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Building the Capacity of California's Safety Net: Lessons From the Strengthening Community Dental Practices Demonstration

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Key Points

· Community dental practices provide "safety net" services to populations who would otherwise have limited access to care. The financial crisis of recent years has made it increasingly difficult for safety-net dental practices to serve people most in need while still balancing their books.

· The California HealthCare Foundation (CHCF) and the California Pipeline Program (CPP) funded a demonstration project to test the effectiveness of practice-management consulting as a strategy for helping California's community clinics survive and thrive. This model emphasizes customized technical assistance to enhance the business infrastructure behind the delivery of care.

· The evaluation of this demonstration revealed that most clinics made measurable improvements in increasing net revenue, reducing expenses, enhancing payer mix, and increasing patient visits

· The experiences of participating clinics pointed to several factors that create an environment for success, including buy-in at the executive and clinic levels, a clear project champion, a culture that supports change, clear and compelling project goals, and the availability of internal resources. CHCF is now implementing a second phase of the project that builds on lessons learned from the demonstration.

Introduction

Grantmakers are increasingly interested in strengthening nonprofit capacity to improve program performance and ensure the sustainability of community-based programs in the face of an economic downturn. However, the literature on effective models for nonprofit capacity building is still emerging (Silverman et al., 2001). Likewise, evaluators have been challenged to find meaningful measures of organizational effectiveness and development, along with methods that capture the true impact of capacity-building initiatives (Backer, Bleeg, & Groves, 2010).

This article describes the results of a demonstration project funded by the California HealthCare Foundation (CHCF) and the California Pipeline Program (CPP) that sheds light on both these issues. The purpose of the Strengthening Community Dental Practices (SCDP) demonstration was to assess the effectiveness of practice-management consulting in helping California's safety-net dental practices survive and thrive. The SCDP capacity-building model provides customized technical assistance to enhance the business infrastructure behind the delivery of care. The SCDP evaluation revealed that most clinics exhibited substantive improvements in clinic operations and financial performance. The experiences of participating clinics pointed to several factors that create an environment for success. CHCF is now implementing a second phase of the project that builds on lessons learned from the demonstration.

This article first describes capacity issues facing safety-net dental practices and provides an overview of the SCDP demonstration. It then discusses CHCF's and CPP's joint interest in evaluation, the conceptual framework and methodology used to evaluate the initiative, and the findings from

this work. This is followed by a discussion of lessons learned for grantmakers and others interested in both designing and evaluating nonprofit capacity-building initiatives.

The Strengthening Community Dental Practices Demonstration

Community health centers play a crucial role in providing access to dental services for California's underserved populations. However, a statewide fiscal crisis compounded by the recent economic downturn has created unprecedented challenges for community dental practices across the state. These trends threaten the sustainability of safety-net dental clinics and may ultimately reduce access to care for many low-income and uninsured Californians:

- The California Legislature eliminated most Medicaid dental benefits for adults effective July 2009.[1] This public program had been the primary payer source for most safety-net dental clinics in the state and was a vital source of coverage for more than 3 million Californians (Hughes & Diringer, 2009).
- As resources are waning, the demand for safety-net services is rising. California's high unemployment rate (12 percent as of August 2011) speaks to the rising uninsured population.
- Many dental practices are faced with reduced funding from private foundations and local agencies. Without these funds, clinics will find it difficult to subsidize care for the uninsured.

Even as challenges mount, there are still opportunities for growth through the Patient Protection and Affordable Care Act of 2010 (ACA) and the American Recovery and Reinvestment Act of 2009 (ARRA). Provided clinics can contain costs, ACA presents an opportunity for clinics to strengthen their services, networks, and infrastructure (Katz, 2010). Furthermore, under ARRA, federally qualified health care centers (FQHCs) nationwide were allotted $1.5 billion of infrastructure improvement funding and $500 million of operations funding (National Association of Community Health Centers, 2009). As more health centers move toward electronic record systems, there is potential to improve the operational efficiency of safety-net dental clinics. In addition, FQHCs have additional funding at their disposal, some of which could be directed toward improving the efficiency and quality of their dental services.

> *As more health centers move toward electronic record systems, there is potential to improve the operational efficiency of safety-net dental clinics.*

Despite opportunities, many safety-net clinics may not be positioned to fully realize potential efficiencies in dental-service delivery. For clinics to meet the needs of their communities, they must find ways to increase productivity in the face of waning resources and find ways to strengthen their financial position. However, clinical productivity varies widely across safety-net clinics and can impede the optimal delivery of services (Scott, Bingham, & Doherty, 2008). To address this need, CHCF and CPP jointly funded a demonstration project designed to ascertain the effectiveness of practice-management consulting as a model for building the capacity of safety-net clinics:

- The goals of CHCF's Innovations for the Underserved program are to promote lower-cost models of care, improve access to care for underserved populations, increase patient enrollment and retention in public health care programs, and improve operational efficiency of the safety net.
- CPP partners with community clinics to provide training for dental students.[2] This university-based program aims to help dental students build greater competency in serv-

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[1] The cuts did not affect federally required adult dental services (primarily emergency services), pregnancy-related services, and dental services for people living in nursing facilities.

[2] The California Pipeline Program is funded by the Robert Wood Johnson Foundation and the California Endowment and administered by the University of the Pacific.

ing diverse populations while also providing needed services in community clinics and encouraging more students from low-income and underrepresented communities to join the dental profession.

CHCF and CPP saw a synergistic partnership – clinics need dentists who are committed to community dentistry, and operationally strong clinics provide better learning opportunities for dental students.

Practice-management consulting is designed to improve clinical productivity and financial viability within dental practices, thereby strengthening their capacity and sustainability. However, safety-net dental clinics operate within a larger context comprised of factors at multiple levels.

The demonstration consisted of several components:

- *Clinic selection.* Nine California dental clinics serving low-income and uninsured populations participated. Five of the clinics were recruited by CHCF through an open application process. These clinics were selected based on community need for oral health care; willingness to participate in all phases of the assessment, implementation, and evaluation process; evidence of support for participation from clinic leadership; and need to improve fiscal operations. When CPP learned of the CHCF demonstration, it proposed incorporating four of the clinics with which it partners in the demonstration, given the potential benefits for CPP's larger program goals. These clinics were selected based on CPP's assessment of clinics' interest in and need for such consultation, and CPP subsidized the cost of these clinics' partici-

pation in the demonstration.
- *Practice-management consulting.* Over the course of one year, the nine clinics received practice-management consulting from one of two consulting groups: Safety Net Solutions and Pride Institute. The two consulting groups varied in terms of their characteristics and approach.
- *Advisory group.* CHCF and CPP convened an advisory group of clinic and policy experts to provide feedback on the design, implementation, and results of the demonstration project.
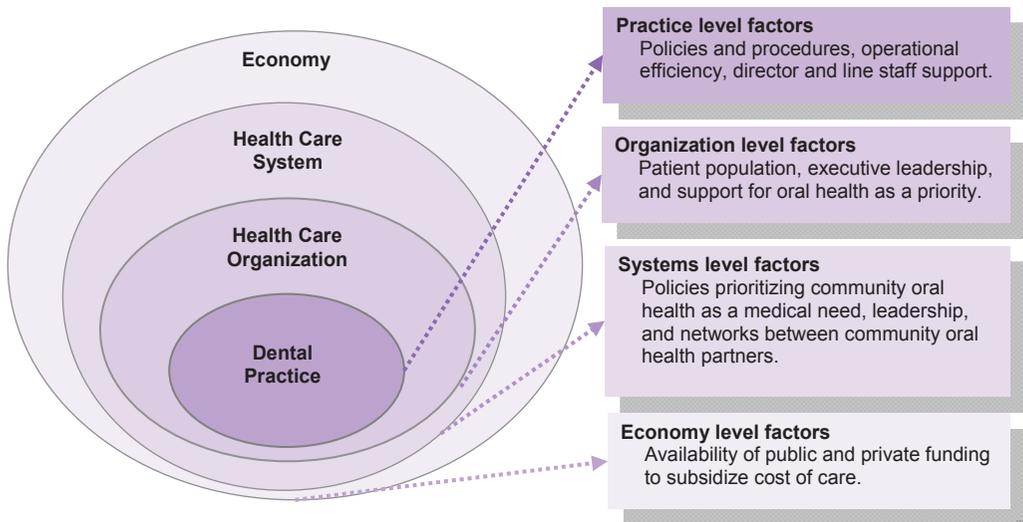
Evaluation Framework and Methods

Practice-management consulting is a relatively new model for strengthening the financial viability of safety-net dental practices. Therefore, CHCF and CPP commissioned an independent evaluation to understand the potential of this capacity-building model for safety-net dental practices statewide, and to capture lessons learned for the greater safety-net oral health community. The evaluation conducted by Harder+Company Community Research, a national consulting firm that specializes in research and planning for the social sector, addressed the following questions identified by CHCF and CPP:

1. What kinds of organizational changes do pilot sites make as a result of participating in practice-management consulting?

2. How successful are the nine pilot community dental practices in improving efficiency according to key practice-related measures related to clinical and financial productivity?

3. How effective are the practice-management consulting models delivered to the community dental practices?

4. What are the long-term prospects for implementing the practice-management consulting model for safety-net dental clinics throughout California?

Conceptual Framework
Practice-management consulting is designed to improve clinical productivity and financial viability within dental practices, thereby strength-

FIGURE 1 Conceptual Framework: Factors Influencing Dental Practice Capacity

Economy

Health Care System

Health Care Organization

Dental Practice

Practice level factors
Policies and procedures, operational efficiency, director and line staff support.

Organization level factors
Patient population, executive leadership, and support for oral health as a priority.

Systems level factors
Policies prioritizing community oral health as a medical need, leadership, and networks between community oral health partners.

Economy level factors
Availability of public and private funding to subsidize cost of care.

ening their capacity and sustainability. However, safety-net dental clinics operate within a larger context comprised of factors at multiple levels. Harder+Company developed a conceptual framework to map the influence of practice-management consulting within this larger context (Figure 1). Clinics often operate within a larger health care organization such as an FQHC, a county health clinic, or a nonprofit. These health care organizations in turn operate within a larger system of health care resources, policies, actors, and institutions. This framework informed the study design as well as interpretation of findings.

Practice-management consulting primarily influences practice-level factors such as patient policies, scheduling, and billing procedures. While this model may address some factors at the parent organization, such as support from executive leadership, it has little influence on the greater health care system and economic context. The goal of this framework is not to minimize the potential of practice-management consulting to improve long-term sustainability, but to recognize that sustainability is a result of action and change at multiple levels. Each clinic operates within a unique set of constraints and supports at each level, and therefore the outcomes of practice-management consulting may be affected by variables from this larger context. For example,

six of the nine clinics in this study relied heavily on California's Medicaid adult dental coverage, which was eliminated by the state legislature during the study period. The evaluation's assessment of financial improvement therefore took into account the effect of this funding cut on clinic progress.

Methodology
Harder+Company used a multicase study design, an approach that is particularly useful when interventions are implemented across unique sites (Stake, 2006). First, the evaluation team developed individual case studies of each of the nine SCDP clinics, incorporating content analysis of all qualitative data and a quantitative analysis of data on clinic operations and finances. The team next analyzed all nine case studies to identify cross-cutting themes as well as situational influences and constraints. Data sources included:

1. site visits incorporating in-person interviews with dental-practice directors, dental line staff, and clinic medical and executive leadership at project launch;

2. telephone interviews with dental directors or other key staff members at project completion;

3. review of documents generated through the consulting process (i.e., practice assessments, clinic enhancement plans, progress reports, and final reports provided by the consultants);

4. interviews with the consultants; and

5. quarterly financial reports submitted by each clinic.

With respect to the fifth item, clinics provided quarterly data specific to their dental practice at baseline and for the following three quarters. Metrics included financial (i.e., net revenue, expenses, payer and patient mix) as well as productivity measures (i.e., number of patient visits, wait time to next available appointment, no-show rate). While qualitative data sources provided a look into what happened at each clinic, the financial and operational data added an important dimension to the evaluation by grounding clinic staff responses in objective measures.

From a grantmaking perspective, demonstration projects that intentionally incorporate diversity can yield a richer analysis and a deeper understanding of factors that influence success.

To understand the model's long-term prospects (question 4), the cross-case analysis was supplemented by interviews with CHCF and CPP staff, potential partnering agencies and other state stakeholders, and dental clinics outside of the demonstration project. These interviews went beyond the experience and results of pilot sites to examine the perspectives of key stakeholders on the applicability of this model to California. All told, more than 60 interviews informed the evaluation.

Diversity of Clinics and Consultants

From a grantmaking perspective, demonstration projects that intentionally incorporate diversity can yield a richer analysis and a deeper understanding of factors that influence success. An important element of the SCDP demonstration project was the incorporation of diversity in the clinic and consultant selection process. CHCF and CPP selected participating demonstration practices to represent a range of safety-net dental clinics in California. The diversity of clinics enabled an understanding of how practice-management consulting affected clinics in a variety of settings. Clinics varied by type (federally qualified health centers, public health clinics, nonprofit clinics), size and structure (mobile, single-site, multisite), setting (urban and rural), tenure (startup versus more established practices), and patient mix (serving primarily adults or primarily children).

As discussed previously, CHCF and CPP also contracted with two practice-management consulting providers:

- Safety Net Solutions (SNS) is a program of DentaQuest Institute, a Massachusetts-based oral health organization that specializes in providing practice-management consulting to safety-net dental clinics. SNS's approach can be summarized as diagnostic assessment based on analysis of practice data, discussion of findings with clinic staff, development of an improvement plan, and supported implementation of improvement strategies. SNS worked with seven of the nine participating clinics.
- Pride Institute is a California-based consulting firm that provides practice-management consulting primarily to private, as opposed to safety-net, dental practices. Pride uses a two-year consulting model: the first year focuses on information gathering and systems building, and the second year focuses on implementation. Pride modified its approach for SCDP; it included diagnostic assessment and creation of vision based on a site visit, a one-day course based on the findings and vision, self-directed implementation based on the new vision, and ongoing consultant support via phone and periodic visits. Pride worked with two of the participating clinics.

Both consultants recommended common practice-management improvements such as adjusting fees to match local rates, modifying patient mix to focus on pediatric patients, altering scheduling practices to maximize use of each dentist's time, and establishing policies and procedures with respect to patient care and clinic expectations.

Similar Strategies, Different Results

This evaluation sought to assess the added value of consulting services for the participating clinics. One of the key challenges of the evaluation was that clinics had varying starting points and goals. Success should look different for each clinic, so how does one examine success across clinics? For example, one participating organization was a nonprofit mobile dental clinic established to serve children through age five and pregnant women in rural areas through prevention and early intervention services. In the wake of the statewide fiscal crisis, this clinic faced an 80 percent cut in its grant funding and found that it needed to chart an entirely new course to survive, one that emphasized treatment and restorative care. There was also an urban medical clinic that has been serving the local community for more than 30 years; it recognized the need for affordable dental care and started a dental program. This clinic started with a strong infrastructure, but desired expert advice regarding how to create an organized, efficient, and financially stable dental practice.

How did the evaluation define success across a variety of clinic characteristics, needs, and capacities? The evaluation team developed an approach to indexing consulting success along four dimensions:

1. *Breadth of implementation.* Based on reports from clinic staff and consultants, to what extent did the clinic implement the consultant's recommendations?

2. *Improved finances.* Within the clinic's unique context and challenges, do the data demonstrate improved finances? For some clinics, this could mean improving the margin between the dental clinic's net revenue and expenses, while for others holding steady in the face of serving a growing share of uninsured patients could constitute an improvement.

3. *Improved operations.* Did the clinic improve internal policies, procedures, and practices designed to increase productivity? Staff and consultants reported operational improvements such as reduced wait time for appointments and reduced occurrence of missed appointments.

4. *Anticipated longevity of improvements over time.* Were the improvements likely to sustain over time? Improvements were judged as sustainable if clinic staff and consultants reported high clinic buy-in and close alignment between improvements and the clinic's mission and values.

In each dimension, clinics were rated "high," "moderate," or "low" based on their success relative to other participating clinics. The overall

> *Three of the clinics realized a high degree of success, three experienced moderate success, and three experienced low success with practice-management consulting.*

ranking for each clinic was based on these four factors, then reviewed and discussed with CHCF, CPP, the consultants, and individual clinics to ensure their accuracy.

As indicated in Table 1, clinic experiences were varied: Three of the clinics realized a high degree of success, three experienced moderate success, and three experienced low success with practice-management consulting:

• *High-success case.* As a newly established clinic, Clinic A looked to consultants for guidance on how to create an organized, efficient, and

TABLE 1 Assessment of Consulting Success[3]

Clinic	Overall success	Breadth of implementation	Improved finances*	Improved operations	Longevity of improvements
A	High	High	High	High	High
B	High	High	High	High	Moderate
C	High	High	Moderate	High	High
D	Moderate	Moderate	High	Moderate	Moderate
E	Moderate	Moderate	Moderate	Moderate	Moderate
F	Moderate	High	Low	Moderate	High
G	Low	Moderate	Low	Moderate	Low
H	Low	Low	Low	Moderate	Low
I	Low	Low	Low	Moderate	Low

* All financial calculations exclude grant funding.

financially stable clinic. With support from the executive director and clinic staff, Clinic A adopted nearly all of the consultant's recommendations to strengthen its foundation for the future. By the end of the engagement, Clinic A lifted its finances out of the red and cut its no-show rate from 41 percent to 20 percent.

- *Moderate-success case.* As an organization founded to be the "safety net of safety nets" for uninsured adults, Clinic E relied heavily on private foundation funding. Its funding deteriorated with the downturn of the economy, and the clinic turned to practice-management consulting to streamline operations and strengthen financial viability. As a result, Clinic E realized success in implementing new fee schedules and scheduling practices. However, several recommendations were not implemented due to perceived conflicts with the clinic's mission and purpose.
- *Low-success case.* Although Clinic G implemented many of the recommendations, the clinic did not experience as much success. Clinic G's main focus was to improve scheduling, which had been a source of significant frustration for staff at all levels. Despite high hopes, Clinic G experienced significant drops in productivity after implementing new scheduling practices. Staff theorized that this was

due in part to Clinic G's proximity to Mexico – patients could easily substitute care from across the border if they were unable to receive desired appointments.

Effective Consulting Strategies and Characteristics

Of the strategies recommended by consultants, four areas seemed to help clinics make the greatest strides toward sustainability. In each of the strategy areas, it is important to recognize that some people benefit from changes, and others do not. When clinics increase fees, some patients must pay more for services. When clinics elect to enforce a no-show policy, patients may have to wait longer for care. These are just some of the tradeoffs with which clinics struggle in order to keep their doors open and maintain services for underserved populations.

Across the nine participating clinics, findings suggest that there is no one-size-fits-all recipe, and what worked well for some clinics did not work well for others. The unique qualities and characteristics of each clinic therefore necessitate a tailored approach.

- *Adjusting fee schedules.* Given their mission to serve low-income and uninsured patients, many clinics charged fees well below the usual rates for the area. Consultants suggested fee increases coupled with a steeper sliding scale – such clinics collect higher fees from those who

[3] This article masks individual clinic names, though full results were shared with the California HealthCare Foundation, the California Pipeline Program, and participating clinics.

could afford it while providing larger subsidies for those at the lowest income levels. The five clinics that implemented new fee schedules all saw increased revenue.

- *Modifying patient mix.* Due to significant cuts to adult public dental benefits, consultants advised clinics to focus their efforts on pediatric patients. Patient-mix modification is a strategy that enables struggling clinics to remain solvent while meeting their goal of serving uninsured adults. While uninsured adult patients would not be turned away, they may have to wait longer for nonemergent care (up to 30 days at most clinics). Many clinics took this strategy to heart and recruited pediatric patients into their practices through active outreach and portable clinics at schools.

- *Altering scheduling practices.* Though sometimes seen as a peripheral function in clinics, scheduling practices are a cornerstone of clinic efficiency and financial viability. Scheduling practices have considerable potential to reduce the sense of chaos in daily operations while maximizing the use of each dentist's time, not only with regard to the number of patients served but also the quality of care. Most clinics implemented practices such as eliminating double-booking, scheduling no more than 30 days in advance, and scheduling by operatory rather than by dentist. When applied together, these practices can help clinics streamline provision of care while reducing incidence of missed appointments and maximizing productivity.

- *Establishing policies and procedures.* Policies and procedures help standardize and bring greater transparency to how staff members respond to patients in daily interactions. While policies and procedures entail a broad range of strategies, some stand out as the most noteworthy: defining clear policies on missed appointments, implementing triage to identify patients who need urgent care, requiring proof of income for the sliding-scale rate, improving follow-up on account receivables, and clarifying internal clinic policies. Clinics appreciated that consultants were able to identify what they needed and then bring in policies and procedures that clinics could tailor to their needs.

Overall, clinics expressed a high level of satisfaction with the consulting model. However, findings did point to potential refinements to the model. Some clinics felt overwhelmed by the long list of consultant recommendations, and suggested that the work be divided into modules so that they could focus on one operational area at a time. Some clinics reported challenges in working with an out-of-state provider due to scheduling constraints and limited availability for hands-on assistance. Key policy stakeholders who were interviewed recommended considering alternative delivery mechanisms (i.e., webinars, in-person training, conference calls) to provide access to technical assistance to a larger number of clinics.

> *Consultant characteristics also appeared to influence success. Specifically, clinic staff appeared to be more receptive to suggestions and open to change when they perceived the consultants as credible, experienced, and collaborative.*

Success-Enabling Factors at Clinics

While all clinics showed improvements, some clinics were more successful than others. CHCF and CPP wanted to understand why certain clinics were more successful, and how to support greater success. What was it about the clinic context or the consulting approach that brought greater success for some over others? How might the model deliver more consistent, positive results?

For the most part, clinics attempted similar changes but results varied because of each practice's local context and constraints. The evaluation pointed to several factors that created an environment for success (see Table 2): executive and clinic level buy-in, a culture that supports change, clear and compelling project goals, a designated project champion at both the health-center and dental-department level, and availability of

TABLE 2 Factors That Influenced Success

Factors	Key questions
Buy-in at executive (CEO, CFO, COO) and clinic levels	Is the clinic administration committed to providing leadership, resources, and other support for the work? Are staff members ready and willing to change existing practices?
Clear and compelling goals	Does everyone at both the administrative and clinic levels understand the project goals? Clear, compelling goals should portray: • a shared vision for change. • a sense of urgency for change. • clear benefits for patients, administration, and staff members.
A culture that supports change	Are staff members encouraged to speak up, raise new ideas, and try new things? Does this culture exist at both the administrative and clinic levels?
Project champions	Are there project champions at both administrative and clinic levels that will lead the work and advocate for the support and resources necessary for success?
Availability of resources	Are existing resources, including technological resources and facilities, adequate to support change? Will the dental director, clinic manager, or other leaders have release time to work on change?
Consultation customized to clinic needs	Which issues are at the core of the clinic's needs? What should be the role of practice-management consulting in helping the clinic move forward?

resources for the consulting work. By understanding these factors and addressing them prior to the consulting engagement, clinics could potentially have greater and more predictable success with practice-management consulting.

Consultant characteristics also appeared to influence success. Specifically, clinic staff appeared to be more receptive to suggestions and open to change when they perceived the consultants as credible, experienced, and collaborative. Clinics who worked with SNS commented that the consultants they worked with brought deep knowledge as practicing community dentists, and understood the legal mandates and strict reimbursement guidelines under which safety-net clinics operate. Staff also appreciated consultants who approached them as collaborative partners rather than simply telling them what to do. As one staff member shared, "They worked with us to develop recommendations and strategies. They didn't tell us what to do. It was a collaborative effort and they spoke with authority, knowledge, and experience."

Lessons Learned: Program Design Considerations

There were some clinics that were highly successful and some clinics that were less success-

ful. Collectively, the experiences of participating clinics yielded some interesting lessons learned relevant to grantmakers interested in building the capacity of safety-net clinics as well as those more generally interested in building the capacity of nonprofit organizations.

- *Improve likelihood of success through early assessment and support.* The bottom line for this demonstration project is that practice-management consulting offers great potential, but the success was varied. One way to reduce this variability would be to consider more stringent requirements for participation. In fact, many foundation-sponsored capacity-building initiatives incorporate assessments of nonprofit readiness for change. However, this approach risks excluding some nonprofits – and the communities they serve – that are most in need of assistance. Perhaps a better strategy would be to identify and support those who require assistance in establishing necessary success factors prior to their consulting engagement. Based on this evaluation, Harder+Company developed a potential typology for considering nonprofit needs and the possible implications for a capacity-building approach (Table 3). Some nonprofits require assistance understanding how capacity building may help them,

TABLE 3 A Potential Typology of Nonprofit Capacity Needs

	High stress	High resistance	Positioned for change
Nonprofit attributes	Chaotic and stressful operations. Limited staff time and data capacity to participate.	Champion sees need for change but faces resistance. Needs third party to help prioritize resources.	Well-positioned for change, but needs tools and/or buy-in to move forward.
Consulting approach	*Coach.* Nonprofit has minimal culture of change. Help managers see why operations are stressful so they recognize need for change.	*Facilitator.* Nonprofit is ready to expand culture of change. Extend buy-in to staff and executive leadership to enable implementation.	*Catalyst.* Nonprofit already has culture of change. Help identify final pieces required to put ideas into action.

while others may need assistance in rallying support and buy-in for the work. Those who are most positioned for change understand the need for capacity development and have buy-in at all levels of staff. All they need is someone to provide new ideas and guide them through implementation. Depending on whether a nonprofit is high stress, high resistance, or positioned for change, grantmakers may find that some nonprofits will require additional support to address requisite issues either prior to receiving support or as part of the technical assistance process.

- *Match consultants with the unique needs of nonprofits.* Clinics tended to have greater buy-in and commitment when they saw the consultant as someone who understood the unique challenges of their organization. In particular, clinics that participated in this demonstration valued working with consultants that brought deep experience working with safety-net dental practices and as well as an understanding of the health care system under which they operate. They felt such consultants were able to tailor their recommendations and approach to the specific needs of the clinic and provide appropriate hands-on assistance.
- *Determine if the nonprofit's core concerns and challenges can be addressed through capacity building.* In this demonstration, practice-management consulting helped clinics become more efficient and productive, thereby putting them on the right track toward financial stability. For some clinics, however, core issues may not be rooted in operational efficiency, policies, or procedures. One clinic viewed itself as "the safety net of safety nets," established to serve uninsured patients who could not afford

services and had nowhere else to go. While practice-management consulting was helpful, it had limited effects on financial sustainability given its focus on those who could not pay. Ultimately, the clinic felt that some of the consultant's recommendations were at odds with their founding purpose. In such cases, other modes of assistance might be more effective such as strategic planning or advocating for public policy and systems change.

Lessons Learned: Evaluation Considerations

Harder+Company has evaluated numerous nonprofit capacity-building initiatives on behalf of grantmakers. These programs have ranged from leadership development for individuals leading nonprofits to broader organizational development and field-building initiatives. Due to the range of perspectives gathered – quantitative practice-related measures and qualitative data from staff at all levels – this evaluation yielded some interesting lessons learned for capturing changes in nonprofit capacity.

- *Recognize that participants have different starting points.* When evaluating capacity-building initiatives, capturing the program impact can be a considerable challenge because each participant has a different starting point. One should not expect a high-stress nonprofit to achieve the same things that a nonprofit positioned for change may achieve within the same timeframe (see Table 3). Success will look different for each participant. Assessments that fail to account for varying starting points and context may not capture important successes for struggling nonprofits or missed opportuni-

ties for the more established nonprofits.

- *Incorporate the nonprofit ecology in assessing outcomes.* Isolating the effect of a particular capacity-building program from contextual influences can be challenging if not altogether impossible. It is more sensible to incorporate these contextual influences as contributing factors when interpreting the data. In this evaluation, this was done by establishing a conceptual framework to systematically examine the array of factors affecting organizational effectiveness and capacity. For example, in the analysis of clinic finances, this evaluation recognized that "no change" can be a success. Maintaining financial stability, as opposed to increasing net revenue, was a major success for clinics strongly affected by the elimination of adult Medicaid dental benefits in the evaluation period. Accounting for contextual influences such as this helps to reduce biases in the analysis.

- *Create a safe space for evaluation.* A considerable challenge of evaluating capacity-building initiatives is to promote full, honest participation in evaluation by fostering the trust of participants. Clinics were initially concerned about openly expressing their capacity needs and their experiences with foundation-sponsored consultants. The consultants, too, desired to come across as experts in the process, but recognized the potential of evaluation to inform their own practice. One of the evaluation's successes was the establishment of a learning environment in which clinics and consultants were open to sharing their views about strengths, challenges, and lessons learned. This was accomplished by working closely with CHCF and CPP staff to share clear messages regarding the purpose of the demonstration project – to understand the potential of this capacity-building strategy and to identify ways to strengthen it. Grantees were also invited to review and provide feedback on their individual case studies, which identified them by name, prior to their inclusion in the full report. This process further strengthened the analysis as grantees shared their insights regarding what worked best and supports needed for success.

Looking to the Future

In summary, the evaluation described how most clinics showed high or moderate levels of improvement in clinic operations and financial performance. The technical assistance models had strengths and weaknesses, and the evaluation identified elements for a modified model to increase predictability and success. Given the promising results of the demonstration, CHCF became interested in increasing access to practice-management technical assistance for a greater number of California clinics. The foundation recognized the need to develop a sustainable statewide infrastructure.

Building upon the knowledge established by the SCDP demonstration project, CHCF is working with the California Primary Care Association (CPCA) to develop a sustainable technical assistance program and to align it with federal resources. CPCA, an advisor to the pilot demonstration, represents more than 800 nonprofit community clinics and strengthens its member clinics through advocacy, education, and services in order to improve the health status of their communities. CPCA is thus optimally positioned to act as the hub for this second phase, developing needed infrastructure and determining the sustainability of the revised model.

Safety Net Solutions is working with the CPCA to develop online technical assistance resources that incorporate lessons learned from the evaluation. This includes developing a self-assessment tool for clinics to identify needs and readiness for change and to recommend specific practice-management strategies for each clinic to pursue. All clinics have access to online practice-management modules as well as a data warehouse for benchmarking their performance against other clinics. Customized, on-site consulting is available for clinics that require additional support. In addition, CPCA is partnering with the Center for the Health Professions at the University of California, San Francisco to deliver dental-director leadership training that focuses on managing organizational change and coordinating with medical directors, in response to some of the lessons learned from this evaluation.

The new, lower-cost model will be evaluated based on the following outcomes:

- use of online technical assistance services by at least 25 percent of clinics with dental operations,
- demonstrated improvement in dental operations and financial performance among participating clinics,
- development of a robust and active dental-director peer group, and
- development and continuation of a sustainable technical assistance model for safety-net dental practices.

Ultimately, this next phase of the project will make education and consulting services available to a much broader swath of state dental clinics with the ultimate goals of improving efficiency, promoting financial sustainability, and increasing access to low-income and uninsured Californians.

References

Backer, T., Bleeg J. E., & Groves, K. (2010). *Evaluating foundation-supported capacity building: Lessons learned.* Encino, CA: Human Interaction Research Institute. Retrieved August 30, 2011 from http://www.humaninteract.org/images/finalrep129c.pdf.

Hughes, D., & Diringer, J. (2009). *Eliminating Medi-Cal adult dental: Costs and consequences.* Sacramento, CA: Oral Health Access Council, California Primary Care Association, and the Dental Health Foundation.

Katz, M. H. (2010). Future of the safety net under health reform. *Journal of the American Medical Association, 304*(6): 679-680.

National Association of Community Health Centers. (2009). *The American Recovery and Reinvestment Act of 2009: Frequently asked questions.* Retrieved August 30, 2011 from http://www.nachc.com/client/documents/NACHC%20ARRA%20FAQ.pdf.

Scott, M. K., Bingham, D., & Doherty, M. (2008). *The good practice: Treating underserved dental patients while staying afloat.* Oakland, CA: California HealthCare Foundation.

Silverman, L., Taliento, L., Baumann, H., Salinas, D., McCabe, R., & Banos, M. (2009). *Effective capacity building in nonprofit organizations.* Reston, VA: Venture Philanthropy Partners. Retrieved August 30, 2011 from http://www.vppartners.org/sites/default/files/reports/full_rpt.pdf

Stake, R. E. (2006). *Multiple case study analysis.* New York: Guilford Press.

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