

# New Practice Models and Trends in the Practice of Oral Health

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Various internal and external factors are beginning to influence the delivery of dental care in North Carolina. This article reviews some of the current trends that have led to a shift toward new practice models—some of which are in stark contrast to solo private practice.

In recent years, the practice of dentistry has undergone a series of changes that have led to the discussion of new practice models. This discussion has not been without controversy since the practice of dentistry is the last cottage industry remaining in health care. And while the vast majority of dental practices in North Carolina are general dentists in solo private practice, various marketplace and socioeconomic factors have begun to cause some people to question whether this practice mode will remain viable in the foreseeable future.

## Trends

Among the many drivers of change has been the increasing amount of research supporting the connection between oral health and systemic health. This connection has generated an interest in closer collaboration between the medical and dental communities. It has also led to greater interest in the dental profession by organizations outside of the traditional health care community, some of which have proposed what they perceive to be possible solutions to the uneven availability of dental care in North Carolina. Another important factor is the recent economic downturn, which was the genesis of a cascade of the following events and circumstances that have affected the dental profession:

**Rise in unemployment.** As workers became unemployed, they also became uninsured, losing their dental benefits. Lack of insurance coupled with a significant loss in income resulted in people delaying dental care, which had a dramatic impact on the number of patients seeking care in dental practices.

**Decrease in state revenue.** Budget woes have triggered a reduction in state funding for dental education, which translates into a rise in tuition costs for dental students. A rise in dental school tuition suggests that most dental students will have a greater debt load upon graduation. The pressure of repaying this increased education debt vastly narrows a dental student's career choices as they begin to enter the

dental workforce. Those interested in locating a practice in a rural or underserved area of the state find it difficult due to the economic pressures of starting a practice and servicing their educational debt.

**Difficulty in obtaining credit.** The credit crisis that precipitated the economic downturn also had a chilling effect on entrepreneurial dental graduates who aspired to open their own practice. Changes in the qualifications and credit history necessary to obtain adequate funding to open a dental practice made this dream unattainable for most new dentists.

**Stock market woes.** The decline in the value of the stock market, along with the drop in demand for dental services, caused many practitioners to delay plans for retirement. The traditional transition plan for most senior doctors is to employ new dental school graduates as associates with the hope that the junior doctor will eventually purchase the practice. This strategy has had to be temporarily delayed or abandoned since the senior doctor can no longer justify adding another provider to the practice.

**Regulatory burdens.** The escalating number of regulatory burdens placed on health care practitioners has significantly added to the complexity of managing a dental practice. This not only requires more time of the dentist/owner, it also involves more expense, which makes it more difficult for a solo practitioner to be competitive in the current marketplace.

**Third party payers.** The economic downturn triggered a dramatic increase in the number of dentists in the larger urban areas of North Carolina who may consider participating in Preferred Provider Organizations (PPOs). Dentists who elect to become a member of a PPO agree to accept a fee that is typically 10%-20% lower than their usual and customary fee in an effort to fill empty chair time.

**Socioeconomic/generational changes.** While this trend may not be directly due to the recent economic downturn, it is important to note that many of the new graduates don't seem to be as interested in learning the business skills that

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are necessary to manage a successful dental practice. For this segment of dentists, working as an employee or an associate rather than opening a solo practice allows them more free time and greater balance in their personal life and also decreases the time spent on administrative and business tasks.

## New Models of Care

**Group practices.** Due to the complex nature of operating a small business in today's regulatory and business climate, many dentists are considering joining a multi-doctor practice. Some of the multi-doctor practices include both general dentists and dental specialists. Many patients perceive this as an advantage since specialty services are available in the same location where they receive their routine care. With an in-house referral, there is no concern regarding the availability of the patient's records, and the likelihood of gaps in communication between the referring general dentist and the specialist is reduced.

Other group practices are a conglomeration of general dentists who have expertise in different areas of general dentistry. For example, it is becoming more and more common to see restorative general dentists associating with general dentists who have completed post-graduate education in the surgical placement of dental implants or another specialized area of general dentistry such as temporomandibular joint dysfunction.

Some group practice owners elect to expand their business model into multiple locations. As the overall success of this concept grows, a point is reached where these groups have several economic advantages over a dentist who is in solo practice. For example, some larger group practices are able to negotiate a better price for goods and services provided by dental suppliers and dental laboratories. If the practice elects to participate in various dental insurance plans, they may be able negotiate a more favorable reimbursement rate with insurance carriers.

The modern practice of dentistry requires the availability of highly specialized equipment. Most of this equipment, such as Cone Beam Imaging and CAD/CAM machines, is extremely expensive and can be cost prohibitive for solo practitioners. However, multi-doctor offices may find that investing in this type of high-tech equipment is a sound business decision.

In addition to administrative efficiencies, there are also potential personal and professional benefits. These include the opportunity to share the frequency of emergency and after-hour calls, as well as the availability of colleagues to discuss complex cases and offer second opinions.

Since there are multiple dentists, a group practice has the potential to be open non-traditional hours, which may allow each practitioner to practice hours that are convenient to their personal schedule.

**Corporate practice.** Although the current number of dental practices in North Carolina affiliated with dental man-

agement corporations is relatively low, the number of dental management corporations is increasing rapidly across the country. A series of circumstances has transpired over the past several years that have energized the corporate practice model. Some of the factors influencing the growth of corporate practice include an expanding supply of practices for sale due to the pending retirement of baby boomers, a growing supply of low-cost professionals in the workforce (dentists and dental auxiliaries), a large pool of venture capitalists interested in investing in a health care space that provides the potential of greater returns than can be gained in the current stock market, growth in expanded function staff which allows various procedures to be performed by non-dentists, and the increased market penetration of managed care.

The Dental Group Practice Association is a non-profit trade group composed of members of dental management corporations. According to the Web site, dental management corporations are affiliated with more than 3,500 dental practice locations in 46 states in the US, Canada, Australia, and New Zealand with more than 6,500 owner/affiliated dentists [1]. Industry experts estimated that these corporations generated more than \$3 billion in revenue in 2010. It is important to note that not all dental management corporations are members of the Dental Group Practice Association. In fact, a significant number are not. It is estimated that the total number of dental practices run by publicly traded or privately held dental management corporations now exceeds 4,000 and is growing rapidly.

Where allowed by law, dental management corporations offer many of the same economies of scale as a large group practice. However, corporate ownership of a dental practice is not allowed in North Carolina. Current statutes state that only a licensed dentist is permitted to own, manage, supervise, control, or conduct a dental practice. Similar statutes also exist for the practice of law and medicine. These statutes were put in place due to the divergence of philosophy, culture, and outcomes inherent in corporations versus those of the health and legal professions. By definition, the first responsibility of a corporation is to bring profits to its shareholders, whereas the fundamental focus of a health professional is on the well-being of the patient.

Although it is illegal for corporations to own dental practices in North Carolina, corporations are allowed to provide various business support services, similar to other vendors, as long as the net effect of that relationship does not influence so many facets of the practice that it gains control over policies and procedures that have the possibility of affecting patient care.

**Dental workforce.** The recent focus on access to care has led to heated debates over the dental workforce. In order to address one of the major obstacles to care, there is a need for an adequate dental workforce that is located where it is needed and is sufficiently funded to carry out its mission. This includes having sufficient numbers and types of allied

personnel available to support the dentists who ultimately are responsible for diagnosing, planning treatment, and delivering those services that only dentists are adequately educated and trained to perform.

Proponents of adding another member to the dental team—sometimes referred to as a mid-level provider or dental therapist—claim this new type of non-dentist provider will solve the uneven availability of dental care in some parts of North Carolina.

The logic behind this notion seems to be based upon the medical model wherein physician's assistants and nurse practitioners provide mostly diagnostic and non-invasive medical treatment without the supervision of a physician. However, there is a significant and poorly understood difference among these models. Physician's assistants and nurse practitioners require up to 6 years of post-high school education, not the 2 years or less currently mandated by many dental therapist models.

There are serious concerns about placing someone with far less training and education than a dentist in a rural environment without the supervision of a licensed dentist where dental therapists are expected to provide irreversible surgical procedures (fillings and extractions) under local anesthesia on patients, some of whom may have complex medical histories or may be taking several prescription medications.

With funding made available from national foundations, several states have elected to begin educating and deploying dental therapists. Upon graduation, dental therapists are afforded a very similar scope of practice to that of a licensed dentist who has graduated from college and has obtained a 4-year post-graduate degree from an accredited dental school. It will be interesting to determine if the dental therapist model will truly be a remedy to the concerns regarding the utilization of and access to dental care. Questions remain

regarding the economic viability of the dental therapist model due to the high costs of setting up and maintaining a dental practice. There are also questions regarding sources of funding to pay for the treatment provided to patients from lower socioeconomic groups.

The American Dental Association is piloting a new dental auxiliary called the community dental health coordinator (CDHC). Modeled on the community health worker, which has proven extraordinarily successful on the medical side, CDHCs will function as oral health educators and providers of limited, mainly preventive, dental services. They help patients navigate the system, including locating a dentist, arranging appointments, and helping provide critical logistical support such as securing childcare, transportation, and obtaining excused absences from work to receive treatment. While workforce has an impact on access, a myriad of other factors such as transportation, childcare, cultural/language preferences, and oral health literacy, also have a major influence on an individual's ability to utilize and access the dental care they need.

As economic, practice, and generational trends evolve, so too will the practice of dentistry. And while stakeholders may disagree on how best to adapt to the changing economic and social environment, the dental profession must maintain its focus on how to best serve the oral health needs of the people in North Carolina. NCMJ

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#### Reference

1. Dental Group Practice Association. Dental Group Practice Association Web site. <http://www.dgpaonline.org>. Accessed April 24, 2012.

