

Administrative Challenges to the Integration of Oral Health With Primary Care

A SWOT Analysis of Health Care Executives at Federally Qualified Health Centers

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Abstract: Inadequate access to preventive oral health services contributes to oral health disparities and is a major public health concern in the United States. Federally Qualified Health Centers play a critical role in improving access to care for populations affected by oral health disparities but face a number of administrative challenges associated with implementation of oral health integration models. We conducted a SWOT (strengths, weaknesses, opportunities, and threats) analysis with health care executives to identify strengths, weaknesses, opportunities, and threats of successful oral health integration in Federally Qualified Health Centers. Four themes were identified: (1) culture of health care organizations; (2) operations and administration; (3) finance; and (4) workforce. **Key words:** *Federally Qualified Health Centers, health administration, health workforce, health care management, oral health, oral health integration, primary care, underserved communities*

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THE ORAL HEALTH CRISIS

Preventable dental diseases (eg, dental caries, dental decay) are among the most common medical conditions affecting the US population (Benjamin, 2010). Inadequate access to preventive oral health care services perpetuates the burden of such diseases and disproportionately affects individuals from racial and ethnic minorities and individuals residing in rural or medically underserved communities (Dye et al., 2007; Edelstein & Chinn, 2009; Vargas et al., 2003). Although most

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dental diseases are entirely preventable, the Centers for Disease Control and Prevention reports that 21.9% of Mexican and 22.4% of black or African American children still suffer from untreated dental caries; both rates are significantly higher than the national average (15.6%) and the rate among white children (12.8%). Oral health disparities among American adults are just as disturbing (National Center for Health Statistics, 2013).

INTEGRATION: A POTENTIAL HEALTH CARE DELIVERY SYSTEM SOLUTION

Effectively expanding access to oral health care and improving oral health require changes in perceptions and health system solutions (Committee on an Oral Health Initiative & Institute of Medicine, 2011). One means would be integrating oral health with primary care. In 2014, the Health Resources and Services Administration published a report titled *Integration of Oral Health and Primary Care Practice* (IOHPCP). The IOHPCP initiative seeks to improve access to preventive oral health services and promote early detection of dental disease by enhancing the clinical competency of primary care clinicians in oral health. This integration has become a national priority, but it has yet to be realized. While the health system as a whole grapples with oral health integration, Federally Qualified Health Centers (FQHCs) are leading the way in the development and implementation of integration models in underserved communities.

THE ROLE OF FQHCs

FQHCs are comprehensive primary health care organizations that receive federal funding under Section 330 of the Public Health Service Act to “ensure” access to comprehensive primary health care in communities recognized as medically underserved. As major providers of health care services in underserved communities and the largest component of the dental safety net, FQHCs are critical in improving access to comprehensive health care services, including preventive oral health services. FQHCs provide oral health services to

patients through strategies such as colocation of dental services within primary care facilities and referral programs linking patients to community dental resources (Maxey, 2015).

Although FQHCs must ensure access to preventive oral health services, such access remains a problem among patients. For instance, FQHCs with referral programs utilize vouchers to reimburse community dentists for services provided to referred patients. Unfortunately, many dental vouchers go unpaid and many patients report not receiving the dental care for which they were referred (Maxey, 2015). There is little research on the effectiveness of these referral programs for dental services at FQHCs, making it difficult to quantify their impact on care access. Among FQHCs offering their own dental services, approximately half of all patients reported not having a dental visit within the last year and only 20% reported that their dental care was delivered at the FQHC (Jones et al., 2013).

Integration of oral health and primary care would improve the reach of FQHC dental services and increase the success of their current programs. Such integration would align with FQHCs’ adoption of the Patient-Centered Medical Home (PCMH) model (Qualis Health, n.d.; Quinn et al., 2013). Nevertheless, integrated, comprehensive health services cannot be realized without strategies for improving FQHCs’ internal means of addressing threats and exploiting environmental opportunities. To do so, we thought it necessary to identify FQHC executives’ perspectives on integration. As such, we identified and discussed administrative challenges associated with the implementation of oral health integration models via focus groups with FQHC executives.

METHODS

We conducted focus groups with executives of Indiana FQHCs to perform a SWOT (strengths, weaknesses, opportunities, and threats) analysis of integrating oral health and primary care. SWOT analysis was selected because it is effective for strategic analysis and has previously been used in policy research to systematically evaluate organizational

environments (Helms & Nixon, 2010; Van Durme et al., 2014, Yelken et al., 2012). Focus groups were selected for data collection because they promote collective engagement and dialogue and help achieve greater understanding of an issue (Denzin & Lincoln, 2011).

Purposive sampling was employed to ensure that study data were representative of the perspectives of the executives and other administrators of FQHCs. A total of 29 individuals ultimately participated, including chief executive officers (n = 11), chief operating officers (n = 7), chief financial officers (n = 6), and dental directors (n = 5). Many participants were executives overseeing multiple clinical sites within a single FQHC grantee; in total, our sample covered 118 clinical sites throughout Indiana.

Participants were randomly assigned by position type to one of 3 focus groups to ensure that groups were homogenous and representative of the perspectives of multiple FQHCs and position types. Focus group composition is presented in Table 1. The characteristics of participants' clinical sites are shown in Table 2.

The 3 focus groups were conducted simultaneously and lasted approximately 60 minutes. A scribe documented and audio recorded each group. Both moderators

Table 2. Clinical Sites Represented (N = 118)

Site Characteristics	n (%)
Rurality	
Urban	105 (89)
Rural	13 (11)
Grantee type	
FQHC	12 (10)
State-funded FQHC	106 (90)
Setting type	
All other clinic types	90 (76)
Correctional facility	2 (2)
Domestic violence	1 (1)
School	25 (21)

Abbreviation: FQHC, Federally Qualified Health Center.

and scribes completed standardized training to ensure consistency across the groups (Morgan et al., 1998), and moderators followed a script to ensure consistent facilitation. The script is included as a Supplemental Digital Content Technical Appendix (available at: <http://links.lww.com/JACM/A57>).

Two researchers with expertise in health administration and dental care delivery then conducted thematic content analysis (Denzin & Lincoln, 2011). The researchers coded the data independently to identify the major themes before meeting to discuss any variations in these themes. The interrater reliability was measured as the percentage of absolute agreement (76.32%). Discrepancies were resolved via consultation with a third researcher and referring to the original transcripts and audio recordings.

RESULTS

In discussing what successful oral health integration would resemble in FQHCs, participants identified the critical components of oral health integration necessary for successful implementation. Four recurring themes emerged: (1) culture of health care organizations and the US health system; (2) operations and administration of oral health care services; (3) financing, funding, and reimbursement;

Table 1. Focus Group Composition

Participants	Focus Groups		
	I	II	III
Chief executive officer/executive director	1	5	5
Chief operating officer/operations	2	2	1
Chief finance officer/finance manager	3	0	3
Dental director/clinical affairs	3	1	3
Total	9	8	12

and (4) workforce capacity, training, and scope of practice.

Theme 1: Culture of health care organizations and the US health system

Oral health care has historically been separated, clinically and administratively, from the larger health care system (Cunnion et al., 2010; Lee et al., 2010). This separation has fostered a culture wherein oral health is not valued as a part of overall health, which poses a major challenge to reform efforts focused on strengthening the oral health care system. Participants recognized that a shift in thinking must take place at the local, state, and federal levels to promote a culture that values dental care as much as medical care and establish a health system that delivers comprehensive patient care for improving overall health.

I think [oral health integration] also takes . . . complete culture change. Because for whatever reason, dental seems to be so separate . . .

Strengths

FQHCs' primary aim is to improve access to primary health care in underserved communities. Being located in such communities, FQHCs have greater access to underserved populations than do other health care institutions. FQHC leadership embraces integration of oral health and primary care to improve access to comprehensive health care services. The passion to "serve," commitment to the organizational mission, and buy-in from leadership were all strengths identified within FQHCs.

Weaknesses

Participants identified lack of awareness of the importance of oral health among FQHC patients as a key weakness. This lack of awareness was believed to contribute to poor patient compliance/adherence to treatment plans and poor oral health outcomes. In addition, the current health system culture incentivizes procedure-driven care instead of comprehensive, coordinated care. Therefore, the health system culture was also a major weakness.

Opportunities

Identification of a "champion" for oral health integration within the FQHC leadership was identified as a strategic opportunity.

Threats

Significant threats to oral health integration in FQHCs included lack of patient and provider education, dental professional culture, and deficiencies in public health.

Theme 2: Operations and administration of oral health care services

Participants noted that to successfully implement innovative models of oral health care delivery within the primary care setting, there must be adequate infrastructure to ensure that operations are efficient and cost-effective.

Strengths

The strengths of this theme were provision of comprehensive care, ensuring a coordinated care approach, and the availability of certain services (walk-ins and emergency visits). Other strengths included operation of sealant programs in school-based settings and the existence of colocated dental programs or collaborative agreements with community dentists.

Weaknesses

Unfortunately, weaknesses in operations and administration can hinder FQHCs' ability to deliver patient-centered care. These included poor infrastructure, lack of interoperable electronic medical record systems, deficiencies in comprehensive care evidenced by limited integration of medical and dental providers, undefined scope of services, and scheduling conflicts.

Opportunities

Previous successes in behavioral health integration could serve as models for oral health integration and were identified as a major opportunity. In addition, participants suggested that mobile health units were opportunities for increasing capacity and providing dental screening to populations with limited or no access to dental care.

... In Indiana, we've done a lot of work with behavioral health integration and so we just need to borrow from the successes we have with that program in doing the integration with dental care.

Threats

The threats to clinical operations and administration for oral health integration at FQHCs included lack of definition of the "scope of oral health services" required by the US Health Center program (or lack of understanding of participants of this scope). In addition, other health care organizations located in FQHC service areas were competing for "paying" customers, or patients seen at the FQHC.

Theme 3: Financing, funding, and reimbursement

The financial stability and sustainability of oral health integration models were a major theme discussed throughout the focus groups. The high cost associated with dental clinic operation has commonly been cited as a barrier to on-site delivery of dental care at FQHCs (Jones et al., 2013). As such, oral health integration models must be financially sustainable. Federal grants, on average, represent only about 20% of FQHCs' operating revenue. The remainder comes from sources such as Medicaid, Medicare, private insurance, and patient fees.

Strengths

Federal support provided under Section 330 of the Public Health Service Act was perceived as a major strength of FQHCs. Furthermore, the Healthy Indiana Plan (HIP 2.0) has recently expanded to include a variety of preventive dental services, effectively increasing reimbursement for select dental procedures.

Weaknesses

The financial sustainability of dental programs was a major weakness to oral health care delivery in FQHCs. Other identified weaknesses included payer mix, reimbursement rates, Prospective Payment System (PPS) rates, and billing for multiple encounters.

If your PPS rate is \$350, your scope of services can be pretty large as far as providing dental care, [but] if your PPS rate is \$125 [and] you provide [dental] care you're going to lose money, in most cases.

The lack of capital funding was also identified as a weakness to oral health integration in FQHCs. Oral health care delivery requires specific equipment, which can be costly and require significant capital investment to develop the necessary infrastructure.

Opportunities

Opportunities to address financial concerns of FQHC administrators included federal grants for capital funding, federal grants specifically to support integration, dental coverage expansion, and the adoption of a differential PPS rate.

Threats

The biggest threat for this theme was the funding environment. Several participants indicated that the uncertainty of Section 330 funding and PPS rates significantly limited their ability to make sound strategic decisions regarding facility operations.

[Another threat is] the unknown question of whether grant funding from the federal government will continue at the same level and also the unknown of whether the PPS rate will continue.

Theme 4: Workforce capacity, training, and scope of practice

Workforce issues were the fourth theme identified, with sufficient capacity, adequate training, and supportive policy and regulatory environments identified as critical to successful oral health integration at FQHCs.

Strengths

Health care providers that are passionate about patient care, especially for underserved communities, were considered a major strength of the FQHC workforce. Participants suggested that FQHC providers tend to be open-minded and committed to delivering comprehensive patient care for the underserved.

I have a new, young dentist who is very open-minded, in oral surgery training and pediatric training, so my dentist is my strength.

In addition, access to grants and federal funding to aid in recruitment and retention of health care professionals was identified as a strength of FQHCs. FQHCs are eligible for the National Health Service Corps Loan Repayment Program, which offers loan forgiveness to eligible primary care providers committed to serving underserved communities for a defined period.

Weaknesses

Dental workforce shortages and challenges in recruitment of dental professionals were identified as key weaknesses. Consistent with previous studies (Jones et al., 2013), the oral health workforce capacity was a significant weakness, as was workforce regulation, specifically the scope of practice for the dental hygiene profession in Indiana. In other words, current supervision requirements and reimbursement policies do not allow Indiana FQHCs to leverage the expertise and training of dental hygienists to the same extent as do FQHCs in other states. A final weakness was the lack of oral health training for primary care providers.

Opportunities

Indiana has an opportunity to expand the scope of dental hygiene practice regulations to fully leverage the oral health workforce. In addition, the existing oral health curriculum for primary care providers should be used to provide training for the current workforce.

Threats

Dental workforce shortages in underserved communities represent the largest threat to successful oral health integration. The regulatory (ie, political) environment was also identified as a threat likely to perpetuate said workforce shortages. Professional organizations, policy makers, and researchers do not currently support expanded scope-of-practice regulations for dental hygienists or physician reimbursement for oral health services. Participants also expressed concerns about the

feasibility of integrating oral health with primary care due to oral health workforce capacity and a lack of support in the political and professional environment.

DISCUSSION

FQHCs are strategically positioned to be leaders in oral health integration. Indeed, as health care organizations committed to providing comprehensive and coordinated health care services to underserved populations, the adoption of integration models aligns with their organizational mission and designation requirements. FQHC executives tended to understand the importance of oral health and were supportive of integrating oral health and primary care. However, these leaders also recognized that there are numerous barriers to “successful” and complete integration of oral health within their facilities.

This study highlights the importance of engaging key stakeholders in meaningful dialogue during health care reform. Furthermore, our results afford researchers and health policy makers the opportunity to view initiatives for oral health integration from the perspective executives who operationalize these health care delivery models. These executives stressed 4 themes, or areas of improvement, which should be addressed to facilitate oral health integration at FQHCs.

Creating a new culture

First, the culture of health care organizations and the US health system in general must value oral health. This is a fairly new concept in health care policy discussions: it has only been 15 years ago since the US Surgeon General published the seminal report *Oral Health in America* (US Department of Health and Human Services, 2000); 12 years since the Surgeon General published a follow-up report identifying poor oral health as a silent epidemic (US Department of Health and Human Services, 2003); 4 years since the Institute of Medicine suggested that oral health care be made multidisciplinary (Committee on Oral Health Access to Services & Institute of Medicine, 2011); and 1 year since the

US Department of Health and Human Services called for improving primary care clinicians' oral health clinical competency (Health Resources and Services Administration, 2014). Before these seminal documents, oral health was a minor element in health care discussions in the United States. These publications stimulated conversation about oral health and led to many related initiatives and interventions, including integration of oral health with primary care as a systems approach to oral health improvement.

The mission to "serve" and provide comprehensive patient care is woven into the fabric of FQHC culture. As such, this culture uniquely positions FQHCs to activate "champions" for oral health integration within their organizations. A recent article examining 5 successful models of oral health integration in FQHCs identified a common factor across all of the organizations: a champion (Maxey, 2015). The Agency for Healthcare Research and Quality (2013) defines a champion as an individual "who is committed to the idea and process of continuous improvement . . . [and] should be interested in building capacity in the practice for ongoing improvement and implementing effective processes . . ." (para 3). Buy-in from executives and having a champion to lead these initiatives are critical to changing the culture and increasing the value of oral health as a component of comprehensive patient care.

Developing infrastructure

FQHCs are adopting the PCMH model for health care delivery. According to the Agency for Healthcare Research and Quality, the PCMH model comprises 5 key principles: patient-centered orientation, comprehensive care, coordinated care, accessible services, and a systems-based approach (Peikes et al., 2011). Integration of oral health with primary care aligns with the FQHC adoption of the PCMH model, but for this integration to succeed, FQHCs must overcome several challenges.

Insufficient infrastructure for oral health care delivery is likely the largest obstacle that FQHCs must overcome to successfully inte-

grate oral health with primary care. From an administrative perspective, adequate space, coordination between medical and dental providers, and lack of interoperable electronic medical records significantly hinder productivity and will likely threaten integration efforts. In addition, administrators identified that they must have the proper dental equipment to deliver oral health care services. However, all of this infrastructure would require considerable resources to implement.

Federal funding to expand FQHC operations has been made available over the past decade. The Patient Protection and Affordable Care Act provided \$9.5 billion to support ongoing Community Health Center operations, create new health center sites, and expand preventive and primary health care services including those of oral health (Bureau of Primary Health Care, 2015). Nevertheless, further capital investments specifically dedicated to expanding facilities, obtaining appropriate equipment, and developing necessary infrastructure may be needed to support the successful integration of oral health with primary care at FQHCs.

Financing, funding, and reimbursement

As organizations located in medically underserved communities, FQHCs provide health care in communities where a significant portion of patients are either uninsured or receive Medicare/Medicaid benefits. The Centers for Medicare & Medicaid Services (2015) use a PPS to determine the reimbursement rate for patients covered by Medicare/Medicaid. This PPS rate is a predetermined and fixed amount and only covers a portion of the costs for select services. This makes it challenging for FQHCs to recoup the actual costs of providing oral health care services. A possible way to alleviate this financial burden to some degree would be implementation of a differential PPS rate in Indiana. This rate reimburses providers the difference between a health center's established reimbursement rate for various payment plans and programs and the actual cost of the provided service.

Indiana recently expanded dental coverage for uninsured and underinsured

populations under the HIP 2.0, which was developed as the state's response to the federal requirement for Medicaid expansion under the Patient Protection and Affordable Care Act. FQHC executives recognized the limited opportunities for reimbursement through HIP 2.0; they felt there was room for improvement in coverage and reimbursement under the new plan.

At the state level, advocacy efforts should focus on increasing reimbursement rates, scope of services, and patients eligible for dental coverage. Advocacy must also exist at the federal level, directed at preserving Section 330 funding to ensure continual support for FQHCs and advancing health care in underserved communities.

Workforce capacity, training, and scope of practice

Capacity

The health workforce, arguably the most critical component of America's health care system, is positioned at the intersection of medical science, individual health, and access to care. FQHCs are located in veritable health care deserts, with health workforce shortages of all types, including the dental workforce. Successful oral health integration hinges on FQHCs' ability to recruit sufficient dental professionals to practice in these health care deserts. Furthermore, it requires innovation in health care delivery, additional training for oral health and primary care providers, and supportive practice environments.

Training

Integrating oral health with primary care relies on cooperation and collaboration between medical and dental providers. Unfortunately, primary care physicians appear to have inadequate oral health knowledge and practices to promote oral health in their patients (Krol, 2004; Mouradian et al., 2005). Therefore, additional training using existing oral health curriculum—such as the national curriculum, *Smiles for Life* (Society of Teachers of Family Medicine, 2010)—must be pro-

vided to primary care physicians to prepare them for oral health integration.

Regulation and policy

The oral health workforce largely comprises 2 professions: dentistry and dental hygiene. Dentists are trained at the doctoral level and licensed to perform comprehensive dental treatment, including surgical, restorative, and preventive services. Dental hygienists are trained at the undergraduate level and focus on oral health prevention. Dental hygienists provide additional capacity to deliver preventive oral health care services, especially in areas with prevalent workforce shortages. In many states, including Indiana, supervision requirements and other practice restrictions limit dental hygienists' ability to provide care without direct oversight from dentists. In addition, reimbursement policies are tied to specific professions: Indiana's Medicaid program only permits dentists to receive reimbursement for dental services, and current provisions prevent FQHCs from billing or being reimbursed for preventive dental service provided by dental hygienists or primary care providers. Reforms in practice regulation and reimbursement policy would allow Indiana to better leverage both the dental hygiene and primary care workforces, allowing for exploration of innovative workforce models to support oral health integration.

State-level advocacy is needed to ensure that policy environments are supportive of comprehensive patient care and do not limit the effectiveness of health care organizations such as FQHCs. Health care professionals should be allowed to practice to the fullest extent of their education and training; this would alleviate the health workforce shortage, which is a significant contributing factor to oral health disparities in the United States.

Limitations

The primary limitation to this study was selection bias. Study participants were selected on the basis of purposive sampling to capture perspectives of FQHC executives in finance, management, operations, and clinical affairs. Thus, some key perspectives

may have been missed. Furthermore, this study was conducted within only one state (Indiana) and therefore may not be generalizable to FQHCs operating in states with differing policy and regulatory environments. Future studies should focus on obtaining the perspectives of FQHC executives in multiple states and regions across the United States.

As is inherent to qualitative research, subjectivity could have influenced our results. However, several measures were taken to limit this potential influence. First, a multidisciplinary team of researchers participated in the data collection and content analysis. Second, study participants were randomly assigned to focus groups to ensure homogeneity. Notably, focus group 2 had no participants in a financial position due to limitations of focus group administration. Third, content and theming were consistent across all focus groups, suggesting that group makeup was not an influencing factor. In addition, standardized training was completed by each researcher, moderator, and scribe to ensure consistency throughout the administration of the focus groups and content analysis. Despite

these limitations, our study findings should still be considered because of their important implications and contributions to the literature.

CONCLUSION

This study identified the strengths, weaknesses, opportunities, and threats associated with integration of oral health with primary care according to FQHC executives. FQHCs' mission to serve and their passion to provide comprehensive patient care within their communities were perhaps their greatest strength for oral health integration. However, advocacy efforts at the local, state, and federal levels are needed to foster a culture that values oral health, develop sufficient infrastructure, create a supportive funding environment, and build workforce capacity. Although FQHCs are already leading the way in oral health integration, improving on the 4 domains we identified will allow FQHCs to further advance their mission to provide comprehensive patient care to underserved communities in order to promote overall health.

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