Safety Net Dental Clinic Manual

Chapter 1: Partnerships and Planning

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Chapter Introduction

Once a passionate member of the community recognizes that access to dental care is a real problem for uninsured and underinsured families, the dream of a new community dental clinic is born. Converting such a dream to reality requires unlimited energy, "hard work and a thick skin." There is usually a mountain of decisions to climb and storms to weather before the dream becomes reality. Much of the territory may be unfamiliar. Although passion is essential, it must be tempered by reality checks to determine the ability to create a sustainable new clinic. Should you take the challenge? One person may be all that's needed to get started. See Appendix A to read one person's success story of converting passion to reality.

Chances of success are greatly increased by partnering with others. In this endeavor, there truly is strength in numbers. In addition to a number of partners, however, you'll need other numbers (data and financial projections) to make your case, as well as anecdotes and photos to make the problem real.

This chapter discusses two phases for establishing a safety net dental clinic:

1. building partnerships/gaining support (ch.1, sec.1, topic A), and

2. strategic planning (ch.1, sec.2, topic A).

Section 1: Building Partnerships / Gaining Support

A. How do I start building partnerships?

Potential Partners

First, remember why you want a partnership. Partners are essential to success. They will:

- Help you better understand local needs and assets,

- Build the necessary political will for funding and establishing a clinic,

- Sustain the clinic over time.

The links below will tell you more about why other public health and oral health leaders decided to make community partnerships a core element of their projects and initiatives.

Don't expect all potential partners to share your passion from the start. You may have to market the dental clinic concept to them. Even at this early stage, seek assistance. Contact the local (health department) dental director (if you are fortunate enough to live in an area that has one) or the state dental director (astdd.org). If you live in a state with no state dental director, contact the federal regional public health office (www.hrsa.gov/staff.htm) to see if there is a public health dental consultant.

Do the groundwork and organize an initial meeting to explore the idea. At this meeting, make your pitch about the seriousness of the problem, and describe your vision for a dental clinic. Try to elicit a level of commitment sufficient to move forward. If you are successful in this phase, you will emerge with a working group committed to the next phase - planning.

<u>Additional Resources for building partnerships</u>

Community Engagement: Definitions and Organizing Concepts from the Literature [http://www.cdc.gov/phppo/pce/part1.htm]

"<u>The Community as Full Partners in Public Health Initiatives.</u>" [http://healthlinks.washington.edu/nwcphp/wph2000/community_nop hoto.pdf]

"A Health Commons Approach to Comprehensive Oral Health for Low-income Populations in a Rural State" [http://hsc.unm.edu/som/outreach/Legacy/OralHealthComm.pdf]

"Improving Oral Health for People With Special Needs Through Community-Based Dental Care Delivery Systems" [http://www.cda.org/member/pubs/journal/jour598/improve.html]

"Forming a Community Coalition" A training module on "how to form a community coalition. Although focused on childhood injury prevention, this is a clearly written, well-researched document. [http://www.nfpa.org/riskwatch/pdfs/leaderguide/RWCOALITIONS.P DF]

B. How do I describe the problem to convince potential partners of the need?

Acquiring data and anecdotes

Well-presented "quick and dirty" data and a couple of compelling anecdotes usually will get people's attention. Initial data collection may be as basic as calling hospital emergency rooms to ask how many dental emergencies they see, or calling Head Starts or school nurses for the number of children they see in a year with toothaches. You have two tasks at this point:

1. acquiring data and anecdotes (ch.1, sec.1, topic B), and

2. packaging the data and anecdotes so they tell a compelling story (ch.1, sec.1, topic B).

You may want to divide your data collection into two phases: 1) the "quick and dirty" data that already are available on a website or by talking with someone on the phone, and 2) more "in-depth" (ch.1, sec.2, topic C) data that will take more time and effort to collect, often involving surveys.

Problem Description Worksheet- Phase 1

Use the following "Problem Description Worksheet", Phase 1 to decide how much information you want to gather now to tell your story vs. what you will need once you have a task force.

Phase 1: "Quick and Dirty"	
	Information	**Data Sources**
1	Local Demographics (age, race, poverty)	http://www.census.gov/
2	Local resources for low-income populations: • Number of dentists and ratio of dentists to the population • Number of dentists accepting new Medicaid patients • Number of safety net dental clinics	State dental board (http://www.aadexam.org) Yellow pages Dental offices to ask if they accept new Medicaid patients Local or state dental director to identify clinics
3	Local need indicators: • Federal designation as a dental health professional shortage area • Safety net dental clinic capacity • Emergency room dental visits • Children with toothaches at school	http://bphc.hrsa.gov/databases/newhpsa/newhpsa.cfm or the state primary care office: http://bphc.hrsa.gov/phpc/primarycare_programs/ stateprimary_careoffice.html Clinics to find out about waiting times for appointments Local hospital emergency rooms School nurses and Head Start programs
4	State data (oral health status, resources, dental care utilization, prevention programs)	State dental director (http://www.astdd.org); National databases: http://www2.cdc.gov/nohss/statemap.asp http://www2.cdc.gov/nccdphp/doh/synopses/index.asp http://apps.nccd.cdc.gov/brfss/index.asp

Packaging the data   Present concise facts that convey a consistent message about a compelling problem with a solution. Although professionally-prepared national fact sheets (http://www.mchoralhealth.org/pubs1.html) serve as good models, local fact sheets (Appendix B) should be even more effective. Later on, you can use this fact sheet or a variation when seeking funding for your clinic. While numbers are important, putting a human face on the problem makes it more compelling. These Sample Anecdotes (Appendix C) may help you to frame your own stories.

C. Who are the potential partners?

Potential Partners

Identify people and organizations that bring a diversity of experiences, connections, opinions, cultural beliefs and resources to your efforts. Don't limit your partners to dental professionals. While some dentists in the community will welcome a safety net dental clinic, others may oppose it because they do not appreciate the level of need. Knowledge of the players in your community will influence who needs to be at the table. The links below provide ideas on people or organizations to consider as partners.

Potential Partners Chart (Appendix D)
Potential Partners List (Appendix E)

Additional Resources on Partnerships

Healthy People 2010: Identifying and Engaging Community Partners
[http://www.healthypeople.gov/state/toolkit/partners.htm]

Healthy People 2010 Toolkit: Checklist
[http://www.healthypeople.gov/state/toolkit/partners.htm#Action]

REACT: Community Organization web site from the University of Minnesota School of Public Health.
[http://www.epi.umn.edu/react/main/community_org/framework_org.html]

Institute of Medicine: Improving Health in the Community: A Role for Performance Monitoring
[http://books.nap.edu/books/0309055342/html/59.html#pagetop]

Butterfoss, FD.   Checklist on coalition development, with focus on setting the structure and recruiting partners.
[http://ncth.confex.com/ncth/responses/2002/135.doc]

D. How do I gain support from potential partners?

Gaining support

With well-packaged information describing the problem in hand, and a vision for a dental clinic, call potential partners together to hear your case. This is an exploratory meeting because you are exploring whether or not there is sufficient interest and commitment to embark upon the road to establishing a clinic. At the meeting you will market your vision to the potential partners who can help you reach your goal. The outcome of the meeting will either result in 1) commitments from a critical mass of attendees to pursue the idea, 2) the need to collect and present additional data or gather additional partners, or 3) a decision to abandon or defer the effort and seek other options to address the dental access problem.

What is the best way to invite (Appendix F) people to a meeting? The more personal the contact, the greater will be the chances of success. Clearly state why you are contacting people and give them good reasons to attend. The initial contact is the first opportunity to "define the problem". Provide written follow-up with the meeting time, location, and directions. Include an agenda (Appendix G). By developing an agenda in advance, you help to assure that the meeting will answer your key questions:

"When it comes to ham & eggs, the chicken is involved, but the pig is committed."

- Will the group form a task force? If the answer is "yes":
  - o How often will the task force meet?
  - o What commitments of time and resources are people prepared to make?
  - o Responsibilities (e.g., chair, secretary, fiscal agent)?
  - o Estimated duration of process?

If you are to be successful, you will need a solid core of committed people who have some level of passion for the cause. If that passion and commitment is lacking, you may need to regroup, find additional partners, or refine your story until you can generate the level of passion you will need to be successful.

Additional Resources on Partnerships

Setting the Stage for an Oral Health Coalition (checklist from Washington State)
[http://www.doh.wa.gov/cfh/OralHealth/manuals/Roots/step1.pdf]

Summary of coalition building principles, with references (University of Pittsburgh).
[http://www.pitt.edu/~ocdweb/pdfdnlds/mar99sr.PDF]

WATCH YOUR MOUTH: Framing the Issue
[http://www.kidsoralhealth.org/framing/index.html]

WATCH YOUR MOUTH: Who's doing what in Washington State?
[http://www.kidsoralhealth.org/about/WA/whats_doing.html]

California Campaign (Watch Your Mouth)
[http://www.kidsoralhealth.org/about/CA/index.html]

E. How do we establish a task force?

Establishing a task force

If the group has the passion and commitment to move forward with the process, organize into a task force or work group. Task forces are organized according to varying levels of formality. At a minimum, establish ground rules (Appendix H), agree on methods for making decisions (Appendix I), and define roles (Appendix J) and expectations in order to become a functional body. To make and maintain a commitment, members must feel their time is being well spent. Well-organized groups can "hit the ground running."

There are keys to successful coalitions [www.pitt.edu/~ocdweb/pdfdnlds/mar99sr.pdf] and books [www.doh.wa.gov/here/bookshelf/bookshelf.asp?id=2&cat=community+mobilization] that go into greater detail about organizing and facilitating community groups.

Section 2: Planning

A. What kind of planning is necessary?

The development of a plan is crucial to the success of a collaborative work group. You may be familiar with terms such as strategic- or long-range planning (http://www.allianceonline.org/faqs/spfaq1.html). For our purposes, we will not label the planning but focus instead on the key questions and critical decisions that must occur.

Suggested Sequence for the Planning Process

1. Assess the current situation (needs assessment)
    o Describe the dental access problem (ch.1, sec.2, topic C)
    o Assess the task force members' resources (human and financial)

2. Envision the desired situation (regarding access to dental care)

    o **Vision statement**

    Through a collaborative process of consensus, the group should decide on a vision. A vision will tell you "where you want to be in the future". It should be inspirational and determine the group's destination. The vision should be easy to understand and so energizing that it will stimulate skills, talents and resources to make it happen. An example of a vision statement would be: *To enhance oral health and oral health care access for underserved people in our community.*

    o **Mission statement**

    Next, the group may want to create a mission statement. The mission statement should be clear and easy to understand by everyone. It should be brief enough to be remembered and contain no jargon. Your mission statement will define who you are and your reason for existing as well as your primary constituencies. A well constructed mission statement would be:

    To create the highest quality, cost effective, sustainable oral health care delivery system for the underserved populations to promote and integrate oral health in the community.

Planning process, continued

3. Specify goals and objectives to achieve the vision

   o **Goals**

      Once the vision and mission of the collaborative work group have been determined, establish sustainable goals. A goal is a target for strategies, usually stated in general rather than specific terms. Goals provide the work group a direction in which to move, an idea of what the group would like to accomplish. In addition, goals reflect the collaboration's priorities and should be ranked accordingly. Include long term as well as short term goals in your strategic plan. This encourages a future for the collaboration and prevents the tasks from initially appearing overwhelming.

      An example of a short term goal would be: *To provide examinations and referrals for underserved children in the school based health center.*

      In contrast, a long term goal would be: *To provide comprehensive dental care to children and their families in the town of Pleasantville.*

   o **Objectives**

      Unlike goals, objectives will be very specific, measurable and include time-based achievements. Objectives will serve as benchmarks to be attained on the way to accomplishing your goals. When determining objectives, be sure that your expectations are based in reality with regard to time and available resources. Setting unrealistic objectives will produce failure and cause group members to become discouraged. Your objectives, as well as goals, should reflect the priorities of the collaboration and should be presented in a numbered format.

      Examples of objectives would be:

      1. To expand the dental staff by hiring 1 FTE hygienist by Spring, 2000.

      2. To institute a sliding fee scale for dental clients to be implemented by Spring, 2000.

      3. To purchase two complete portable dental units for providing dental hygiene services by Spring, 2000.

Planning process, continued

4. Detail the steps for getting there (implementation/action plan)

   o **Action Plan**

   Your action plan lets you know exactly how your objectives will be accomplished. It is best to include concrete steps or activities with timelines for specific members of the work group. Your action plan will serve as your road map for meeting the goals and objectives of the collaboration. A clear, detailed action plan encourages members to complete their tasks in an efficient manner by providing them with a clear understanding of what is expected, how it should be accomplished and a deadline for presenting results from the assigned task.

   While developing the action plan, it may be helpful to create subcommittees of the collaborative work group. It is here where members have an opportunity to utilize their individual talents and participate in activities, which they find relevant to their specific areas of expertise. Depending on the scope of the activity, the subcommittee may be as broad as to include a chairperson and several members, or as narrow as to need only one member. The presentation of the strategic plan at your town meeting should provide an opportunity for the work group to recruit additional interested parties (people power) to carry out your tasks.

5. Carry out the plan

   o **Tasks**

   No two communities are exactly alike. The strategic plans of each collaborative work group will be unique and will target the individual needs of each community. However, within the action plan of a collaborative work group trying to enhance oral health in a community, there are some basic tasks, which should be included.

When putting your plan to paper, you can use a Health Improvement Plan. (Appendix K) This tool helps you link your problem, community assets and resources, community barriers and needs, goals and outcomes, action steps and, evaluation and measurement of progress together into a table format.

Adjusting the Plan

Periodically, throughout any planning process, assess progress, determine the feasibility of your vision, and adjust the plan accordingly. For example, your vision of a 6-chair clinic may need to be revised to a 3-chair clinic with potential for future expansion. The Institute of Medicine's report, entitled Improving Health in the Community: A role for performance monitoring, [http://www.nap.edu/books/ 0309055342/html/index.html] may find this document useful in developing in monitoring outcomes for your plan.

See Appendix L) for an example from the Connecticut Department of Public Health, which defines the group's vision, mission, goals, and objectives. It also serves as a guide for the development and implementation of the proposed project. The Connecticut approach structures the plan in the following manner:

- A one-page bulleted summary
- Clearly defined vision, mission, goals and objectives
- Assigned tasks and responsibilities for workgroup members
- A timeline for the accomplishment of assigned tasks.

In the states of California and Washington, two groups have organized to implement a campaign for oral health media communication, education and treatment. To read more about these campaigns, go to the Watch Your Mouth Website [www.kidsoralhealth.org/framing/index.html]. Also, other examples of activities resulting from community groups can be found in Addressing Oral Health Needs: A How To Guide, a publication that can be found on the Community Catalyst Organization's Web page, [www.communitycatalyst.org] a national advocacy organization.

B. How will the clinic's mission & goals affect access and financial sustainability?

Many of the critical decisions that you make along the way will stem from the manner in which the mission and goals that you establish early on achieve balance between access to care and financial sustainability of the clinic. Although all safety net clinics do not seek the same balance, it is important to clearly understand and articulate the balance that **your** clinic will seek.

Effects of different mission statements

The following table illustrates how different mission statements yield different policies, and the need for revenue beyond that generated from patient care:

	City Health Dept. "Bring Me Your Tired, Your Poor" Dental Clinic	"Pay to Play Health Center Dental Clinic"	High Wire Center (Balance)
Mission	Provide dental care to all those who seek it, regardless of ability to pay.	Operate a self-sustaining dental clinic that serves Medicaid patients and makes care more affordable for other low-income individuals who can pay for a reasonable portion of their care.	Increase access to dental care by serving Medicaid patients and other lower-income people in a clinic with limited subsidy (grants/ fundraising).
Clinic Policies	• Full fees based on Medicaid fee schedule. • Sliding fee schedule discounts = 90%, 80%, 60%, 40%, 20% • Minimum fee=$5/visit (will provide care even if the fee is not paid)	• Full fees based on 75th percentile of UCR. • Sliding fee schedule discounts = 50% & 25% • Minimum fee=$50/visit (will not provide care if the fee is not paid) • 65% Medicaid • Market clinic to public programs that serve women and children.	• Full fees based on 50th percentile of UCR. • Sliding fee schedule discounts = 75%, 50%, 25% • Minimum fee=$20/visit (will provide care for pain or acute infection even if the fee is not paid)
Patients Treated	5070	5070	5070
Medicaid	$85,000	$350,400	$150,000
SCHIP	$45,000	$75,700	$50,000
Self-pay			
Full pay	$1,000	$13,200	$7,500
Sliding Fee Schedule	$25,000	$20,000	$62,000
Minimum Pay	$10,000	$45,700	$41,000

	City Health Dept. "Bring Me Your Tired, Your Poor" Dental Clinic	"Pay to Play Health Center Dental Clinic"	High Wire Center (Balance)
Commercial Insurance	$1,000	$10,700	$10,000
Revenue			
Patient Care Revenue (Net)	$167,000	$515,700	$320,500
Non-Patient Care Revenue (Grants, Fundraising)	$0	$0	$125,000 ($100,000 FQHC grant+ $25,000 state grant)
Total Revenue	$167,000	$515,700	$445,500
Expenses	$500,000	$500,000	$500,000
Bottom Line	($333,000)	$15,700	($55,500)
Other Subsidy	$333,000 City Subsidy via Recurring Line Item	$0	$55,500 from other cost centers at Health Center
Long Term	This program relies on a line item in the City budget to subsidize the cost of uncompensated care that results from maximizing access through a sliding fee schedule that offers significant discounts. There is an extensive waiting list. As long as the City's priority for this activity holds, the clinic continues providing services.	This clinic is in a health center that requires it to be self-sufficient. Therefore, the clinic turns away a considerable number of patients who can't afford the minimum fee. The waiting list for the clinic is very manageable. The clinic operates in the black.	This clinic relies on grants to offset the cost of uncompensated care due to providing a sliding fee schedule. The minimum fee of $20/visit still excludes some patients. The waiting list in this clinic has 200 names on it. Even with non-patient care revenues, the clinic did not cover its costs last year. The Health Center budget, however, balanced due to positive balances in other cost centers.

C. How do we assess the need for a clinic (needs assessment)?

Assessing the need
Assessing need is a function of community values. Two communities may look at similar information and make different decisions about starting a dental clinic. Nevertheless, you have to gather information for a decision to be made. How much information is enough? In some communities, the quick and dirty information you already have in hand may be enough. In other communities a more in-depth analysis is required.

Don't make the critical decision of wheter to start a dental clinic based on passion alone. Even the best intentions of passionate people may end in frustration if a clinic is not sustainable.

A needs assessment considers:
- population demographics (e.g., poverty, uninsured/underinsured, ethnicity) because dental disparities occur in may population subgroups
- dental needs of the target population(s)
- accessibility of current dental care resources for target populations (availability and utilization of private and public dental care)
- community perceptions of the need for dental care resources.

Problem Description Worksheet- Phase II If you need more information, then use Phase 2 of the "Problem Description Worksheet" for guidance.

Phase 2: In-Depth (Possible requiring primary data collection)		
	Information	**Data Sources**
1	**Oral Health Status** Data collected through state or local surveys on different age groups: • Dental caries (tooth decay) • Periodontal health· Oral cancer • Oral defects (e.g., clefts, malocclusion) • Other oral conditions	Local or state dental director ASTDD Seven-Step Model (http://www.astdd.org) ASTDD Basic Screening Surveys (http://www.astdd.org), click on Publications for an order form
2	**Perceived Need for Dental Care** Perceptions of: • Consumers (accessibility, acceptability, affordability) • Oral health care providers (e.g., dentists, dental hygienists) • School personnel (e.g., teachers, nurses, principals) • Health care providers (e.g., pediatricians, well child clinic providers, nurse practitioners) • Key informants (local leaders)	Local or state dental director ASTDD Seven-Step Model (includes sample surveys) (http://www.astdd.org)

Phase 2: In-Depth (Possible requiring primary data collection)	
	Information	**Data Sources**
3	**Medicaid and SCHIP Coverage** • Utilization of services by Medicaid eligibles • Dentists' participation in Medicaid (# of dentists according to number of Medicaid claims in the past year) *[Note: Medicaid data may not be readily available, particularly at the local level]* • Utilization of services by SCHIP eligibles • Dentists' participation in SCHIP (# of dentists according to number of SCHIP claims in the past year) *[Note: SCHIP data may not be readily available, particularly at the local level]*	State Medicaid agency, find contact information at: (http://www.aphsa.org/links/statecontacts.asp). If the Medicaid agency doesn't handle the SCHIP data, someone should be able to direct you to a data resource.
4	**Insurance** % of population who are uninsured for dental care vs. % who are uninsured for health care: • By age • By race or ethnicity *[Note: These data will be hard to come by, particularly at the local level]*	Questions in consumer survey (see "Perceived Need," above)
5	**Prevention Programs** # and type of public dental disease prevention programs (e.g., fluoride mouthrinse, educational, sealants); # and age of individuals served.	Local or state dental director

D. How do we decide if a clinic is feasible?

Determining feasibility

In addition to the *need* for a clinic, assess the potential *viability, sustainability* and, therefore, *feasibility* of a clinic. You must answer several questions to develop the estimates needed to make your decision. Your answers may be influenced by the requirements or limitations of specific funders. Some of the questions require a level of detail found in other chapters in this manual. Chapters 2 and 3 include interactive tools to help answer some critical planning questions. Your mission and goals (Ch.1, Sec.2, Topic B) will steer you toward many answers, as well.

Ten critical planning questions

1. Whom do we want to serve? (Ch.1, Sec.2, Topic E)

2. What level of service do we want to provide? (Ch.1, Sec.2, Topic F)

3. What type of "facility" do we want? (Ch.1, Sec.2, Topic I)

4. What agency or organization will own and operate the clinic? (Ch.1, Sec.2, Topic J)

5. How is facility location determined? (Ch.2, Sec.1, Topic B)

6. What size facility should we have? (Ch.2, Sec.1, Topic C)

7. How many staff will we need? (Ch.2, Sec.3, Topic A)

8. What will it cost to start and to maintain a clinic? (Ch.2, Sec.1, Topic A)

9. How much revenue can we expect from patient care? (Ch.3, Sec.1, Topic E)

10. What's the bottom line? (Ch.3, Sec.1, Topic A)

   o Will we need to supplement patient income with other funding (e.g., grants, fund raising)? (Ch.3, Sec.1, Topic N)

      ▪ If so, how much?

   o Should we revise our assumptions (patients, services, clinic size and staffing) to a level that we can afford?

E. Whom do we want to serve?

Determining patient demographics

This critical decision must stem from your mission and goals. Consider the following variables:

- Medicaid eligibles, SCHIP eligibles

- Working poor (typically under 185-200% of federal poverty level (http://www.aspe.hhs.gov/poverty/))

- Geographic boundaries

- Age (e.g., infants and young children, children, adults, elders)

- Ethnic groups (e.g., non-English speaking)

- Special populations (e.g., migrant workers, homeless, children with special health needs)

F. What level of service do we want to provide?

Level of care

Based on the vision, mission and goals, decide what level of care the clinic will provide:

- comprehensive general practice dental care
- limited care (e.g., emergency only, exams and preventive care)
- general and specialty care
- use of various forms of conscious sedation

Conscious sedation

Conscious sedation is used in some dental practices to help manage extremely anxious individuals, the pre-cooperative (very young) child, and other patients who have physical or psychological conditions that make it difficult for them to tolerate certain types of dental procedures.

Properly used, conscious sedation is a safe and effective adjunct to the provision of dental services. When conscious sedation is improperly performed, the patient can be placed in great physiologic, and even mortal danger. Sedation techniques should not be used except when the clinic is properly staffed by credentialed providers, is properly equipped for their safe use, and appropriate indications exist to warrant their use.

Sedative techniques

See Appendix M for indications for the use of sedative techniques.

Additional training and certification in sedation techniques and airway management are usually required for providers to use nitrous oxide. Check your state dental practice act to see what restrictions or regulations are in place for your clinic and staff.

Models for levels of dental service

The Indian Health Service (Appendix N) and the Reforming States Group (http://www.milbank.org/990716mrpd.html) have developed levels of dental service models for program and policy development. If you don't provide comprehensive care, how will you refer patients for their other needs?

G. What role can volunteers play?

Role of volunteers Although this manual is geared primarily toward the development of full-time clinics with paid staff, much of the information applies to clinics that use volunteer staff. Clinics using volunteer staff usually employ paid staff (most often a dentist and/or dental hygienist) who oversee, coordinate, and bring continuity to the services provided by volunteers. Many clinics that use primarily part-time volunteer staff will have more modest objectives than a full-time clinic with paid staff. A full-time clinic may supplement paid staff with volunteers.
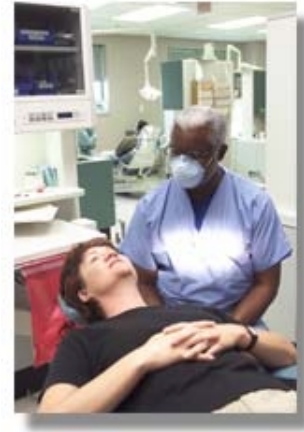
Chapter 3 (Ch.3, Sec.1, Topic R) and Chapter 4 (Ch.4, Sec.2, Topic D) also provide more detailed information on the use of volunteers. In addition to the information provided in this manual, Volunteers In Health Care (http://www.volunteersinhealthcare.org/home.htm) provides a great deal of useful information.

H. Should we apply for a federal Dental Health Professional Shortage Area (HPSA) designation?

Dental HPSA

The Bureau of Health Professions, Health Resources and Services Administration, designates qualified areas as HPSAs. The primary advantage of being designated as a dental HPSA (http://bhpr.hrsa.gov/shortage/hpsacritdental.htm) is that dentists and dental hygienists employed by the clinic may qualify for substantial repayment of student loans. Offering this benefit may help you recruit and retain staff. Contact the state primary care office (http://bphc.hrsa.gov/phpc/primarycare_programs/stateprimary_care office.htm) for more information or assistance in preparing an application. The state primary care office will submit the application to the federal Division of Shortage Designation. Additional information on loan repayment is presented in Chapter 4 (Ch.4, Sec.2, Topic E).

I. Is a fixed dental clinic facility what we need?

Dental care delivery modes

There are different modes for the direct delivery of dental care, each with its own advantages and disadvantages:

- fixed clinic facility
- mobile
    - self-contained motorized van
    - trailer (non-motorized)
- portable equipment

Answers to previous questions about target population and level of service will influence the decision about facility choice. For example, if you want to provide basic dental services to children located in schools that are geographically dispersed, then you might consider a mobile van or trailer. If you wish to provide a wide range of dental services to the general population of a community, you would most likely choose a fixed facility.

Fixed Clinic Facility

A fixed clinic facility is the most efficient and effective delivery mode for providing direct dental services to a population of 1400 or more individuals who are able to travel to the facility.

A fixed facility can be either:

1. A new structure that is:
    a. modular
    b. conventional construction
2. An addition to an existing structure
3. The renovation of an existing structure

It usually is the preferred type of facility by patients and dental providers in terms of comfort and efficiency. A fixed facility enables the complete range of dental services to be delivered, and provides space for record storage and business office functions, but is the most costly to construct. In rural areas patients must travel long distances if the service population is dispersed over a wide geographic area.

Mobile Clinics

The mobile clinic is used primarily when oral health care is to be delivered to small pockets of patients that are scattered over a specific geographic area. The mobile clinic generally is parked at a facilility such as a school, residential facility or community center.

Mobile clinics can be either:

1. a self-contained motorized van driven by clinic staff or a hired driver to different locations
2. a trailer that is hauled or towed by a truck to a location

Although the initial cost is not as much as a fixed facility, maintenance costs are higher. This is especially true for a motorized van due to maintenance of the drive train. Useful life is shorter than a fixed facility. Both units require utility, water and sewage connections at each location where used. In cold weather, precautions must be taken to prevent freezing of the water lines.

A van or trailer may consist of one or more operatories, depending on the size. Equipment can be traditional dental equipment found in a fixed clinic facility or portable equipment. The use of portable equipment can allow for multiple program uses of the van (e.g., dental care and immunization clinics).

Vans and trailers provide climate control for a comfortable work environment. Most offer utility service attachments, which allow on-site hookup. Additional considerations may be:

- Generator on board to provide electricity
- Telephone/computer hookup
- Wheelchair lift

Portable Equipment

Portable equipment is used to provide oral health services, especially preventive services, to specific population groups or persons who cannot easily access a fixed facility or mobile clinic, e.g., someone who is homebound or in a residential care facility. It is difficult to provide more than basic dental care using this delivery method. The type of equipment also will affect productivity and patient and provider comfort. Portable equipment allows for a great deal of mobility, taking services to patients in their own community or setting. It is relatively inexpensive to purchase, does not require special utilities or construction to operate, is easily transported by car or other vehicle, and is quick to set up and take down.

Portable dental equipment ranges from units under 60lbs., mid-range units up to 100lbs. and self-contained (water/air sources and waste collection) units and carts. Determining the type of portable equipment to use should be based on:

- The physical environment of the site (e.g., space considerations and electric/water availability)
- The range of dental procedures that will be provided
- The size and weight of equipment based on the capability of the staff that will transport and set-up equipment
- cost

Comparison of delivery modes

This table, developed as part of another project of the Association of State and Territorial Dental Directors, compares the dental delivery modes. The types are not mutually exclusive, however. As an example, some fixed clinics use portable equipment to provide services in schools and a mobile van to travel to isolated communities.

Mode of Dental Care Delivery	Pros	Cons

Fixed Clinic Facility
 	
Indications:
community-based clinic
	• community-based
	• if space is available and adequate for a clinic:
	  o greater potential to optimize facility design and staffing (efficient and productive)
	  o on-site lab and x-ray
	• can be co-located with other healthcare clinics
	• potential for sharing resources (e.g., waiting room, business office staff)
	• storage capacity for supplies and patient records
	• continuity of care
		• services limited to single geographic area
		• occupancy costs
		• patient transportation issues
		• need for low-income clients to leave work, which may be difficult
		• if available space is inadequate, it may force inefficient clinic design to fit space

Mode of Dental Care Delivery	Pros	Cons

Mobile: Self-Contained Motorized Van
 	
Indications:
• schools
• rural areas
• assisted living facilities
• skilled nursing facilities
• group homes
• housing projects
• other congregate settings (e.g., Head Start, day care)
• migrant farmworker families
	• serve multiple populations in broad geographic areas (go where services are needed), many of which would not be able to support a fixed clinic·
	• few limitations on locations
	• high visibility of program
	  o potential funders: side of van becomes a "moving billboard" advertisement for funder
	  o potential users: name recognition
	• the extent of limitations may depend on size (typical size = 25'- 40' in length)
	• on-site lab and x-ray possible
		• initial costs/operating costs may be higher
		• increased coordination required
		• may not be seen as "community-based"
		• community misperceptions and sometimes misused (e.g., perceptions of "emergency only" treatment)
		• continuity of care issues (e.g., "dental home" and emergency care after van has left community)
		• may have challenges finding providers
		• space may limit staff and productivity
		• limited space for supplies and records
		• may be adversely affected by weather conditions (e.g., cold, ice, extreme heat)
		• security/storage of vehicle/trailer
		• maintenance of vehicle/trailer
		• maneuverability (e.g., tight driving conditions on narrow streets)
		• fuel: if you run out, you're down
		• regulatory compliance (Americans with Disabilities Act, fire, etc.)
		• waste disposal (particularly hazardous materials)
		• need driver or training for dental staff to drive
		• increased risk for liability (e.g., motor vehicle accident)

Mobile: Trailer (Non-motorized) Areas that are secure and allow trailer to park for a period of time, such as schools or community centers	• less expensive than motorized van • design more flexible than self-contained van (no cab to deal with) • less maintenance than self-contained van (no drive train) • other advantages are same as motorized van	• need to contract with hauler or tow behind truck • size would limit where it can be parked and maneuvered • unable to move at short notice • many of the same disadvantages as mobile van

Mode of Dental Care Delivery	Pros	Cons
Portable Equipment • homebound • schools • rural • assisted living facilities • skilled nursing facilities • group homes • housing projects • other congregate settings (Head Start, day care, etc) • migrant farmworker families • hospitals	• initial costs lower • can serve multiple communities • adaptable to community changes (can leave a community if an access to care solution is found) • can "go where the people are located" • can expand options of a fixed facility or mobile clinic • least expensive capital investment • greatest versatility (reduces physical barriers) • relatively light • many options for combinations of equipment • maintenance sometimes easier • transportability	• time and effort in packing and unpacking supplies and equipment each time • increased coordination required • may not be seen as "community-based" • environmental issues (light, temp, humidity) • reduced efficiency (e.g., lower capacity of vacuum and air compressor) • generator noise • requires space in facility • access to proper utilities • waste disposal (particularly hazardous materials) • range of services restricted • discomfort - patient and practitioner ergonomics • staff recruitment and retention • equipment durability • unlikely to have on-site lab services and equipment • x-ray processing is limited • storage needed for records, supplies • additional staff responsibilities (e.g., moving equipment)

Design considerations

In 2004, the Association of State and Territorial Dental Directors expects to post design considerations for each type of service delivery mode. When that Website is on-line, you will be able to access it by, going to the ASTDD website (http://www.astdd.org) and clicking on Resources to find the Manual on Portable and Mobile Dental Care Systems.

J. What agency or organization will own and operate the clinic?

Agencies and organizations

When deciding which agency or organization will own and operate the clinic, consider:

- Agency's mission
- Organizational structure and staffing
- Medicaid billing considerations
  - Does any agency or organization qualify for differentials or preferred reimbursement arrangements (e.g., cost-based)?
- Eligibility for outside funding
  - Grant writing track record
  - Non-profit or government status
- Potential for integration with delivery of other health care services (one-stop services).

K. How do we become a private non-profit organization [501 (c) (3)]?

Becoming a non-profit organization

When starting a non-profit corporation, it is advisable to consult an attorney to file the necessary documents, which will incorporate your organization under the proper state statutes. Those documents should include a certificate of incorporation and by-laws and may include additional documents.

In order for the organization to be exempt from federal income taxes, it must obtain exempt status from the Internal Revenue Service. Many states have specific reporting requirements for non-profit organizations as well. You should consult with your accountant to be sure you are complying with all applicable state and federal laws and regulations.

The Non-Profit Resource Center links users to information on becoming non-profit organizations (http://www.1800net.com/nprc/index.html).

L. How is facility location determined?

Facility location   The clinic should be able to expand and adjust in response to changes in the community. The location of the dental clinic should be in reasonable proximity to the target population and accessible to public transportation (if available) and major roads. This decision may be influenced by the availability of space for a clinic and the determination of which agency will own and operate the clinic. Additional considerations can be found in Chapter 2 (Ch.2, Sec.1, Topic B).

M. What's the bottom line: clinic or no clinic?

Clinic or no clinic? This is a very critical, but often overlooked, question. If you have followed the suggested steps in this chapter, you will have a sound basis for comparing anticipated revenue and expenses. Depending on your decisions (e.g., type and size of clinic, staffing, scope of services), along with your assumptions (e.g., salaries, payer mix, clinic productivity), you should be able to anticipate whether you will need to supplement patient care revenue with other funding. In some situations, the need for subsidy is unavoidable to maximize access with low minimum fees and generous sliding fee scales. In other situations, however, dental clinics break even or have a positive balance sheet by manipulating payer mix and having higher minimum fees and less generous sliding fee scales.

Chapter 3 provides tools to answer this critical question and offers advice in seeking funding. If the task force doesn't feel that the funds can be raised, you must then reconsider your earlier planning decisions or assumptions. For example, recalculate the revenue and expense projections based on a 3-chair rather than a 6-chair clinic, or a less generous sliding fee scale, or clinic fees. You may be able to build in the flexibility for future expansion. More information about these considerations is provided in Chapter 3.

After revising your planning decisions or assumptions, if you still don't feel that a clinic is feasible, consider other alternatives.

N. What are the alternatives to a clinic?

Clinic alternatives

If you have decided not to tackle starting a dental clinic, you still can take action to improve access to dental care in your community. There may be other approaches that use private practice dentists and hygienists in the community. Your success will be tied directly to the dental community's commitment to increase access to dental care for under- served populations. Other approaches, however, may have a more modest impact than if you had chosen to establish a full-time safety net dental clinic.

The American Dental Association's Council on Access, Prevention and Interprofessional Relations has published the following three resource monographs about local access programs. There is considerable variety among the approaches described (e.g., referral networks, transportation voucher programs):

- "Obtaining Funding for Dental Access Programs: An Overview" (2001, 55 pages)
- "Dental Access Program Marketing: How to Build Public Image and Participation" (2001, 54 pages)
- "Manual on Dental Care Access Programs" (2000, 108 pages)

All three documents are available for a nominal charge ($10 for ADA members and $15 for non-members, plus tax where applicable) by calling CAPIR at 800-621-8099 or by e-mailing babcockj@ada.org.

Some local alternatives also are described under the "State Practices" section of the Association of State and Territorial Dental Directors website (http://www.astdd.org).