Helping Dentists Succeed in a Changing Paradigm

Kathleen O’Loughlin, D.M.D.
Executive Director, COO
What is the ADA?
DIRECT MEMBER BENEFIT OR VALUE: SOLVES A SPECIFIC PROBLEM FOR A MEMBER-SPECIFIC SOLUTION or ENABLES A STATE TO DO SO

INFLUENCES OR IMPACTS THE ENVIRONMENT THAT DENTISTS OPERATE IN SO THE MEMBER HAS A BETTER CHANCE OF SUCCEEDING

HEALTH ASSOCIATIONS, LEGISLATORS, REGULATORS, DEANS, MEDIA, COALITIONS, DENTAL TRADE ALLIANCE, SPECIALTIES, THE PUBLIC, COALITIONS AND ADVOCACY GROUPS, FOUNDATIONS, GOV AGENCIES DENTAL BENEFITS INDUSTRY, GLOBAL DENTAL COMMUNITY, ETC
Power of Three:
National, state, local ADA societies collaborate to increase focus on member value and experience, regardless of practice location or practice type.
ADA 2014-15 Group Practice Initiative

• Multiple ADA Agencies
  – Health Policy Institute
  – Council on Dental Practice
  – Council on Membership
  – Council on Ethics, Bylaws and Judicial Affairs
  – Department of Product Sales
  – Council on Annual Sessions
  – Council on Communications
  – Council on Members Insurance and Retirement Plans
Objectives

1. Increase knowledge and understanding of group practice models
2. Disseminate knowledge to state and local dental societies
3. Foster dialogue and engagement among group practice stakeholders
4. Develop products, benefits and services to encourage membership
### ADA 2014 Group Practice Taxonomy

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentist Owned and Operated Group Practice</td>
<td>An aggregation of a variable number and/or type of dentists in a single practice that may be located at a single or multiple sites completely owned and operated by dentists, usually organized as a partnership or professional corporation.</td>
</tr>
<tr>
<td>Dental Management Organization Affiliated Group Practice</td>
<td>A group practice that has contracted with a dental management organization to conduct all of the business activities of the practice that do not involve the statutory practice of dentistry, sometimes including the ownership of the physical assets of the practice. There are several types of dental management organizations and there can be significant variations in the nature of the agreements between the dentist and the dental management organization.</td>
</tr>
<tr>
<td>Insurer-Provider A group practice that is part of an organization that both insures the health care of an enrolled Group Practice population and also provides their health care services.</td>
<td></td>
</tr>
<tr>
<td>Not-for-Profit Group Practice</td>
<td>A group practice that is operated by a charitable, educational or quasi-governmental organization that often focuses on providing treatment for disadvantaged populations or training healthcare professionals.</td>
</tr>
<tr>
<td>Government Agency Group Practice</td>
<td>A group practice that is part of a government agency. It is organized and managed completely by the agency. All dentists are government employees or contractors and operate according to agency policies.</td>
</tr>
<tr>
<td>Hybrid Group Practice</td>
<td>A group practice that does not clearly fit into any of the above categories and can exhibit some characteristics of several of them.</td>
</tr>
</tbody>
</table>
Deliverables – 2 Year Timeline

1. Development of group practice database
2. Research and analytics for baseline of market, trends, indicators and member personas
3. Development and delivery of unique member benefit and service portfolios to meet needs of member dentists who own or are employed in group practice settings
Current Activities: Outreach

- ADSO
  - Advisors to ‘My GPS’ initiative
  - Roundtable

- AADGP
  - Speakers from ADA to AADGP’s annual meeting
  - Roundtable

- DOHI
  - Survey of dentist employees on value of ADA membership (DOHI)
• **HPI**
  – Dentist Satisfaction Survey
    • To be submitted to JADA
    • Compared dentists in solo, small group and large group practices
  – **Key Findings**
    • Dentists in large group practice settings least stressed
    • Dentists in large group practice settings most dissatisfied
Current Activities

CDP Forums at Annual Meeting

2012—Has the Economic Downturned Changed Dentistry Forever?

2013—The Growth of Group Dental Practice

2014—Understanding Group Practice Models

2015—Group Practice: The Inside Story

2015: Every Practice Model Can be a Model Practice

2016--???

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Our time today

• Dental Trends: Health Policy Institute
• ADA and Dentistry in a New Paradigm
• Collaboration Opportunities
  – What value does ADA membership have for Group Practice Employee Dentists?
  – What value does ADA have for Group Practice Business Models?
Total Dental Spending

Figure 1: National Dental Expenditure ($ millions)

Figure 1: General Practitioner Dentist Earnings, 1981 to 2013

Source: ADA Health Policy Institute; Bureau of Economic Analysis; Bureau of Labor Statistics. Note: Net income data are based on the ADA Health Policy Institute annual Survey of Dental Practice with years 2000-2013 weighted to adjust for nonresponse bias. Shaded areas denote recession years according to NBER. GDP is deflated using the GDP deflator. Net income is deflated using the all-item CPI. All values are in constant 2013 dollars.
Dental Care Use

**Figure 1:** Percentage of the Population with a Dental Visit in the Year, 2000-2012

Source: Medical Expenditure Panel Survey, AHRQ. Notes: For children ages 2-18, changes were statistically significant at the 1% level (2000-2012) and at the 10% level (2011-2012). Among adults ages 19-64, changes were statistically significant at the 1% level (2003-2011). For adults 65 and older, changes were significant at the 5% level (2000-2012). Changes from 2011 to 2012 among adults 19-64 and the elderly 65 and above were not statistically significant.
Barriers to Dental Care

Figure 3: Percentage Indicating Financial and Supply-Related Barriers to Needed Dental Care

Source: 2003-2004 and 2011-2012 NHANES. Notes: Change from 2003-2004 to 2011-2012 in the percentage indicating supply-related barriers was significant at the 1% level.
Cost Barriers to Dental Care Use

Figure 1: Percentage of the Population Who Needed But Did Not Obtain Select Health Care Services during the Previous 12 Months Due to Cost, 2000-2013

Source: National Health Interview Survey, National Center of Health Statistics. Notes: Changes from 2000 to 2010 for all services were statistically significant at the 1% level. Changes from 2010 to 2013 for all services were statistically significant at the 1% level. Changes from 2012 to 2013 were not statistically significant.
Cost Barriers to Dental Care Use

Figure 2: Percentage of the Population Indicating Cost as a Barrier to Receiving Needed Dental Care by Age Group, 2000-2013

Source: National Health Interview Survey, National Center for Health Statistics. Notes: Changes from 2000 to 2010 for age groups 21-34, 35-49, 50-64 and 65+ were statistically significant at the 1% level. Changes from 2010 to 2013 for age groups 2-20, 21-34 and 35-49 were statistically significant at the 1% level. Change from 2010 to 2013 for age group 50-64 was statistically significant at the 5% level. For adults ages 21-34, the change from 2012 to 2013 was statistically significant at the 1% level. For other age groups, changes from 2012 to 2013 were not statistically significant.
Reasons for Not Seeking Dental Care

Figure 2: Reasons Why Adults Do Not Plan to Visit a Dentist in the Next 12 Months by Household Income (Percentage of the FPL)

- **Cost**
- I do not have time to get to the dentist
- I cannot easily travel to the dentist
- I cannot find a dentist that accepts my insurance
- I have dentures/no teeth
- Anxiety over visiting the dentist
- Other reason

Source: ADA Health Policy Institute analysis of Harris Poll survey data collected April 2014. Notes: Results based on 875 observations. Income categories are based on household income as a percentage of the FPL based on HHS 2014 Federal Poverty Guidelines. All survey responses are weighted by general population weights provided by Harris Poll.
Reasons for Not Seeking Dental Care

Figure 3: Reasons Why Adults Do Not Plan to Visit a Dentist in the Next 12 Months by Health Insurance Status

Source: ADA Health Policy Institute analysis of Harris Poll survey data collected April 2014. Notes: Results based on 965 observations. Health insurance categories are based on respondents’ reported source of health insurance. All survey responses are weighted by general population weights provided by Harris Poll.
Dental Benefits Coverage

Figure 1: Source of Dental Benefits, Children Ages 2-18, 2000-2012

Source: Medical Expenditure Panel Survey, AHRQ Notes All changes were significant at the 1% level (2000-2012). Changes from 2011 to 2012 were not statistically significant.
The Medicaid Expansion

Potential Increase in Adults on Medicaid due to the ACA in States with Adult Dental Benefits

- CO: 123%
- ND*: 152%
- WA: 102%
- RI: 120%
- OR: 101%
- OH: 93%
- NM: 91%
- IL: 77%
- IA: 61%
- CA: 44%
- AK*: 38%
- WI*: 31%
- NY: 30%
- CT: 28%
- MA: 10%
- NC*: 9%
- AR: 205%
- KY: 198%
- NJ: 156%
- PA*: 93%
- MI: 67%
- MN: 46%
- MT*: 30%
- DC: 25%
- SD*: 22%
- VA*: 16%
- WY*: 15%
- VT: 15%
- LA*: 15%
- SC*: 14%
- NE*: 12%
- IN*: 11%

8.3 million
The Medicaid Expansion

The Adult Dental Benefits Expansion in Select States

States Expanding Medicaid under the ACA

States Not Expanding Medicaid under the ACA

<table>
<thead>
<tr>
<th>State</th>
<th>Expanded Medicaid</th>
<th>Total Gaining Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illinois</td>
<td>632,000</td>
<td>45,580</td>
</tr>
<tr>
<td>Ohio</td>
<td>590,000</td>
<td>23,016</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>496,000</td>
<td>85,225</td>
</tr>
<tr>
<td>Michigan</td>
<td>426,000</td>
<td>52,628</td>
</tr>
<tr>
<td>New Jersey</td>
<td>337,000</td>
<td>32,358</td>
</tr>
<tr>
<td>Arkansas</td>
<td>236,000</td>
<td>8,194</td>
</tr>
<tr>
<td>New Mexico</td>
<td>153,000</td>
<td>6,227</td>
</tr>
<tr>
<td>Iowa</td>
<td>113,000</td>
<td>5,409</td>
</tr>
<tr>
<td>North Dakota</td>
<td>86,000</td>
<td>23,000</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>141,000</td>
<td>18,746</td>
</tr>
<tr>
<td>North Carolina</td>
<td>138,000</td>
<td>38,000</td>
</tr>
<tr>
<td>Louisiana</td>
<td>129,000</td>
<td>37,501</td>
</tr>
<tr>
<td>Virginia</td>
<td>49,483</td>
<td>21,035</td>
</tr>
<tr>
<td>Indiana</td>
<td>24,156</td>
<td>26,000</td>
</tr>
<tr>
<td>Alaska</td>
<td>2,175</td>
<td>13,000</td>
</tr>
<tr>
<td>Montana</td>
<td>5,146</td>
<td>7,000</td>
</tr>
<tr>
<td>Nebraska</td>
<td>3,824</td>
<td>6,000</td>
</tr>
<tr>
<td>South Dakota</td>
<td>1,515</td>
<td>5,000</td>
</tr>
<tr>
<td>Wyoming</td>
<td>1,495</td>
<td>2,600</td>
</tr>
</tbody>
</table>

Public Dental Benefits via Medicaid | Private Dental Benefits via Health Insurance Marketplaces
Are We in a Medical Education Bubble Market?

David A. Asch, M.D., M.B.A., Sean Nicholson, Ph.D., and Marko Vujicic, Ph.D.

COVER STORY

Educational debt and intended employment choice among dental school seniors

Tanya Wenchek, PhD; Sean Nicholson, PhD; Marko Vujicic, PhD; Adriana Nemezes, Anthony Ziebert, DDS, MS

ABSTRACT

Background. The authors examine the association between educational debt and dental school seniors’ intended activity after graduation.

Methods. The authors used multinomial logit regression analysis to estimate the relationship between educational debt and intended activity after graduation, controlling for potentially confounding variables. They used data from the 2004 through 2011 ADA [American Dental Education Association] Survey of Dental School Seniors.

Dental school students’ debt levels are rising. The average educational debt of graduating dental school seniors, including both dental school debt and prior educational debt, rose from $122,000 in 2004 to $179,000 in 2011 according to calculations we performed by using data from the ADA [American Dental Education Association] Survey of Dental School Seniors. Dentists’ income has not risen as rapidly over the same period. As a result, average edu.
Although it seems unlikely that we’re in a bubble market for medical education, we may already be in one for veterinary medicine. That bubble will burst when potential students recognize that the costs of training aren’t matched by later returns. Then the optometry bubble may burst, followed by the pharmacy and dentistry bubbles. At the extreme, we will march down the debt-to-income-ratio ladder, through psychiatrists to cardiologists to orthopedists . . . until no one is left but the MBAs.
Career Choices – Student Debt

The graph illustrates the change in likelihood of choosing private practice among dental professionals given various factors:

- An increase of $10,000 in debt.
- Being female compared to male.
- Being Black compared to White.
- Parenting being a dentist.

The variables influencing employment choice are shown in the legend:

- Advanced Education
- Teaching, Research, and Administration
- Government Service
- Public Health

The graph shows a significant negative impact on the likelihood of choosing private practice for females and Black individuals, especially when there is an increase in debt.
The probability that a female dentist owns her practice is 22 percentage points lower than a male dentist.

Whites are much more likely to own a practice than Hispanics (by 12.9 percentage points), Asians (by 18.0 percentage points), and blacks (by 19.4 percentage points).

Females and non-whites are more willing to accept poor patients than males and whites.

Debt does not affect ownership or willingness to accept poor patients.
Career Choices – Group Practice

• Dentists in large group practices…
  – reported lower satisfaction levels associated with work hours, scheduling, and overall work-life balance
  – reported less ability to influence the organization or to advance within it
  – reported higher satisfaction levels with income and benefits
  – were less likely to report feeling stressed in their jobs
  – were less likely to be satisfied with the care delivered in their practice
  – were less likely to report satisfaction with their careers in dentistry
Supply of Dentists

Graduates
Foreign-trained
Re-licensure
Un-retirement

Practicing Dentists

Retirement
Death
License lapse

Exit labor force
Emigration
## Supply of Dentists

### Table 8: Summary of Workforce Projection under Nine Scenarios, Dentists per 100,000 Population

<table>
<thead>
<tr>
<th>Assumptions</th>
<th>Inflow rate</th>
<th>Outflow rate</th>
<th>Projections</th>
<th>Estimated Likelihood</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>2013</td>
<td>2018</td>
</tr>
<tr>
<td>High</td>
<td>Low</td>
<td></td>
<td>61.7</td>
<td>62.6</td>
</tr>
<tr>
<td>High</td>
<td>Medium</td>
<td></td>
<td>61.7</td>
<td>62.1</td>
</tr>
<tr>
<td>High</td>
<td>High</td>
<td></td>
<td>61.7</td>
<td>61.5</td>
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<tr>
<td>Medium</td>
<td>Low</td>
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<td>62.6</td>
</tr>
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<td>61.7</td>
<td>61.6</td>
</tr>
<tr>
<td>Low</td>
<td>High</td>
<td></td>
<td>61.7</td>
<td>61.0</td>
</tr>
</tbody>
</table>

**Source:** ADA Health Policy Institute analysis of ADA masterfile; U.S. Census Bureau, Intercensal Estimates and National Population Projections. **Notes:** Data for 2013 are based on the ADA masterfile. Results after 2013 are projected. Baseline scenario is shaded. See Data & Methods for more details. “Estimated Likelihood” is the authors’ assessment. See methods section for more details. Key to Estimated Likelihood: ***** = Most likely; **** = Highly likely; *** = Somewhat likely; ** = Unlikely; * = Highly unlikely.
Figure 4: Historical and Projected U.S. Dentists per 100,000 Population, by Age Group, Baseline Scenario

Source: ADA Health Policy Institute analysis of ADA masterfile; U.S. Census Bureau, Intercensal Estimates and National Population Projections. Notes: Data for 2003, 2008, and 2013 are based on the ADA masterfile. Results after 2013 are projected. Assumes (a) U.S. total annual dental school graduates will increase linearly to 2018 and then remain flat (b) future outflow rates are same as 2008-2013 historical percentages.
ADA Health Policy Institute is taking a fresh look at practice setting, asking dentists about:

- Work/Life Balance or Stress
- Overall Job Satisfaction
- Satisfaction with Patient Care
ADA is Focused on Future of Dentistry

- Finding a job and mobility
- Keeping pace with the speed of innovation after dental school
- Ethics, standards, accountability
- Income
- Work/life balance
- Contributing to higher good
Age Demographics By Practice Size

<table>
<thead>
<tr>
<th>Group Size</th>
<th>Median Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very small (&lt; 5 dds)</td>
<td>50</td>
</tr>
<tr>
<td>Small (5-10 dds)</td>
<td>46</td>
</tr>
<tr>
<td>Medium (11-20 dds)</td>
<td>43</td>
</tr>
<tr>
<td>Large (21-100 dds)</td>
<td>41</td>
</tr>
<tr>
<td>Very large (&gt; 100 dds)</td>
<td>39</td>
</tr>
</tbody>
</table>
Gender By Practice Size

The graph shows the percentage of male and female dentists in different practice sizes. The practice sizes are categorized as:

- Very small (< 5 dds)
- Small (5-10 dds)
- Medium (11-20 dds)
- Large (21-100 dds)
- Very large (> 100 dds)

The bars for male and female dentists are represented in green and blue, respectively. The percentage values are indicated on the y-axis.
Experience by Practice Size

![Bar chart showing experience by practice size. The x-axis represents group size with categories: Very small (<5 dds), Small (5-10 dds), Medium (11-20 dds), Large (21-100 dds), Very large (>100 dds). The y-axis represents percent. The chart includes bars for Established DDS, Young DDS, and New DDS.](chart_image)
Access to ADA Benefits for Young Dentists by Group Size

- **Yes**
- **No**
- **Poly. (Yes)**

<table>
<thead>
<tr>
<th>Group Size</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very small (&lt; 5 dds)</td>
<td></td>
</tr>
<tr>
<td>Small (5-10 dds)</td>
<td></td>
</tr>
<tr>
<td>Medium (11-20 dds)</td>
<td></td>
</tr>
<tr>
<td>Large (21-100 dds)</td>
<td></td>
</tr>
<tr>
<td>Very large (&gt; 100 dds)</td>
<td></td>
</tr>
</tbody>
</table>
Group Practice Size

Plot of Group Practice Size on Average Percent of Dentists with ADA Benefits

- **Ave. percent with ADA benefits**
- **Group size on benefits regression**
- **Pct. of all dentists with ADA benefits**

**Note:**

- Data points represent the average percent of dentists with ADA benefits across different group practice sizes.
- The trend line indicates a decreasing percentage of dentists with ADA benefits as the group practice size increases.

**Source:** American Dental Association

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Key Points from ADA Analysis

- **Dentists in large group practices were less satisfied with income and benefits**
  - They did report making about $1,000 less on average, but this salary difference is small

- **Dentists in large group practices reported lower satisfaction levels associated with work hours, scheduling, and overall work-life balance**
  - Dentists in small group practice may have the flexibility to work out coverage arrangements with partners to provide sufficient flexibility
  - Dentists in large group practices spend 1 hour less than dentists in small group practice on administrative tasks, suggesting some degree of relief from administrative tasks associated with working in a large group
Key Points from ADA Analysis

• Dentists in large group practice reported less ability to influence the organization or to advance within it
  – Large group practice might be more hierarchical in nature and potentially more difficult for any one given dentist to influence – this conflict between employer and employee is not necessarily unexpected as it is most likely ubiquitous in any large organization
• Dentists in large group practice were less likely to report feeling stressed in their jobs
  – No other differences by practice setting related to emotional exhaustion on the job
  – Note that lower level of reported stress did not translate to an increased level of satisfaction
• Dentists in large group practice were less likely to be satisfied with the care delivered in their practice and were less likely to report satisfaction with their careers in dentistry
Key Points from ADA Analysis

• NOTE: findings are not generalizable to all dentists in these practice settings

• Lower satisfaction does not necessarily mean any practice setting is worse than another.
  – Large group dentists reported less satisfaction with numerous aspects of practice but they were also tended to disagree with the statement that their current practice is what they envisioned when they chose dentistry. Perhaps a mismatch between expectations and reality account for some of this dissatisfaction.

• Each setting has advantages and disadvantages; what is the “best” practice setting for a dentist depends on that dentist’s personal preferences
Customized CE Program via ADA Studios

Fully functional dental operatory designed for live-patient webcast educational program, along with green screen room and production facilities.
Access to 150+ CE courses online
20-40 new courses added annually, live-patient demonstrations

**EMERGENCY MEDICINE: ALTERED CONSCIOUSNESS - SECTION 4**

You will receive 2 hours of continuing education credit upon successful completion of this course. The purchase price of this course is $25.00

**DESCRIPTION:**

Sepsis, hypoglycemia and seizures are not uncommon emergencies in the dental office. This program reviews the prevention, recognition and management of these common causes of altered consciousness.

**AUTHOR:**

Stanley Mohamed, D.D.S.

**BIOGRAPHY:**

Dr. Mohamed was born and raised in the Bronx, New York, graduating from the New York University College of Dentistry in 1989. He then completed a dental internship and residency in anesthesiology at Montefiore Hospital and Medical Center in the Bronx, New York before serving for 2 years in the U.S. Navy Dental Corps at T. Hayes, Kentucky. In 1993, Dr. Mohamed joined the faculty of the Herman Ostrow School of Dentistry of U.S.C., in Los Angeles, where today he is Professor of Anesthesiology. Dr. Mohamed is a diplomate of the American Board of Anesthesiology, as well as a recipient of the Heideman Award (1996) from the American Society of Anesthesiology and the Horace Wells Award from the International Federation of Dental Anesthesists. 1997 (IFDAS). Dr. Mohamed has authored more than 130 scientific papers and 7 chapters in various medical and dental textbooks in the areas of physical evaluation, emergency medicine, local anesthetics, sedation and general anesthesia. In his spare time, Dr. Mohamed is an avid runner, exercise enthusiast, and admits an addiction to the New York Times crossword puzzle, which he has done daily since his freshman year in dental school.
Collaboration on Developing Principles

- ADA convened group to develop principles
- May be used to create model legislation
- Designed to keep group practice, ADA in harmony
- Clear separation between business and clinical decisions
Customized Access to CE at ADA Annual Meeting

- More than 300 educational opportunities in 4 days
- 100+ hands-on sessions including cadaver workshops
- Innovative learning environments utilizing adult learning methods
- Live-patient procedures in Education in the Round
State by State Model Legislation

Education for State Dental Boards and Collaboration with AADB
ADA Welcomes Your Input

Tell us what you and your employee dentists need from the ADA at the national, state and local levels to be more **successful**.