Expanding Access with Not-For-Profit Dental Practices:
Financially Viable Solutions for Improved Access to Oral Health Care





Mary Kate Scott, MBA
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Washington Dental Service Foundation
Community Advocates for Oral Health

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Table of Contents

Introduction

Washington Dental Service Foundation's (WDS Foundation) is pleased to share five case studies on successful not-for-profit (NFP) dental centers throughout the county. The goals of this project are to document how different organizations moved through the process of expanding oral health access, provide tools to increase oral health access for the underserved, and inspire more communities to consider new NFP dental centers.

The implementation of the Affordable Care Act and Medicaid Expansion resulted in the number of low-income adults with medical and dental coverage increasing. However, low Medicaid reimbursement and provider participation rates mean accessing oral health care remains a barrier for many. Dental pain remains a common reason for emergency room visits, and if untreated, can negatively impact overall health and employment opportunities. NFP dental centers are a key resource to expand oral health access, and our desire to understand the factors that contribute to NFP dental centers started with New Day Community Dental Clinic, a dental center in Vancouver, Washington. After seeing New Day grow from an idea to a fully functional dental practice, we commissioned a case study on New Day and began looking for other successful NFP dental centers to profile.

What we found was that there was not one mold for sustainable dental centers. Across the country, we found thriving practices ranging from ones with multiple locations and $13 million in revenues to others with four operatories and less than $500,000 in revenue. These dental centers were all operating at near-capacity and seeking to expand, while serving those in the greatest need including the developmentally disabled, participants in addiction recovery programs, immigrants, and low-income Americans. WDS Foundation approached the leaders of these centers to interview them and document their origins and secrets to success.

Our team included former FQHC Dental Director Martin Lieberman, DDS and health economist MaryKate Scott, MBA. They met extraordinary people at each center, heard inspiring stories and learned their secrets to success. "As we listened to their stories we found the people and their experiences stayed with us," commented Ms. Scott. "Their commitment, passion, ideas and hard work, and their successes stopped us and made us think. In fact they keep making us think," shared Ms. Scott.

While many dental centers had similar strategies for success, each was unique. Nevertheless they all have implemented strategies to reach those in the greatest need of care and to remain viable. Across all five centers common lessons were identified that can be shared and used by others.

Their lessons:

- **Create economies of scale.** Don't go too small. Think big and go big. Scale allows for efficiency and for hiring (and paying) experienced, appropriate dentists and other providers. This also ensures high utilization of providers and chairs and streamlined administrative processes. In addition, use electronic records and operate double shifts when possible.
- **Know your patient group.** Focus on a particular audience and provide care for their unique needs; balance your patient mix to ensure financial sustainability.
- **Develop Partnerships.** Partner with organizations that serve your patient population to increase awareness and create a patient pipeline for efficient operations.
- **Seek partnerships with dental colleges for AEGD residents.** Utilizing the skills of dental students and/or residents is a win-win-win (low provider cost for the center; top learning opportunity for the students; high satisfaction for experienced dentists who enjoy teaching).
- **Find the right providers.** It takes a special provider to deliver quality care with compassion and efficiency in a NFP center setting. Look for providers with common values and a passion for working with your patients. Volunteers can be help increase patients visits, but it is difficult to build a dental center around volunteers.
- **Commit to quality improvement programs:** Develop protocols that deliver and demonstrate quality care that you would want to receive. Engage staff, providers and the board on quality measures.
- **Engage a diversified management team and board.** It is hard to go at it alone. Work to leverage skills and relationships from the community; deliberately, proactively recruit dental center managers and the specifically skilled board members that your center needs.

- **Pay attention to the financials.** Most NFP dental centers cover costs only when the center remains busy. Due to low Medicaid reimbursement rates, a fundraising component is necessary for financial sustainability. It is also critical to know, measure and post your key metrics to engage staff and providers on critical financial goals.

We hope these cases inspire other community leaders to consider opening new dental centers. We also hope these serve as a touchstone to NFP dental center leaders to connect, share best practices and learning, and ultimately improve access to oral care, for all Americans.

Laura Smith
President & CEO
Washington Dental Service Foundation

About the Washington Dental Service Foundation

Washington Dental Service Foundation is a non-profit funded by Delta Dental of Washington, the leading dental benefits company in Washington. The Foundation's mission is to prevent oral disease and improve the oral and overall health. The Foundation works with partners to develop innovative programs and policies that create permanent change, leading to improved oral health for all. For more information, visit: www.deltadentalwa.com/foundation.

About the Authors

Martin Lieberman

Martin Lieberman served as Chief Dental Officer at Neighborcare Health in Seattle, Washington from 2002 to 2013. Prior to his community health center work, he worked in private practice in Chicago for 18 years. Dr. Lieberman led a culture change in the way Neighborcare Health's dental program viewed process improvement and quality and has served as faculty member for the HRSA Oral Health Pilot Collaborative, and has also been a faculty member for IHI, HRSA, NNOHA and Dentaquest quality improvement projects. Dr. Lieberman serves on the Board of Directors for NNOHA and chairs the Practice Management Committee. In January 2014, Dr. Lieberman assumed the role of Associate Director of Graduate Dental Education at NYU Lutheran Medical Center in Brooklyn, New York. Martin Lieberman can be reached at *MartinLieberman@gmail.com*

MaryKate Scott

MaryKate Scott is a healthcare economist and business management consultant with experience at McKinsey & Company, Procter & Gamble, and several academic appointments. She works with healthcare leaders in health systems, pharmaceutical and medical device firms, payers, and philanthropic organizations. Focusing at the nexus of health care, business and technology, Mary Kate's work focuses on strategy development, mergers and acquisitions, product launches, competitor response, market shaping campaigns, and economic modeling.

Her oral health work includes supporting The Pew Charitable Trust Children's Dental Campaigns including the ***It Takes a Team*** report and calculator. She has also authored: **IOM: Oral Health Access** (Chapter); **Retail Dental Clinics – a viable model for the underserved**; **The Good Practice: Treating Underserved Dental Patients While Staying Afloat**; and complied **The Oral Health Care Innovation Compendium** for The California HealthCare Foundation. She provided business strategy support for the **Alaska Native Tribal Health Consortium: Dental Health Aide Therapist (DHAT) Program**. She is presenting at NNOHA (2015) **An Economic Model to determine impact of adding a Dental Therapist to a FQHC Dental Clinic**.
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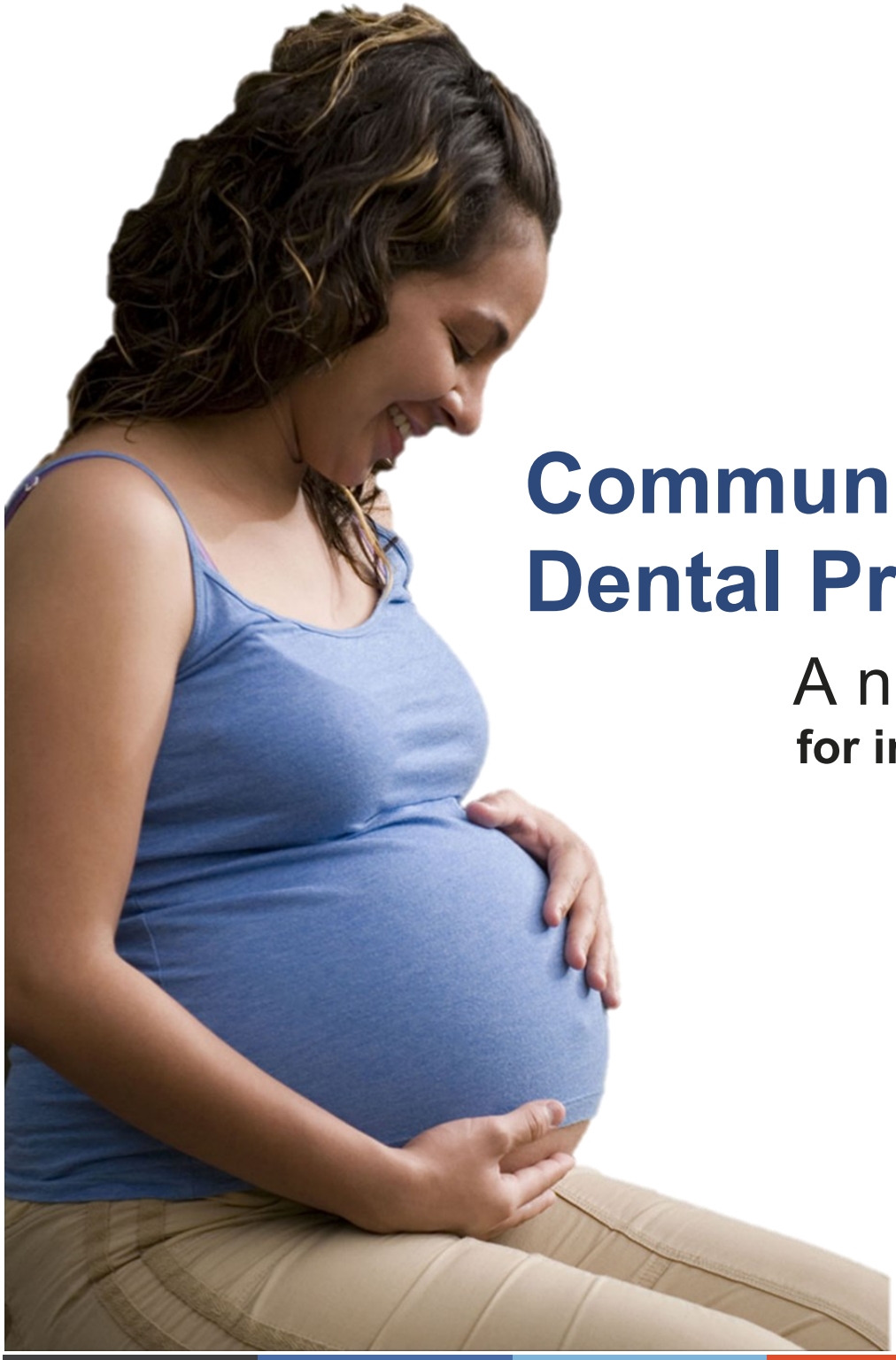
New Day
Community Dental Clinic



Community Owned Dental Practices

A new solution
for increased access

January 2015

Making a Non-Profit Dental Clinic Work:

The Experience of the Community Owned New Day Dental Clinic

Saving Santa

"Nobody wants to see a Santa with no smile. But there I was, broken teeth and all that goes along with a broken smile."

So began the letter from a seasonal Santa Claus who desperately needed dental care, but lacked money to pay for it and a place to go for dental care. Luckily for the children of Vancouver, WA, this local Santa got his smile back thanks to, what he calls, the "wonderful elves at New Day."

The case is a constant source of inspiration to the staff of the New Day Community Dental Clinic. It reminds them why they worked so hard to create and sustain this non-profit dental and denture office. Their sense of purpose and mission is palpable from director Melody Scheer through graduating intern Celess Jollymore. As Val Hebrard, the patient care coordinator says, "If you cut me, do I not bleed New Day?"

A Gap in Care

"Good oral care is an important part of general health and wellbeing," says Scheer, a Registered Dental Hygienist. It's true. Studies have linked poor oral health to increased risk for a range of ailments, including diabetes, cancer, heart disease, stroke, and Alzheimer's disease.

Yet millions of Americans face significant barriers to dental care. People with medium or high incomes often have dental insurance or can pay private dentists for services out-of-pocket.

For low-income adults and children in the Vancouver WA community on public insurance plans, in 2010, options were limited.

The Free Clinic of Southwest Washington provides urgent dental care and emergency services in a dental van. However due to high demand, the waiting period for such care can be five months.

The Sea Mar Community Health Center operates 13 dental clinics statewide, 2 in Vancouver. They provide preventive dental exams and emergency care to 2,462 adults and 5,905 children every year including nearly 14,758 oral health exams in Clark County.

This still left a huge gap in dental care options for low income people seeking routine preventive and restorative care. Says Scheer, "The Free Clinic is a vital part of the dental care ecosystem here, but it barely puts a dent in the potential demand for ser-

vices. New Day was created and exists to address this gap in care, and while we have met some needs there are still long waiting lists and there remains a gap in care."

New Days Origins

Scheer came to realize the extent of the lack of access to affordable dental care during her 23 years at the Clark County Health Department, where she coordinated the oral health programs offered by the county.

"We would see many people who had public insurance, Medicaid, but couldn't find dentists that accepted it. There were some dentists who served the low-income populations, but not enough to make a big difference," she said.

In the early 1990s Scheer established the "Southwest Washington Oral Health Coalition," organized around the idea of solving the access challenge. Scheer garnered the group to consider starting a nonprofit dental clinic to serve (rather than study) these unmet needs. The Washington State Department of Health required the various county health departments to form coalitions to focus on oral health issues in their county. But where others might have been content to address policy issues, understand and document the need for care, Scheer's focus was all about increasing access.

"We would see many people who had public insurance, Medicaid, but couldn't find dentists that accepted it "

"As gratifying as my work at the Health Department was, I wanted to create capacity, not just policy documents," she said. "Each time we'd get something accomplished, we'd ask, 'Okay, what's the next step to solve this problem and how do we do it?'"

Transforming Lives One Smile at a Time!

Make no small plans

Scheer and Sakai discovered that it was difficult to get people excited about a small non-profit dental clinic, especially when the demand for services was so acute. Says Scheer, "A small clinic wouldn't solve access because it doesn't serve enough people.

The coalition also recognized that simply relying on the free market to solve the problem of access to affordable dental care would not work. The coalition believed it would be unlikely for a private practice dentist to serve a substantial number of publicly insured patients, since few traditional dental practices choose to serve Medicaid insured or low-income uninsured patients.

The reason for this isn't a lack of compassion on the part of dentists, according to dental consultant Martin Lieberman, DDS, but rather, "the economics of paying off dental school loans and general dentists' aspirations to own their own practice. Dentists who run for-profit practices often serve a mix of patients – both commercially insured and publicly insured – and subsidize the cost of the public patients with the more profitable private side of the practice." It's no secret that the amount Medicaid pays providers for services is well below what the provider would receive from privately insured patients. The coalition also determined that a sizable dental clinic was necessary. "A dental clinic needs a certain minimum size to be economically viable. Once we ran the numbers we discovered you can't really make a go of it with less than six chairs", commented Scheer.

"A dental clinic needs a certain minimum size to be economically viable. Once we ran the numbers we discovered you can't really make a go of it with less than six chairs"...

Adds Sakai, "A larger clinic helps from a recruitment perspective as well. You need a viable, busy clinic to attract dentists and staff."

Scheer moved on to her next challenge: Convincing local dentists New Day wasn't going to take patients away from them.

Concerned local dentists were won over by understanding that New Day wasn't trying to take market share; they were trying to expand market of patients served. Sharif Burdzik, president of the clinic's board of directors, confirmed "We're looking for people who aren't getting care because of the expense."

With the vision, a business plan, and community support from dental providers, The New Day team sought and received 501(c)(3) not for profit status and formed a legal entity. This not for profit entity enabled the team to apply for grants from the WDS Foundation and other grant makers given funders' requirements to provide grants to legal entities (vs a committee or coalition).

The grant funding was vital as it provided the capital to create the clinic, hire providers and become a financially sustainable clinic. The key to securing this grant funding was to show the oral health needs, the capability to provide the services and the plan for long term sustainability.

Creating the clinic

To conserve capital during its opening and early expansion days New Day looked to creative sources for its equipment. Rather than buy chairs, cuspidors, sterilizers, and x-ray machines new, they found sources of perfectly adequate used dental equipment. The Ronald McDonald Foundation provided funding for an entire operatory and was offered naming rights to room.

"Here was a group that started a coalition, built momentum, and formed an entity that got something concrete done to benefit the community"

Recruiting poviders for a non-profit dental clinic also presents unique challenges. Scheer is quick to point out that, just because New Day is a non-profit doesn't mean nobody gets paid. "Do our dentists and staff get paid as much as they might make in a private practice? Not quite, but we pay well, provide a salary and paid holidays. There are also intrinsic rewards to be had at New Day that providers can't always get in private practice.

Helping people who have nowhere to turn, alleviating someone's chronic pain, fixing a child's teeth so they aren't afraid to smile, and working with top notch, passionate dental providers -- these are the things that motivate us."

Scheer says that the clinic tried using a cadre of volunteer dentists to supplement the paid dentists, but she discovered that it was harder to acclimate the part-time volunteer dentists to the New Day way of doing things and more difficult to hold them accountable to production goals.

Planning began in earnest

Buy or build?

Scheer says that their first impulse was to look for an existing practice to buy. By finding a dentist seeking to sell his or her practice, New Day might be able to get up and running even faster. A retiring dentist was found however this seemingly simple solution presented two complications.

First, if New Day bought this existing practice they would be liable for all prior work and any liabilities the practice might have incurred. Second, Scheer discovered that the practices they found for sale used antiquated computerized record systems that would need substantial upgrades. Porting prior records and data over to a modern patient management system would be a significant technical and expensive challenge.

These hurdles prompted the New Day board to explore options for building a location from scratch. She looked for a space with the proper zoning, parking, and access to transportation nodes. In 2010 she found a place that not only fit her criteria, it already had most of the needed build out for a dental practice in place (HVAC, plumbing, electricity).

Inside New Day Community Dental Clinic

New Day's services

The clinic offers a range of dental services to a patient mix spanning all income levels, ranging from working people whose employers don't offer dental insurance to the unemployed to senior citizens living on fixed incomes.

They serve mostly adults and some children. About 75% of patients served by New Day are on Medicaid, and 25% pay cash at reasonable rates.

For patients who pay cash, New Day charges on a sliding scale, depending on a patient's income.

New Day services and example of sliding fees

Preventive care - cleanings, exams, fluoride treatments and sealants

Restorative care - fillings, crowns, bridges, root canals, extractions and repair of broken teeth

Prosthodontics - dentures, partials, relines and flippers

Periodontal care - root planing (deep cleanings) and periodontal maintenance

Dental procedure	Normal rate	Reduced rate
Periodic exam	$ 57.00	$39.00
Cleaning	$106.00	$64.00
Simple extraction	$140.00	$84.00
Upper denture	$800.00	$500.00

After an initial exam $99, New Day's fees for cash patients are on a sliding scale based on household income. The chart below is an estimated example of discounted rates for a family of three with an annual household income of $27,000, as compared to their usual rate.

Strength from adversity

By 2011 the clinic was fully operational and the New Day team was feeling exhilarated at the progress they had made in making dental treatment more affordable to Vancouver's underserved population.

Then the clinic suffered a tremendous blow – financially and emotionally – when a New Day employee was arrested and charged with embezzling $41,000 from the clinic during its first two years of operation.

The scheme was uncovered when a second receptionist noticed discrepancies between the clinic's income and deposits and then discovered evidence that the first receptionist had been deleting appointments and payments from the computerized record system.

Scheer acknowledges, "We didn't have the right financial controls in place. It struck a blow to our confidence in our competence. It was a cold shower awakening that we were not running the clinic as a business."

Yet out of something bad came some positive changes and new strength.

First, Scheer and the New Day board of directors committed the clinic to more business-like operations.

They had their financial controls and procedures audited for free by students in the finance department at Washington State University at Vancouver. Then they instituted the recommended system of checks and balances.

Second, the incident forced New Day to ask for further financial support from the WDS Foundation. WDS Foundation responded first with a message to not give up and guidance and support from Dr. Martin Lieberman DDS, a dental productivity consultant.

In exchange for the support, New Day was required to provide a monthly financial report to WDS Foundation, a much-needed step in helping them to determine and track the necessary productivity required for a financially sustainable clinic.

Third, New Day expanded its board of directors and sought external assistance with improving operations.

Laura Smith, President and CEO of WDS Foundation, says, "It's relatively easy to provide money; we try to couple our funding with expertise (in this case through Dr. Lieberman), management support and team accountability."

"It's relatively easy to provide money; we try to couple our funding with expertise (…) management support and team accountability."

Sharif Burdzik, President of the clinic's board of directors (and manager of the local bank) liked the concept of a loan versus 100% grant funding. "The loan keeps us all aware of the monthly financial results, a grant could have made us complacent."

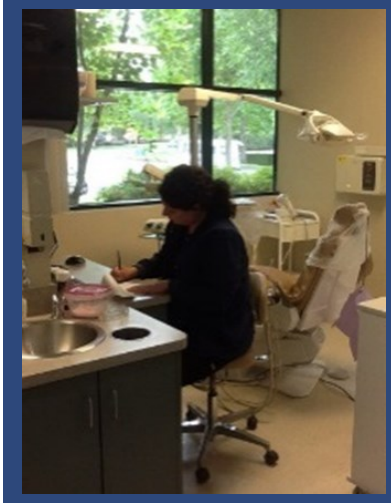
Through the process of making these changes, New Day forged a stronger relationship with its board.

"We recognized the need to increase the leadership and management skills we could tap into," said Scheer.

Starting January 1, 2014 and continuing over the next two years, a quarter-million adults in Washington State begin to gain dental coverage as the state expands its Medicaid rolls under the Affordable Care Act.

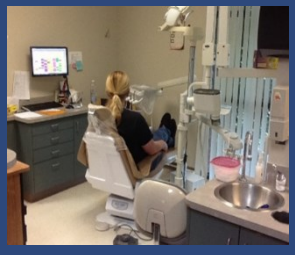
Open for business

New Day opened its doors in February, 2011 with a single dentist and two fully equipped operatories, with capacity for eight operatories.



To Lieberman this was a tremendous accomplishment. "Here was a group that started a coalition, built momentum, and formed an entity that got something concrete done to benefit the community. That's not the norm. They formed a team and had a real sense of clarity as to what they needed to do," he said.

Today New Day features eight fully-equipped operatories and employs three dentists, two hygienists**, and one denturist.**



Working with Medicaid Expansion

New Day recovered from the embezzlement and set a strong foundation for the future, focusing on expanding care and treating more patients.

In January 2014, the Medicaid adult dental program in Washington State was restored (it had been eliminated in 2011 except for a few populations) and coverage extended to the "Medicaid expansion population." This meant that suddenly there were over 700,000 low-income adults who had coverage, many of them "working poor" who had dental coverage for the first time. This has caused some capacity issues at New Day, giving it a waiting list of 300 to 400 people as of June 2014.

This Medicaid expansion was a two-edged sword – it provided insurance for the working poor yet the fees provided to New Day were considerably less – about half or less of the fees than people were paying as cash payments, even at the substantially discounted fees that New Day offered.

To respond to the new demand the team hired a new dentist and another full time person for the front desk to handle inquiries from newly insured patients. To manage the reduction in fees, the initial lower productivity of new hires and cost increases New Day encouraged providers to work differently, adopting the principles of quadrant dentistry providing multiple treatments in a single appointment and ensuring providers were aware of the demand and need for productivity.

"It's fair to say we (as dentists) spend a little less time with each patient" commented one provider, "however we try to allocate our time across all of our patients, and we work as a team with our hygienists to maximize the care we provide by enabling each of the team to practice at the top of their credential."

Even though it isn't difficult for New Day to attract new patients, Scheer says she still needs to actively engage with the agencies that refer patients to New Day. "We work closely with social service agencies, homeless shelters, and school districts."

Coordinating care with the Free Clinic of Southwest Washington is also a way for New Day to manage its costs. For example, consider a patient who comes into New Day needing extractions and dentures but has no money to pay for it. New Day can coordinate with the Free Clinic to get the extractions performed at the Free Clinic, and then New Day can create the dentures. New Day management is aiming to get more cash paying patients and is now thinking about creating marketing programs. Fundraising is also a key priority given the new financial constraints.

The team is also working to build their financial reserves and assemble a deeper bench in their board of directors to help with new outreach programs.

New Day Board of Directors

It's vital that a non-profit create an engaged board and leverage their skills.

It's also important that the composition of the board evolve with changing needs.

Here is the current roster of New Day's board.

Community leader –

provides leadership and a respected public face

Finance person –

helps look at the books

HR person –

leadership, staffing, policies

Dentists –

provide dental guidance and expertise

Physician –

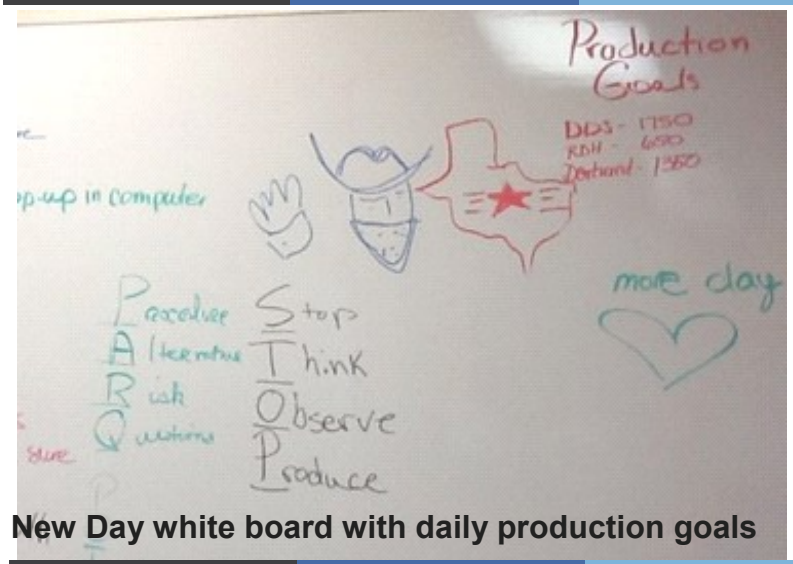
how oral health impacts health. Best if physician has Medicaid experience

Social services person – connects to social services community

Attorney –

human resource and legal issues

Dental hygiene person –
assists with public health issues and grants



New Day white board with daily production goals

Strengthening the Board

Says Scheer:

"We've made a transition from a small board to a bigger board. At first our board was mainly dental professionals, but our needs evolved. You need to tap expertise in all areas. You need to

seek specific people that can help you make things happen. And it's not necessarily going to be all the people that you know. You have to reach out and make new connections. For example, our current board chair is the manager of a bank and he helped us get the best deals and advice on the financial services we needed. You need the right board at the right time."

Making it work – meeting goals

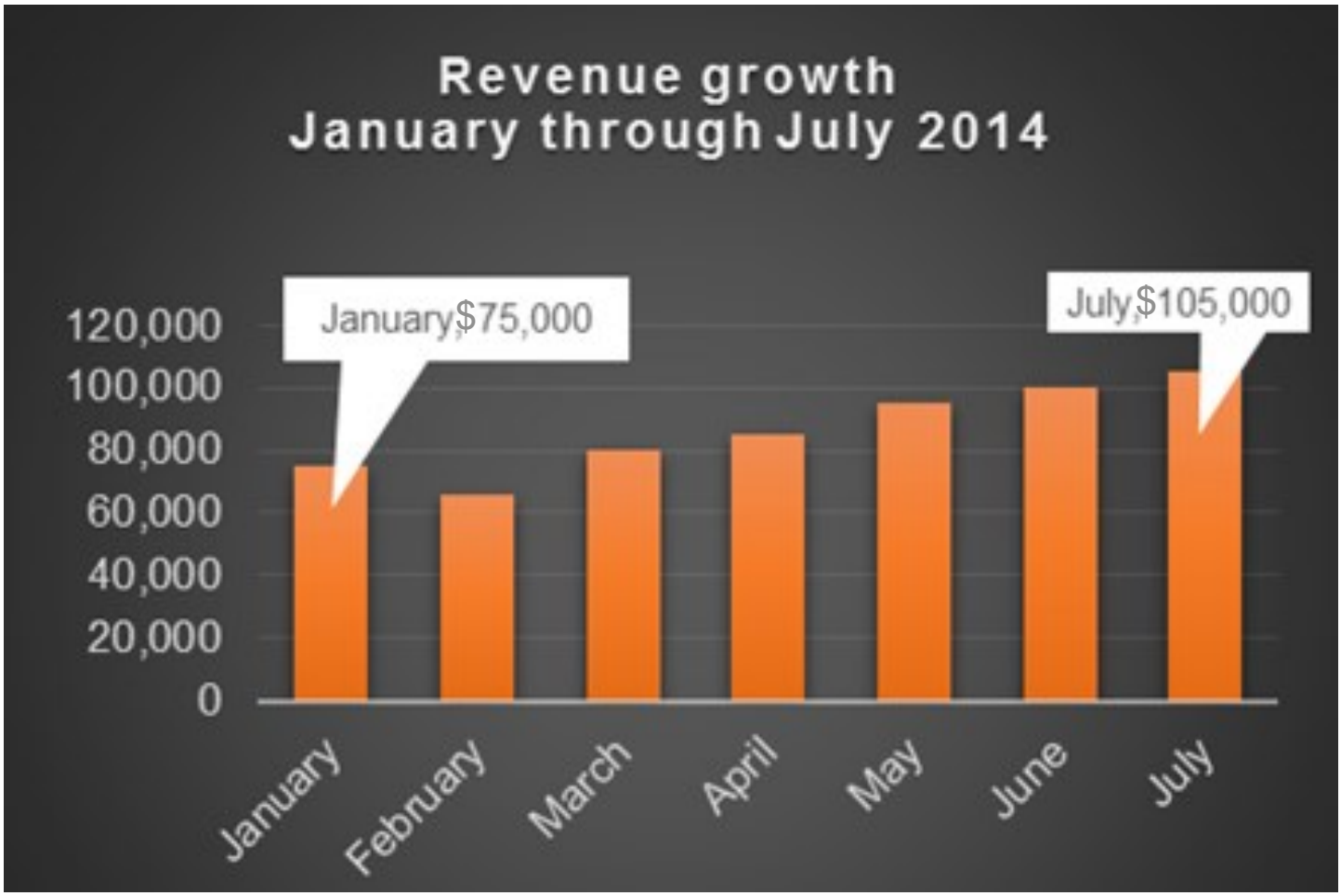
According to Scheer, New Day has moved well beyond simply checking their productivity and financials every month. They post the productivity goals and run the numbers every day with a large whiteboard in the team room.

In fact, Scheer believes the dentists and staff at New Day have internalized a lot of the clinic's efficiency and productivity goals. By now the employees know the level of patient volume and production the clinic needs to hit to meet its operating goals, and everyone works hard to meet those targets.

"We are so glad that your clinic is available for those who can't afford regular dental care." Julia

Meeting productivity goals is important for New Day in light of its lean operating budget. Scheer explains how the cost structure at a non-profit clinic like New Day differs from that of a traditional dentist. "In many ways we're the opposite of a traditional dentist. A traditional dentist is always searching for new patients and spends more to attract patients. We have a steady supply of patients. We are paid less per patient than a private practice dentist and our patients come less often. Our patients take more time per visit because they typically need more care and more oral health education. The bottom line is we need to be efficient, as we have to balance business and benevolence."

President Burdzik emphasizes that New Day's goal is to not rely on fundraising on an ongoing basis, but rather to have, "the right payer mix, efficient operations, and maximize procedures done in a single visit in order to have fees cover costs over them long-term. Nevertheless, we do have a small shortfall right now as we adapt to the new environment." In the immediate term, New Day is relying on modest fundrais-



ing and short term operating loan to cover these monthly shortfalls.

And what does efficient operations look like at New Day? Scheer points to three main concepts. The first is team-based dentistry – if work can be performed by a hygienist instead of the dentist, so be it. "We encourage our professionals to practice to the top of their license," she says.

The second key to running efficiently is hiring practitioners who can practice quadrant dentistry. In quadrant dentistry instead of treating each tooth individually, the dentist works on a set of teeth at once. This is beneficial for patients who need extensive dental care because it reduces the number of visits and injections needed to complete their dental work. For the clinic quadrant dentistry optimizes the dentists' time because completing multiple restorations on a single patient takes less time than doing the same number of restorations on multiple patients. Quadrant dentistry is truly a win-win for both patient and clinic.

But not every practitioner is comfortable working in quadrants and handling multiple restorations at once. Consequently, new recruits at New Day shadow working practitioners to ensure it is right for them.

New Day Financials	Profit & Loss Statement	January - June 2014
Revenues		
	Fee for service	610,000
	Grants	10,000
	Total Revenues	620,000
Expenses		
	Dentists	150,000
	Other oral health providers	200,000
	Staff	90,000
	Payroll Tax	50,000
	Supplies	55,000
	Lab fees	10,000
	Professional Fees	10,000
	Rent, janitorial, repairs	15,000
	Other (insurance, depreciation, computer)	75,000
	Total Expenses	655,000
	Net income	(35,000)

3 Keys to efficiency: team based dentistry, quadrant dentistry and a focus on functional oral health.

The third principle that New Day embraces in its drive to run efficiently is focus on functional oral health – the critical needs of cavities, fillings, extractions, dentures. New Day is not the place for veneers, teeth bleaching, or other purely cosmetic procedures.

To Scheer, functional oral health is about pain and presentation: "We work to eliminate dental pain, especially during eating, and we make it so a person present themselves in public without feeling like they are a second-class citizen because of the condition of their teeth. We work to make people not feel stigmatized."

Efficient operations at New Day (by the numbers) for 2014

Payer mix		Procedure mix (by revenues)		Patient mix	
Medicaid	75%	Preventive	25%	Adults	80%
Private	25%	Dentures	20%	Children	20%
		Restorative	45%		

Lessons for other organizations

For organizations considering establishing and operating a non-profit dental clinic, Dr Lieberman offers these key insights:

1. Size for efficiency. "There is a minimum size necessary for efficiency and to generate enough income to create a sustainable practice."

2. Be selective in hiring. "Not everyone is cut out to work in a non-profit. You need to hire the right provider team, one that is both interested in this patient group and capable of performing team-based care and quadrant dentistry."

3. Cultivate a referral network and engage local providers. "Even if your clinic has lots of patients it's important to maintain strong relationships with referring partners in the social services arena to ensure patient flow and a clear understanding of the role of your clinic with other providers."

4. Take charge. "Strong leadership is essential. It can be an uphill battle to get something off the ground. You need to be able to articulate a vision to attract and retain talent – providers, staff, board members – and to engage the community and develop those referring relationships."

5. Build a first-rate board. "Contributions of wisdom and advice from members of the board of directors has been invaluable across every aspect of the clinic – finance, legal, operations, community engagement, HR, general health, oral health. We could never have succeeded without them."

6. Balance benevolence with business. "Ensure the team understands that meeting business goals ensures the livelihood of the clinic and that high productivity enables continuity of care".

7. Reach out for expertise. "I realized we didn't need to solve it all ourselves. There are resources out there that made us stronger."

Keys to economic sustainability at New Day

- **Establish daily production goals for all staff**
- **Ensure awareness of goals**
- **Achieve high productivity using quadrant dentistry**
- **Get the team working together seamlessly**
- **Allow a long enough learning or shadowing period for new dentists to ensure it's a good fit both ways**

Transforming lives… one smile at a time

It's been a long road to get the New Day Community Dental Clinic up and running, but to Scheer it was well worth it.

She can recount stories of dozens of patient whose lives have been truly set on a different trajectory as a result of the Clinic. Pausing as she paged through the clinic's scrapbook of the many thank you notes from patients, she cites the work of New Day's "First Impressions" program, which aims to provide job seekers with a necessary physical asset — a smile.

Scheer says, "One fellow came into the clinic and his oral health was so poor that his teeth were brown and falling out. It definitely gave him an off-putting appearance in a job interview, and as you'd expect, he wasn't able to find work. We helped him get his teeth extracted and made him dentures. Now he works as a chef."

Considering setting up a dental clinic?

Ensure you have the right leader. Strong leadership skills are required to establish and operate a non-profit dental clinic.

A good leader must be able to:

Articulate a vision – Be a big picture thinker who trusts their intuition and is able to formulate a clear and persuasive vision and communicate it to other stakeholders.

Rally and motivate others – Appreciate the unique talents each person brings and activate their diverse motivations to bring out their best efforts.

Take charge – Have a bias for action and a willingness to take responsibility even if it is not formally delegated.

Build bridges – Forge and manage alliances with those whose support may be needed.

Communicate with conviction – Speak and write clearly and in ways that move people toward embracing a shared vision.

Demonstrate character – Through words and deeds, ensure that others view the leader as a person of integrity.

Get smart on financials — Smart leaders create several P&L scenarios, and run the numbers to ensure the right economics considering both the revenues and expenses.

Resources and data

Melody Scheer's go-to resources:

Safety Net Dental Clinic Manual, 2011 National Maternal and Child Oral Health Resource Center

The Pew Charitable Trust Children's Dental Campaign:
It Takes a Team report and calculator, December 2010 http://www.pewtrusts.org/en/research-and-analysis/reports/2010/12/06/it-takes-a-team-how-new-dental-providers-can-benefit-patients-and-practices

"The Good Practice: Treating Underserved Dental Patients While Staying Afloat," report by the California HealthCare Foundation, August 2008, www.chcf.org/publications/2008/08/the-good-practice-treating-underserved-dental-patients-while-staying-afloat WDS Foundation, www.deltadentalwa.com/Guest/Public/AboutUs/WDS%20Foundation.aspx

About this case study:

WDS Foundation helped establish several different not-for-profit dental clinics that care for underserved populations, with different ownership structures. One such clinic is New Day in Vancouver WA, a non-profit clinic with a 501(c)(3) structure.

WSD Foundation publishes case studies on these clinics to explain their operations, governance, and impact to inspire the development of more non-profit dental clinics with the goal of increasing access to dental care for the underserved.

About the WDS Foundation

WDS Foundation, a non-profit funded by Delta Dental of Washington, is committed to lasting approaches to improving the oral, and overall health, of people in Washington.

With an emphasis on prevention, WDS Foundation works closely with partners to develop and implement long-lasting, innovative programs and public policies. Its partners include business, labor and education groups, children's and seniors' organizations, dental and medical providers and state and local agencies.

WDS Foundation analyzes oral health data and trends, shares best practices provides grant funding and works across the state to advocate for improved oral health. Educating the public and policymakers about the importance of oral health and how to prevent oral disease is a priority.

We Care Dental

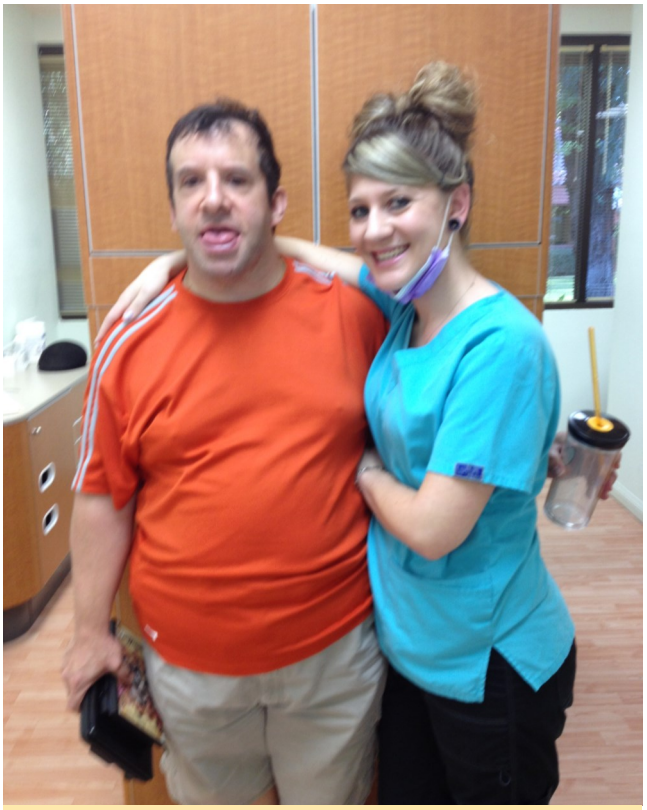
Caring for the Developmentally Disabled Population

June 2015

We Care Dental: Caring for the Developmentally Disabled Adult

"I never thought I'd be running a not-for-profit dental center for developmentally disabled adults and children or any dental center for that matter," said Marianne Benson, President, Desert Friends of the Developmentally Disabled (DFDD) and DFDD Clinical Services (dba We Care Dental), in Rancho Mirage, California. "And yet here we are, making it work, and so busy that we need to find new space for a larger dental center with three times as many chairs."

We Care Dental (WCD) is one of the largest Denti-Cal providers in the Coachella Valley, a 300 square-mile valley in Southern California encompassing Palm Springs. WCD provides a full range of low-cost dental services to adults and children, primarily the developmentally disabled. With four operatories, WCD currently serves 2,400 patients and handles 7,000 visits annually .



Kevin and dental assistant Jen Regos

We Care Dental: Origins

WCD's origins stem from deeply personal reasons for founders Russ and Marianne Benson – their adult son Kevin, has been diagnosed with mild mental retardation and autism.

In 2008 the Bensons moved from Las Vegas to Rancho Mirage, California. There the Bensons formed a 501(c)3 non-profit foundation DFDD to address the needs of the developmentally disabled population in the Coachella Valley. The main purpose of this group was advocacy for the disabled – things like Special Needs Trusts and Conservatorships, financial services, and public awareness. Oral health was not a focus at this time.

Then around June of 2010, the State of California discontinued many Medicaid benefits including dental, vision, and podiatry, even for the disabled population. A combination of severe fiscal pressures from the recession plus an increasing Medicaid caseload growth drove many states to curtail or eliminate these so-called "optional" benefits.

WE CARE DENTAL
42-900 BOB HOPE DRIVE
RANCHO MIRAGE, CA 92270

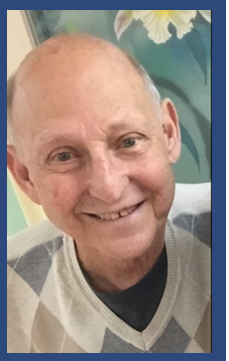
Location & Facilities	**Rancho Mirage, CA** 1 location with 4 operatories, open 5 days a week, 9-5 2nd location under consideration and planning
Providers & Staff	**1 paid FT Dentist with 2-4 4th year Dental School Students** (for ~7 week rotations), **1 volunteer PT Dentist, 1 paid FT Dental Assistant, volunteer and paid administrative staff**
Patients	**7,000 visits annually** Mainly low income adults, many developmentally disabled, some children
Services	**Preventive and Restorative services**
Total Revenues	**~$340k annually**
Patient Payments	**80% Denti-Cal payments** (now adult Medicaid has been partially restored in California); **cash fees** on a reduced fee scale for other low income patients.

Gap in care

Suddenly the Bensons couldn't get dental care for Kevin. When a dentist finally was willing to see him, the dentist required Kevin to be sedated, against his and his parents' wishes. The dentist also required cash prior to treatment. "It felt impersonal, disrespectful, as if Kevin was not acknowledged as a person", said Marianne.

The Bensons discovered this was a common occurrence. Many dentists did not want to treat the disabled adult population. In addition, most dentists insist on sedating all disabled adults which can be problematic since many of these adults are on numerous medications. Adverse drug interactions between the sedation and their drug regime are a real concern. Besides the sedation battles (dentists insisting, parents resisting), many dentists didn't want patients that might take more time in the chair, who were part of the low paid Medi-Cal program, and might offend their other patients.

The Bensons realized many other developmentally disabled adults and children must be facing similar challenges securing care so they decided to try to find care options for these patients. In their quest to find care, Russ and Marianne Benson were interviewed by a local reporter and profiled in the newspaper, *The Desert Sun*. Melvin Glick, DDS read the newspaper, saw the story and called Russ Benson, offering his help.



In 2000, Dr. Melvyn Glick retired from his Northern California dental practice. He read in The Desert Sun that Russ and Marianne Benson were trying to open a dental center to help the developmentally disabled adult population. Right away he wanted to get involved in their efforts.

"Many providers don't want to treat the disabled. They think they can't make any money. That population is made to feel like they are insignificant," he says. "My mom and dad taught me that I had a responsibility to others who were less fortunate. In private practice, I would take care of the poor people and the disabled. It's part of who I am. I'm very passionate about it. We need to have compassion and our patients need to feel our compassion. It has to be real."

For Dr. Glick the rewards are spiritual, not financial. "I've never taken money out of this," he says. "This morning I had a developmentally disabled patient who heard about us and drove 250 miles for a denture. The patient walked out the door happy and laughing. That's what I did today. That's my reward."

Early ideas

Initially Russ and Dr. Glick believed they could create a solution by finding space in existing dental practices. Given that Rancho Mirage is a retirement community many practices in the area operate only two to four days a week, leaving many practices with an empty chair several days a week. It turned out this wasn't possible. They couldn't convince a dental practice to release a chair. The local dentists were not entirely welcoming as they believed their existing patients would be uneasy with developmentally disabled patients in the waiting room.

Taking the leap

Left with no other viable options, the Bensons decided to open a dental center themselves, investing their retirement funds to create We Care Dental. Start up costs were approximately $150k to create 4 operatories and secure the necessary equipment.

Marianne Benson stated, "my husband and I both wanted this dental center but Russ was the organizer, the one who signed the lease. He just couldn't retire and he believed in this dental center." He and Dr. Glick found an empty but suitable space in a Rancho Mirage medical office building that had to be renovated from the floor up. Meanwhile Marianne got PR efforts going through local newspapers to secure volunteers, donations, chairs, and services. WCD opened its doors in September 2011 with three complete operatories (and space for a fourth, completed later).

Start up cost were approximately $150k to create 4 operatories and secure the necessary equipment.

Initially Dr. Glick volunteered one day a week at the dental center along with two additional volunteer dentists, who were encouraged to come to We Care by Dr. Glick. In the beginning things were slow. Marianne Benson said, "We had the dentists, but until the word got out, WCD did not have the patient base to sustain the volunteer dentists."

Marianne Benson with a photograph of her late husband Russ Benson

WCD needed patients, so WCD staff contacted the Inland Regional Center (who serve developmentally disabled clients who were previously covered under Denti-Cal). Soon the Regional Center began sending WCD patients, some of whom could afford to pay for their own services at reduced rates. Then *The Desert Sun* ran a story that generated some patients. After several months, as a result of the Regional Center's leads, fundraising events, local media coverage and a TV public service announcement, word got out and a steady stream of patients began to flow through WCD's doors.

Still, at this early stage, WCD depended on the Bensons tapping into their personal funds to keep the center afloat as they struggled to manage costs and low payments from patients.

A devastating loss

Suddenly tragedy struck. On March 17, 2012, just six months after We Care Dental opened, Russ Benson died. "It was a devastating loss," said Marianne Benson, his wife of 49 years. "My first inclination was I didn't know what to do. Russ was the financial wizard and our leader and he was my rock." Following Russ's death, Marianne needed time to grieve and did not come to the dental center regularly for about a year and a half. In her absence, a practice manager oversaw the finances and administration.

Coming back from her hiatus, Marianne realized that the dental center needed her attention and management. "Over time, I decided I needed to continue what we started. This was what he wanted." Marianne came back to WCD to a new challenging situation.

Denti-Cal restored and a busy WCD needed stronger management systems

Denti-Cal restored some payments in June 2013 and with this public insurance, WCD was increasingly busy.

Denti-Cal presents several challenges for a dental practice: reimbursement rates are low, patients have a $1 co-pay, payment process rules are complex and denial rates (from the State for reimbursement for patient services) can be high given the myriad of documentation required for each invoice submitted. The practice needed to update its management systems to ensure it was paid under this program. Managing within the Denti-Cal rules is no small challenge and many practices face high denial rates from this program, mainly due to submission procedures.

In fact when surveyed in 2012 dentists reported that "complex administrative procedures and processes" were the second most cited reason for not taking Denti-Cal patients, with the first reason being low reimbursement (cited as less than one-third of the commercial rate).

In 2014 with Denti-Cal payments restored, and the Inland Regional Center sending patients to WCD, the stream of patients became a river.

Today Marianne dedicates herself full-time as a volunteer to WCD center, ensuring provider satisfaction, efficient office management, productive fundraising, and community involvement.

(DFDD) plans to offer more services to its clients, after receiving a $25,000 Coachella Valley Spotlight grant.

Finding the right providers

Finding the right dental providers to meet the needs of WCD special needs patients is not easy.

Dr. Glick found Dr. Hala Shakir who volunteered one day a week and encouraged her to be part of WCD given her ability to care for complex patients and her love of teaching. "I love these patients and I really love to provide care for them. WCD lets me take the time the patient needs to get care," said Dr. Shakir.

The We Care Dental Team

Providing care to the developmentally disabled

Dr. Hala Shakir

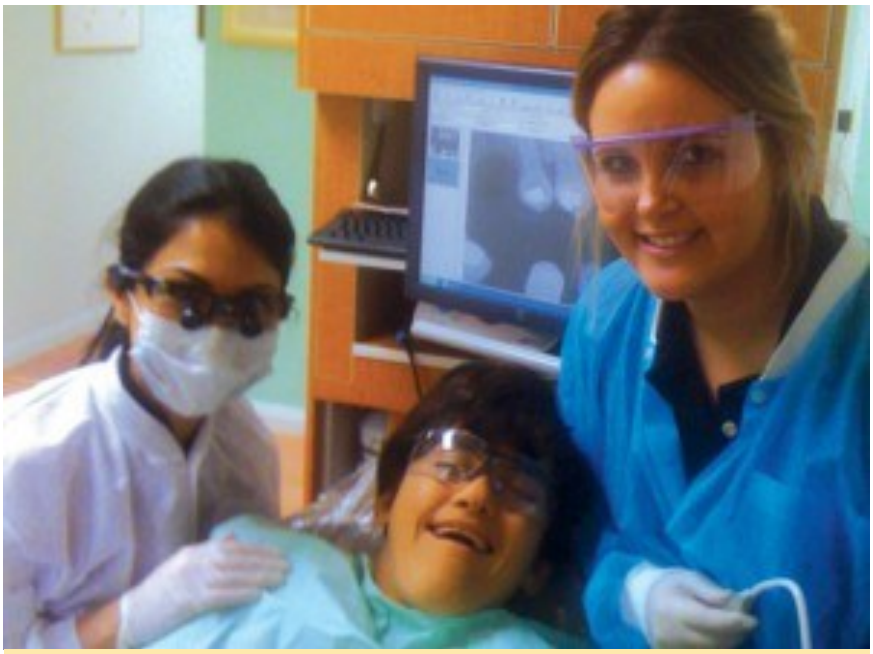
Certain techniques help WCD dentists treat the developmentally disabled. To reduce patient anxiety WCD dentists carefully explain which procedures will be necessary and the dental assistant will often hold a patient's hand during treatments.

Some patients visit WCD several times before they can be persuaded to even sit in a chair or open their mouths. "Patience and compassion is the key," said Dr. Shakir. "One patient came to WCD and would not leave the waiting room. I came to the waiting room, without any instruments and asked if I could count his teeth. We counted out loud as I gently touched each tooth. We finished and the patient smiled. On the next visit the patient was willing to sit in the dental chair. On the third visit he was willing to open his mouth while in the chair so I could treat him."

Building provider capacity with Dental School Students

In 2011, Dr. Timothy Martinez from the Western University College of Dental Medicine in Pomona, California contacted WCD about creating a partnership where fourth-year dental students would come one day a month to help treat patients.

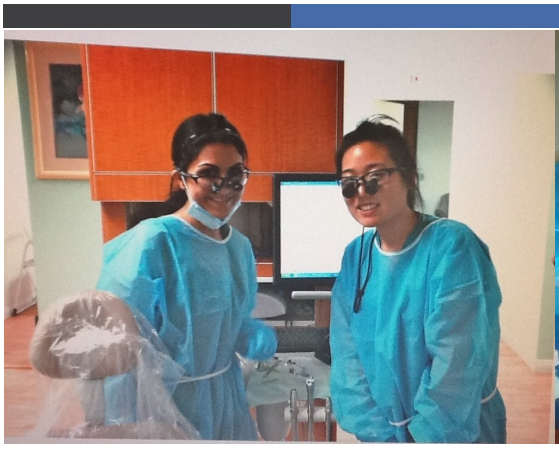
After two years of having the students come one day a month, the program was expanded. Western University now sends up to four fourth-year students as part of a seven-week rotation during the school year. It is a triple win: Dr. Shakir loves to teach; the dental center offers students hands-on opportunities to provide care under Dr. Shakir's expert instruction; and the combination of Dr. Glick, Dr. Shakir, plus these students creates the capacity to care for the patients. Dr. Shakir provides the supervision and guidance to these students, teaching them excellent dentistry and how to provide care to a special population.

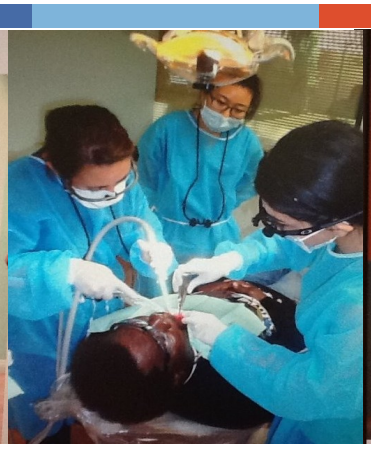


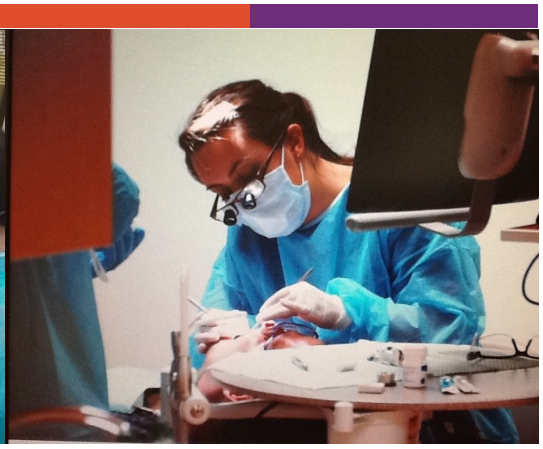
Western University dental students with their smiling We Care Dental patient

The combination of a steady stream of patients, with even the low Denti-Cal payments, generated a more robust and predictable revenue stream, of ~$30-$40k per month. With the new patients and revenues generated from Dr. Glick and Dr. Shakir, and the dental students, WCD was able to hire Dr. Shakir four days a week, which increased capacity in two essential ways: direct care for patients and supervision time for greater numbers of dental students.

"This is the job that I've always wanted. I love to teach and I love to care for these patients. The combination of the challenge of dentistry and education is exciting and rewarding for me", explained Dr. Shakir.







Making it work financially

Economics are challenging for We Care Dental. Expenses are higher: Many patients have longer appointments than other adults given their disabilities and most appointments are billed through Medicaid at low reimbursement rates that don't account for the additional time taken by WCD providers. Revenues are lower: Not only due to low Medicaid reimbursement rates but also a challenging denial rate that WCD is now more carefully managing. (The "denial rate" is the number of rejections of invoices submitted to the Medicaid program due mainly to either incorrectly submitted bills or the program disputing the necessity of the service). Lowering their Denti-Cal denial rate could have a significant impact of the bottom line. WCD has about one-third of its claims rejected by Denti-Cal, many for clerical errors. Brining this down to 10% could generate about $100k annually.

Managing the Denti-Cal payment "denial rate" due to incorrect invoicing is critical to success

WCD has several strategies for economic sustainability and is close to break-even but still requires fundraising and donations.

1. **Keep provider costs low by paying only Dr. Shakir and a dental assistant** and using 4th year dental students (that are free, and supervised by Dr. Shakir), and through services provided by volunteer dentist Dr. Glick. In July 2015 WCD will further expand service delivery with a AEGD resident from Lutheran Medical College who is unpaid by WCD yet is able to deliver services that WCD can bill for.

Profit and Loss Statement

Revenues	
Patient Fees Denti-Cal	$260,000
Patient Fees Cash from Low income adults	$30,000
Donations	$25,000
Fundraising Events	$25,000
Total revenues	**$340,000**
Expenses	
Salaries (DDS and staff)	$250,000
Rent/Utilities	$30,000
Supplies, Other Expenses	$50,000
Total	**$340,000**

Strategies for economic Sustainability

1. Keep provider costs low by using dental students.
2. Keep supplies costs in check through donations.
3. Ensure invoices for Dental Care are submitted correctly.
4. Create a strong fundraiser program.
5. Leverage volunteers.
6. Keep productivity high with a steady stream of patients.

2. **Keep supplies costs in check** by reaching out and asking for generous donations from Patterson Dental and Henry Schein (dental suppliers)
3. **Ensure all invoices submitted** to the state Medicaid program are done correctly including providing imaging records of patients and other critical information required by the state.
4. **Create and execute a strong fundraising program** with several events each year, personal requests for donations and an active communications campaign using local media For example, their recent fashion show (with patients as models) generated approximately $10,000 and hopefully additional future financial support from attendees.
5. **Leverage volunteers.** Marianne Benson, the original funder of the dental center is a full time volunteer practice manager. Dental students provide their time at no cost, and the volunteer Board is active in fundraising and communications.

WCD payer mix is about 80% Denti-Cal and 20% cash paying patients that are low income but not part of the government assistance program, who pay on a reduced fee schedule One key to making the practice work financially is to keep productivity as high as possible and chairs busy. Many practice expenses are fixed costs so the more revenues that can be generated from those fixed costs the better. To keep the chairs busy, WCD has a partnership with Angel View, a non-profit organization that runs 18 group homes for people with disabilities. Angel View sends WCD their Denti-Cal patients. WCD also stays in close contact with the Inland Regional Center and accepts their patient referrals. WCD works hard to manage their no-show rates by ensuring patients value the appointments and by reminding patients and families of appointments.

We Care Dental at a health fair

Partnerships are vital

WCD created many partnerships with other programs who served developmentally disabled adults such as Angel View. Forming mutually beneficial partnerships is crucial for a non-profit dental center and WCD excels at developing partnerships. WCD also partners with Patterson Dental for dental software and equipment and with Henry Schein Cares Foundation for supplies.

Recently WCD held an event with Lauren Potter (an actress on the TV show Glee who has Down Syndrome) and also holds an annual fashion show with patients as fashion models to increase awareness of their services and generate needed funds from the community to increase the care they can provide.

WCD becomes solvent

It was a struggle, but the center has rebounded from the loss of one of its founders. Said Marianne, "It's been a rough road to get to today, but we did it. It's amazing to think that now we are one of the largest providers in the valley for Denti-Cal and for developmentally disabled adults and children. Compared to the early days when the dental center struggled for existence, now after a little over three years, we have our first full-time dentist, many providers, plenty of patients, but no room. We have to expand. And finally, after three years, we are solvent."

What's next?

Marianne sees WCD engaging the community and legislators on raising the reimbursement rates for Denti-Cal. "The rates have not been adjusted since 2001, this issue is not just for WCD but for all the children and disabled adults across the state that cannot get care given low rates", she said.

Marianne also says it's time for expansion. "First we needed dentists, then we needed more patients, and now we need more space." She is seeking a way to expand to a new dental center with 11 chairs, allowing WCD to care for other developmentally disabled children and adults and to diversify its patient mix by bringing in new private fee patients. Marianne is also seeking grants and other funding to create new space for more care for a very special population.

We Care Dental at a health fair

Lessons to share with others

1. **Find the right provider(s) for your dental center** leveraging publicity on the clinic and by encouraging providers to reach out within their professional communities -- The right provider is someone who loves to care for your patients and appreciates their unique needs.
2. **Create partnerships for both providers and patients.** Dental schools can supply students and non-profits can be a source of patient referrals. Engage the Medicaid managers in the community, working with them to create shared expectations for patients and families.
3. **Pay attention to the financials** and, in particular, manage your denial rates.
4. **Generate publicity.** Engage the community in your mission and create strong fundraising programs. Publicity can lead to patients, providers, donations, and capital. Recruit a Board member with PR experience, proactively searching for community members with relevant expertise who could be engaged on the dental center mission.

We Care Dental in the news

About the Washington Dental Service Foundation

Washington Dental Service Foundation is a non-profit funded by Delta Dental of Washington, the leading dental benefits company in Washington. The Foundation's mission is to prevent oral disease and improve the oral and overall health. The Foundation works with partners to develop innovative programs and policies that create permanent change, leading to improved oral health for all. For more information, visit: www.deltadentalwa.com/foundation.

About the Authors

Martin Lieberman

Martin Lieberman served as Chief Dental Officer at Neighborcare Health in Seattle, Washington from 2002 to 2013. Prior to his community health center work, he worked in private practice in Chicago for 18 years. Dr. Lieberman led a culture change in the way Neighborcare Health's dental program viewed process improvement and quality and has served as faculty member for the HRSA Oral Health Pilot Collaborative, and has also been a faculty member for IHI, HRSA, NNOHA and Dentaquest quality improvement projects. Dr. Lieberman serves on the Board of Directors for NNOHA and chairs the Practice Management Committee. In January 2014, Dr. Lieberman assumed the role of Associate Director of Graduate Dental Education at NYU Lutheran Medical Center in Brooklyn, New York.

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MaryKate Scott

MaryKate Scott is a healthcare economist and business management consultant with experience at McKinsey & Company, Procter & Gamble, and several academic appointments. She works with healthcare leaders in health systems, pharmaceutical and medical device firms, payers, and philanthropic organizations. Focusing at the nexus of health care, business and technology, Mary Kate's work focuses on strategy development, mergers and acquisitions, product launches, competitor response, market shaping campaigns, and economic modeling.

Her oral health work includes supporting The Pew Charitable Trust Children's Dental Campaigns including the ***It Takes a Team*** report and calculator. She has also authored: **IOM: Oral Health Access** (Chapter); **Retail Dental Clinics – a viable model for the underserved**; **The Good Practice: Treating Underserved Dental Patients While Staying Afloat**; and complied **The Oral Health Care Innovation Compendium** for The California HealthCare Foundation. She provided business strategy support for the **Alaska Native Tribal Health Consortium: Dental Health Aide Therapist (DHAT) Program**. She is presenting at NNOHA (2015) **An Economic Model to determine impact of adding a Dental Therapist to a FQHC Dental Clinic**.

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The Foundry

Dental Center

A Community Partner for Recovery and Restoration

THE FOUNDRY
DENTAL CENTER

June 2015

Foundry Dental Center: A Higher Calling

Foundry Dental Center, AL

Dr. Mike McCracken grew into a desire to help the less fortunate. So in 2010 the dentist showed up to volunteer at the Foundry Rescue Mission and Recovery Center (Foundry), an addiction recovery program in Bessemer, Alabama, near Birmingham.

Said Dr. McCracken, "I was impressed with the Foundry's work therapy program that helps adults get back on track and back to work. I thought I'd be a mentor and help somehow, but the first thing I noticed was that these residents needed dental care. After a day of painting I offered them my dentistry services."

The Foundry's CEO, Micah Andrews, was immediately receptive to the idea. The dental need among the program residents was enormous. Dr. McCracken said, "The first thing we did was to look around for a room to put in a dental chair. Yes, a single chair. We even looked at 10 by 12 closets, attics, and in their thrift store. There were some crazy ideas. But it got Micah and me thinking and we quickly saw that a single chair would not come close to meeting the demand."

Four years later, Dr. McCracken finds himself at the helm of the Foundry Dental Center, a clinic which serves nearly 50 patients a day. "Really all this started with a calling from God and a billboard," he said, sharing his story.

Answering the call


Dr. Michael Mc Cracken

Explained Dr. McCracken, "I was driving down the interstate and I saw a billboard for the Foundry Rescue Mission and Addiction Recovery Center. It was more than just an idea, though. In that moment I felt God's direction. I ignored it for a few months, and then I saw another Foundry billboard, and had this same deep pull to go to this place I had never been before and help. I believe God calls us to love our neighbor and help others, and that call demands that we get up and do something. So I just showed up on the Foundry campus."

The Foundry Addiction Recovery program has 350 participants who live on campus for about a year receiving treatment and participating in work therapy. Work therapy gives participants the opportunity to build relationships, learn new skills, work towards a common goal, and develop discipline.

"The Foundry participants fight difficult battles," said Dr. McCracken. "I was impressed with the Foundry's program, their expectations, and how everyone contributes and the participants grow. Their success record is very good. However even if people do well with recovery, many had pain, couldn't smile due to dental issues, and they couldn't get a job when they finished the program, and this starts the addiction cycle all over again."

Foundry Dental Center: Snapshot

Location & Facilities	**Bessemer, Alabama** 1 location with 12 operatories, open 5 days a week 2nd location underway
Providers & Staff	2 FT Dentists with 8 AEGD Dental Residents and 20-24 Dental Assistants (part of a training programs), 2 lab technicians for dentures and crowns, several volunteer administrative staff
Patients	• 11,000 visits annually, all adults, many part of addiction recovery and homeless programs, all uninsured • 6-20 emergency walk-ins daily, some from hospital EDs
Services	#1 eliminate pain (extractions) #2 get healthy (fillings and periodontal therapy) #3 create a smile (dentures, implants, crowns)
Total Revenues	$1m annually
Patient Payments	• Cash payments from Foundry patients at very reduced rates (e.g., $35 per extraction/filling); • Cash payments for uninsured low income adults (e.g., $60 per extraction/filling) • FDC does not accept dental insurance • There is no adult Medicaid in Alabama

Foundry Dental Team

Humble Beginnings

After considering creating a single chair and offering services at the home location of the Foundry, Dr. McCracken (then a Professor of Dentistry at the University of Alabama, Birmingham) found a dental practice that one of his former students was offering for lease. The dental student had graduated seven years earlier and was moving from his first practice to a larger site. This practice had three chairs and old but functional equipment. The former student, now a successful practitioner, offered Dr. McCracken very low rent and the use of all the equipment: chairs, compressors, drills, and vacuums. "All I had to get was anesthetics and supplies. For $500 we opened the doors and I practiced there one day a week," said Dr. McCracken.

The first clinic enabled Dr. McCracken to test the viability of a not-for-profit clinic, using a $35 fee, dental assistants in training, and front desk volunteers.

The clinic charged a $35 cash fee for all services, which covered utilities and supplies. Dr. McCracken volunteered his time and Foundry participants trained by Dr. McCracken were used as dental assistants. The clinic now provided The Foundry a third option for its work therapy program – residents could work at The Foundry's thrift store, its auto sales and service center, and now a dental clinic.

"Our volunteers (from the church) took the Foundry ladies out to buy scrubs and they chose pink, so the 'pink team' was created," said Dr. McCracken. The volunteer front desk assistant came from Dr. McCracken's church and ran the practice, along with other volunteers from the church and community, who work part time at the clinic.

The first clinic enabled Dr. McCracken to test the viability of a not-for-profit clinic, using a $35 fee, dental assistants in training, and front desk volunteers. Patients were willing to come and pay cash. Soon the clinic was busy with 8-10 patients a day.

Dr. McCracken said he'll never forget the clinic's first patient. "I had three new assistants who had never seen an oral exam and a patient with a wisdom tooth that needed to be extracted. I probed the tooth, the patient groaned, all three assistants gasped. Later my first piece of advice to our new pink team was, 'Never gasp!' I extracted the tooth and the patient was grateful. I look back on it now and I truly never anticipated how I'd mentor these assistants and help them create careers and new lives."

Our Location

1700 Sixth Avenue North

Bessemer, AL 35020

(205)434-2031

Handling a setback

8 months after it opened its doors, the low-rent clinic was sold to a weight loss group, and the dental space was lost. For Dr. McCracken this came as a large and unexpected setback. Ultimately however, Dr. McCracken said this closure forced him to rethink the whole clinic, take a coolheaded look at the demand for services, and devise a more permanent solution. "At the time I was crushed, but being kicked out was good for us," he said.

Coming up with a solution

Dr. McCracken created a 501(c)3 not-for profit entity, the Foundry Dental Center (FDC). He then happened to see a foreclosed building (6,000 ft^2) near the Foundry and purchased it for $42k. Dr. McCracken's religious faith kept him going. "I believe God lead me to this building. I had faith that He would help us find the right way forward," he said. Dr McCracken then sold the building to the FDC non-profit for the same purchased price.

The building needed major renovations. Dr. McCracken turned to his church community and sparked an interest in the dental center. One church member, a retired construction executive, volunteered to lead the renovation effort alongside Foundry volunteers.

The Foundry provided labor – tilers, electricians, plumbers, and general laborers. After $150k in renovations, FDC opened with six operatories and a lab. Today, two years later, they have added six more chairs and an additional 5,000 ft^2.

Find a second champion

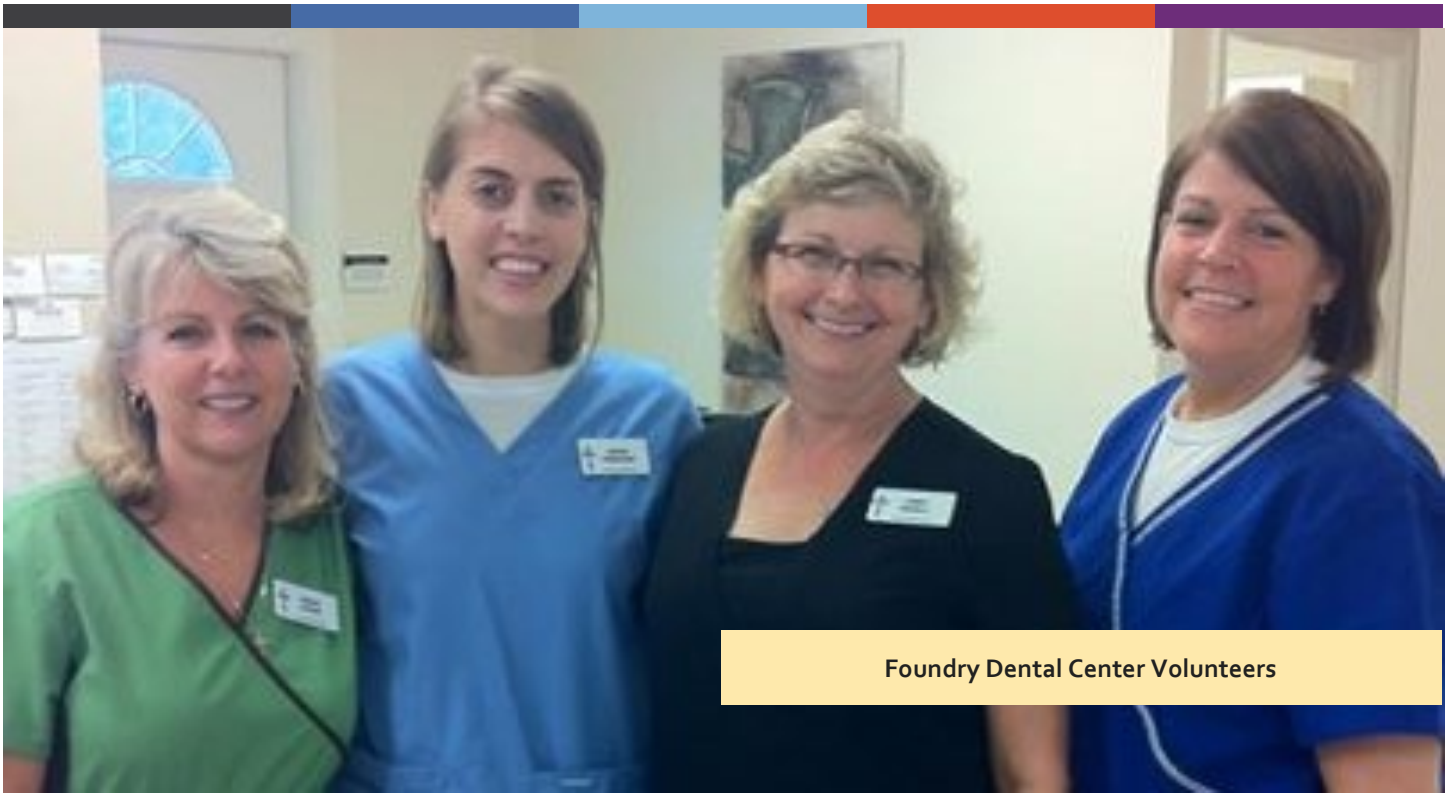
A nonprofit is stronger when it has two champions instead of one.
Dr. McCracken has found his second champion in Dr. Rosenstiel.

"Dr. Rosenstiel brings a lot to the clinic. He's got strong oral medicine experience, implant expertise, and is an extraordinary general dentist. Plus he is exceptionally generous. He donates his time, a camera, and even brings his three assistants when he volunteers. He brings energy, passion, new ideas, and strong community relationships," said Dr. McCracken.

Creating partnerships: a second champion and additional volunteers

"I met Guy Rosenstiel when I was teaching an implant class. I told him I was building a not-for-profit clinic and he immediately said 'I'm in.'". Dr. Guy Rosenstiel became a key collaborator and partner with Dr. McCracken. Dr. Rosenstiel is a board member, educator, and highly skilled dentist. “He's the one who signed the $150k renovation loan. He provides patient care and supervises dental students” said Dr. McCracken. Other church members continue to provide fundraising support, office assistance, financial contributions, and other donations. “Our church, Asbury United Methodist, is very committed to very committed to the clinic and the community that we support,” commented Dr. McCracken.

Dr. Guy Rosenstiel



Foundry Dental Center Volunteers

Staffing with AEGD Residents makes it work

FDC has grown to include eight AEGD residents from Lutheran Medical Center working with them. FDC also uses about 15 volunteer dentists. Volunteers work at least one day each month, and some work one day per week. These volunteers serve as faculty for the Lutheran residents. They provide direct patient care and they help drive support in the community by telling other people and dentists about the clinic.

Faculty member volunteer and board-certified periodontist Dr. Peter Jezewski, Dr. Michael McCracken, and two residents

The residents provide supervised care and FDC provides them training. This is foundational to FDC's care and business model, as these residents are paid for by Lutheran and so are free to the FDC.

Profile of a volunteer dentist

Dr. Matthew Holley graduated in 2000 from UAB in general dentistry and manages a busy practice in Prattville, AL. He lives locally in Birmingham with his wife and four sons.

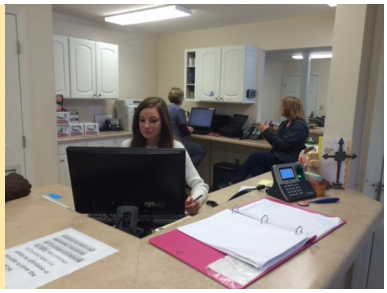
He was introduced to the Foundry Dental Center through a continuing education course, and liked what he saw there. Dr. Holley wanted to be part of FDC. He has now been a regular volunteer for over two years providing both direct patient care and serving as faculty, supervising and educating students.

"Every day at FDC is a rewarding experience where everyone benefits from the care provided and the atmosphere of the clinic. It is so gratifying when I see a patient complete treatment and have an immediate boost in confidence. I love it when they say 'they got their smile back'. I really believe it's an important part of the overall path to a better, stronger person with a purposeful life."

Finding patients through other not-for-profit programs

The FDC serves a steady stream of patients that began with The Foundry. Now FDC has developed relationships with other non-profit service providers for the poor, homeless, and those recovering from addiction, abuse, or re-entering society after incarceration.

For example, the Jimmie Hale Mission is a homeless shelter and recovery program for men. They send FDC a van load of patients about every week. FDC also gets patient referrals from a federally qualified health center (FQHC). Today only one-third of FDC's patients come from addiction programs. FDC helps other non-profits meet their missions by supporting them with access to dental care. "Without good oral health, it's hard for these programs to get their residents back on the right path, so we are a critical resource for the folks that lead these programs," said Dr. McCracken.



Foundry Front Desk

According to Dr. McCracken, FDC is "Crazy busy, almost in triage mode, facing more patients than we can accommodate. Every chair is full, every hour of every day." To help meet the demand, FDC is expanding to a second site 12 miles away with six more chairs. “We need more room,” McCracken said.

Why not treat pediatric patients?

"Alabama children in low-income families are eligible for Medicaid and have good access to dental care mainly through providers in our area such as Sarrell Dental and Jefferson County Health Department," Dr. McCracken says. "Sarrell is five minutes away and they are focused on children. They have providers that really work well with children. They have all the right skills and equipment and pediatric chairs, so it makes sense to send children there. Our focus and our mission is adults, particularly recovering adults. We send our dental residents to Sarrell to expand their education with an excellent clinical rotation that provides them pediatric experience."

Advanced Dental Education Programs

Dr. McCracken and Dr. Rosenstiel provide a for-profit continuing dental education implant course that has several positive ripple effects. Community dentists come to the clinic and receive instruction on implants. The education program includes hands-on surgery, allowing clinic patients who could not afford an implant to get this procedure. Even States that have adult Medicaid programs and cover dental care do not include implants as part of their allowed procedures, decayed teeth are simply extracted.

Dr. Michael McCracken

Dr. McCracken and Dr. Rosenstiel donate funds from these courses to keep the clinic financially solvent, and pay the clinic for space and staff for the programs, generating critical revenue for the FDC. Many of the dentists who come for the implant education, stay as dentist volunteers and supportive dentists within the community of the FDC.

From Foundry Participant to Private Practice Hygienist

Aarika H: Graduate of the Foundry and The Foundry Dental Center "Pink Team"

"In May 2011 I admitted myself to The Foundry. It was my decision. My mother had passed away and then my brother passed, and I found myself addicted to prescription medications. The Foundry is a 12-month commitment, so you have to really want to do this. We all do work therapy at The Foundry and I was working at the thrift store. It's a good job and a good place but it wasn't the right fit for me. Then I heard that we could apply to work at the Dental Center. I jumped at the opportunity and in the essay I wrote (it was competitive to get in) I talked about my college studies to be a nurse and my prior experience with patients as a medical assistant.

It was exciting to be accepted at FDC but it was so new, I had no idea what I was doing at first. I didn't know how to sterilize, how to hold the suction -- nothing! We learned on the job, and the dentists trained us.

When the dentists came to take the implant course, I hoped it would be my opportunity to work with one of these dentists and potentially get myself a permanent job in the real world. The pink team job is great and provides hands on training that no other dental assistant program offers, but I kept wondering: What would I do when I graduated from the Foundry? Where would I work? Who would hire me?

I was offered a job by a dentist who graduated from the implant course – first as a temp and then, after I graduated from the Foundry, I was offered a permanent position as a dental assistant. My dentist (my boss)* and Dr. McCracken encouraged me to keep studying and go to dental hygiene school. It's nine months, one weekend a month, three solid days of book work, and this May (2015) I take my State Boards. I may go on to Dental School. I'm capable of it. I just have to figure out how I can do it and take care of my 18-month-old daughter.

This dental center is why I am who I am. It took me in a new and good direction. I'm working hard, raising my daughter right, and living in a pretty house. I'm super busy but I like it that way. I'm still connected to The Foundry and my dentist (my boss)* is on the Board of the Foundry. It's been such a blessing. I'm grateful for a new life. God gets the glory for my success."

Aarika H. Graduate of FDC

Aarika's dentist, Dr. Ben Crunk, serves on the Board of Directors of the Foundry.

The business model

Economics are challenging for The Foundry Dental Clinic yet a focus on productivity, use of AEGD residents, lower cost dental assistants and fees paid by the education programs for FDC facilities make it work. The Foundry Dental Center has several strategies for financial viability. On the revenue side, FDC ensures their chairs and providers are constantly busy with high utilization. FDC has created several partnerships with many programs that serve adults in need and many of these programs send patients to FDC by the van load. An empty chair is a rare site at FDC.

Economics are challenging for The Foundry Dental Clinic yet a focus on productivity, use of AEGD residents, lower cost dental assistants and fees paid by the education programs for FDC facilities make it work.

FDC receives payments from an education program (on implants) for hosting the course at FDC and using their dental assistants and space. The training program is a "quadruple win": training for local dentists on implants, job opportunities for dental assistant graduates, quality implants provided at low cost to Foundry participants and modest income to FDC. FDC is also supported by sustaining contributions from churches, board members, and AEGD graduates.

FDC also requests patients pay for services, according to ability, with lower fees for Foundry patients and modestly higher fees for low-income (uninsured) adults.

On the expense side FDC controls costs with 3 main strategies:

1. Use unpaid AEGD residents;
2. Train dental assistants from the Foundry who volunteers as they train and then paid a low rate while they are housed at The Foundry and provided advanced training by FDC
3. Pay only very modest wages to faculty members, who mostly volunteer their services due to a dedication to the mission of the clinic.

FDC Profit & Loss

Revenues	
Patient fees	$820,000
Education Program Donation	$100,000
Donations	$100,000
Total Revenues	**$1,020,000**
Expenses	
Salaries (faculty, DAs, staff))	$360,000
Supplies	$240,000
Labs	$240,000
Building utilities/maintenance	$120,000
Miscellaneous	$ 60,000
Total Expenses	**$1,020,000**

Revenues

FDC generates about $1m in revenues annually.

About 80% of FDC's revenues come from patient fees and the rest comes from donations from dentists, the Board, and the church, as well as payments received for hosting dental education CE programs.

Two-tiered fees

FDC uses a two-tiered fee structure with one fee schedule for Foundry residents and others enrolled in a full-time addiction recovery program, and a higher, but still affordable fee for community patients.

	Foundry resident	Community patient
Standard fee	$35	$60
Extraction	$35	$60
Dentures	$250	$325
Crown	$100	$500

"Community patients really help us run the clinic," said Dr. McCracken. Since their prices are about 20% of the market rate for Foundry residents and about 50% of regular price for low income community residents, this translates to FDC providing dental services valued at about $5-6m annually.

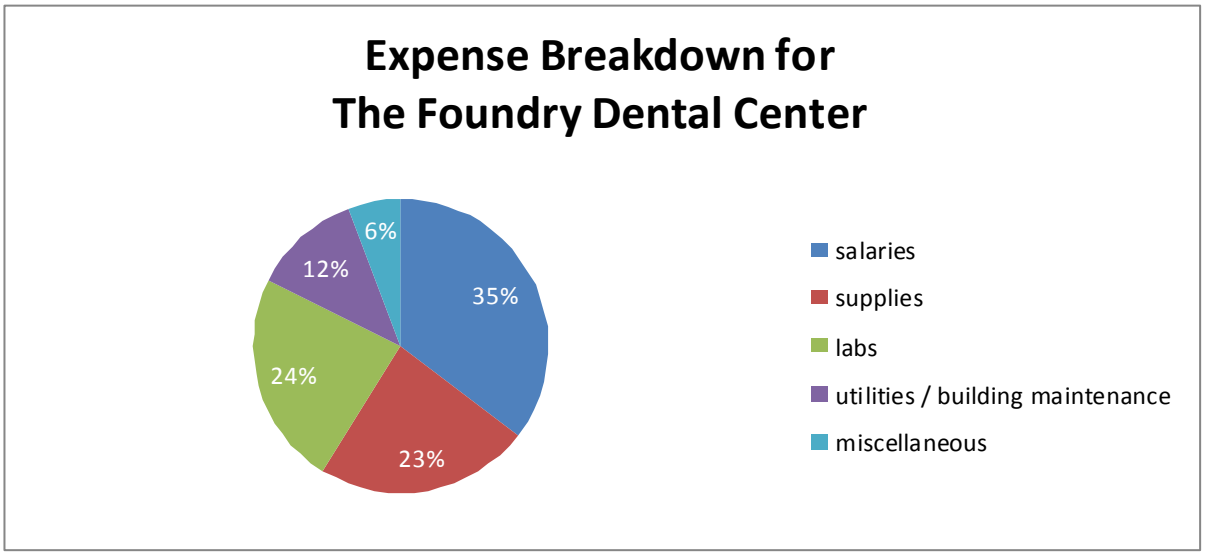
With such low fees for services Dr. McCracken said the clinic needs a laser focus on productivity and managing expenses to break even. "We are constantly looking for new efficiencies. Using our software we track how much care we provide and how much we give away," he said.

Keeping expenses low

FDC's expenses are just over $1m annually and break down as follows:
Total expenses for salaries (currently ~$360,000 annually) are very low due to use of unpaid Lutheran AEGD residents, the very modest wages paid to Dr. McCracken and his team, and the Foundry participants training to be dental assistants.

A crucial element in this value chain is the work therapy program for dental assistants through the Foundry. Work therapy helps the person learn general work-ready life skills as well as the specific skills of being a dental assistant so they have future employment after graduating from the Foundry addiction recovery program.

The dental clinic trains the assistants and they work as work therapy volunteers as they gain knowledge and experience. This low wage is possible as their food and shelter is provided by the Foundry. After they graduate from the Foundry, many are hired on as dental assistants full-time and they continue to make contributions to the clinic as dental assistants and staff members. Approximately 75% of the staff at the clinic are graduates from the Foundry addiction recovery program.



Initially a small number of community dentists were concerned about the start of the non-profit dental clinic, viewing FDC as a potential competitor and believing that FDC was unfairly competing by using unpaid AEGD residents.

These perceptions have been largely overcome by FDC's key decision not to accept dental insurance. FDC believes that if a patient has insurance they have other options and they should go to a community dentist. This policy reassures local colleagues that FDC is not competing with them for patients.

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Dr. McCracken explained, "I was influenced by the book When Helping Hurts by Steve Corbett and Brian Fikkert. It suggests that sometimes when volunteers try to assist the needy they can have unintended negative consequences, such as putting a local dentist out of work. I wanted to be sure I wasn't hurting our local dentists. That's when I realized that not accepting insurance was the right thing for us, for our patients, and for our local colleagues. This policy changed the equilibrium and now the local dentists really understand that we are not competing with them."

Now local dentists send FDC patients and sometimes volunteer their time. "People started to realize that we help the dentists as well," said Dr. McCracken. "We are a place for dentists to refer patients who are in need. Local dentists will send us indigent or underserved people for low-cost, subsidized care. And when we have a patient with insurance, we send them to a local dentist. It works for everyone. We are a small connected community and sometimes it just takes asking someone (a local dentist) to come in and get to know us or asking them for their help to care for our patients or teach our dental residents." FDC is also a place for local dentists to source well-trained residents. Residents who studied at FDC are now working in private practices throughout the Birmingham area. "We have trained dental providers to serve the Alabama population and become valuable associates for dental practices. We believe our residents are improving the quality of care all over the State, because they have had an extra year of training. Studies show that dentists tend to stay in the state where they do a residency, and we are glad to have these clinicians in our communities."

Dr. McCracken also sees FDC as providing a vital economic steppingstone for The Foundry participants looking to rebuild their lives. "Many of our pink team are now working in private practice. That's part of the goal – educate people and transition them into private practice where they earn higher wages. Here are people that have come from addiction or prison or homelessness and now have skills and jobs that pay $12-24 an hour," he said. Recently one of the clinic's volunteer dentists hired one of his favorite dental assistants. "She's had a tough road and now she is going to make it with a new job and a new start. That part is incredible," said Dr. McCracken.

Dr. Mc.Cracken speaking to AEGD resident Dr. Courtney Michelson from Tufts

Is this not for profit clinic replicable by others?

"I believe it is", said Dr. McCracken.

"Not-for-profit dental clinics will always have modest income due to either low patient payments or low government reimbursement. However the use of AEGD residents, and the job training program that provides dental assistants at lower cost are strategies that all clinics could consider," commented Dr. McCracken. "The magic, if there is any, is really engaging the community to contribute to a program that delivers care and provides a way to re-enter society for sustainable change."

Planning for the future

Dr. McCracken wants to ensure the clinic continues to thrive. "I do think about the longevity of the clinic," he said. "I want to create an Executive Director position and find someone who is retired or a missionary who is able to live on what we can pay. I definitely want the clinic to be able to run without me and Guy."

THE FOUNDRY DENTAL CENTER

As for the long-term growth plan, Dr. McCracken doesn't believe patients are the limiting factor. "The demand is there," he said. "We could continue to grow. Eventually we'll run out of residents and that would be a limiting factor. Our business model depends on Lutheran residents. At some point we'll reach a cap on residents. We could go to 12. My next goal is to do a non-Foundry clinic with a church in Montgomery."

Lessons to share

1. **Just do it.** Dr. McCracken's first piece of advice is, "Don't over plan. It's not possible to think everything through. When you put something like this down on paper, it won't look like it will work, because you can't imagine all the help you'll get along the way and how people will support you to make it happen. Too little planning is a bad thing, but if you plan too much you'll get paralyzed."
2. **Partnerships** are essential. Create strong partnerships with social programs that serve adults with addiction, homelessness, and prison re-entry. Proactively find other programs that serve similar populations, contact them and inform them of your care services and/or work training programs. Work with these social programs to be part of their work therapy programs. Train people to be job-ready, teach them skills, and use this low-cost labor to deliver care to the underserved. Then help them find private practice jobs in the community. Create partnerships with dental schools to train their residents and students. Engage dentists in the community and keep the wider dental community on board.
3. **Ask for help and be specific.** Ask for construction help, front desk help, equipment donations, office supplies, scrubs, free labor, even money. People want to give, sometimes you just need to ask. Be bold!
4. **Pay attention to finances.** Nonprofits have tight operating margins. Track key productivity (such as total services provided) and financial metrics (total revenues and costs on a monthly basis). Intervene early when things dip. FDC tracks revenues weekly and limits purchases when revenues are down. Sometimes this means FDC won't be able to provide a specific service for a time, because it is too costly. Patients understand this.
5. **Get smart on volunteers.** Be thoughtful on how you use them. They aren't just an extra pair of hands, but also a way to get community support for what you do. Bring dentists to your site and get them engaged.
6. **Find a second champion – and then a third!** It's important to find a collaborator who shares your vision. Having a second champion helps ensure the longevity of the nonprofit and provides extra energy and ideas.

About the Washington Dental Service Foundation

Washington Dental Service Foundation is a non-profit funded by Delta Dental of Washington, the leading dental benefits company in Washington. The Foundation's mission is to prevent oral disease and improve the oral and overall health. The Foundation works with partners to develop innovative programs and policies that create permanent change, leading to improved oral health for all. For more information, visit: www.deltadentalwa.com/foundation.

About the Authors

Martin Lieberman

Martin Lieberman served as Chief Dental Officer at Neighborcare Health in Seattle, Washington from 2002 to 2013. Prior to his community health center work, he worked in private practice in Chicago for 18 years. Dr. Lieberman led a culture change in the way Neighborcare Health's dental program viewed process improvement and quality and has served as faculty member for the HRSA Oral Health Pilot Collaborative, and has also been a faculty member for IHI, HRSA, NNOHA and Dentaquest quality improvement projects. Dr. Lieberman serves on the Board of Directors for NNOHA and chairs the Practice Management Committee. In January 2014, Dr. Lieberman assumed the role of Associate Director of Graduate Dental Education at NYU Lutheran Medical Center in Brooklyn, New York.

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MaryKate Scott

MaryKate Scott is a healthcare economist and business management consultant with experience at McKinsey & Company, Procter & Gamble, and several academic appointments. She works with healthcare leaders in health systems, pharmaceutical and medical device firms, payers, and philanthropic organizations. Focusing at the nexus of health care, business and technology, Mary Kate's work focuses on strategy development, mergers and acquisitions, product launches, competitor response, market shaping campaigns, and economic modeling.

Her oral health work includes supporting The Pew Charitable Trust Children's Dental Campaigns including the ***It Takes a Team*** report and calculator. She has also authored: **IOM: Oral Health Access** (Chapter); **Retail Dental Clinics – a viable model for the underserved**; **The Good Practice: Treating Underserved Dental Patients While Staying Afloat**; and complied **The Oral Health Care Innovation Compendium** for The California HealthCare Foundation. She provided business strategy support for the **Alaska Native Tribal Health Consortium: Dental Health Aide Therapist (DHAT) Program**. She is presenting at NNOHA (2015) **An Economic Model to determine impact of adding a Dental Therapist to a FQHC Dental Clinic**.

Mary Kate Scott can be reached at *MKS@MaryKateScott.com*

Community Dental Maine

Raising the Bar on Quality after a Century of Service.

June 2015

Community Dental Maine:
A Not-For-Profit Dental Center

Raising the Bar on Quality after a Century of Service

Lisa Kavanaugh looked around the contemporary dental center in Biddeford, Maine, with its eight operatories, digital panoramic radiography, and state-of-the-art facilities—one of five dental center locations she and her team manage. "Here's how I evaluate our dental centers: Would I want to receive care here? Today I can say, 'Yes I would,' but when I first started working here ten years ago, I would not have been able to say that," she acknowledged.

The story of Community Dental Maine (CDM) starts nearly a century ago when early 20th century Maine was thriving, with fishing, lumber, pulp and paper, textiles, and shipbuilding driving the economy. In 1918, as the Spanish flu pandemic took its toll on Portland's population, the number of orphaned children in need of shelter and healthcare increased amid scarce resources. That year, a committee of dedicated women collaborated with the Red Cross to establish a free children's dental clinic in Portland's Old Port.

Over the course of the next 50 years, this clinic would gradually expand and begin to serve people of all ages and become CDM.

In the 1970s and 80s, CDM expanded its service to adjacent Maine counties York and Androscoggin. In the 90s, CDM opened several additional rural dental centers and continued to expand into central Maine.

Today CDM is the largest nonprofit provider of quality, comprehensive oral healthcare in Maine, with five dental health centers

Today CDM is the largest nonprofit provider of quality, comprehensive oral healthcare in Maine, with five dental health centers and multiple community programs to improve the oral and overall health of about 20,000 people each year across five large Maine counties.

Dental Center in Biddeford, ME

Prior to Ms. Kavanaugh's taking charge of CDM in 2005, the centers were managed by an executive director who died unexpectedly, forcing the board into a more hands-on management role. The board visited centers, talked to the providers, and saw firsthand the challenges faced by the providers, staff, and patients. Despite CDM's decades of success in delivering affordable oral healthcare to adults and children, it was clear that the sites needed upgrading.

Equipment was outdated and inconsistent across the centers, and strategies to ensure quality were not in place.

The transformation started at the board and CEO level

"I didn't apply for the job," said Ms. Kavanaugh. "A board member called me and explained the challenge. The board realized that the facilities and the services provided were in need of a major overhaul. They recognized they might not have the right locations, even the right programs to deliver quality care. I had never run a dental center. I'm a hospital executive. However, I ran the state psychiatric hospital and worked closely with the state on programs that are covered under MaineCare, our Medicaid program, so I understood the patient population and their needs." Ms. Kavanaugh continued her story, "The board members met me for lunch but never at the centers. I agreed to the job, as I wanted to stay in Maine and I love a challenge. Plus I passionately believe that everyone deserves a great healthcare experience and the same quality care regardless of income."

She saw few computers, no electronic records, no policies, no tracking of quality metrics. Expansion had been done in a hodgepodge fashion

"I really should have visited the sites before agreeing to be hired," commented Ms. Kavanaugh. When she first visited the centers as the new CEO, it came as a shock to see how they had been allowed to languish. She saw few computers, no electronic records, no policies, no tracking of quality metrics. Expansion had been done in a hodgepodge fashion. For example, one center had an operatory that staff walked through to get to and from their lunch room.

Ms. Kavanaugh immediately set about working with the board to create a transformation plan guided by their vision to deliver quality care.

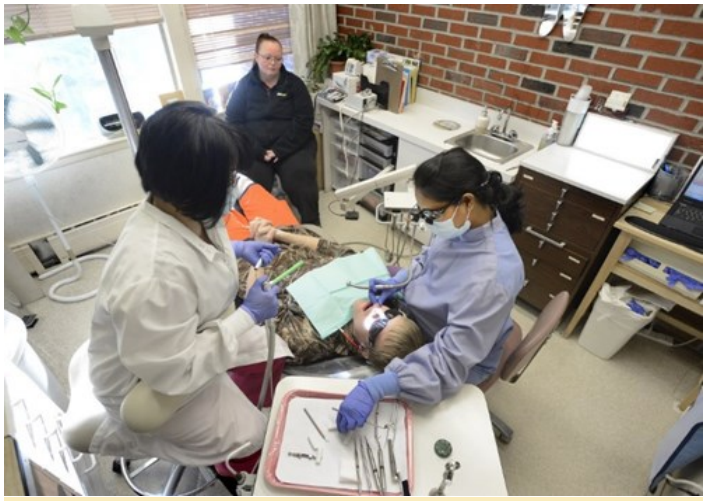
Snapshot Community Dental Maine

Location & Facilities	5 locations in Southern, Central and Western Maine (urban and rural) with a total of 35 operatories, open 5 days a week, 8:00 a.m. to 4:30 p.m.
Providers & Staff	• 70 employees including 13 dentists (mix of FT and PT), 3 AEGD dental residents, 13 dental hygienists, 16 dental assistants, and 2 EFDAs; administrative staff manage scheduling, front desk, finance, HR, and other management functions • Advanced Education in General Dentistry • Expanded function dental assistant
Patients	• 43,000 visits annually (5800 emergency visits) from 18,000 patients, aged 1–98 with 47% under 21 • 79% of all patients live at or below 150% of the federal poverty level; notably, 780 special needs patients received 4700 services
Services	Full suite of preventive and restorative services
Total Revenues	$6m annually
Patient Payments	For 2014, the patient visit payer mix was ~ 50% MaineCare, 27% sliding fee patients paying cash, 17% with private insurance and 6% paid through a State of Maine contract for adults with special needs

Transformation 1: Closing centers to enable sustainability

After running the numbers to determine if she could operate the centers at breakeven, Kavanaugh decided that the best course of action would be to close locations where the cost of renovation would have exceeded the cost of creating a new, high-quality center with the right economies of scale for financial viability. In 2006, CDM closed the Auburn dental center and relocated to Lewiston. They closed centers in Saco and Sanford in 2009 and transitioned patient care to a larger, eight-operatory state-of-the-art facility in Biddeford. Community Dental-Biddeford is located near Southern Maine Medical Center and other healthcare offices.

"I visited the Portland center and heard ten language interpreters, all working on the same day, across our eight operatories"



Community Dental Maine Portland Center

Community Dental-Biddeford

On the plus side, patient demand was strong, and at the beginning of the transformation, MaineCare still paid for oral health services for children, the disabled, and low-income childless adults. The Portland center in particular was very busy, with a full waiting room, high rates of chair utilization, and a diverse patient population. "Early in my CDM career, I visited the Portland center and heard ten language interpreters, all working on the same day, across our eight operatories," commented Ms. Kavanaugh.

Transformation 2: Investing in new centers

With the board's approval, Ms. Kavanaugh decided to seek financing for several new centers that would utilize electronic records, in the process creating a networked group of practices that could serve patients affordably through economies of scale. "Small centers with just a few chairs are not viable," Ms. Kavanaugh explained. "You need about six to eight operatories to create a thriving practice that can support the fixed cost infrastructure like rent, front desk staff, computers and dental equipment."

Another insight Ms. Kavanaugh had was to take advantage of financing with low interest rates. "Nonprofit organizations sometimes assume they need to pay cash as opposed to expanding with lower-cost debt financing. Businesses don't think like this; they recognize the power of inexpensive, conservative financing," she shared.

With patient demand strong and payments coming in from MaineCare, the numbers added up, and CDM invested in opening two new centers. The Rumford

Ms. Kavanaugh had another insight - to take advantage of financing with low interest rates. Nonprofit organizations sometimes assume they need to pay cash as opposed to expanding with lower-cost debt financing. Businesses recognize the power of inexpensive, conservative financing

Center (located in Western Maine) opened in February of 2008, and in December of 2009, the Saco and Sanford Centers closed and the Biddeford Center was opened, combining those patient bases into a new, larger facility. The new centers were created using innovative debt financing with low-cost loans in leased, not owned, premises. Ms. Kavanaugh convinced the owners of the Biddeford site to finance the refit of the site, allowing CDM to pay off the refit over the 15-year lease. Both parties were equally committed to the success of the new center.

A critical element of the investment into redesigning the many centers was to overhaul the IT infrastructure. "IT is critical. It enables us to track and improve quality and operate across the centers for economies of scale with a single patient electronic record and a scheduling system (for staff and patients) that is shared by all five centers," said Ms. Kavanaugh.

CDM created centers where all patients would want to receive care. To ensure that the centers stayed busy, CDM created partnerships with social programs that served low-income populations. Eligible patients pay fees for service according to an income-based sliding fee scale. Limited patient assistance funds are utilized for individuals with no means to pay for necessary oral health services. To ensure that patients have a stake in their own health, these patients are asked to contribute what they are able toward the cost of the care provided. CDM also became a preferred provider for most dental insurance plans, with the goal of a good mix of publicly and privately insured patients (at lower and higher fee rates), for stronger financial viability. While the payer mix has changed over time because some of the

"IT is critical. It enables us to track and improve quality and operate across the centers for economies of scale with a single patient electronic record and a scheduling system"

population were removed from MaineCare programs, currently, CDM's patient mix is 27% self-pay, 50% MaineCare and 17% private insurance (the remaining 6% is from fees paid by the state for special needs patients).

Transformation 3: Finding co-champions who are passionate about quality care

The next wave of transformation came in the form of Dr. James Schmidt and Ms. Susan Isenman, who become champions alongside Ms. Kavanaugh.

Dr. Schmidt was the recently retired chief of dentistry of the Togus VA Medical Center in Augusta, Maine, after 33 years of service to veterans. Ms. Kavanaugh and some of the board members knew Dr. Schmidt and recruited him to be the chief dental officer for CDM. "We couldn't afford Jim, but he graciously accepted a position one day a week and was central to our transformation to provide top-notch quality care," said Ms. Kavanaugh.

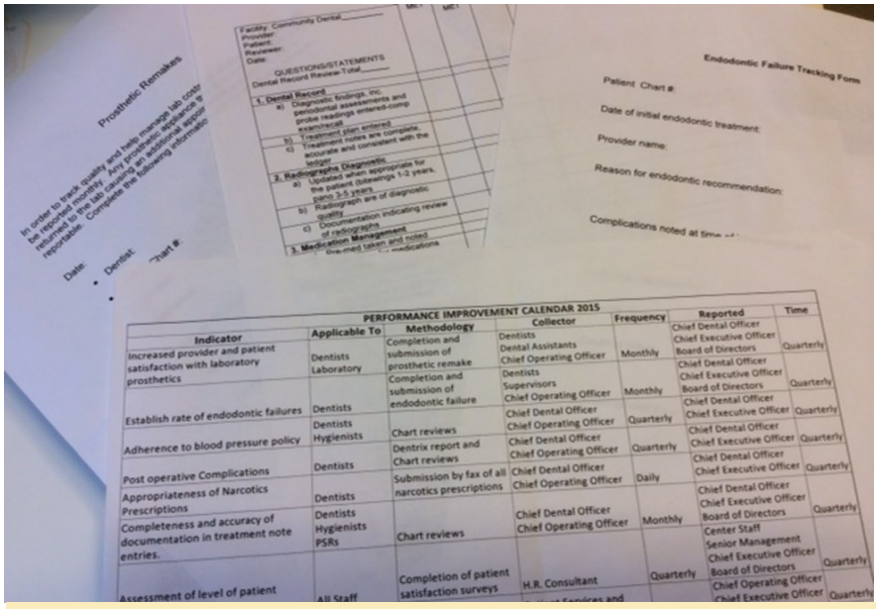
"This is our performance improvement calendar. We track many things: provider and patient satisfaction with laboratory prosthetics, adherence to blood pressure policy, appropriateness of narcotics prescriptions, completeness and accuracy of documentation in treatment entries"

Susan Isenman was a dental hygienist who reached out to Lisa Kavanaugh to express her interest in the CDM centers and programs. Said Ms. Kavanaugh, "We certainly didn't have a position open, nor the money to hire Susan, but the moment we met, I knew that I'd do just about anything to bring her on board. Susan and I complement each other. She is very analytical, with a big heart that translates numbers into quality care measures and patient-focused care. The only way to hire her as our clinical administrator was to ask her to go back to her dental hygiene skills and work as a provider, along with working on the management side. She provided chair-side care for about one day a week for several months and then we were able to transition her to a management position that she was hired for."

Working chair-side also gave Ms. Isenman a unique view of how the center operated and the challenges faced by the providers.

With Dr. Schmidt working one day a week, and partnering with Ms. Isenman and Ms. Kavanaugh, they implemented several solutions to track and improve the clinical quality and productivity of the centers. "We each bring our backgrounds from working in hospitals and care centers that focus on performance improvement and meeting or exceeding accreditation standards, so our different skills complement each other," said Ms. Isenman.

To illustrate, the team implemented a policy that each visit (for patients aged three years or older) would include a blood pressure reading. Providers were provided information on this policy for all patient visits. Within a year, blood pressure testing went from 46% to 99%. "Providers have a healthy competitive drive and desire to provide the highest-quality care. And no one wants to be the outlier or at the bottom of the list," shared Ms. Isenman.



Performance Improvement Calendar and tools

Ms. Isenman is now the COO of CDM and is passionate about enhancing the quality of patient care through measurement and improvement programs. She pulled out a sheet of paper and explained, "This is our performance improvement calendar. We track many things: provider and patient satisfaction with laboratory, prosthetics, adherence to blood pressure policy, appropriateness of narcotics prescriptions, completeness and accuracy of documentation in treatment entries. We have ten reports; all are quarterly and are presented to the board, except for the 'achievement of minimum production standard'—that's monthly and goes to our CEO, chief dental officer, and all clinical providers.

"Our early results are very good, but we need to track this and hold ourselves to a high standard"

With these measures in place, everyone on the team, in all dental centers, knows how they are doing and where and how they might improve."

Dr. Schmidt conducts peer reviews with the dental providers and now "officially" works two days a week. He is in constant contact with the provider team by email, phone, text, and fax. He discusses different quality assurance programs: "Let's take root canals. We need to ensure that we are doing quality work that lasts. A root canal for an infected or broken tooth sometimes will need a crown… So by the time we are done and the patient has invested time and money, often two thousand dollars (and in private practice, this might be thirty-five hundred dollars or more), it should be a high-quality outcome and last five years. We track our success rate. We know nationally it's

Dr. James Schmidt, Chief Dental Officer, CDM

"After dental school, I served in the Navy for two years and then returned to Maine and set up a private practice. I loved the dentistry but not managing the business side of the practice. I also realized how much I liked being part of a large team, and how I love teaching and collaborating with other professionals. I joined the VA program in Togus [Maine], and there I taught and practiced dentistry, becoming their chief of dental services.

I retired early at 64 and when Lisa contacted me and suggested I work one day a week with students, residents, and young dentists, this appealed to me. I thought I could use my experience with quality programs and apply it to CDM. And I really enjoy it; I can offer real value based on my experience. I love working with our providers across the many centers…I drove seven thousand miles last year spending time in each of the centers. We have some challenging cases, and we have a great group of providers. I'm very proud of our quality work and how CDM as a whole is embracing our quality assurance programs.

Our board is pretty special. Other boards sometimes use meeting time only to tell us what they are doing, but CDM board meetings are different. We debate options available to CDM. At recent meetings, we considered an option to acquire a new practice in Central Maine; they approached us about being part of CDM, and we looked at their care, providers, and the financials behind this. We've also weighed in on how to make our new partnership with MaineMed work for all of us, bringing our different backgrounds to bear. We look at the strategy and consider risks to CDM, and more recently, we had several board members really own a fundraising effort. We are passionate about CDM.

My advice for others setting up a not-for-profit model: make sure you create a large enough practice to ensure there are at least two or more dentists for collaboration and to ensure economies of scale to make it work financially. Hire providers and staff who have a passion for serving your patients and set it up for quality care. Make sure you create a diversified board and really tap into their experience. **I think my advice is to just do it."**

around eighty-eight to ninety-two percent, so we hope to have a similar or better rate and if not, we need to understand the reasons for our results. We are also looking at unexpected events after oral surgery, for example extractions. If patients return due to unexpected pain, swelling or need resuturing, we need to know why. So we are tracking these details and analyzing these unexpected events to find the patterns that might relate to our providers, our processes, or our patients. Our early results are very good, but we need to track this and hold ourselves to a high standard."

John Welsh, board chair, commented: "A major element of the transformation was to invest in IT to make us efficient but even more so to provide us with the tools to improve by tracking and analyzing our care. I have a lot of pride in our process improvements. We have an incredible commitment to doing it right, and I think this separates us from other practices. Private practices are not as used to or comfortable with being measured. We are willing to be scrutinized and show our results externally."

Transformation 4: Building a team of providers

Having a high-quality, well-functioning team of providers is critical to the success of CDM. They shared their seven-part comprehensive plan for building a cohesive provider team:

1. **Build a team of providers that includes dentists, hygienists, dental assistants, and expanded function dental auxiliaries (EFDAs)** who can work together and across the different centers.
2. **Strive to have a deep bench of dental staff** (DDS, DMD) that includes residents, new graduates, and highly experienced dentists to foster two-way sharing of the latest techniques and the tried-and-true methods in formal programs and informal one-on-one teaching moments with residents and patients.
3. **Invest in providers** by offering them opportunities to further develop their skills at CDM's expense, such as offering dental assistants a fully paid education to become EFDAs with a contractual agreement where CDM invests and the providers agree to stay at CDM for at least two years after the education program is completed.
4. **Create partnerships with dental schools** to educate a range of oral health providers and extend CDM's ability to provide patient care. In the early days, CDM had partnerships with A.T. Still University's Arizona School of Oral Health and with Tufts School of Dental Medicine for their

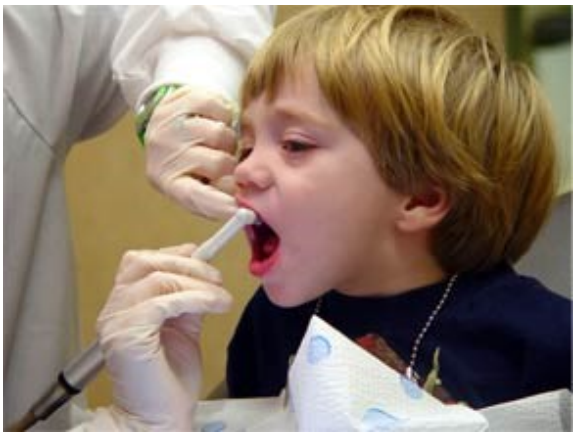
Rumford Center - Nitrous Oxide - Dorine Wright, RDH and Dr. Mohammed

fourth-year dental students. They now have a partnership with Maine Medical Center and Tufts for dental residents, extending their ability to provide care by offering education and by not having to pay the salaries of these residents. CDM had a partnership with the University of New England for dental hygiene students to gain supervised experience and has an agreement with the University of Maine at Augusta to provide clinical rotations for students enrolled in their Certified Dental Assisting program. The clinical rotation for dental assistants is a triple win: dental assistants get a good education and CDM extends their ability to provide care and leverages these programs to recruit and retain hard-to-find dental assistants.

Community Dental Biddeford with Janet Chapais, Center Supervisor, Cassie, a UMA Dental Assistant and Dr. Laura Fishburn

5. **Create an excellent working environment** that attracts top providers, including quality facilities, team-based care, and good benefits.
6. **Recruit creatively.** Work with universities and online services to attract the right providers and staff.
7. **Ensure that all team members** (providers and staff) **are cross-trained** and able to "wear multiple hats."

Dr. Laura Fishburn shared her insights about working at CDM. "I walked in here shortly after I graduated, and knew I wanted to join CDM. I love the environment. I work with a great team of dentists, hygienists, and dental assistants. Not every practice has embraced EFDA, but I think it's the way to provide great care. I enjoy teaching my EFDA colleague additional skills, and I appreciate how much extra care we can provide as we work together. It takes a lot of trust."



Community Dental

Transformation 5: Further integrating with the mainstream healthcare system (now underway)

While the CDM team had success transforming the smaller more rural centers, the Portland center continues to operate in cramped conditions with a heavy patient load; it is the largest, busiest, and now the least modern of all the centers. Ms. Kavanaugh explained, "We need more space and we need to upgrade our facility. Simply installing new equipment will not solve the capacity challenge. We needed to rethink our Portland strategy, and we [the board and executive team] challenged ourselves to consider the ideal location, size, and center design. We knew we also wanted to create new ways to integrate oral healthcare to mainstream healthcare for overall better health."

We wanted to create new ways to integrate oral healthcare to mainstream healthcare for overall better health."

While CDM was busy reinventing itself, healthcare on a wider scale was reforming and changing the way medical providers delivered and were paid for care. Hospitals are now healthcare systems that employ primary care physicians and are compensated based on the quality they deliver and the savings they achieve through accountable care organizations (ACOs). ACOs are a key element of the Affordable Care Act's drive toward a "whole health" approach for delivering better patient outcomes and lower costs. Healthcare systems now have a new incentive to consider how to integrate oral health into their patient care. To illustrate, providing good oral healthcare to a patient with diabetes can improve the overall health of the patient and potentially save the whole system approximately $3,200

Our plan is to co-locate and integrate with Maine Medical Center, a six-hundred-thirty-seven bed teaching hospital in Portland. A partnership offers each of us attractive elements. We would get a large and well-located space for a new facility. We can refer patients to each other's facilities and providers. From MaineMed's point of view, they will likely see healthcare improvements in their diabetic and other populations that will accrue to their ACO.

Farmington pregnant patient with Dr. Singh and Barbie Brann, Assistant

annually. Similar figures exist for patients with heart and other conditions, based on current research.

Against this backdrop, Ms. Kavanaugh explained the plans to integrate CDM with the Maine healthcare system: "Our plan is to co-locate and integrate with Maine Medical Center, a six-hundred-thirty-seven-bed teaching hospital in Portland. A partnership offers each of us attractive elements. We would get a large and well-located space for a new facility. We can refer patients to each other's facilities and providers. From MaineMed's point of view, they will likely see healthcare improvements in their diabetic and other populations that will accrue to their ACO.

"Being affiliated with a health system is very important to our strategy," said John Welsh, board chair

While we don't know the precise financial arrangements, we appreciate that each of our organizations can help each other meet the care needs of our populations and hopefully other business goals."

The Maine Medical Center was a key facilitator of CDM's relationship with Tufts University School of Dental Medicine, where the three parties came together to establish an Advanced Education in General Dentistry (AEGD) residency program in Maine in 2014. And with the recent successful Commission on Dental Accreditation (CODA) assessment of their dental education program in April 2015, CDM is well positioned to be a strong partner with Maine Medical and Tufts. Adds Dr. Schmidt, "This partnership with Tufts and MaineMed will make us stronger, and will help us be even better providers".

It's fair to say that CDM has had strong partnerships with the local medical and dental communities where their centers are located. "Being affiliated with a health system is very important to our strategy," said John Welsh, board chair. "We have several dental centers on or near hospital campuses. We connect to and engage the medical community on oral health and provide them with continued education on the critical role of good oral health."

Case Study -Dr. Walawender, AEGD Director and Dr. Flavell, AEGD Resident

Accountable Care Organizations

An ACO is a healthcare payment and delivery model that ties provider reimbursements to quality metrics and reductions in the total cost of care for an assigned patient population. Under Medicare's traditional fee-for-service payment model, doctors and hospitals are generally paid for each test and procedure performed. According to experts, this approach drives up costs by rewarding providers for doing more even when it may not be warranted. ACOs don't eliminate fee for service, but they do incentivize providers to be more efficient by offering bonuses when they keep costs down. Providers have to meet specific quality benchmarks with a focus on prevention and prudent management of patients with chronic diseases. In other words, providers can earn more by keeping their patients healthy and out of the hospital.

Dr. Peter Bates, Senior Vice President, Medical and Academic Affairs, Chief Medical Officer and Academic Dean for the Maine Medical Center - Tufts University School of Medicine Medical School Program, was delighted with the program.

"We are finishing our first year of the residency program, and this was the core reason that brought us together with Community Dental. We now have several well-trained graduates that will stay in Maine, and this was one of the key goals for this program," he said. "Both parties are looking to expand the program with more residents; it's right for the students, the patients, and long-term, our state to have highly qualified providers."

"I see us working together even more closely. I walked into the [CDM] practice and immediately I felt their commitment to the patient. Everyone says it about patient first, but here you really feel it. They care about their patients. The dentists are highly qualified and selfless individuals. This is their mission, and it's infectious. I was impressed."

"I see us working together even more closely. I walked into the [CDM] practice and immediately I felt their commitment to the patient. Everyone says it's about patient first, but here you really feel it. They care about their patients."

CDM and Maine Medical are exploring several options to extend their partnership including either locating a CDM center on the MaineMed campus or creating a joint tenancy arrangement. "Sadly, the number one reason for emergency room visits by our MaineCare [Medicaid population] is dental emergencies, so co-locating would make sense. We could create the right care plans for patients and ensure the right medical and dental care is provided," commented Dr. Bates.

Both parties acknowledged that they are at the visioning stage, exploring ways to integrate and incorporate dental care into ACO models (Medicaid, Medicare, and commercial plans), and they both agree that while it's complex to work through the payments, it's worth the effort. "Honestly, no matter the payment model, if we can reduce emergency use by our Medicaid population, it's a huge win for the patients and for all of us….We're all very interested in that."

Maine Medical Center, located in Portland, expands Services and Facilities

Economic strategy built on partnerships and careful expense management

Today CDM has five centers, generating approximately $6 million in revenues from a mix of adult and pediatric patients and some grants.

Core to CDM's economic strategy is to ensure a steady stream of patients by proactively creating partnerships. One partnership is with Portland Community Health Center (PCHC), a federally qualified health center, which enables multiple points of access for PCHC's patients to oral health services. CDM and PCHC have established a "connection process" to ensure that homeless individuals have access to urgent oral healthcare with a bus fare voucher and confirmed appointment time.

When the oral health treatment is finished, the CDM providers "close the loop" and provide treatment notes back to PCHC via secure fax transmission for inclusion in the patient's medical record.

The partnership with the Cumberland County Head Start and WIC (Women, Infants, and Children) program involves providing oral health education, dental exams, preventive care, and help in creating a dental home for students and their families.

Community Dental on YouTube

Kathy Gregory

Patient Services & Community Programs Manager

Kathy Gregory showed us around the Farmington Dental Center, located on the campus of Maine Medical's Franklin Memorial Hospital. The center felt immediately familiar—it had the same layout and design as the other centers from the floor tiles to the operatory equipment.

"Right now Tina is at the front desk; she is also a dental assistant, and some shifts, she is chair-side and some she's greeting patients and managing the schedule. While Tina is in Farmington today, she could be working in Lewiston tomorrow. Each center has the same setup and layout, so it's easy for the staff to work across the centers. We personalize it with artwork from the local area, but the flow of the offices is the same."

"We love being on the hospital campus, not just for the atmosphere but also it provides so many opportunities to create partnerships," commented Ms. Gregory. Ms. Isenman chimed in, "Kathy is the queen of partnerships. She can get people to work together and find common ground and shared goals."

Another aspect of financial management is to work closely with the state on programs for safety net populations and help state legislators and leaders understand the true cost of providing oral healthcare. "We were very disappointed that the state did not expand Medicaid and also removed low-income childless adults from MaineCare. However I was one of the people that spoke out recently against providing an adult oral healthcare benefit; the payment rate the state was offering to providers was too low. If we accepted the low rate, we would not be financially viable. And we are the low-cost provider," said Ms. Kavanaugh.

work closely with the state on programs for safety net populations and help state legislators and leaders understand the true cost of providing oral healthcare

Jeff Walawender, DDS

CDM manages expenses very tightly. They developed a template for the construction of new centers that includes facility design and construction, type of cabinetry installed, dental equipment, and a formulary for dental supplies to be utilized.

By using the same cabinetry, equipment, and materials, providers can easily work across centers and deliver consistent care. It also provides for economies of scale when purchasing equipment and supplies.

CDM Revenue and Expenses 2014

REVENUE		EXPENSES	
Maine Department of Human ServicesMaineCare)	$1,821,609	Salaries and Fringe Benefits	$4,117,654
Contractual Services	$928,424	Dental Supplies, Lab Fees and Misc. Expenses	$605,852
Client Fees	$2,166,422	Professional Services	$181,335
United Way	$180,840	Rent and Insurance	$341,677
Private Source Grants and Other Revenue	$678,483	Support Expenses	$238,998
Government Grants	$219,874	Utilities, Repairs and Maintenance	$189,865
Capital Campaign/Fundraising	$51,477	Depreciation	$176,819
TOTAL UNRESTRICTED REVENUE	**$6,047,129**	**TOTAL EXPENSES**	**$5,852,200**

Economics are challenging for CDM, but by employing several strategies to manage within their tight budget, they have achieved financial sustainability:

1. Ensure that chairs and providers are constantly busy with high utilization through partnerships for patients and strong front desk operations with efficient scheduling. As with most practices, broken appointments are a challenge. Scheduling templates (e.g., grouping similar appointments at the same time each day) are employed, and the practice is currently piloting the use of patient engagement software in some of the centers to determine the viability of its use organization-wide. All clinical staff work to coordinate walk-in emergency patients.
2. Create dental centers that all patients are delighted to use, enabling a mix of self-pay and publicly and privately insured patients
3. Create a team of providers to fully utilize dental assistants, expanded function dental auxiliaries, dental hygienists, hygienist students, dental residents, and dentists. Complement the providers with staff who function well in many different roles.
4. Track and manage provider productivity alongside quality measures and patient and provider satisfaction rates.
5. Manage construction and supply costs with a formulary (a single design and a set of selected supplies to be used) to ensure cost-effective operations and purchasing across five centers.
6. Fund expansion with low-cost debt financing and innovative leasing arrangements such as the property owner's agreeing to finance a center fit-out, with payments spread across the 15-year lease term.
7. Invest management time in writing grant proposals for specific programs and equipment to augment operations funds.

Kathy Gregory providing oral health education to 2nd graders

An engaged and diversified board guides CDM

Community Dental is guided by a board of directors who are committed to the mission of the organization and engaged with CDM's strategy. Kavanaugh and the board work to ensure a diversity of skills and community representation. John Welsh, board chair, notes, "We come with a range of professional experience: dentistry, hospital management, finance, advertising, HR, legal, and dental insurance." All directors serve on a board committee. "We are an active board," observes Dr. James Schmidt. "We spend considerable time and effort debating appropriate expansion, critical new partnerships, opportunities, and threats to CDM."

Keeping the board engaged, fresh, and diversified has been part of CDM's success.

Keeping the board engaged, fresh, and diversified has been part of CDM's success. Five directors have served for over ten years, and several are newer to the board. New members were recruited to provide guidance on human resources, legal issues, banking, and marketing and to increase the geographical representation. As the organization became more professionally managed, two key board members opted to resign, sensing their efforts had been well utilized and that it was time for them to pursue other interests and for the board to recruit new talented, committed members.

"Our board is effective, and we work hard to use their time well," shared John Welsh. "Each board member is really dedicated to the mission of CDM. It's not about prestige, and not something expected by their employer; they are each very committed to our patient population. If I was asked to provide advice…I would make sure the board has a diversified skill set, is personally engaged on the mission, and willing to debate the issues. We don't have dissension, but we have healthy debate, and it's critical for a leadership team (the board chair, CEO, and management) to ensure that meetings enable this interaction."

In 2010, CDM hired a consultant to engage all CDM board members in an active discussion to set the CDM vision. This vision still guides Community Dental today. In 2014, the CDM team was again engaged with the vision and reflected on the successes achieved and the work yet to be done.

"…we have healthy debate, and it's critical for a leadership team (the board chair, CEO, and management) to ensure that meetings enable this interaction."

Future transformation:
Develop marketing and fundraising skills for ongoing expansion

The board and executive team have lofty goals for fundraising to ensure a strong capital base for CDM's expansion plan. John Welsh observed, “Fundraising is a new focus for us. CDM is good at grant writing but not as experienced with fundraising. It’s challenging as we are spread out across many different communities in Maine, so we need to do local fundraising, as we did in Rumford, to generate funds for a specific center and to ensure strong local dental and medical community relationships, and we need to do fundraising across our communities for our major expansion plans.”

Fundraising is a new focus for us. CDM is good at grant writing but not as experienced with fundraising. It’s challenging as we are spread out across many different communities in Maine, so we need to do local fundraising

Portland is a key element of the CDM plan and is the “flagship” of CDM given the tremendous need in Maine’s largest city. "We need about one point six million for the new Portland center, which is targeted to have twelve operatories, and we aim to have five hundred thousand dollars of this budget in cash. We're not looking to overextend the organization's borrowing capacity, but we are keen to move forward quickly and are seeking low-cost financing for about one point one million," said Ms. Kavanaugh.

The $500,000 will come from grants and fundraising. Recently, CDM held a murder mystery fundraiser dinner and auction. "The board took the lead, made it a reality, and truly owned this event, creating something special. I invited my neighbors, and they made a substantial donation," commented Dr. Jeff Walawender. "We raised about $22,500," said Ms. Isenman, but, "equally importantly, we have begun to create relationships with donors in the community."

“...and we need to do fundraising across our communities for our major expansion plans.”

Lessons learned

1. Find several champions with a broad set of dental, financial, management, and organizational skills.
2. Engage a diversified, strong board and leverage their skills.
3. Create and leverage a team of many high-quality providers.
4. Track quality of care metrics and constantly strive for improvement.
5. Work with major healthcare players who view oral health as part of whole health.
6. Understand that dental centers need scale and consistency for care delivery and financial viability.
7. Use modest borrowing to carefully expand operations.
8. Advocate at the state and local levels

Community Dental

About the Washington Dental Service Foundation

Washington Dental Service Foundation is a non-profit funded by Delta Dental of Washington, the leading dental benefits company in Washington. The Foundation's mission is to prevent oral disease and improve the oral and overall health. The Foundation works with partners to develop innovative programs and policies that create permanent change, leading to improved oral health for all. For more information, visit: www.deltadentalwa.com/foundation.

About the Authors

Martin Lieberman

Martin Lieberman served as Chief Dental Officer at Neighborcare Health in Seattle, Washington from 2002 to 2013. Prior to his community health center work, he worked in private practice in Chicago for 18 years. Dr. Lieberman led a culture change in the way Neighborcare Health's dental program viewed process improvement and quality and has served as faculty member for the HRSA Oral Health Pilot Collaborative, and has also been a faculty member for IHI, HRSA, NNOHA and Dentaquest quality improvement projects. Dr. Lieberman serves on the Board of Directors for NNOHA and chairs the Practice Management Committee. In January 2014, Dr. Lieberman assumed the role of Associate Director of Graduate Dental Education at NYU Lutheran Medical Center in Brooklyn, New York.

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MaryKate Scott

MaryKate Scott is a healthcare economist and business management consultant with experience at McKinsey & Company, Procter & Gamble, and several academic appointments. She works with healthcare leaders in health systems, pharmaceutical and medical device firms, payers, and philanthropic organizations. Focusing at the nexus of health care, business and technology, Mary Kate's work focuses on strategy development, mergers and acquisitions, product launches, competitor response, market shaping campaigns, and economic modeling.

Her oral health work includes supporting The Pew Charitable Trust Children's Dental Campaigns including the ***It Takes a Team*** report and calculator. She has also authored: **IOM: Oral Health Access** (Chapter); **Retail Dental Clinics – a viable model for the underserved**; **The Good Practice: Treating Underserved Dental Patients While Staying Afloat**; and complied **The Oral Health Care Innovation Compendium** for The California HealthCare Foundation. She provided business strategy support for the **Alaska Native Tribal Health Consortium: Dental Health Aide Therapist (DHAT) Program**. She is presenting at NNOHA (2015) **An Economic Model to determine impact of adding a Dental Therapist to a FQHC Dental Clinic**.

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Community Dental Care:

Quality Dental Care and Preventive Education for all

June 2015

Community Dental Care:

Defying the Skeptics; Serving the Needy

"Fifteen dentists and many more bankers told me I'd go bankrupt as a dentist," Dr. Vacharee Peterson recalls from the early days of her practice. "Even the person I hired to make our first sign told me he was wasting his time making it." It was unheard of at the time for an immigrant woman to become a dentist in Minnesota. Dr. Peterson persisted through all the negativity that she faced, citing her faith in God and in herself. "My principle was to serve God, not people who discouraged me," she says.

Thirty-three years later, she leads Community Dental Care (CDC) in the Minneapolis/St. Paul metro area, a thriving practice with four locations.

"… a thriving practice with four locations. In 2014, CDC served 37,500 patients, experienced 85,000 patient visits (111,000 patient encounters), and generated generated 15 million in revenues…"

In 2014, CDC served 37,500 patients, experienced 85,000 patient visits (111,000 patient encounters), and generated ~$15 million in revenues ($19 million in dental service value). They currently employ 215 staff (including 34 dentists) who speak 21 languages. And all of this through a not-for-profit dental practice structure that focuses on education and prevention. So much for the naysayers.

Services provided

CDC provides a full range of services, including prevention, restorative, and complex care. On an average day, they treat 330 patients and 40 emergencies across four clinics.

Services include:

- **Preventive care (exams, x-rays, teeth cleaning, and fluoride treatment)**
- **Emergency care**
- **Fillings**
- **Root canal treatment**
- **Extractions**
- **Implants**
- **Crowns and bridges**
- **Partial and full dentures**
- **Minor orthodontic procedures**

COMMUNITY DENTAL CARE

[1] One patient may be seen by both a hygienist and a dentist during one visit. This would equal two patient encounters.

Snapshot of Community Dental Care Minnesota

Location & Facilities	• 4 locations, including Minneapolis and Rochester. Within two years, expansion at these two locations will add an additional 16 operatories in Rochester and 9 in Minneapolis. • Currently: 4 locations with a total 49 operatories, open 6 days a week, 14 hours per day Monday–Thursday, 7:30 AM–9:30 PM; Friday, 7:30 AM–5:00 PM; and Saturday, 8:00 AM–1:00 PM
Providers & Staff	• 215 employees (175 full-time, 40 part-time)-including 34 dentists (23 FT and 11 PT), 27 dental hygienists, and 66 dental assistants—who collectively speak 21 languages; 63% are of an ethnic minority • 81 administrative staff manage scheduling, appointments, finance, HR, and other non-clinical functions
Patients	85,000 visits annually from 37,500 patients, primarily low-income and immigrant populations; 46% children, 54% adults
Services	Full suite of preventive and restorative services
Total Revenues	~$15m annually
Patient Payments	83% Medicaid beneficiary payments, 7% uninsured, and 9% commercial insurance.

Beginnings

CDC's beginnings were humble, but they were busy from the start. Dr. Peterson's dream of serving low-income and minority dental patients took shape when she found a local orthodontist with a three-operatory practice that was open three days a week. He offered her a room that would house a single chair. A banker then offered her a $23,000 loan for the chair to create her own private practice in the space. She was quickly busy with patients and able to help this orthodontist pay his rent.

Dr. Peterson served a predominantly immigrant population, most of whom were on public program insurance. Within two years, she moved to a new space, expanded to three operatories, and offered space to the very orthodontist who had taken her in: He was now helping to pay her rent.

The 6,400-square-foot space was a shared tenancy: Dr. Peterson's dental practice and a grocery store that served immigrants. The location was ideal because it allowed her room for gradual expansion along with a steady stream of traffic past her doors for a simple but effective marketing campaign. Potential patients found Dr. Peterson very easily.

She expanded six times, adding operatories every few years until the grocery store moved and the entire space was turned into a single tenancy of her practice featuring 16 operatories.

A growing private practice

To meet demand, the practice hired five more associate dentists. And, in a move that was vital to the private practice's solvency and stability, Dr. Peterson's husband Andrew, an Air Force-trained dentist, joined the practice. He focused on the business side, managing collections through Minnesota's Department of Human Services (DHS) for the many patients who received medical assistance.

Says Dr. Peterson, "My willingness to take the Minnesota medical assistance patients and my ability to connect with immigrants brought me patients. But it was my husband who reformed the business side of the practice to ensure we kept the doors open and lights on. He was responsible for adapting or creating innovative operational and administrative systems to increase cost-effectiveness and productivity, including developing dental software that simplified the electronic submission of claims to the state."

Creating long-term plans

After 22 successful years in private practice, Dr. Peterson considered how to ensure the perpetuity of her clinic, which treated so many underserved, working-poor, loyal patients in the immigrant and other socio-economically disadvantaged communities. She says, "My associates were interested in buying our clinic. It was established and busy, and selling to associates is the traditional path many dentists take. But we realized that the associates could transform the practice and while they might take some of our needy patients, they could also shift to a more profitable practice serving mainly patients with insurance."

Exploring options to continue care

The question "How can we ensure that our practice will exist long after we retire and continue serving our community?" kept Dr. Peterson awake at night.

Her first idea was to allow CDC to be purchased by Apple Tree Dental, a not-for-profit dental practice. Apple Tree is a large, successful 501(c)3 that operates dental clinics in Minnesota, but it would have been a large purchase and at the time, it was not the right financial move for them. However, Apple Tree, with its size and success, was a source of inspiration for Dr. Peterson and later proved to be a valuable partner.

Dr. Peterson's second idea was to approach the IRS with the view to becoming a not-for-profit (NFP) practice. It took nine months for the IRS to respond and initiate a long investigation into why Dr. Peterson wanted this transition. "It took hours of questioning," she says. "They couldn't decide if I was an angel or a crook trying to avoid taxes."

One IRS attorney provided a crucial piece of advice. He recommended making an incremental transition to nonprofit status: create a 501(c)3 and operate the private practice as nonprofit for two days a week while continuing to operate the core practice four days a week as a private, for-profit enterprise. This strategy allowed the not-for-profit practice to demonstrate its viability.

The NFP model proved viable

The not-for-profit practice proved financially viable because the State of Minnesota paid higher reimbursement rates to NFP practices that qualified under the Critical Access Dental Payment Program (CADPP). Minnesota provides two price lifts with CADPP participation: they offer an additional 20% on the Medicaid rate for services because Community Dental Care is a community clinic and an additional 35% for providing care under critical access rules. To illustrate: a for-profit practice could earn $1.00 (commercial rate) on a procedure, or $0.27 for the same procedure if they billed it through Medicaid. CADPP rules allowed a not-for-profit practice to earn $0.27 (Medicaid rate) plus 20% for being a not-for-profit community clinic ($0.27 x 1.20 = $0.32 and an additional 35% for providing critical access ($0.32 x 1.35), for a total of $0.43 for the procedure. While the $0.43 is much less that the commercial rate of $1.00 and less what an FQHC (federally qualified health clinic) would be paid, it is enough to cover costs. CDC survives with tight financial controls and hard-working employees.

Operating as a 501(c)3 also offered CDC the opportunity to apply for foundation grants, something not available to a private practice. These grants enable new programs and services, some equipment purchases, and ongoing support.

Partnering with Apple Tree Dental

Transitioning to nonprofit status took a little over a year; in August 2004, CDC was granted its 501(c)3 determination letter. Throughout the process, Dr. Michael Helgeson, CEO of Apple Tree Dental, proved to be a valuable partner. CDC needed the higher rate that was paid to NFPs that were eligible under CADPP and that served Medicaid patients, but the Minnesota DHS could only provide this rate to an existing CADPP entity. The DHS created an exception for Dr. Peterson and allowed her to provide services and then bill for these services through Apple Tree, which then passed the funds to CDC. Explains Dr. Peterson, "The DHS needed us to care for these patients. They told us that CDC can be the sixtieth practice that patients call seeking care and that for many we are a last resort. The department really wanted us to be successful and helped us get our start. Mike Helgeson was a good friend to us and helped us in our early days to establish our clinic as a not-for-profit entity."

CDC can be the sixtieth practice that patients call seeking care and that for many we are a last resort

To qualify as a CADPP provider, dentists must meet certain criteria. Please see this link for current rules: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_147765http://www.dhs.state.mn.us/main/

Transition to NFP status

The practice was professionally valued in accordance with IRS rules, and over time, the not-for-profit practice earned money and bought the practice from Drs. Vacharee and Andrew Peterson. The practice then secured the CADPP status. Thus, "Community Dental Care" was created, and it is managed by a community board. The nine-person board carefully watches the finances and ensures full compliance with the IRS on all 501(c)3 rules.

It takes a team

If you ask Dr. Peterson about "her" practice, she gives you a puzzled look, smiles, and shakes her head.

"It's not my practice. It belongs to all of us and it's run by all of us," she says, gesturing to her three colleagues: Carolyn Bass (General Manager of the St. Paul location), Ann Copeland (Director of Programs), and Bonnie Seymour (General Manager of the Maplewood location). "We have been together since college. We have exchanged Christmas cards for the past thirty years. We attend the same church. It takes all of us to make this work," Dr. Peterson says. Carolyn Bass stresses the importance of collaboration and a team with a wide range of skills. "We respect each other and what we each bring to the team and CDC. It's a team effort—collectively we are good at dentistry, grants, software, business, operations, communication, human resources, and education programs," she says.

"If I were run over by a bus, our clinics will continue...we have a whole team focused on meeting patient needs and ensuring smooth operations."

- Dr. Vacharee Peterson

Providers are also organized in teams. The staffing schedule has each dentist routinely working with the same two dental assistants. Carolyn comments, "When the same people work together, they become familiar with each other's style and can function more efficiently. Also, a bond usually develops between the team, and this also creates an efficient flow with good communication. CDC can't always do this given the long hours and Saturday schedules but when we can, we do so."

Ann Copeland, Bonnie Seymour, Carolyn Bass and Dr Vacheree Peterson

Robbinsdale Office

Rochester Office

East St. Paul Office

Maplewood Office

The board of directors

The board has been with CDC for a long time, and they are a diverse group of nine talented, committed community leaders with backgrounds that include business, investment banking, dentistry, law, interior designer, and community activism. “Our board has been fantastic in guiding CDC into a very healthy direction. They have deep compassion for the patients we serve,” commented Dr. Peterson. She continued, “It’s important to recruit from the heart. Your board members need to believe in the mission and have compassion for the patients you serve.”

Board members have term limits, and when their terms are up, they refer colleagues who are able to provide strong guidance to CDC. Term limits enable recruiting because membership is finite, and they also enable the board to refresh its skills and talents as needed.

One way Dr. Peterson keeps the lines of communication open between managers and the board is by inviting the entire management team to attend all board meetings. "The team always knows what I think and what the board is thinking," she says.

Linda Kay Smith, a board member, talks about joining the CDC board

“I am a fairly new member of the board. I learned about the organization from a friend who serves on the board. My initial meeting with Dr. Vacharee Peterson drove my interest to join the board. The way she started CDC thirty-two years ago and led it to its present important position serving the community is impressive. Dental care is so important to the overall health of children. The role that Community Dental Care plays in the life of the underserved of our area is amazing. I continue to be impressed with the dedication of the staff and the other board members to assure maximum benefit to the community.

One of the reasons I was asked to join the board is to help CDC start a fundraising program with individual donors. They have been successful raising money from foundations but do not yet have an annual or major giving program. The board has traditionally not been involved with development, but we plan to change that by helping board members understand their role in helping the organization raise money from the community. One of the first steps is to approve a Culture of Philanthropy (currently in process) to have an overall guide for the new direction. We have a board retreat planned for September at which we will begin the process of involving board members with this program. I am confident that this will be successful.”

Recruiting and compensating providers

With the viability of the practice confirmed, Dr. Peterson and her team significantly expanded services and hired more associate dentists for their four locations.

Dr. Peterson explains the myriad factors that make CDC attractive to providers: "Some want to practice community dentistry and serve our population. Others appreciate our team-oriented practice model. Others enjoy the challenging dental cases our patients present, along with the education and experience we provide. And many of our providers appreciate that we provide good benefits and support them by considering their whole family situation, providing family-friendly working hours and offering other solutions to enable them to practice."

Dr. Peterson adds that providers don't have to trade off such dividends against compensation. "Our provider compensation is competitive with other nonprofit dental practices," she says. And CDC providers don't have quotas to meet. Their pay is tied to their production, but there is no set expectation of volume or procedures, and the free care they provide counts toward their production.

Currently, CDC employs 34 dentists, a mixture of experienced and young practitioners. "Some stay a long time, while some view us as a stepping stone to other things, like private practice or a different residency," says Dr. Peterson.

CDC Staff and providers

CDC's mission

- Provide access to quality care
- Hire from the community so the whole community wins through employment and education
- Deliver preventive education
- Treat people in a culturally sensitive manner
- Train people for ourselves and our community

Training the next generation

CDC has also carved out an important role for itself training up-and-coming dentists, hygienists, and dental assistants. "I like to hear that young dentists want to start a practice," Dr. Peterson says. "We will help them. We can help them become successful and refer them patients. We value being a provider of dentists, hygienists and dental assistants to our communities."

CDC has also carved out an important role for itself training up-and-coming dentists, hygienists, and dental assistants.

In 2014, CDC trained 131 dental hygiene students, 34 dental assistant students, and 61 nursing students from nine colleges and university programs. Students increase their knowledge and skills through hands-on clinical training and mentoring. They are trained to treat patients who are culturally diverse and have limited health literacy. Students learn to explain complex procedures simply. "We hire people from the community. It's important to raise the skill level and income of people in your community," says Dr. Peterson.

Funding for training comes from several grants and provides some relief for the additional expenses related to training (such as equipment and supplies), but it doesn't cover the cost of lost time in the chair, given the slower pace of providers who are in training. CDC estimates that they invest about $200,000 annually to provide this training, and grants do not cover all these costs.

CDC providers

Patient turned dentist

Aroone Vang was a patient at CDC when she was a child — now she is a CDC dentist.

Many CDC employees began as CDC pediatric patients. Says Dr. Vang, "I feel so fortunate to work at Community Dental Care. I've had the opportunity to hone my skills as a dentist and do so much quality dentistry in a short period of time. It is like dental boot camp where tough, sometimes seemingly impossible, tasks are put before you but the rewards are so amazing. With this experience under my belt, I'm ready for any dental clinical experience to come."

Finding the right role for volunteers

Unlike some not-for-profit dental clinics, CDC does not use many volunteer dentists. While the cost savings are appealing, integrating uneven volunteer schedules is difficult in a large practice that needs to be very efficient with time, given the low reimbursements from the state.

Carolyn Bass explains, "We appreciate the interest from prospective volunteer dentists, but it can be difficult to integrate very experienced part-time volunteers. We need to train them on the new procedures on infection control, new technology, the team-based approach we use, and this can be time-consuming. We remain interested in this option, but haven't yet worked out the details on how to make it work."

CDC does not use many volunteer dentists. While the cost savings are appealing, integrating uneven volunteer schedules is difficult in a large practice that needs to be very efficient with time, given the low reimbursements.

CDC does utilize volunteers who aren't dentists to help them deliver programs, including dental students from the University of Minnesota who help with equipment sterilization and volunteer at outreach events, such as the "Give Kids a Smile" event. Student nurses deliver nutrition education. "We hired a volunteer coordinator about a year ago to help us recruit and integrate these many volunteers," says Bonnie Seymour.

Further Expansion Underway

In 2012, several major foundations supported Community Dental Care in its expansion into Rochester. Six operatories were not enough, however, and with a six-month wait list for 2,500 patients, CDC has started plans for further expansion. CDC has just signed a purchase agreement for land and hopes to build and open a new dental clinic with 16-18 operatories by 2017.

An attempt to expand CDC

"One attitude that shapes us is not fearing expansion, as there are countless needy patients and so much that we can do to help them," says Dr. Peterson.

In 2007, a major space expansion opportunity presented itself when the local library in Ramsey County was put up for sale. Says Dr. Peterson, "I really thought we could offer a lot of patient care in this lovely building. However, our board cautioned that it would be risky to take on such large debt, and the bank would not agree to a loan to CDC. When we look at new locations, we consider the size, space available, the construction we would need to do to create private and semi-private operatories, along with cost, parking, and access to public transportation."

The board and the bankers' points of view were that the thick cement floors were not suitable for a dental practice and that the building was too big for CDC's needs. CDC passed on the opportunity. The building was first sold to a fitness group that later pulled out from the deal, and then to a medical group. Just before the medical group was due to move in and renovate, they too pulled out of the contract.

Persistence pays off

When the purchase of the other practice fell through, Dr. Peterson jumped at the chance to rekindle the deal. "I still wanted this building," she says. "It was a good size with 34,000 square feet and the right location for our patients. I prayed on how we might make this work. Then the county (who was selling the building) offered to be a tenant with a fifteen-year lease for half the building for their visiting nurses. CDC could not afford the down payment, so my husband and I decided to buy it by refinancing our house and putting everything we had into the down payment. The bank was willing to finance the purchase given the steady income from the county. After appropriate scrutiny and due diligence to be certain we were in full compliance with all regulations, Community Dental Care leased the space from us," shared

Dr. Peterson.

Community Dental Care renovated the building and now uses about half of the space; the visiting nurses have the entire lower level, and the Dental Therapist Training College, managed by Metropolitan State University, is another tenant.

Over the years, CDC has perfected a model for successfully managing expansion. They raise funds for the initial renovations and equipment for one or two operatories in a new location. Then they add equipment and staff for additional operatories as they obtain follow-on funding for them. Says Dr. Peterson, "This incremental buildout takes a little more time, but allows CDC to build our patient load and ensure production. In other words, we aren't sitting with empty operatories and staff with nothing to do. It also gives us time for marketing and staffing. Funders have seemed to like this as it shows we can be successful on a small scale before they invest additional funds."

The Maplewood expansion was the first exception to this rule: in 2008, CDC added 16 chairs at once, at a cost of $2 million. They raised funds from foundations and individual donors (~$300,000) and secured a loan for $1.7 million from a local bank. Current patients were diverted from a crowded St. Paul location (five miles away), and to attract new patients CDC placed advertisements announcing the clinic and their acceptance of public insurance. Within six months, this new location was very busy. CDC added another seven chairs in 2013.

CDC dental clinics include several types of operatories including private, semi-private and education rooms. The majority of operatories are semi-private due to both patient and provider preference and to ensure efficient use of space. The busy clinics all use certified electronic health record-keeping with Open Dental software that meets all mandatory Centers for Medicare and Medicaid Services requirements.

The Business Model

Economics are challenging for CDC in Minnesota, but a focus on high utilization of their space and equipment coupled with the higher rates paid for critical access providers and the community clinic add-on ensure viability.

CDC employs five strategies for financial success:

1. **Deliver strong operations:** ensure their operatories and providers are constantly busy with high utilization through double shifts; between the four dental clinics they operate 10-14 hours a day, five days a week; one of the dental clinics is open on Saturday for five hours. CDC tracks several productivity measures including total patients seen, total number of procedures provided, and productivity by provider, all to ensure that their valuable providers and space are thoughtfully utilized by leveraging their IT infrastructure certified electronic health record system.
2. **Ensure strong demand for clinic services:** The need for dental care is extremely high in the community, so CDC proactively manages at least 30–40 partnerships with hospitals, emergency departments, schools, other healthcare clinics, dental offices, and organizations that enable healthcare access for underserved populations.
3. **Work with the state's Medicaid program** to claim the highest fees allowable.
4. **Operate as a 501(c)3**, which allows CDC the opportunity to apply for foundation grants; they raise approximately $500,000 annually. These grants support community programs and services, some equipment purchases, clinic expansion, and ongoing operational support. CDC has built strong skills in grant writing and is able to leverage their data to demonstrate their impact to their funders. CDC has about 160 funders including foundations, corporations, community organizations, and many individual donors.
5. **Hire a highly competent team of dentists, dental assistants, and hygienists and train them well**. The dentists need to be willing to see the whole family, and CDC trains them to do so. CDC hires experienced preceptors to coach newly graduated dentists to empower them. Quality work is of paramount importance to CDC as an organization.

Thoughtful expansion also is a key business strategy for CDC.

1. **Initially, expansion is done slowly to make sure that the clinic will survive the expansion**. CDC will invest in two to three operatories and ensure that these operatories are fully utilized prior to adding additional capacity.
2. **Thoughtful financing for expansion enables long-term security and lower operating costs.** CDC has both leased and owned buildings and, when possible, prefers to buy the building as nonprofit organizations such as CDC do not pay property tax on owned buildings.

CDC is also exploring the use of dental school residents (Advanced Education in General Dentistry program participants) to further expand their ability to care for more patients.

Maintaining efficient operations is CDC's "secret sauce." There is a constant hum of busy providers and patients in the clinic. The walls are lined with dentists' licenses, patient photographs, and posters in four languages. Dental assistants click on the computerized schedule, which is color-coded for each type of room and provider, and the schedule is full. CDC operates the clinic 14 hours a day, with two shifts, maximizing the use of its facilities and equipment. Long hours help meet the needs of working people, many of whom are only able to come before or after work and students so they don't have to miss school.

The double shift also enables economies of scale. Approximately 85% of CDC's patients are served under the state's Medicaid program, which has the unfortunate distinction of paying one of the nation's lowest Medicaid rates: 27% of the usual and customary fees.

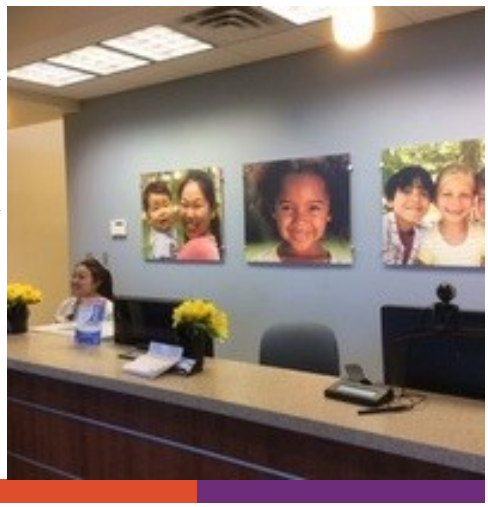
Keeping productivity high enables the practice to extend a helping hand to the truly needy. Says Carolyn Bass, "We don't turn anyone away. While most of our patients have public insurance, some don't but still need emergency care. In those situations we provide mini-grants, that is, free care. Most uninsured people pay the nominal $35 fee, while some people say 'I'll pay you when I get paid.' Most of those

patients come back to us on the day they get paid and pay their bill."

These mini-grants are funded by donations from private donors, foundations, and clinic revenue. In 2014, CDC provided $32,748 in free care for 500 patients, two-thirds of them children. CDC's charity care policy provides for dental care free of charge or at reduced rates based on a sliding fee scale related to the patient's income, household size, and federal poverty guidelines. Because the organization does not collect on qualified charity care, the costs of this type of care are not reported as revenue. The amounts of foregone charges, based on established rates, were approximately $783,000 and $536,000 for the years ending December 31, 2014 and 2013, respectively. CDC received grants and contributions of $13.590 and $8,241 to help subsidize the cost of providing these services for 2014 and 2013, respectively.

The patient schedule is carefully managed. CDC uses statistical measures to predict an average "show" rate for all patients for a given day, and they schedule two patients at once for each provider (and dental assistant team), with some gaps in the appointment schedule. The schedule has a mix of patients, with some complex and some simpler procedures. Unless there is a specific request, patients can be seen by different providers, with the treatment record enabling the provider team to ensure continuity of quality care. The combination of the scheduling gaps, some no-show appointments, emergency appointments (on average 8–12 appointments per day) and providers helping each other out, providers are kept busy.

No-show rates are a fact of life for all practices, including community dentistry. CDC's population has less dependable transportation, often greater child care needs, part-time work with varying schedules, and other lifestyle hurdles. CDC provides compassion along with reminders; after three broken appointments within two years, they advise the patient on their policy to no longer provide reserved appointment times. These patients are placed on a "wait list"; they choose the day to get on the wait list and show up at the clinic, and then they wait until there is a break in the schedule. After they keep their wait-list appointment (by coming in on the day they chose in advance) on three occasions, they can again reserve an appointment time.



Garnering support within the medical, dental, and broader communities

CDC keeps a steady stream of patients flowing by creating partnerships with other not-for-profit organizations, shelters, and hospitals. They partner and collaborate with a number of community organizations and medical and dental providers to increase access to oral health and preventive care for low-income populations. "Our goal is to be a strong partner and receive and provide patient referrals," said Dr. Peterson. CDC also creates partnerships to band together to advocate for increased dental care access and affordability for the underserved, and it is a member of several safety net collaborative groups. Finally, CDC is creating new partnerships to extend the children's prevention and education services with program-related partnerships. By participating on community task forces and committees to improve health access and oral health, the CDC team makes important connections with other healthcare providers that serve their communities, which stimulates further partnership.

...steady stream of patients flowing by creating partnerships with other not-for-profit organizations, shelters, and hospitals.

Finances

Finances in $000s	
Revenues	
Patient-related payments	$14,200
Grants and donations	$520
Other Revenues	$460
Total Revenues	**$15,180**
Expenses	
Provider salaries & benefits	$7,420
Interpreters	$70
Supplies	$900
Misc care expenses	$1070
Total care delivery expenses	$9,460
Management & hourly workers	$2,050
Professional fees	$350
Office supplies	$80
Rent, utilities, depreciation	$820
Total non-care expenses	$3,300
Other Business Expenses	$1040
Total Expenses	**$13,800**

Note: Surplus used for debt services, capital equipment, purchases, and modest staff bonuses.

Referral partners

Referral partners

- Twin Cities FQHCs
- Open Cities
- West Side Community Health Services
- Project Homeless Connect
- The Center for Victims of Torture
- Portico Healthnet
- Victim and domestic abuse agencies
- Public Health Service
- Union Gospel Mission
- Head Start
- St. John's and St. Joseph's hospitals in St. Paul and North Memorial Hospital in Robbinsdale.
- Olmsted Medical Center, Olmsted Public Health, Mayo Clinic
- Rochester WorkForce Center

Advocacy partners

- Minnesota Oral Health Coalition
- Hmong Healthcare Professionals Coalition
- Minnesota Healthcare Access Network
- The Refugee Health Task Force
- Olmsted County Children's Oral Health Task Force
- United Ways

Children's prevention and education partnerships

- Women, Infants, and Children program clinics
- Early Childhood Family Education centers
- Community health fairs
- English language learner classrooms
- 18 metro elementary schools
- Community Health Services Inc.
- Good Samaritan Clinic
- Rochester Community and Technical College's dental hygiene program

Interpreting services*

- Intercultural Mutual Assistance Association
- Surad Interpreting
- Itasca

* - According to CDC surveys, 70% of patients come via interpreter referrals; this is only a small sample of their interpretation providers

Shifting the focus to prevention

Dr. Peterson and other CDC providers were very concerned about the prevalence of oral health problems they treated and had a strong desire to shift their efforts from fixing decay to preventing it in the first place. In response, they created the Program to Improve Community Oral Health (PICOH) to focus on education and prevention. The education program is staffed by CDC providers. "It's sad that we are paid so much less, sometimes nothing, to prevent disease and paid more to fix the problem," says Dr. Peterson.

...they created the Program to Improve Community Oral Health (PICOH) to focus on education and prevention.

Dr. Peterson tells the story of a four-year-old girl from Burma who arrived at CDC with cavities in every tooth. A PICOH health educator worked with the girl's family to understand what was causing this and discovered that it was because she had been bottle-fed sugary fruit juices for extended periods.

Says Ann Copeland, Director of Programs, "We need to go beyond treating cavities and fix the source of the problem. That's not on the operatory side. It's here in our education room where we meet with parents and children together and understand their needs and lives. We have educators and interpreters to help us communicate in a multilingual, multicultural environment and create changes in our patients' daily lives." Ann passes over plastic baby bottles filled with sugar cubes and explains that parents are educated to understand how much sugar is in fruit juice. She picks up the toy alligator and shows how she has children brush the toy's teeth and then helps the child and parent with better brushing techniques. She pulls out an accordion folder with oral health information printed in 11 languages. "It's about understanding the source of the challenge and helping parents provide better care for their children; it's about stopping the decay before it starts."

"It's sad that we are paid so much less, sometimes nothing, to prevent disease and paid more to fix the problem."

Ann Copeland

Medicaid reimbursement does not allow billing for education sessions, and CDC's patients are generally unable to pay for this counseling. CDC makes it work by convincing foundations to support their education programs. Foundations and private donors have donated over $4 million since 2006 for special programs like PICOH, student training, sealant programs, and capital for expansion and equipment.

Program to Improve Community Oral Health (PICOH)

School-based Prevention & Education	2013	2014
Participating elementary schools	10	18
Children receiving classroom education	1,996	2,910
Children receiving fluoride varnish	349	590
Children receiving sealants	223	450
In-Clinic Prevention & Education		
Children served (0–12)	3,394	3,525
Pregnant women served	295	250
Community Outreach		
Number of presentations at schools and community events	76	103
Children, pregnant women, parents, and seniors participating	2,388	5,072

CDC's mission

PICOH received recognition from the Robert Wood Johnson Foundation and ICF International as one of 25 national initiatives that offer innovative solutions to increase access to preventive oral health care.

Dr. Vacharee Peterson has received a number of awards for her exemplary work to eliminate dental health disparities. In 2005, she was one of three small business leaders to receive an award in honor of her leadership, success, vision, and contributions to the community from the US Pan Asian American Chamber of Commerce. Also that year, she was recognized as one of the Twin Cities' top minority business owners by the Minneapolis/St. Paul Business Journal. In 2012, she received the Humanitarian Service Award from the Minnesota Dental Association for "extraordinary humanitarian service to the local and global community." In 2014, she received the Lou Fuller Award for Distinguished Service in Eliminating Health Disparities from the Minnesota Department of Health.

Dr. Peterson receiving the Lou Fuller award

Dr. Peterson's vision for CDC is clear—continued expansion with an emphasis on education. Expansion enables CDC to maintain efficient operations and strong productivity while extending its reach into the community with oral hygiene education and the message of prevention.

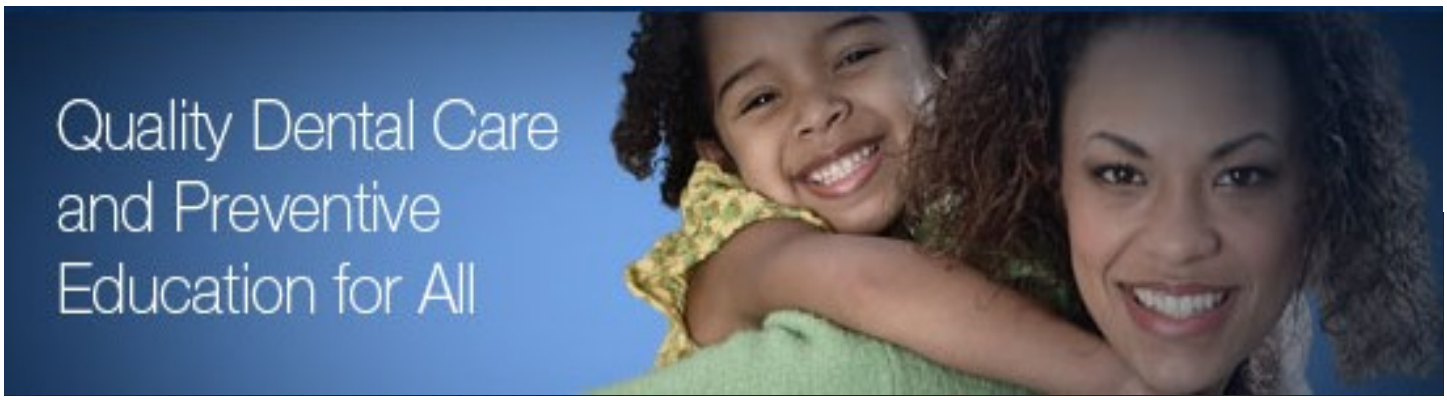
Expansion enables CDC to maintain efficient operations and strong productivity while extending its reach into the community with oral hygiene education and the message of prevention.

"My goal is to get babies and toddlers to develop good oral hygiene habits from their parents," Dr. Peterson says. "We're rethinking how we invest money and effort. I want our clinics to spend less time fixing problems and more time on education and disease prevention. We need to affect behavior in our patients' homes to help them prevent decay and disease."

Community Dental Care is also the sponsor of the Early Dental Prevention Initiative bill, recently passed by the Minnesota legislature. As part of the project, CDC will assist the Department of Health in implementing this "...statewide initiative to increase awareness among, communities of color and recent immigrants on the importance of early preventive dental intervention for infants and toddlers before and after primary teeth appear."

As Dr. Peterson reflects on her legacy with CDC, she sees no shortage of opportunities to improve the community's oral health. "I have four grandchildren, and even my eight-month-old granddaughter gets her newly erupting teeth brushed by her parents," she says. "It's my dream to do preventive dentistry for the two and under population and I am living that dream right now—to really change the health of babies and toddlers. So yes, eventually I'll retire. But we have an experienced team, solid infrastructure, and a great board to ensure that CDC will continue to provide care long after I'm gone."

"We have an experienced team, solid infrastructure, and a great board to ensure that CDC will continue to provide care long after I'm gone."



Lessons to share

1. **Create a deep bench.** Build a team of leaders, managers, providers, and staff with a broad set of skills and a collaborative culture. Include the leadership in board meetings.
2. **Train your team well.** Make sure they understand the importance of quality care and the clinic's mission and vision. Send them to continuing education seminars.
3. **Focus on finding ways to drive efficiencies**. With low fees for service, a nonprofit must streamline its processes and use resources as effectively as possible. Look for economies of scale; operate double shifts to maximize the use of equipment, space, and providers with efficient scheduling management.
4. **Use high-end equipment.** Quality equipment will help you treat patients effectively and efficiently and will last a long time, translating into less down time for clinic operations.
5. **Build capacity.** Once the service model proves itself, continue to invest in additional capacity to serve more patients. The demand is there.
6. **Create partnerships to reach patients**. Reach out to other nonprofits who can help you or who serve people who could be your patients. Work with your state's Department of Human Services to help align your services with their priorities. Talk to county officials about innovative leasing arrangements or real estate opportunities.
7. **Empower patients.** When serving disadvantaged or immigrant populations, it's important to provide them with culturally relevant education on oral health and prevention.
8. **Track your care statistics for quality improvement.** Collecting data on the care you provide helps you to continuously improve the quality and reach of that care.
9. **Leverage your passion and statistics for fundraising efforts.** Share care statistics with foundations to demonstrate your impact and generate additional funds to meet your goals. Communicate the need and your impact with funders.
10. **Ensure that the governing board members share the same dreams and vision** and have a similar passion to serve the underserved with compassion.

About the Washington Dental Service Foundation

Washington Dental Service Foundation is a non-profit funded by Delta Dental of Washington, the leading dental benefits company in Washington. The Foundation's mission is to prevent oral disease and improve the oral and overall health. The Foundation works with partners to develop innovative programs and policies that create permanent change, leading to improved oral health for all. For more information, visit: www.deltadentalwa.com/foundation.

About the Authors

Martin Lieberman

Martin Lieberman served as Chief Dental Officer at Neighborcare Health in Seattle, Washington from 2002 to 2013. Prior to his community health center work, he worked in private practice in Chicago for 18 years. Dr. Lieberman led a culture change in the way Neighborcare Health's dental program viewed process improvement and quality and has served as faculty member for the HRSA Oral Health Pilot Collaborative, and has also been a faculty member for IHI, HRSA, NNOHA and Dentaquest quality improvement projects. Dr. Lieberman serves on the Board of Directors for NNOHA and chairs the Practice Management Committee. In January 2014, Dr. Lieberman assumed the role of Associate Director of Graduate Dental Education at NYU Lutheran Medical Center in Brooklyn, New York.

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MaryKate Scott

MaryKate Scott is a healthcare economist and business management consultant with experience at McKinsey & Company, Procter & Gamble, and several academic appointments. She works with healthcare leaders in health systems, pharmaceutical and medical device firms, payers, and philanthropic organizations. Focusing at the nexus of health care, business and technology, Mary Kate's work focuses on strategy development, mergers and acquisitions, product launches, competitor response, market shaping campaigns, and economic modeling.

Her oral health work includes supporting The Pew Charitable Trust Children's Dental Campaigns including the ***It Takes a Team*** report and calculator. She has also authored: **IOM: Oral Health Access** (Chapter); **Retail Dental Clinics – a viable model for the underserved**; **The Good Practice: Treating Underserved Dental Patients While Staying Afloat**; and complied **The Oral Health Care Innovation Compendium** for The California HealthCare Foundation. She provided business strategy support for the **Alaska Native Tribal Health Consortium: Dental Health Aide Therapist (DHAT) Program**. She is presenting at NNOHA (2015) **An Economic Model to determine impact of adding a Dental Therapist to a FQHC Dental Clinic**.

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