

“Consider Community Health Centers as an Employment Option” by Dr. Shaila Garasia

Many of you are ready to graduate or will be graduating in the near future. Your most daunting professional decision lies ahead. What is the next major move in your career path? Perhaps some of you are considering opening your own practice, working with someone who owns a reputable practice, pursuing a more specialized field in dentistry, a residency program, or entertaining the thought of teaching. My goal is to give you food for thought and an additional employment option to consider. Have you considered working at a Community Health Center (CHC)?

In July of 1998, I accepted a position at Westside Health Services (WHS), a federally qualified CHC in the city of Rochester. Fortunately, WHS was an approved NHSC loan repayment site. While working at the center, I was exposed to a diverse and underserved population with a variety of dental needs. At this juncture, I felt the strong desire to devote my time and talents to the less fortunate and the underserved. I came to the realization that in order to make a difference and to induce change, I needed to take on a leadership role at my center. In October of 2001, I was offered a position as a Dental Director.

As a Dental Director, I am an integral part of the management team. I am actively involved in the daily operations and major decisions that affect our center. I report to the CEO and the Board of Directors. In addition to treating patients, I'm also responsible for the daily operation of the dental department, researching and writing grants for the diverse dental needs of our center. I have no regrets or second thoughts about the decision I made eight years ago to work at WHS. My experiences are positive and have given a new dimension and purpose to my life. In summarizing my experiences at WHS, all I can say to you is, “You don't know what you are missing until you give it a try.”

A brief explanation of a CHC would be appropriate before I explain and justify the reasons why you should consider this employment option. CHCs were first funded by the Federal Government as part of the Johnson Administration's War on Poverty in the mid-1960. By the early 1970s, about 100 neighborhood health centers were established under the Economic Opportunity Act (EOA). These centers provide accessible, affordable personal health care services to low-income families, the underserved and the under privileged. The Public Health Service began funding neighborhood health centers in 1969. Currently, the CHC Federal grant program is authorized under section 330 of the Health Centers Consolidation Act of 1996. ⁱ

CHCs provide comprehensive, coordinated, culturally appropriate health care services including pre-natal care, obstetrics, chronic disease management, preventive services and inpatient care. To be classified as a CHC and to be eligible for federal

funding the following requirements must be met: be not-for-profit; governed by a board of directors controlled by patients of the centers; serve a Medically Underserved Area (MUA) or a Medically Underserved Population (MUP); provide comprehensive preventive and primary care services; assure that care is accessible; and provide care regardless of the patients' ability to pay. ⁱⁱ Patients consist of uninsured families, homeless, people living in hard to reach and isolated rural communities, the working poor, migrant workers, and new immigrants.

In a fact sheet published by National Association of Community Health Centers (NACHC), 12.5% of all Americans are at or below the federal poverty level, nearly 69% of the health center patients had family incomes at or below poverty (poverty in 2003 was \$15,260 annual income for a family of three) and 90% are low income. In addition, nearly 40% of the patients are uninsured and another 36% depend on Medicaid. Finally two-thirds of health center patients are members of racial and ethnic minorities.

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Community Health Centers make a difference by providing high quality and cost effective care, reduce health disparities, effectively manage chronic illness, improve access to primary and preventive care, reduce infant deaths, create jobs and stimulate economic growth. These centers are located in all 50 States, the District of Columbia, and the territories.

CHCs serve 1 of every 8 uninsured Americans; 1 in 5 low income uninsured; 1 of every 9 Medicaid beneficiaries; 1 of every 7 people of color, including 20% of minority populations in most southern states; 1 of every 10 rural Americans; and 1 of every 5 low income children. In 2003, health centers served 700,000 migrant farm workers and nearly 680,000 homeless persons. These statistics demonstrate the pivotal role CHCs play in low-income, underserved, and underprivileged communities all across the US.

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According to the Federal Government there are an estimated 38 million Americans who live in areas that lack adequate dental services. While oral health care in America has improved dramatically over the last 50 years, these improvements have not occurred evenly across all sectors of our populations particularly among lower income individuals and families.

NACHC states that in 2003, there were 890 federally-funded health center grantees that provided services through more than 3,600 comprehensive health care delivery sites, 461 of which are located in rural areas. In addition, there are approximately 2,477 Dental Health Professional Shortage Areas (HPSA). This number has doubled since 1990. In addition, 11% of the rural population has never been to a dentist. Nationally, health centers employ 1,416 dentists and these dentists had 3,826,872 dental patient visits. This averages to 2,702 patient visits per dentist. A final

statistic puts the role of CHCs into proper perspective. A total of 12,391, 270 patients were treated at federally funded CHCs in 2003, and another million were served by non-federally-funded health centers. ^v

The number of patients is projected to grow in the years ahead. This is obvious when we examine the dental health of low-income individuals and families. According to ADA and the U.S. Department of Health and Human Services the ratio of dentists to population is projected to decline throughout a 2020-year projection period, to about 54 active dentists per 100,000 population. ^{vi}

In the Community Voices commentary Dr. Burton Edelstien stated that “Disparity” is the single word that best describes oral health in America today. More and more Americans, especially low-income and underserved citizens of all ages, continue to suffer from a range of oral diseases and disabilities that ironically, are overwhelmingly preventable.” He also mentioned several structural barriers that have yet to be addressed. One in particular is shortage of dental professionals. This is obvious when we examine the dental health of low-income individuals and their families. ^{vii}

The AP recently included a story about a nationwide shortage of dentists. The *Portsmouth Herald* says, “Nationwide, there are about 152,000 active dentists, more than one-third of them over 55, according to the ADA. Experts estimate that dentists’ ranks will begin to decline in about 10 years as the number of dental school graduates (now about 4,000 annually) falls below the number of dentist leaving the work force due to retirement or other reasons.” ^{viii}

Even President Bush is in touch with the needs of the lower income, underprivileged, and underserved populations. In a speech in Cleveland, Ohio on January 27th, 2005 he said,

“... here are some practical ways for us to deal with the rising costs in health care. One is to make sure that people who can’t afford health care have got health care available to them in a common-sense way. And that’s why I’m such a big backer of expanding community health centers to every poor county in America. We really want people who cannot afford health care – the poor – the indigent - to be able to get good primary care at one of these community health centers, and not in the emergency rooms of the hospitals across the United States of America.” ^{ix}

I know it takes a special breed of dentists to work at CHCs. I have very positive and memorable work experiences at my center. The joy and satisfaction that I experience from treating the lower income patients cannot be compensated nor equated to any monetary value. These experiences have shaped the new “Me.”

A crucial and critical motivator for working at a CHC might be the loan repayment program. For some this might be a temporary motivator. The average dental student has a large debt (\$155,234 for private/private state related schools and \$99,553 for public schools) by the time he/she graduates from dental school. ^x This might be a strong incentive and motivator for you. The fact that one is able to devote two years to serving the community is a step in the right direction. The goal of the loan repayment program is that candidates will be inspired to continue to serve at these centers after their loans are paid off.

Health centers rely on the National Health Service Corps (NHSC) program to secure doctors and dentists to serve an increasing numbers of patients. The NHSC plays a critical role in providing care for underserved individuals by placing clinicians in urban and rural communities with serious shortage of health care providers, including health centers. Of the nearly 3,600 clinicians participating in the Loan Repayment and Scholarship programs, approximately 1,700 are serving at health centers. ^{xi}

Another motivator might be that one has an option to work part-time or full-time. I strongly suggest that if you are uncertain about working at CHCs; consider working at a center part-time to get a feel and understanding of the internal workings of these centers. In some rural communities, you might be the only oral health care expert and may be involved in common policy decisions that affect the oral health care and needs of the community.

In addition to the above motivators, CHCs offer additional benefits like malpractice insurance, health and life insurance, sickness and disability insurance, paid time off, license renewal and Drug Enforcement Agency (DEA) fees, continuing education, paid and unpaid holidays, death in the family leave, pension plan, and tax sheltered annuities. Obviously, these benefit plans vary from center to center.

There are several good resources to find additional information about and possible employment opportunities at CHCs. Some of the renowned and excellent organizations are NHSC (<http://nhsc.bhpr.hrsa.gov>), National Rural Recruitment and Retention Network (www.3Rnet.org), and National Association of Community Health Centers, Inc. (NACHC - www.nachc.com). Those seriously considering working at CHCs should visit your local CHCs to get a true understanding of what they do and how they operate.

My sincere hope and sole intention for writing this article is that you will give serious thought and consideration to working at a CHC. If you wish to make a positive impact and contribution to the lives of the people in your community, this is the path to follow. I can assure you, it will be a decision you won't regret. You will cherish and treasure the memories and experiences you have at your CHC.

In closing, I would like to share a quote that always inspires and reminds me why I chose the dental profession and why I'm working at a CHC.

"I expect to pass through this life but once. If, therefore, there can be any kindness I can show, or any good thing that I can do to any fellow being, let me do it now as I shall not pass this way again." William Penn.

ENDNOTES

ⁱ <http://bphc.hrsa.gov/programs/CHCPrograminfo.asp>

ⁱⁱ Quality Health Care At An Affordable Price: New York's Community Health Center, 2002.

ⁱⁱⁱ NHPF Background Paper. The Fundamentals of Community Health Centers – Jessamy Taylor, Research Associate, George Washington University. August 31, 2004.

^{iv} A Nation's Health at Risk II: A Front Row Seat in a Changing Health Care System. National Association of Community Health Centers, Inc (NACHC). August 2004.

^v Health Center Fact Sheet. NACHC. United States – 2003.

^{vi} 2002/2003 Survey of Advanced Dental Education, American Dental Association. American Dental Education Association (ADEA) – Dental Education At-A-Glance.

^{vii} Turing the Corner with Policymakers on Access to Oral Health Services – Burton Edelstein.
<http://www.communityvoices.org/Commentary.aspx>

^{viii} Wednesday Edition: National Dentist Shortage – Al Tompkins.
<http://www.poynter.org/dg.lts/id.2/aid.49010/column.htm>

^{ix} A Nation's Health at Risk II: Growing Uninsured, Budget Cutbacks Challenge President's Initiative to Put a Health Center in Every Poor County. NACHC and the George Washington University. March 2005.

^x 109th Congressional Kit. Southern Illinois University School of Dental Medicine.
http://www.adea.org/CPPA_Materials/109_Congressional_kit/109CK_DC_Howard.doc

^{xi} <http://www.nachc.com/press/nhsc.asp>

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