



SAFETY NET DENTAL  
CLINICS IN ILLINOIS:  
THEIR ROLE IN ORAL  
HEALTH CARE

*Illinois Regional*

Health

Workforce

Center



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## Executive Summary

In Illinois and across the nation, problems with access to oral health care for underserved populations have been well documented, and improving access to care is a national public health goal. Yet, there is little information available on the role of dental safety net clinics in providing dental care to low-income and other underserved groups. Therefore, the purpose of this study was to describe (1) the dental safety net clinics in Illinois, (2) the care provided, including types of services, dental personnel, and patients, and (3) the resources used by these clinics and the barriers faced in providing oral and dental health care. This exploratory study provides a framework for understanding whether these clinics can positively affect access to dental care in their communities. This study was conducted in Summer 2001 through a mail survey of all identified safety net dental clinics in the state; 71 of 94 dental clinics responded to the survey. Major findings and conclusions are discussed below.

*Illinois safety net dental clinics include a diverse, well-established group of providers, treat a wide range of patients, and offer a broad array of services.* Safety net dental clinics in Illinois include federally qualified health centers (FQHCs), community health centers (CHCs), local health departments, private not-for-profit clinics, schools of dentistry and dental hygiene clinics, and school-based clinics. The responding clinics were located in 26 of Illinois' 102 counties, with just over half in Cook County. These clinics have served their communities for an average of 18 years, and offer a wide range of services to low-income adults and children, and many special population groups (e.g., disabled, HIV/AIDS, homeless). On average, each site provided 3,150 dental visits annually. Almost all clinics provided preventive (97%), diagnostic (94%), and basic restorative (86%) dental care, as well as emergency (76%) and complex restorative (55%) care, and oral surgery (62%). Many clinics (79%) also provided oral health outreach and education programs in a variety of community settings for various targeted groups.

*Dental clinics operated with limited resources and, thus, had service limitations.* Almost two-thirds of dental clinics had an annual budget of less than \$200,000. Medicaid payments made up more than half of the patient fee revenue. Clinics operated with few staff – 36 clinics (51%) had only one full-time paid dentist, and 25 clinics operated with only part-time paid or volunteer dentists. Forty-two clinics (59%) had *no* dental hygienists on staff and only 15 clinics (21%) had a full-time paid dental hygienist. Notably, only 8 clinics reported that they were able to meet all of their patients' dental needs, although 41 clinics indicated plans to expand services in the next five years.

Limited resources meant that patients faced barriers in obtaining services. Few dental clinics were open any evenings (25 clinics) or weekends (7 clinics). Not all clinics offered a full range of dental services, and about half had jurisdictional and financial restrictions that limited the type of patients who could receive services. Medicaid patients had to wait an average of five weeks to obtain an appointment for routine care. Dental clinics reported difficulty in referring patients to other sources of care, particularly uninsured patients and those needing complex restorative care, oral surgery, and other specialty services. Almost three-fourths of Illinois counties had *no* safety net dental clinic.

*Safety net dental clinics compared to private dentist practices.* Safety net dental clinics treated more Medicaid patients, relied more on Medicaid payments for patient fee revenue, and had more sources of revenue, than private dental practices. Compared to national data on private practice dentists, proportionately fewer safety net clinics than private practitioners employed dental hygienists. Safety net dental clinics also provided a large amount of oral health outreach and education to the community, an activity generally not conducted by dentists in private practice.

*The dental safety net is a small but important provider of dental services in Illinois. On average, the safety net dental clinics responding to our survey provided 3,150 dental visits during 2000, or an estimated 300,000 dental visits for all 95 Illinois safety net dental clinics (respondents and non-respondents). While these visits represent less than 2% of all estimated visits to a dentist, they are a crucial component of oral health care for low-income and underserved populations. In addition, it is unlikely that the substantial amount of outreach provided by safety net dental clinics could be replicated by the private sector.*

*Conclusions.* Safety net dental clinics are essential in bringing oral health services to Medicaid and other low-income or underserved populations in Illinois. Despite constraints in funds and staffing, these clinics provide care to many vulnerable and high-need individuals who fall outside of most private dental practices. Study findings suggest that additional funding and staffing may allow for expanded care. It is important to note the many parts of the state have no safety net dental clinics. These study findings should assist dental professionals, educators, and policymakers in Illinois in their efforts to improve the delivery of oral health and dental care services to low-income and underserved population groups.

## Introduction

A recent study by the Illinois Center for Health Workforce Studies, *Access to Dental Care for Low-Income Children in Illinois*, examined Medicaid children's utilization of dental services and dentists' participation in Medicaid. Over \$29 million was spent on dental care for Medicaid children in the twelve-month period ending in February 2000. This study found that only 33% of Illinois children enrolled in Medicaid or KidCare received any dental service during the study year. Only 25% of active general and pediatric dentists participated in Medicaid at any level. However, that study did not allow us to assess the contributions of dental providers who traditionally care for low-income groups (safety net clinics).

The purpose of this study was to describe (1) the dental safety net clinics in Illinois, (2) the care provided, including types of services, dental personnel, and patients, and (3) the resources used by these clinics and the barriers faced in providing oral and dental health care. This study provides a framework for understanding whether these dental providers can affect access to dental care in their communities.

## Background

The Institute of Medicine (IOM) defines the health care safety net as "those providers that organize and deliver a significant level of health care and other health-related services to uninsured, Medicaid, and other vulnerable populations" (IOM, 2000). The health care safety net is further described as "a patchwork of institutions, financing, and programs" that is not comprehensive, nor well-integrated. Studies of health care safety net providers in general, and community health centers specifically, note their important role in providing care to uninsured and underinsured populations, minority and immigrant patients, rural patients, and patients with otherwise limited access to health care (Davis, et al., 1999; IOM, 2000; Kaiser, 2000; Lurie, 2000).

However, there is limited information on the dental and oral health care safety net. National reports have indicated that dental safety net providers and programs are inadequate to meet the oral health care needs of underserved communities (DHHS, 2000; GAO, 2000a). Several studies note barriers clinics face in meeting the dental needs of the communities they serve, including inadequate funding, staffing, space, and equipment (Chovan & Shin, 2000; GAO, 2000a; Mertz, et al., 2000). A California study noted both the current innovation in some dental safety net programs as well as the need for creative solutions for maintaining and expanding the dental safety net (Mertz, et al., 2000).

Dental safety net providers include public health departments, community health centers (CHCs), federally qualified health centers (FQHCs), Indian Health Services (IHS) clinics, private, not-for-profit clinics, dental schools, dental hygiene schools, primary or secondary schools, as well as mobile dental vans. Some clinics serve very specific populations (e.g., IHS), while others treat all patients within a geographic area (e.g., many county health department clinics) and/or those who have incomes below certain financial guidelines. Clinics at schools of dentistry and dental hygiene serve dual purposes of educating future practitioners and providing services to the community. The groups most likely to use the dental safety net (low-income, minority, etc.) also have lower oral health status and greater needs for oral health care services (Edelstein, et al., 2000; GAO, 2000b; Moeller & Levy, 1996; DHHS, 2000; Vargas, et al., 1998). Safety net dental clinics are generally limited in the types of services they provide.

Illinois has a number of programs that support dental safety net or encourage private practice dentists to treat low-income and special populations. A variety of organizations and government agencies sponsor these programs. A summary is included in Appendix 1.

## Methods

This study was conducted through a confidential written mail survey and included all identified safety net dental providers in the state. A list of 102 safety net dental providers was obtained in the spring of 2001 from the Illinois Department of Public Health Division of Oral Health, which maintains and regularly updates the list. A number of sites were removed from the list because they did not provide dental services or because they offered referral services only, leaving 94. These are listed and shown on a map in Appendix 2. The dental clinics on the list included FQHCs, local health departments, clinics within schools of dentistry and dental hygiene, school-based clinics, and other safety net dental providers. If an organization had dental clinics at more than one site, each site was eligible for participation due to differences in staffing, capacity, service provision, etc. by site; thus, each site was considered a unique provider and received a survey. A group of stakeholders (Appendix 3) reviewed the list for accuracy and completeness; this group also reviewed the written questionnaire.

The written questionnaire consisted of 44 questions that asked about the type of safety net dental provider; clinic information, including types of services provided and hours open; clinic capacity and utilization; referrals; staffing; funding and financing; and future needs. The full survey is included in Appendix 4. The first mailing was sent out in June 2001. A reminder postcard was sent a few weeks later. A second questionnaire was sent out in August 2001. The stakeholder group assisted by encouraging their colleagues to complete and return the survey. The Center also called non-respondents to encourage participation in this project.

Responses from each survey were entered into an Excel spreadsheet, and analysis was done using SAS software. There were a few questions that were problematic due to large numbers of non-responses, such as some questions about the level of difficulty for finding a referral source, and number of missed appointments per week. Therefore, the percentages in the tables are based on the total number of responses to the question, which may not be the same as the total number of respondents. Appendix 5 provides a table which shows number of respondents for questions with less than 100% response.

## Results

A total of 71 safety net dental clinics from 52 organizations returned completed surveys, for a response rate of 76% (71/94). The number of sites per organization varied from one to eight sites. The organization and clinic were frequently the same entity, although sponsoring organizations included county or city health departments, schools of dentistry, and charitable agencies. The latter generally sponsored private, not-for-profit clinics. Organizations with many sites were typically public health departments. Among respondents, 23 (32%) were a federally qualified health center, community health center, or look-alike community health center<sup>1</sup> (referred to from now on as FQHC/CHC), 21 (30%) were a local public health department, 13 (18%) were a private, not-for-profit organization (private NFP), 7 (10%) a dental hygiene school, 2 (3%) each were a school-based or dental school clinic, and 3 (4%) were other types of providers (Exhibit 1). The list in Appendix 2 shows that the dental safety net in Illinois is a diverse, varied group of clinics. Results are only presented and discussed for all sites combined, as well as for the larger categories of FQHC/CHCs, public health departments, and private NFPs.

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<sup>1</sup> This category includes 4 federally funded community health centers (CHC), 11 FQHC or look-alike community health centers, 2 clinics that were both of the above, and 3 clinics that were both FQHC or look-alike community health centers AND public health department clinics.

The number of respondents for the dental school, dental hygiene school, school-based, and other categories was too small to present on their own.

Exhibit 1. Respondents by Clinic Type and Sponsoring Organizations

Clinic Type	Clinics Responding	Sponsoring Organizations
FQHC/CHC	23	13
Local public health department	21	15
Private NFP	13	12
Dental hygiene school	7	6
Dental school	2	1
School-based	2	2
Other	3	3
<b>TOTAL</b>	<b>71</b>	<b>52</b>

The 71 responding clinics were located in 26 of Illinois' 102 counties with 37 clinics in Cook County, 21 clinics in 14 other urban counties, and 13 clinics in 11 rural counties. Cook County accounted for approximately 43% of Illinois' population and a greater than average percentage of children enrolled in Medicaid (Byck, et al., 2000).

The 24 non-respondents included all types of clinics and were distributed geographically throughout the state. The non-responding clinics were located in nine counties, seven of which also had responding clinics. There were 15 non-responding clinics in Cook County, 6 clinics in other urban counties, and 3 clinics in rural counties. Therefore, there were 28 counties, covering about 80% of Illinois' population, that had safety net dental clinics, and 74 counties, covering about 20% of Illinois' population, that did not have a dental clinic.

#### *Dental Clinic Profile*

Respondents were asked to provide operational information about their dental clinic. Illinois dental clinics were open an average of 18 years (median=12 years, range = less than one year to 86 years). Private NFP dental clinics were open an average of 22 years (median=12, range=1-86), while public health department dental clinics have been open an average of 13 years (median=10, range=2-53). Dental clinics had an average of 4.3 chairs (median=3, range=1-36). The dental school and dental hygiene school clinics tended to have a larger number of chairs. Dental visits ranged from 3 minutes (reported by a CHC/FQHC) to 240 minutes, with the higher appointment times generally at the dental hygiene school clinics. Appointments at FQHC/CHCs lasted an average of 29 minutes, and were 34 minutes at public health departments and 39 minutes at private NFPs.

Dental clinics were usually located at a site where medical or other services were also provided. Only 29% of dental clinics operated at a site where no other services were provided. Almost three-fourths (74%) of clinics reported a formal arrangement for referrals for medical care, especially FQHC/CHCs (96%) and private NFPs (85%).

#### *Staffing*

Dental clinics operated with very few staff, including a small number of volunteer staff (Exhibit 2). On average, each clinic had 4.1 full-time and 2.9 part-time paid staff, and 1.7 (mainly part-time) volunteer staff. Public health departments operated with the fewest staff. Private NFPs relied heavily on volunteer staff, mostly part-time volunteer dentists. If dental

schools and dental hygiene schools are excluded from the analysis, due to higher than typical staffing, the total number of paid staff decreases to about 3.1 full-time and 2.2 part-time staff; volunteer staff remains unchanged.

There were 36 clinics (51%) which only had 1 full-time paid dentist (some of these clinics also had part-time paid and/or volunteer dentists) and 25 clinics, which only had part-time paid and volunteer dentists. Only 15 clinics (21%) had any full-time paid dental hygienists. There were 42 clinics (59%) with no dental hygienists, paid or volunteer, and 12 clinics (17%) with no dental assistants; four clinics had neither dental hygienists nor assistants. Only 29% of private practice general practitioners did not employ at least one full-time or part-time dental hygienist (ADA, 2000). A total of 8 dentists at all of these clinics were on loan repayment programs.

Exhibit 2. Dental Clinic Staff, Paid and Volunteer  
(Average number per clinic)

	All Clinics	FQHC/CHC	Public health dept.	Private NFP
<b>Paid Staff:</b>				
Full-time				
Dentist	1.4	1.0	0.8	0.5
Dental Hygienist	0.5	0.1	0.2	0.2
Dental Assistant	1.3	1.8	1.0	0.8
Admin./Clerical	<u>0.9</u>	<u>0.9</u>	<u>0.6</u>	<u>1.1</u>
Total Full-time	4.1	3.7	2.6	2.6
Total Part-time	2.9	2.6	1.2	3.4
<b>Volunteer Staff</b> (almost all part-time):				
Total	1.7	0.22	0.6	7.0

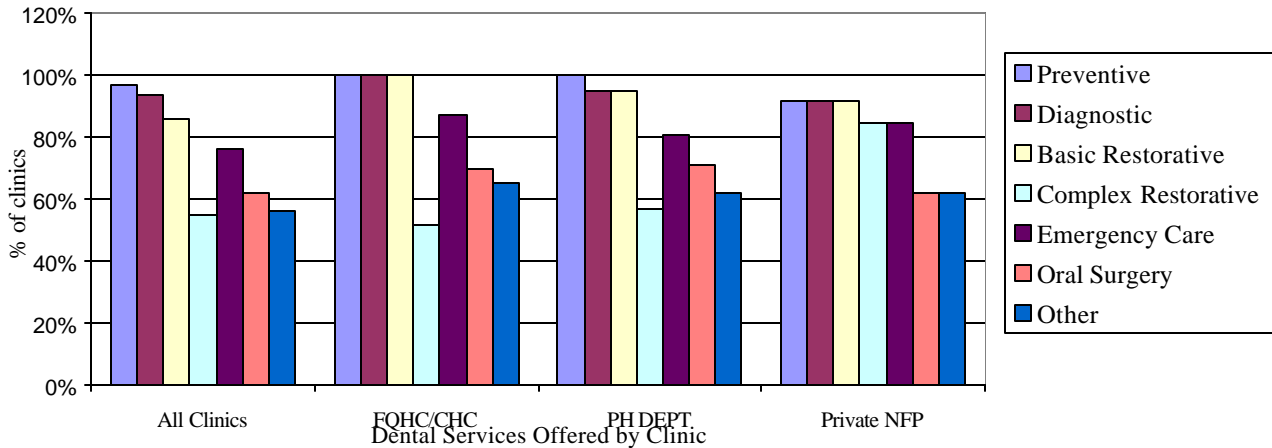
The most common resources used by clinics for recruiting staff were local advertising (62%) and affiliations with educational institutions (56%). Of those clinics recruiting through educational affiliations, 79% used dental schools and 68% used dental hygiene schools. Public health departments also utilized programs with local dental/dental hygiene associations, the Internet, and the federal National Health Services Corps (NHSC) program. The most common challenge reported in recruiting staff was the low wages/salaries/benefits package offered (reported by 22 respondents). Other challenges involved the need for bilingual staff, finding qualified staff, and clinic location (e.g., rural, small town). In addition, seven respondents reported reasons relating to the mission, philosophy or status of safety net clinics (e.g., "concept of public health dental care," "defeating the health department reputation," "commitment to our mission").

When asked what would make recruitment of qualified staff easier, 21 respondents mentioned the ability to provide better pay (with some also mentioning providing any, or better, benefits). Other responses included increases in funding, grants, and Medicaid reimbursement, more dental assistant training programs, easing the recruitment process (e.g., having a regional/state database of jobs available, collaborative recruitment with federal/state/local governments with active involvement from the dental society), limiting the uncertainty of the loan repayment program, having a larger pool of dentists to draw from ("closing of dental schools has impacted our agency"), and more volunteerism from dentists/dental societies.

*Services/Visits/Patients*

Almost all of the 71 clinics indicated that they provided preventive (97%) and diagnostic (94%) services and most provided basic restorative (86%) and emergency care (76%) (Exhibit 3). More than half of respondents indicated they provided oral surgery (62%), complex restorative (55%), and other services (56%). "Other" services included dental specialty areas such as endodontics, periodontics, prosthetics, and orthodontics, often on a limited basis. We did not collect data on the volume of these services. When asked what percentage of preventive services were provided by a dentist and a dental hygienist, respondents indicated that, on average, dentists provided 76% of all preventive services. When clinics at dental and dental hygiene schools were excluded from the analysis, dentists provided 84% of all preventive services.

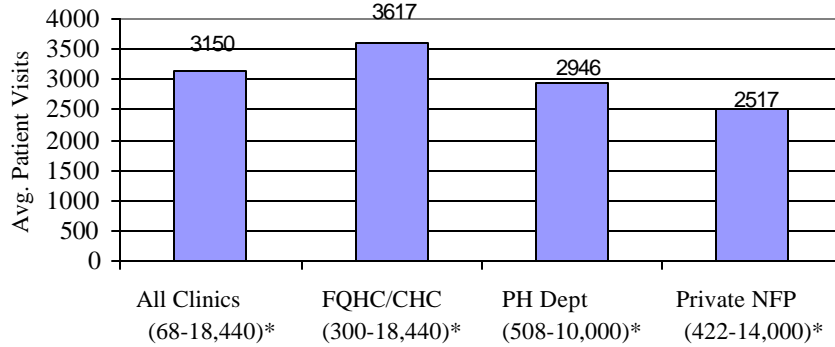
Exhibit 3. Clinics Offering Specific Dental Services



Outreach to the community about oral health was another important service provided by dental clinics. Most clinics (79%) reported conducting outreach programs. All but two public health departments conducted outreach. Of clinics with outreach programs, the average number of outreach programs conducted each year was 20; local public health departments conducted an average of 29 programs each year. Outreach programs included dental screenings, health fairs, school sealant programs, educational and oral health awareness programs to different groups and in different settings (schools, preschools, nursing homes, shelters, facilities for the disabled, adolescent health centers, WIC centers, parent groups, community groups, church groups, social services agencies, senior groups, boy and girl scout programs), peer education, media education, local media advertising, mailings, and tobacco cessation programs.

Illinois dental clinics provided an average of 3,150 dental visits (median=2,084, range=68 – 18,440 visits) during calendar year 2000, with FQHC/CHCs providing notably more and private NFPs providing notably fewer visits (Exhibit 4). While FQHC/CHCs had the most visits, they also had the highest capacity, based on staffing (Exhibit 2) and hours open (see below); similarly, private NFPs had the lowest number of full-time paid dentists and were open the fewest hours per week. Most respondents were not able to provide the number of visits by insurance status (uninsured, Medicaid, private) or age (child/adult), so these results are not reported. Clinics were not asked to provide the number of patients (versus visits) treated.

Exhibit 4. Annual Patient Visits, 2000



\*Denotes range of visits

Dental clinics served a number of different populations (Exhibit 5), most commonly Medicaid/KidCare children (90%). Almost three-fourths (70%) of clinics served HIV/AIDS-afflicted persons, and almost half (46%) served migrant farmworkers. A large majority of clinics treated adults and children, regardless of insurance status.

Exhibit 5. Patient Population Groups Served by Dental Clinics  
(percentage of clinics)

	All Clinics	CHC/FQHC	PH Dept	Private NFP
Adults	83%	96%	81%	69%
Uninsured adults	79%	91%	76%	77%
Medicaid adults	73%	91%	81%	46%
Children	89%	100%	95%	69%
Uninsured children	80%	96%	76%	69%
Medicaid/KidCare children	90%	100%	100%	62%
Special populations				
DCFS wards	87%	96%	100%	62%
Disabled	83%	91%	76%	69%
HIV/AIDS	70%	61%	71%	62%
Homeless	65%	70%	62%	54%
Migrant farmworkers	46%	43%	57%	15%

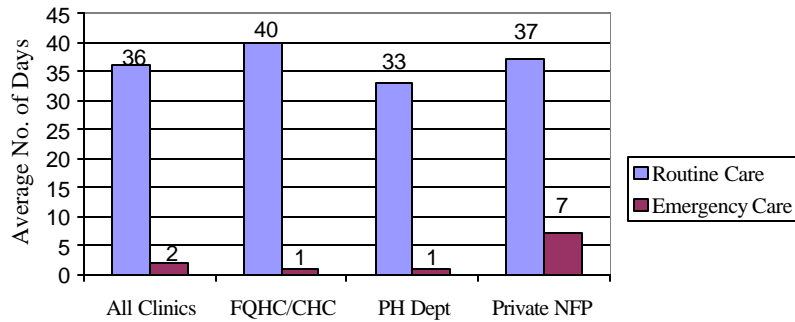
*Clinic Access and Scheduling*

Many clinics had restrictions on the patient populations served, such as jurisdictional limitations (e.g., a county health department which only provided care to county residents) and/or a low-income requirement (e.g., household income equal to or less than 185% of poverty). Public health departments were most likely to have jurisdictional limitations (16 of 20 clinics). Just over half (54%) of dental clinics had low-income or poverty guidelines that their patients had to meet in order to be eligible for services. Again, public health departments most commonly had these guidelines (18 of 21) followed by private NFPs (10/13); only 7 of 23 FQHC/CHCs had low-income or poverty guidelines.

An important component of access to care is waiting time for an appointment. Clinics were asked to report the average number of days it took to obtain an appointment for Medicaid

patients for routine and emergency care (if the clinic provided emergency care). The average wait to obtain an appointment was about 36 days (5 weeks) for routine care and just over 2 days for emergency care (Exhibit 6). At private NFPs, the average wait to obtain a dental appointment for emergency care was 7 days.

Exhibit 6. Days to Dental Appointment, Routine and Emergency Care for Medicaid Patients



Dental clinics reported being open an average of 31 hours per week (median=32, range=3-50) for patient care, with FQHC/CHCs and public health departments open more hours (average = 36 and 32 hours, respectively) than private NFPs (average=25 hours). Exhibit 7 shows the number of hours dental clinics were open each week, with most clinics open more than 30 hours per week. The hours and days a clinic is open also affects access to care for underserved populations. Only 37% (25) of clinics were open any evenings and only 10% (7) were open any weekend days (Exhibit 8). Of the 7 clinics open on weekends, 4 were in Cook County.

Exhibit 7. Hours per Week that Dental Clinics Are Open

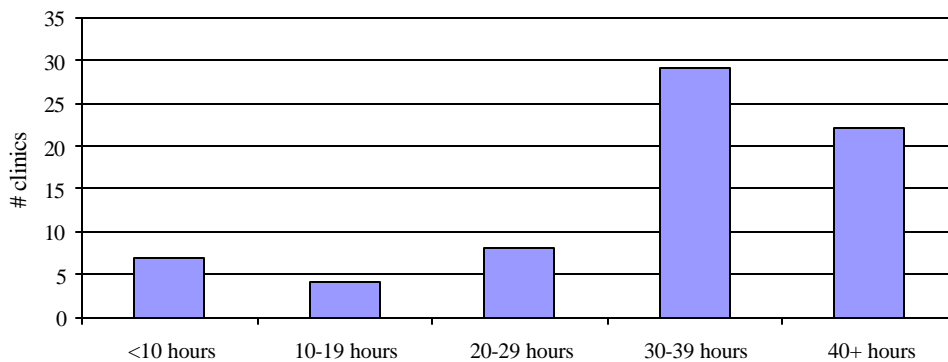
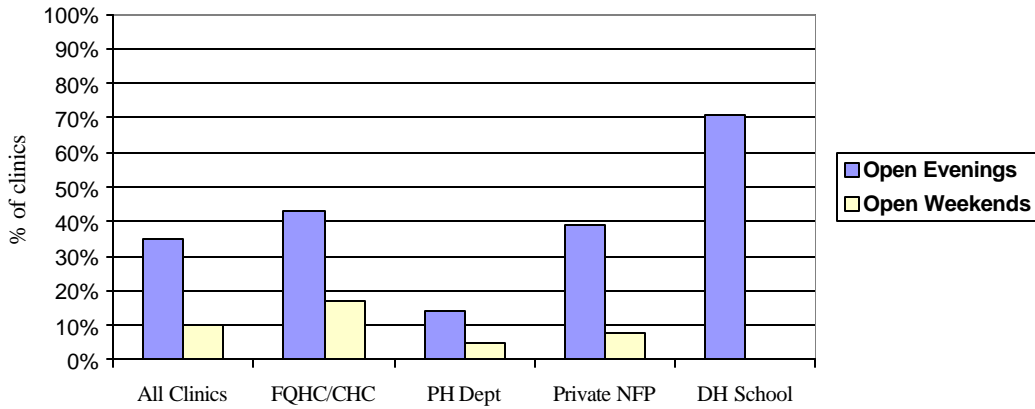


Exhibit 8. Dental Clinics Open Evenings or Weekends

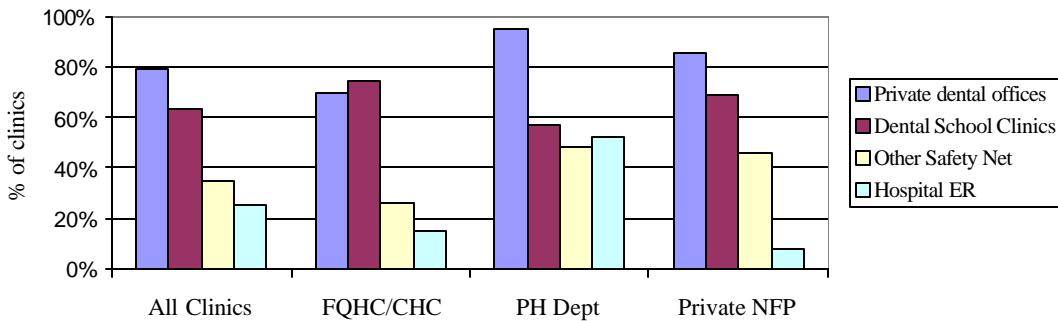


Missed appointments are a commonly reported problem when discussing the provision of any type of health care to low-income populations. For the responding clinics, on average 23% of all appointments were missed each week. FQHC/CHCs were hardest hit, with 32% of all appointments missed each week, followed by public health departments (22%); private NFPs had only 14% of all appointments missed each week. Procedures for handling missed appointments focused on overbooking (36 clinics) and having policies that restrict future appointments for patients after some number, usually two or three, of missed appointments (18 clinics). Only seven clinics reported using penalty fees, six used reminder letters or phone calls, and six filled broken appointment times with walk-in or standby appointments.

*Dental Referrals*

Almost all (68/71) dental clinics indicated that they referred patients to other dental providers for services. Fifty-six (79%) of the clinics referred to private dental offices (Exhibit 9), and those clinics referred to an average of 5.4 private dental offices. It was also common to refer patients to dental school clinics (63%); less common referral locations were to other safety net providers (35%) and hospital emergency rooms (25%).

Exhibit 9. Settings Where Dental Clinics Refer Patients to for Dental Services



Note: responses may total more than 100%.

In addition to knowing the referral resources available to the dental clinics, it is important to understand the ease or difficulty in finding referral sources for specific services or patient populations. Exhibit 10 shows the average level of difficulty in finding referral sources for uninsured children, uninsured adults, and Medicaid/KidCare clients by dental service. Clinics reported that it was fairly to very difficult to refer uninsured adults and children, with somewhat less difficulty for Medicaid/KidCare clients. Private NFPs had less difficulty referring all three types of patients, particularly the uninsured groups, for preventive, diagnostic, and basic restorative care than did FQHC/CHCs and public health departments (not shown).

Exhibit 10: Difficulty of Referring Patients, by Dental Service Need, All Clinics  
(Scale: 1=not difficult, 2=slightly difficult, 3=fairly difficult, 4=very difficult)

	Uninsured Children	Uninsured Adults	Medicaid/KidCare Clients
Preventive	3.2	3.4	2.0
Diagnostic	3.3	3.3	2.1
Basic Restorative	3.3	3.4	2.3
Complex Restorative	3.5	3.8	2.9
Emergency Care	3.3	3.5	2.7
Oral Surgery	3.5	3.5	2.9
Other Specialty Services	3.8	3.8	3.2

### Financing/Resources

Exhibit 11 shows the annual budget categories for clinics. About two-thirds (63%) of the 65 responding clinics had an annual budget of less than \$200,000 in 2000<sup>2</sup>.

Exhibit 11. Dental Clinic Annual Budget

Annual Budget	All Clinics	FQHC/CHC	Public health dept.	Private NFP
<\$100,000	23%	32%	5%	31%
\$100,000-199,000	40%	36%	60%	38%
\$200,000-299,000	18%	9%	25%	15%
\$300,000-399,000	12%	18%	5%	15%
\$400,000 or more	6%	5%	5%	0
Average estimated annual budget	\$187,000	\$178,000	\$193,000	\$171,000

Clinics reported several sources of funding and support, such as grants (71% of clinics), patient fees/revenues (70%), and donated dental equipment (51%), followed by private donations (39%), local taxes (38%) and donated dental supplies (38%) (Exhibit 12). Most CHC/FQHCs reported having patient fees/revenues (91% of clinics), while grants were most frequently reported by public health departments (86%) and private NFPs (92%). Most public health departments also used local taxes (81% of clinics). Other resources not listed in the table

<sup>2</sup> The average annual budget was estimated by using the midpoint for each category. The response categories were: <\$50,000, \$50,000-\$99,999, \$100,000-\$149,999, \$150,000-\$199,999, \$200,000-\$249,999, \$250,000-\$299,999, \$300,000-\$349,999, \$350,000-\$399,999, and >\$400,000. For the lowest category, \$25,000 was used as the midpoint, and for the highest category \$400,000 was used.

included IDPA start-up funding (11 clinics), National Health Services Corps (5), dental hygiene students (9), dental students (5), and dental residents (6). A sizable number of clinics relied on donations or volunteer staff.

Exhibit 12. Resources Used by Clinics  
(percentage of clinics)

Resource Category	All Clinics	CHC/FQHC	PH Dept	Private NFP
Local (county) taxes	38%	17%	81%	8%
Patient fees/revenues	70%	91%	52%	69%
Grants	71%	57%	86%	92%
Private donations	39%	30%	29%	92%
Volunteer dentist time	28%	13%	29%	62%
Volunteer dental hygienist time	16%	9%	10%	46%
Donated dental equipment	51%	70%	48%	46%
Donated dental supplies	38%	30%	38%	62%
Donated space	16%	4%	24%	31%

As patient fees/reimbursement are a significant resource for dental clinics, we asked respondents to provide the total proportion of their clinic income that came from patient fees/reimbursement, as well as to categorize the patient revenues by type of insurance. About 49% of clinic income came from patient fees/reimbursement (based on responding clinics with patient fees/reimbursement). FQHC/CHCs received a much higher proportion of their revenue from patient fees/reimbursement (57% of revenue) compared to 40% for public health departments and 32% for private NFPs. Almost all respondents (65/71) provided information on the percentage of patient revenues by payment source (Exhibit 13). Over half of fee income came from Medicaid/KidCare (54%), followed by patient out-of-pocket payments (30%), while private insurance accounted for very little (4%).

Exhibit 13. Percentage of Patient Fee Revenue by Source.

Patient Revenue Source	All Clinics	FQHC/CHC	Public health dept.	Private NFP
Medicaid/KidCare	54%	43%	84%	43%
Patient out-of-pocket	30%	40%	9%	23%
Private Insurance	4%	9%	0.8%	0.5%
Other	12%	10%	7%	34%

### *Future Needs*

Only 11% (8 clinics) of respondents reported that they were able to provide all dental services needed by their patients. When asked for the most important barriers to meeting patient needs (Exhibit 14), the most common barrier reported was the limited range and types of dentals services offered (mentioned 45 times, 18 times as the most important barrier). Other commonly reported barriers included insufficient facilities/space/number of operatories (24), insufficient funding or other financial issues (22), staffing (17) and insufficient capacity (12). Thirteen responses dealt with dentist limitations (e.g., no or few dentists to refer patients to, who participate in Medicaid, or who donate services). Other barriers included patient transportation, patient education and compliance, and lack of insurance/money for patients.

**Exhibit 14: Barriers to Meeting Patient's Needs:  
Total Number of Times Mentioned by Clinics**

<b>Barrier</b>	<b>Total (listed as most important)</b>
Limited range and types of dental services provided	45 (18)
Insufficient funding	22 (15)
Insufficient space/facilities/ number of operatories	24 (9)
Insufficient capacity (e.g., too busy)	12 (7)
Providers (number, referrals to, participation in Medicaid, donating services)	13 (3)
Staffing	17 (2)

Respondents were given a list of resources and were asked to indicate which were needed by their clinic to allow them to meet their patients' needs. The most common reported resource needs were for new funding sources (76%), additional funding from current sources (75%), and additional dentists (71%) (Exhibit 15). Forty-five clinics indicated they need both new funding and additional funding from current sources.

**Exhibit 15. Resources Needed to Meet Clients' Needs.  
(Percentage of clinics)**

<b>Resources Needed</b>	<b>All Clinics</b>	<b>CHC/FQHC</b>	<b>Public Health Dept.</b>	<b>Private NFP</b>
New funding sources	76%	96%	71%	77%
Additional funding from current sources	75%	87%	76%	62%
Additional dentists	71%	78%	71%	77%
Additional dental hygienists/assistants	62%	87%	52%	54%
More clinic space	60%	74%	62%	39%
Additional dental equipment	56%	70%	67%	39%
Additional admin/clerical staff	41%	61%	43%	8%
Updated dental equipment	44%	57%	43%	39%
Better outreach to target populations	38%	43%	48%	31%
Other	16%	0%	48%	0%

Most dental clinics (62%, 41 of 66) indicated that they had plans to expand services in the next five years. These plans included expanding the number of operatories and/or services offered (24 clinics), opening a new clinic or relocating (19), increasing staff (10), increasing office space or remodeling (9), as well as increasing funding sources or extending hours. When asked for their suggestions for maintaining or expanding capacity, the same themes that arose as in earlier responses, including increasing funding, improvements with recruiting and retaining staff, increasing clinic space/hours open, resolving scheduling issues, obtaining higher Medicaid reimbursement rates, and increasing the awareness of and political interest in public health dentistry.

### *Dental School and Dental Hygiene School Clinics*

While clinics at Illinois' two dental schools represent an important source of dental care for underserved populations, we are unable to discuss these clinics as a separate category due to confidentiality concerns. Since seven dental hygiene school clinics responded, we are able to provide some information on this category of clinics.

Dental hygiene school clinics were open an average of 28 years (from 1 to 38 years), and had 16 chairs (from 6 to 36 chairs, median=15). They were open an average of 26 hours per week and most (5 of 7) were open evenings, although none had weekend hours. These clinics only provided preventive and diagnostic services. On average, dental hygiene school clinics reported the largest number of annual visits (3,527) among all categories, although they also had a larger number of chairs and longer appointment times (average=149 minutes). These clinics treated a broad range of patients without geographic or income restrictions. The average time to obtain an appointment for routine care was somewhat lower than for other clinics – 31 days for Medicaid patients and 20 days for other, non-Medicaid, patients. These respondents reported that about 18% of appointments were missed per week. Not surprisingly, hygienists provided 100% of preventive services. Dental hygiene school clinics had a much higher number of paid staff (average = 14.6) than other clinics. A much lower percentage of their revenue from patient sources came from Medicaid (22%), with the remainder (78%) from direct patient payments.

### **Discussion**

The dental safety net represents a small but vital provider of dental services to low-income and other vulnerable population groups in Illinois. These clinics were distributed throughout the state with many clinics in the metropolitan Chicago area, which accounts for a large proportion of Illinois' population and Medicaid enrollment. Only 28 of Illinois' 102 counties had any safety net dental clinics. Exhibit 16 summarizes the key findings from this study.

*Illinois safety net dental clinics were diverse, treated a wide range of patients, provided a wide array of services, and were relatively well established.* Illinois has almost 100 safety net dental clinics that were sponsored by public health departments, community health centers, private not-for-profit organizations, and colleges of dentistry and schools of dental hygiene. In general, the population groups that seek care from these types of clinics tend to be of all ages, difficult to reach, and have higher than average health care needs; it is likely that this is true of the users of safety net dental clinics in Illinois. These dental clinics had been in existence for an average of 18 years and offered a wide range of services to low-income adults and children and many special population groups (disabled, HIV/AIDS, homeless). The vast majority of these clinics provided preventive, diagnostic, and basic restorative care as well as emergency care, complex restorative care and oral surgery. In addition, most clinics provided oral health outreach and education programs in a variety of settings and to a wide range of groups, and were located at sites where other health care services were also provided.

*Dental clinics operated with insufficient resources and, thus, experienced service limitations.* Almost two-thirds of dental clinics had a budget of less than \$200,000. More than half of their patient revenue came from Medicaid. Clinics operated with few staff and experienced problems in recruiting new staff. These constraints led to a reliance on donations and a volunteer workforce. Only 8 of the 71 respondents said that they were able to provide all of the dental services needed by their clients. Limited resources were often wasted, with almost one-fourth of all appointments missed.

Clinics reported that dentists performed large amounts of preventive care, a service often provided by dental hygienists. This suggests that dentists' time may not have been optimally utilized in the provision of the more complex care needed by this population. It is not known from this study whether it was more difficult to recruit dental hygienists than dentists. Due to the state's dental practice act, a dentist must be present on site when a dental hygienist is treating a patient; and this may have restricted staffing options for dental clinics.

Because of limited resources, patients still faced barriers obtaining oral health care services. Few dental clinics were open any evenings or weekends. Not all types of services were provided (the most commonly reported access barrier by clinics) and not all clinics treated all types of patients, particularly migrant farm workers, persons with HIV/AIDS, and the homeless. Many clinics also had jurisdictional and financial restrictions, which limited the types of patients who could receive services. For Medicaid patients, it took an average of five weeks to obtain an appointment for routine care; while Medicaid patients can also seek care from private dentists, dentist participation in Medicaid is low in Illinois (Byck, et al., 2000). Patients who used dental hygiene clinics faced shorter waits for an appointment but lengthy appointment times. Dental clinics reported difficulty in referring patients to other sources, particularly for uninsured patients and those needing complex restorative care, oral surgery, and other specialty services. In addition, three-fourths of Illinois counties, accounting for over 2.3 million people, did not have a safety net dental clinic within their community.

**Exhibit 16. Key Findings for Illinois Safety Net Dental Clinics**

- ◆ The majority of clinics are well-established
- ◆ Clinics were open an average of 31 hours per week; few clinics were open evenings or weekends
- ◆ Clinics provided a broad range of services to many types of patients
- ◆ Clinics provided numerous and varied outreach programs
- ◆ Most clinics were located where other health services are provided
- ◆ In total, Illinois dental clinics provided over 300,000 visits per year
- ◆ More than half of patient revenue was from Medicaid
- ◆ Two-thirds of clinics operated with an annual budget less than \$200,000
- ◆ Clinics operated with few staff
- ◆ Only 8 clinics reported being able to provide all of the dental services needed by their patients

*Safety net dental clinics compared to private dentist practices.* Our findings show that these dental clinics were similar to a private dental practice in many respects. Clinics in this study were open an average of 31 hours per week; private practice dentists spent an average of 37 hours per week in the office, 34 of which they spent treating patients (ADA, 2001). Both had an average of 4 operatories/chairs and operated with few dentists in the "practice." Nationally, two-thirds of private practitioners were solo dentists and another 20% worked in 2-person practices (ADA, 2001). About half (51%) of responding clinics had only 1 full-time paid dentist (perhaps part-time paid and volunteer dentists as well) and another 35% only had part-time paid or volunteer dentists. While 59% of clinics reported not having a dental hygienist on staff, only 29% of private general practitioners operated without a dental hygienist (ADA, 2000). An important difference between dental clinics and private dentist offices is in the types of patients

treated. While 90% of clinics in this study reported treating Medicaid/KidCare children, only 25% of Illinois dentists participated in Medicaid in a recent year (Byck, et al., 2000).

*The dental safety net is a small but important provider of dental services in Illinois.*

While it is difficult to quantitatively compare a private practice dental office with a safety net dental clinic in terms of visits or capacity, we can make some estimates. In 1998, an average private practice general practitioner provided 2,621 patient visits, not including dental hygienist visits, or 3,883 patient visits, including dental hygienist visits (ADA, 2001). In Illinois, there were approximately 5,903 active patient care general practice and pediatric dentists (Byck, Cooksey & Walton, 2001). Therefore, an estimate of annual private practice patient visits to general and pediatric dentists in Illinois was about 15.5 million to 22.9 million (2,621 x 5,903; 3,883 x 5,903). On average, the safety net dental clinics responding to our survey provided 3,150 dental visits during 2000, or an estimated 300,000 dental visits for all 95 Illinois safety net dental clinics (respondents and non-respondents). While visits to these safety net dental providers are a fraction of the visits to private dentists (<2%), they are a crucial component of access to oral health care for Medicaid and other low-income and underserved populations. About 11.4% of Illinois' population is below poverty (U.S. Census Bureau, 2001a) and 13.5% are uninsured (U.S. Census Bureau, 2001b). The low-income population in Illinois has high unmet oral health needs. Expanding capacity of the dental safety net clinics will help bring oral health care some of the state's underserved populations.

#### *Study Limitations*

This was an exploratory study to provide descriptive data on Illinois safety net dental providers. This survey provides a snapshot in time of the Illinois dental safety net, as reported by the respondents. While the response rate was relatively high (75%), we do not have information on how similar the non-respondents were to the respondents or whether there may have been any respondent bias. Also, there are many questions for which more detailed information is desirable (e.g., utilization data, and percentage of services provided by dentists) as well as the proportion of state Medicaid services provided by safety net dental clinics. These are questions for future studies. Since this was a small sample, it was not possible to look at certain categories of clinics or draw statistical inferences from the data. In addition, while all clinics were grouped together, there are real differences among them (e.g., dental school and dental hygiene school clinics) that may have diluted certain findings; when outliers were observed, the analysis was repeated without the outliers.

#### **Conclusion**

These dental clinics are essential in helping underserved populations in Illinois meet their oral health care needs. In spite of constraints in funding, staffing, and referrals, clinics provided a wide range of oral health care services, including outreach and education, to many vulnerable, high-need population groups. Study findings show that more funding and more staffing are key to enabling these providers to expand oral health care to underserved populations. It is also important to note that there are large geographic areas of the state with *no* safety net dental clinics. These findings should assist educators, dental professionals and policymakers in their efforts to improve the delivery of oral health care in Illinois.

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## Appendix 1. Examples of Illinois Programs which Support Safety Net Dental Providers

### **Illinois Department of Public Aid (IDPA)**

- Local County Health Department Dental Clinic Grant Program: The Department provides \$70,000 over two years to health departments or government entities with health department functions to help them develop a full-time dental clinic, contingent on certain criteria being met. Thus far, two grants have been successfully completed, four are current, and two are in process.
- IDPA also has made the following changes to encourage more dentists to participate in Medicaid: increased reimbursement rates (July 1998, July 1999, July 2000, July 2001); changed to ADA billing forms and coding procedures; reduced the number of procedures requiring prior approval; provided enrollment assistance to dentists; allowed providers to determine the number of Medical Assistance patients they will treat; and added a Policy Review Committee to address dental policy and program needs.

### **Illinois State Dental Society (ISDS)**

- Take TWO – encourages dentists, regardless of enrollment in Medicaid, to provide services to at least two foster children per year. Services are either pro bono or reimbursed by Medicaid.
- Donated Dental Services – dentists volunteer to provide services for the elderly or handicapped for free – these are generally not for routine services but for more serious, expensive treatments or procedures. Some funding is provided by IDPH and from laboratories in Illinois. This program is in partnership with the Illinois Foundation of Dentistry for the Handicapped.
- Continuing education to long-term care facilities – pilot programs in which workers in long-term care facilities will be trained to recognize the importance and daily need of dental care. This program received a three-year grant from IDPH and is in partnership with the Illinois Dental Hygienists' Association.

### **Illinois Primary Health Care Association (IPHCA)**

- Community Health Center (CHC) New Start and Expansions – the Health Resources Services Administration (HRSA) Bureau of Primary Health Care (BPHC) requires that new access points provide comprehensive primary care including oral health services.
- Recruitment services – IPHCA assists member CHCs with recruitment of dentists. There is a liaison to the National Health Services Corps.
- Student and resident experiences and rotations in community health SEARCH – this program, in partnership with the Illinois Area Health Education Council (AHEC) links health professions training programs and CHCs.

### **Southern Illinois University Dental Hygiene Program**

- There are two clinics at the school – a traditional clinic that serves anyone in the community as well as students, and The Heartland Clinic, which serves only Medicaid patients in a 10 county area.
- Dental hygiene students spend over 100 hours each serving the community, including providing educational programs in elementary schools, nursing homes, and at health fairs.
- Sealant programs for children, funded by IDPH.
- Training for other health professionals to help detect and recognize the early signs of oral cancer, funding from IDPH oral health cancer grant.

Appendix 2. Illinois Safety Net Dental Clinics

<b>Clinic/Site Name</b>	<b>City</b>	<b>County</b>
Adams County Health Department	Quincy	Adams
Cairo Dental Service	Cairo	Alexander
Tamms Dental Clinic	Tamms	Alexander
Bureau County Health Department	Princeton	Bureau
Champaign-Urbana Public Health District	Champaign	Champaign
Parkland College	Champaign	Champaign
Lake Land College	Mattoon	Coles
American Indian Health Services	Chicago	Cook
Amundsen High School SBHC	Chicago	Cook
Arai Middle School	Chicago	Cook
Chicago Department of Public Health	Chicago	Cook
Chicago Department of Public Health	Chicago	Cook
Chicago Department of Public Health	Chicago	Cook
Chicago Department of Public Health	Chicago	Cook
Chicago Department of Public Health	Chicago	Cook
Chicago Department of Public Health	Chicago	Cook
Chicago Department of Public Health	Chicago	Cook
Chicago Family Health Center	Chicago	Cook
Children's Memorial Hospital	Chicago	Cook
Cicero Health Department	Cicero	Cook
City of Evanston Department of Public Health	Evanston	Cook
Community Health Partnership of Illinois	Chicago	Cook
Community Nurse Health Association	LaGrange	Cook
Cook County Department of Public Health	Bridgeview	Cook
Cook County Department of Public Health	Harvey	Cook
Cook County Department of Public Health	Markham	Cook
Cook County Department of Public Health	Maywood	Cook
Cook County Department of Public Health	Ford Heights	Cook
Cook County Department of Public Health	Rolling Meadows	Cook
Cook County Department of Public Health	Skokie	Cook
Cook County Fantus Health Center	Chicago	Cook
Family Health Society, Inc.	Chicago	Cook
Howard Area Community Center	Chicago	Cook
Infant Welfare Society	Oak Park	Cook
Infant Welfare Society of Chicago	Chicago	Cook
Kennedy King College Dental Hygiene Clinic	Chicago	Cook
Komed Holman Health Center	Chicago	Cook
Lakeview High School	Chicago	Cook
Lawndale Christian Health Center	Chicago	Cook
Mile Square Dental Clinic	Chicago	Cook
Oak Forest Hospital Dental Clinic	Oak Forest	Cook
Pacific Gardens Mission Dental Clinic	Chicago	Cook
Prairie State College	Chicago Heights	Cook
Ravenswood Dental Clinic	Chicago	Cook
St. Basil's Health Service	Chicago	Cook
Salvation Army Dental Clinic	Chicago	Cook

<b>Clinic/Site Name</b>	<b>City</b>	<b>County</b>
Spang Center for Oral Health Howard Area	Chicago	Cook
Spang Center for Oral Health North	Chicago	Cook
Spang Center for Oral Health South	Chicago	Cook
Stickney Public Health District Dental Clinic	Burbank	Cook
Stickney Public Health District Dental Clinic	Chicago	Cook
Stickney Public Health District Dental Clinic	Stickney	Cook
The Ark, Social Service Agency	Chicago	Cook
The Altgeld Health Center	Chicago	Cook
University of Illinois- Children's Clinic	Chicago	Cook
University of Illinois- Dental School Adult Clinic	Chicago	Cook
University of Illinois- Oral Surgery Residency Clinic	Chicago	Cook
William Rainey Harper College	Palatine	Cook
Worth Township Clinic	Alsip	Cook
DuPage Community Clinic	Wheaton	DuPage
DuPage County Health Department	Wheaton	DuPage
Christopher Rural Health Planning Corporation	Christopher	Franklin
Fulton County Health Department	Canton	Fulton
Hardin County Dental Clinic	Rosiclaire	Hardin
Henderson County Rural Health Center	Oquawka	Henderson
Murphysboro Health Center Dental Clinic	Murphysboro	Jackson
Southern Illinois University- Dental Hygiene Clinic	Carbondale	Jackson
Southern Illinois University- Heartland Dental Clinic	Carbondale	Jackson
Kankakee School Based Health Center	Kankakee	Kankakee
Knox County Health Department	Galesburg	Knox
Lak County Health Department	North Chicago	Lake
Barwell Dental Clinic Inc.	Waukegan	Lake
Lake County Health Department	Waukegan	Lake
Lake County Health Department	Zion	Lake
Lake County Health Department	Round Lake Park	Lake
Zion-Benton Township	Zion	Lake
Livingston County Health Department	Pontiac	Livingston
Macon County Health Department	Decatur	Macon
Lewis and Clark Community College Dental Hygiene	Godfrey	Madison
Southern Illinois University -Alton Dental School	Alton	Madison
McHenry County Cooperative Dental Clinic	Woodstock	McHenry
McLean County Health Department	Bloomington	McLean
M + M Dental Clinic	Litchfield	Montgomery
Illinois Central College	Peoria	Peoria
Peoria Health Department	Peoria	Peoria
East Side Health District Dental Clinic	East St. Louis	St. Clair
Southern Illinois University- Dental School	East St. Louis	St. Clair
St. Clare Health Clinic	Springfield	Sangamon
Tazewell County Dental Clinic	Pekin	Tazewell
Whiteside County Health Department	Rock Falls	Whiteside
Will County Community Health Department	Joliet	Will
Will-Grundy Dental Clinic	Joliet	Will
Crusaders Clinic	Rockford	Winnebago
Milestone Dental Clinic	Rockford	Winnebago

## Illinois Safety Net Dental Clinics



\* 52 Clinic Sites in Cook County

## Cook County Safety Net Dental Clinics



### Appendix 3. Stakeholder Group

Ann Boyle, D.M.D.  
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Southern Illinois University

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College of Dentistry

Judy Redick  
Illinois Department of Human Services

Nelly Ryan  
Bureau Chief of Contract Management  
Illinois Department of Public Aid

Appendix 4. Questionnaire

## Survey of Safety Net Dental Providers

1. Clinic or Site Name:

\_\_\_\_\_

2. Organization Name/Relationship: (if applicable)

\_\_\_\_\_

3. Administrator \_\_\_\_\_ Ph # \_\_\_\_\_ E-mail: \_\_\_\_\_  
 Dental Director \_\_\_\_\_ Ph # \_\_\_\_\_ E-mail: \_\_\_\_\_

4. Survey Completed By:

Name and Title \_\_\_\_\_ Ph # \_\_\_\_\_ E-mail: \_\_\_\_\_

### *Dental Clinic/Site Profile:*

5. Type of dental clinic:

- Federally Qualified Health Center (FQHC) or look-alike community health center
- Local public health department
- School-based
- Dental school
- Dental hygiene school
- Private, non-profit organization (other than CHC/FQHC)
- Other \_\_\_\_\_

6. When did your dental clinic open? \_\_\_\_\_ / \_\_\_\_\_ (mm/yy)

7. How many dental operatories/chairs are at your dental clinic? \_\_\_\_\_ # operatories/chairs

8. How many *hours* are you open a week for patient care? \_\_\_\_\_ # hours

9. Are you open on any *evenings*?  No  Yes

If yes, how many evenings per week? \_\_\_\_\_ # per week

10. Are you open any *weekends*?  No  Yes

If yes, what day(s)? \_\_\_\_\_

11. What dental services are offered by the clinic? (*check all that apply*)

- Preventive (e.g., cleanings, fluorides, sealants)
- Diagnostic (e.g., oral exams, x-rays)
- Basic Restorative (e.g., fillings)
- Complex Restorative
- Emergency Care
- Oral Surgery
- Other (e.g., endodontics, orthodontia, periodontics, prosthetics)

*please specify:* \_\_\_\_\_

12. What other (non-dental) services are provided at the site where the dental clinic operates?

- Medical care
- Other \_\_\_\_\_

13. Do you provide outreach to the community *about oral health*?  No  Yes

If yes, list the types of educational formats that include **oral health**, such as health fairs, programs, etc.

---

14. Approximately how many outreach programs do you conduct each year? \_\_\_\_\_ # programs

**Dental Capacity and Utilization:**

15. Does your clinic provide dental/oral health care to patients *outside* of your county/city/township/authorized jurisdiction?

- No  Yes

16. Who are your **CURRENT** and **POTENTIAL** patient populations for dental/oral health care services?

(Check all that apply in each category)

	<u>We now serve</u>	<u>We would like to serve in the future</u>
All	<input type="checkbox"/>	<input type="checkbox"/>
Adults	<input type="checkbox"/>	<input type="checkbox"/>
Children	<input type="checkbox"/>	<input type="checkbox"/>
Students	<input type="checkbox"/>	<input type="checkbox"/>
Uninsured adults	<input type="checkbox"/>	<input type="checkbox"/>
Uninsured children	<input type="checkbox"/>	<input type="checkbox"/>
Medicaid adults	<input type="checkbox"/>	<input type="checkbox"/>
Medicaid/KidCare children	<input type="checkbox"/>	<input type="checkbox"/>
DCFS wards	<input type="checkbox"/>	<input type="checkbox"/>
Disabled persons	<input type="checkbox"/>	<input type="checkbox"/>
HIV/AIDS-afflicted persons	<input type="checkbox"/>	<input type="checkbox"/>
Homeless persons	<input type="checkbox"/>	<input type="checkbox"/>
Migrant/farmworkers	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

17. Are there financial guidelines that your patients must meet?  No  Yes

If yes, please specify (e.g., less than 200% poverty):

---

18. How many dental visits did you provide in the calendar year 2000 for the following types of patients?

Number of visits in year 2000

- \_\_\_\_\_ Medicaid/KidCare children
- \_\_\_\_\_ Medicaid adults (e.g., emergency services, pregnant women)
- \_\_\_\_\_ Uninsured children
- \_\_\_\_\_ Uninsured adults
- \_\_\_\_\_ Privately insured children
- \_\_\_\_\_ Privately insured adults

- 19. For routine care, what is the average waiting time in DAYS to obtain a dental appointment?**  
 for Medicaid patients? \_\_\_\_\_ # of days  
 for other patients? \_\_\_\_\_ # of days
- 20. For emergency care, what is the average waiting time in DAYS to obtain a dental appointment?**  
 for Medicaid patients? \_\_\_\_\_ # of days  
 for other patients? \_\_\_\_\_ # of days
- 21. What percentage of preventive services are provided by a:**  
 dentist? \_\_\_\_\_ %  
 dental hygienist? \_\_\_\_\_ %
- 22. What is the average length of an appointment in minutes?** \_\_\_\_\_ # of minutes
- 23. How many missed appointments (no shows) does your clinic experience each week?**  
 \_\_\_\_\_ # of missed appointments/week  
 \_\_\_\_\_ % of all appointments that are missed
- 24. How do you handle missed appointments? (for example: overbook, penalty fee, etc.)** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Referrals:**

- 25. To whom do you refer patients for dental services?**  
 Do not refer  
 Private dental offices  
 \_\_\_\_\_ number of dental offices you refer to  
 Hospital emergency rooms  
 Dental school clinics  
 Other dental safety net provider, specify: \_\_\_\_\_
- 26. Do you refer patients to sources outside of Illinois?**  No  Yes  
 If yes, where? \_\_\_\_\_

**27. For each patient group indicated, please circle the level of difficulty for finding referral sources for services listed:**

1 = not difficult    2 = slightly difficult    3 = fairly difficult    4 = very difficult    n/a = not applicable

	Uninsured children					Uninsured adults					Medicaid/KidCare clients				
	1	2	3	4	n/a	1	2	3	4	n/a	1	2	3	4	n/a
Preventive															
Diagnostic															
Basic Restorative															
Complex Restorative															
Emergency															
Oral Surgery															
Other															

28. If your dental clients need *medical* care, do you have formal referral arrangements?

If yes, please describe.

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**Staffing:**

29. Please indicate the number of personnel used to staff your dental clinic:

	Paid	Volunteer/Unpaid
Dentist		
Full-time	_____	_____
Part-time	_____	_____
Dental Hygienist		
Full-time	_____	_____
Part-time	_____	_____
Dental Assistant		
Full-time	_____	_____
Part-time	_____	_____
Administrative/Clerical		
Full-time	_____	_____
Part-time	_____	_____

30. How many of these dentists are on a loan repayment program? \_\_\_\_\_ # dentists

31. Please indicate any vacancies you currently have for the following positions and how long the position(s) have been vacant:

	Number of Vacancies	Length of Vacancy (longest)
Dentist	_____	_____ months
Dental Hygienist	_____	_____ months
Dental Assistant	_____	_____ months

32. How do you recruit staff for your dental clinic? (check all that apply)

- National Health Services Corps
- Educational affiliations
  - Dental schools
  - Dental hygiene schools
- Local advertising
- Programs with local dental/dental hygiene associations
- Internet
- IDPH Center for Rural Health
- Other (specify: \_\_\_\_\_ )

33. What are your biggest challenges in recruiting staff? \_\_\_\_\_

34. What would make recruitment of qualified staff easier? \_\_\_\_\_

**Funding and Financing:**

35. How large was your total dental clinic annual budget last year?

- |  |  |
|--|--|
| <input type="checkbox"/> Less than \$50,000    | <input type="checkbox"/> \$200,000 - \$249,999 |
| <input type="checkbox"/> \$50,000 - \$99,999   | <input type="checkbox"/> \$250,000 - \$299,999 |
| <input type="checkbox"/> \$100,000 - \$149,999 | <input type="checkbox"/> \$300,000 - \$399,999 |
| <input type="checkbox"/> \$150,000 - \$199,999 | <input type="checkbox"/> \$400,000 or more     |

**36. Which of the following resources does or has your dental clinic used? (Check all that apply)**

- |   |  |
|---|--|
| <input type="checkbox"/> IL Department of Public Aid Start Up Funding | <input type="checkbox"/> Volunteer dentist time          |
| <input type="checkbox"/> Patient fees/revenues                        | <input type="checkbox"/> Volunteer dental hygienist time |
| <input type="checkbox"/> Grants                                       | <input type="checkbox"/> Dental school students          |
| <input type="checkbox"/> School/school board funding                  | <input type="checkbox"/> Dental residents                |
| <input type="checkbox"/> Dental/dental hygiene school funding         | <input type="checkbox"/> Dental hygiene students         |
| <input type="checkbox"/> Private donations                            | <input type="checkbox"/> Donated dental equipment        |
|   | <input type="checkbox"/> Donated dental supplies         |
|   | <input type="checkbox"/> Donated space                   |
|   | <input type="checkbox"/> Other                           |

**37. What percentage of patient-generated clinic income came from these sources in the year 2000?**

	Year 2000 <u>patient-generated</u> income
Medicaid/KidCare	_____ %
Sliding Fee	_____ %
Full Fee	_____ %
Private Insurance	_____ %
Other: _____	_____ %
<b>TOTAL</b>	<u>100</u> %

**38. What percentage of total revenue (year 2000) was generated by patient fees/reimbursement? \_\_\_\_\_ % of total revenue**

**39. What type of reimbursement do you receive for Medicaid patients?**

- Encounter rate  
 Fee for service

**Future Needs:**

**40. Are you able to provide all the dental services needed by your clients?**  No  Yes

**41. Please list the barriers to meeting your clients' needs, in order of importance.**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**42. Which of the following resources are needed to meet your clients' needs (check all that apply):**

- New funding sources
- Additional dentists
- Additional administrative or clerical staff
- Additional dental hygienists/assistants
- More clinic space
- Additional dental equipment.
- Updated dental equipment
- Better outreach to target populations
- Other \_\_\_\_\_

**43. Do you plan to expand services in the next 5 years?**     No     Yes → what is your plan?

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**44. What suggestions do you have to help your dental clinic maintain or expand its capacity?**

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## Appendix 5: Number of respondents for questions with less than 100% response rate.

<b>Question</b>	<b>All Clinics # responding</b>	<b>FQHC/CHC # responding</b>	<b>Public Health Dept. # responding</b>	<b>Private NFP # responding</b>
Year clinic opened	62	21	18	12
Hours open per week	70	23	21	13
Non-dental services provided at site?	69	23	20	13
Provide care outside jurisdiction?	69	22	20	13
Number of dental visits, 2000	59	21	18	13
Avg. days for routine care appointment				
Medicaid	61	23	20	9
Avg. days for emergency care appointment, if clinic provides emergency care				
Medicaid	52/54	20/20	17/17	10/11
Percentage of preventive services provided by dentist or hygienist	69	23	21	12
Percent of missed appointments per week	56	21	13	13
Refer patients to non-IL sources?	69	23	31	12
Level of difficulty for referrals by service	32-55	10-22	6-19	3-9
Formal referral arrangements for medical care	68	23	21	13
Number of dentists on loan repayment program	67	21	20	13
Vacancies, number and length	69	23	20	13
How do you recruit staff for your dental clinic?	68	22	20	13
Biggest challenges in recruiting staff (open-ended)	54	13	20	11
What would make recruitment easier? (open-ended)	47	10	18	10
Annual budget	65	22	20	13
Which resources has your clinic used?	69	23	21	13
Percentage of patient-generated income by payment	65	22	21	11
Percentage of revenue from patient fees	51	10	19	12
List at least one barrier to meeting clients' needs (open-ended)	66	21	20	12
Which resources are needed to meet your clients' needs?	68	23	21	13
Do you plan to expand services in the next five years?	66	21	19	13