The blue-collar practice

An interview with Dr. Craig Callen
By Robin Goodman, Group Editor

Your seminar is entitled, “The Million Dollar Blue-Collar Practice,” is that what you are promoting?

I am not really promoting any one form of practice, just showing that there are several different practice models that can be successful, including a practice in a blue-collar area. You can still have a successful practice and provide quite a bit of cosmetic treatment for your patients in a blue-collar setting. You need to know your market and what it will support. I have seen successful cosmetic boutique practices in small towns, but they are few and far between. Often those practices were transitioned from a traditional family practice.

Do you think that blue-collar practices are more profitable than a high-end cosmetic or reconstruction practice?

Not necessarily more profitable, but more realistic based on the demographics of your area. For instance, in Mansfield we have a median income of $30,000 and a shrinking population base. The manufacturing jobs are leaving and being replaced with lower paying service and retail jobs. While it may be possible for one or two strictly cosmetic practices to prosper in the area, it would be a real marketing challenge. However, gearing your practice toward the blue-collar market and offering a variety of services draws in a larger number of patients, some of who will accept cosmetic dentistry. Everyone seems to be going for the same slice of the pie. Many of our patients start out only concerned about a toothache and end up having their mouth rebuilt when all is done.

What cosmetic services do you offer in your blue-collar practice?

We offer probably the same services in the cosmetic realm as many other practices, such as all-porcelain crowns, no amalgams, bleaching, Invisalign, implants and so on. But we also do a lot of root canal treatment, periodontics, and endodontics. One of the biggest profit centers for us is in the area of esthetic dentures and partials.

We have three or four big denture centers advertising in our area that provide low-cost basic dentures. We market ourselves in the other direction with higher cost, esthetically pleasing and comfortable dentures. I spend a lot of time remaking cases where the denture mills provided less than acceptable results. This has become one of the most rewarding and profitable parts of the practice.

Another economic boost for us has been the use of the Cercon CAD/CAM system in the office. We can easily provide a wide variety of porcelain restorations in under an hour. Consequently, we do a lot more inlays and onlays than we ever did before.

What tools do you use to upgrade your patients treatment to accepting cosmetic dentistry in a blue-collar practice?

We use a variety of materials and equipment to help us educate and motivate our patients. It starts with a nice professional “Smile Analysis graphics of your area. For instance, in Mansfield we have a median income of $30,000 and a shrinking population base. The manufacturing jobs are leaving and being replaced with lower paying service and retail jobs. While it may be possible for one or two strictly cosmetic practices to prosper in the area, it would be a real marketing challenge. However, gearing your practice toward the blue-collar market and offering a variety of services draws in a larger number of patients, some of who will accept cosmetic dentistry. Everyone seems to be going for the same slice of the pie. Many of our patients start out only concerned about a toothache and end up having their mouth rebuilt when all is done.

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UCSF receives $24.4 million to fight early childhood cavities

The UCSF School of Dentistry has received the largest grant in its history: $24.4 million from the National Institutes of Health (NIH) to address socio-economic and cultural disparities in oral health. The seven-year grant, which is funded through the NIH National Institute of Dental and Craniofacial Research, will enable the UCSF Center to “address disparities in children’s oral health” (nicknamed CAN DO) to launch new programs in preventing early childhood tooth decay. The programs will include new research to compare methods to prevent dental caries in children, as well as efforts to integrate and improve understanding across a variety of primary care and social service settings. The NIH also tapped UCSF as the Data Coordinating Center for three of the funded centers: UCSF, Boston University and University of Colorado, Denver. These three centers are being collectively called the Early Childhood Caries Collaborative Centers. Each center includes two randomized clinical trials, and all are focused on preventing early childhood caries in different vulnerable, high-risk populations.

“Dental caries is the most common chronic disease among children and it is becoming a prevalent nationwide, disproportionately among children in low-income families and certain minority groups,” said John Featherstone, PhD, dean of the UC School of Dentistry. “This disease is very difficult and expensive to treat in young children, but it is largely preventable.”

The 1999–2004 National Health and Nutrition Examination Survey (NHANES), data from the Centers for Disease Control illustrated these disparities in children by race/ethnicity with 42 percent of Mexican American and 52 percent of black children ages 2–5 having decayed or filled teeth, compared with 24 percent of white children.

The new programs will assess the best way to reach susceptible young children and their caregivers to prevent early childhood caries and reduce oral health disparities. Early childhood caries is a particularly devastating form of dental caries in young children. General anesthesia is often required for treatment of early childhood caries, which is an expensive and traumatic condition to treat, said Jane Weintraub, DDS, MPH, professor and chair of the Division of Oral Epidemiology and Dental Public Health at UCSF.

“We need to get out the message that healthy baby teeth are important for children’s health and well-being,” said Weintraub, who is the principal investigator for the CAN DO Center. “We have an easy, relatively low-cost strategy — fluoride varnish painted on the child’s teeth — that helps prevent teeth from decaying and causing children to have toothaches and difficulty eating, sleeping and speaking.”

Weintraub said this funding will enable the UCSF program to forge new partnerships with dental, medical and primary care colleagues, as well as with the federally-funded Women, Infants and Children (WIC) health and nutrition program, to create effective ways of improving children’s oral health in non-traditional settings. For further information, visit www.ucsf.edu.

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