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

Mary Kate Scott, MBA
Martin Lieberman, DDS
Introduction

Washington Dental Service Foundation's (WDS Foundation) is pleased to share this case study as part of its compendium of 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 touch-stone 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.

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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 compiled 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 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 and multiple community programs to improve the oral and overall health of about 20,000 people each year across five large Maine counties.

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."

"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.**

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### Snapshot Community Dental Maine

<table>
<thead>
<tr>
<th>Location &amp; Facilities</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers &amp; Staff</td>
<td>- 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</td>
</tr>
<tr>
<td>Patients</td>
<td>- 43,000 visits annually (5800 emergency visits) from 18,000 patients, aged 1–98 with 47% under 21</td>
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<td>- 79% of all patients live at or below 150% of the federal poverty level; notably, 780 special needs patients received 4700 services</td>
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<tr>
<td>Services</td>
<td>Full suite of preventive and restorative services</td>
</tr>
<tr>
<td>Total Revenues</td>
<td>$6m annually</td>
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<tr>
<td>Patient Payments</td>
<td>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</td>
</tr>
</tbody>
</table>
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-operator state-of-the-art facility in Biddeford. Community Dental-Biddeford is located near Southern Maine Medical Center and other healthcare offices.

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 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," 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 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).
The next wave of transformation came in the form of Dr. James Schmidt and Ms. Susan Isenman, who became 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.

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.
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.

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...
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
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.

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."
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."

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

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

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.
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.

Accountable Care Organizations

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

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.

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
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’s 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.”

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.

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.

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.

<table>
<thead>
<tr>
<th>REVENUE</th>
<th>EXPENSES</th>
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<tr>
<td>Maine Department of Human Services/MaineCare</td>
<td>Salaries and Fringe Benefits $4,117,654</td>
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<td>Contractual Services</td>
<td>Dental Supplies, Lab Fees</td>
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<tr>
<td>Client Fees</td>
<td>and Misc. Expenses $605,852</td>
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<td>United Way</td>
<td>Professional Services $181,335</td>
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<td>Private Source Grants and Other Revenue</td>
<td>Rent and Insurance $341,677</td>
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<td>Government Grants</td>
<td>Support Expenses $238,998</td>
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<td><strong>TOTAL UNRESTRICTED REVENUE</strong></td>
<td><strong>TOTAL EXPENSES</strong> $5,852,200</td>
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<td><strong>$6,047,129</strong></td>
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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.
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. 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."

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."
### 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.
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

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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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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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