Changing Paradigms in Dentistry

Dave Preble, DDS, JD, CAE
Vice President, Practice Institute
ADA Mission: Help All Members Succeed

Power of Three:
National, state, local ADA societies collaborate to increase focus on member value and experience, regardless of practice location or practice type
Dental Trends Driving the Paradigm Shift

Dentistry has a busyness problem
**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.
Figure. Changes in dental care visits, number of dentists, and US population from 2006 to 2012. FQHC: Federally Qualified Health Center. Sources: Agency for Healthcare Research and Quality, 1,2 Health Resources and Services Administration, 3 American Dental Association Health Policy Institute, 4,5 and the US Census Bureau. 6
Figure 2: National Dental Expenditure per Capita

Dentist Supply

Professionally Active Dentists per 100,000 Population

US


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**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.
Percent of Dentists “Not Busy Enough”

Source: ADA Health Policy Institute annual Survey of Dental Practice. Note: Indicates the percentage of dentists reporting they are “not busy enough and can see more patients.” Weighted to adjust for nonresponse bias.
Reasons for Not Seeking Dental Care

Figure 8. During the past 12 months, was there a time when you needed any of the following, but didn’t get it because you couldn’t afford it?

- Dental care: 25%
- To see a doctor: 15%
- Prescription medicine: 13%
- To see a specialist: 11%
- Follow-up care: 8%
- Mental health care or counseling: 6%

Percent
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)

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.
Options for the ADA

• Status Quo
  – Preserve, protect, defend the current trends
  – Help dentists adjust to more Medicaid, child, senior, low-income patients and less ‘blue chip’ patients
  – Prepare dentists for more opportunities in FQHCs, hospitals, and fewer opportunities in private practices
  – Try to encourage key dental education reforms

• Break the profession out of the ‘New Normal’
  – Take long-term steps to fundamentally shift the “value equation” of a dental visit for key stakeholders
  – Influence perceived cost of dental care
  – Influence perceived value of dental care
Breaking Out of the ‘New Normal’

1. Reform the current dental care financing model
   a) Promote dental plan accountability
   b) Promote “enabling conditions” in Medicaid program
   c) Promote alternatives to the current SADP model

2. Expand dental benefits coverage for adults
   d) Promote value of dental benefits to employers
   e) Promote adult dental care as an “essential” benefit
   f) Promote adequately funded adult dental benefits in Medicaid

3. Increase value proposition of a dental visit
   g) Move dental visits up on the household priority list
   h) Increase referrals to dentists from physicians
   i) Leverage new Potential Sources of Referrals (PSRs) like CVS, Walgreens
50 New Patients

Breakdown of U.S. Adult Population (19-64 years old) By Whether They Visit a Dentist, Physician, and Whether They Have Dental Benefits

- **Visit a Dentist**
- **Do Not Visit a Dentist**

- **19.4 million**
  - Do Not Visit a Physician
  - Visit a Physician for a General Check Up + Have Private Dental Benefits
  - Visit a Physician for a Specific Health Issue + Have Private Dental Benefits
  - Visit a Physician + Do Not Have Private Dental Benefits
New Dentists

Impact of the Millennials on the Dental Market
New Face of America

Age 18-29

- White
- Black
- Hispanic
- Asian
- Other

Age >30

- White
- Black
- Hispanic
- Asian
- Other

Pew Research Center: Millennials: Confident Connected Open to Change 2010
What are Gen Y Millennials Like?

- Special
- Diverse
- Sheltered
- Confident
- Team Oriented
- Achieving
- Pressured
- Conventional
- Live first, Work second
- World travelers

Millenials To To College 2003 by Neil Howe and Willam Strauss
Impact of Student Debt
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.

Educational debt and intended employment choice among dental school seniors
Tanya Warchek, PhD, JD; Sean Nicholson, PhD; Marko Vujicic, PhD; Adriana Nemezes, Anthony Ziebert, DDS, MD

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 dental school debt and intended activity after graduation, controlling for potentially confounding variables. They used data from the 2004 through 2011 ADEA [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 $18,000 in 2004 to $170,000 in 2011 according to calculations we performed by using data from the ADEA ADEA [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.
Changing Dental Delivery Models

ADA Helps All Members Succeed
ADA 2015 Large Practice Model Objectives

1. Increase knowledge and understanding of all group practice models
2. Disseminate knowledge/data analysis to state and local dental societies
3. Foster dialogue and engagement among group practice stakeholders
4. Develop products, benefits and services to encourage membership
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

• 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—???
Dentistry Enters a New Career Paradigm

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
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

- Group Practice Size (Numbers of Dentists)
- Average Pct. of Dentists with ADA Benefits

For further information, please refer to the note...
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

Median Age by Group Size:

- Very small (< 5): 50
- Small (5-10): 46
- Medium (11-20): 43
- Large (21-100): 41
- Very large (> 100): 39
Gender By Practice Size

- **Male**
- **Female**

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

Percent:
- 0.0%
- 10.0%
- 20.0%
- 30.0%
- 40.0%
- 50.0%
- 60.0%
- 70.0%
- 80.0%
Experience by Practice Size

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

- **Established DDS**
- **Young DDS**
- **New DDS**
Key Points from ADA Analysis

• Dentists in large group practices were less satisfied with income and benefits

• Dentists in large group practices reported lower satisfaction levels associated with work hours, scheduling, and overall work-life balance
Key Points from ADA Analysis

- Dentists in large group practice reported less ability to influence the organization or to advance within it.
- Dentists in large group practice were less likely to report feeling stressed in their jobs.
- 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

- Lower satisfaction does not necessarily mean any practice setting is worse than another.

- Each setting has advantages and disadvantages; what is the “best” practice setting for a dentist depends on that dentist’s personal preferences.
Key Issues in Regulatory Environment

**N.C. Dental Board v. FTC**

- Highly impactful Supreme Court decision
- Great scrutiny of actions by professional boards comprised substantially of “market participants”
- Actions by boards must either:
  - Avoid any anticompetitive effects
  - OR
  - Be subject to “active supervision” by the state
Key Issues in Regulatory Environment

Under *NC Dental Board*, what actions might have anticompetitive effect?

– Actions that exclude or restrict actual or potential competitors
  • New practice models; non-dentist practitioners; etc.

– Actions that restrict or regulate ability of professionals to engage in competitive activity
  • Advertising (e.g., of non-ADA specialties, of price, etc.) except to the extent deceptive or misleading; registration requirements; purported ethical restrictions; etc.

– Actions that benefit or protect dentistry or dentists, but arguably not the public
• Texas statute

• A dental support organization shall annually register with the secretary of state

• The secretary of state and the State Board of Dental Examiners shall enter into an interagency memorandum to share the information collected by the secretary of state under this chapter with the board.
Thank You

Dave Preble, DDS, JD, CAE
Vice President, Practice Institute
American Dental Association
prebled@ada.org
312-440-2756