	Half of the time	Most of the time	Always
Endodontist/s					
General Dentist/s					
Oral Surgeon					
Orthodontist/s					
Periodontist/s					
Prothodontist/s					

Other. Please specify. _____

28. How often is it difficult to complete a referral for the following services for child patients (0-18)?

	Rarely or never	Sometimes	Half of the time	Most of the time	Always
Endodontist/s					
General Dentist/s					
Oral Surgeon					
Orthodontist/s					
Periodontist/s					
Prothodontist/s					

Other. Please specify. _____

29. How often is it difficult to complete a referral for the following payor mix?

	Rarely or never	Sometimes	Half of the time	Most of the time	Always
Medi-Cal					
Healthy Families					
Healthy Kids					
Private Insurance					
Uninsured					

Please explain.

30. How often do dental professional/support staff shortages limit your clinic's ability to follow-up on patients who do not return for scheduled visits?

_____ rarely or never
_____ sometimes
_____ half of the time
_____ most of the time
_____ always

Please explain.

31. Has your health center developed a relationship/partnership with an academic health center?

_____ Yes
_____ No

If yes, please elaborate.

32. Do you plan to increase/expand your organization's dental services in 1-3 years?

_____ Yes
_____ No

How?

33. What factors are to be considered?

Capital for facilities
Provider availability
Support staff availability
Other. Please specify. _____

34. What do you see as possible solutions to the access concerns resulting from dental professional/support staff shortages?

Different recruiting strategies
Incentives
Loan repayment
Other. Please specify. _____

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