ADSO Association of Dental Support Organizations

DENTISTS FOR ORAL HEALTH INNOVATION

TOWARD A COMMON GOAL: The Role of Dental Support Organizations in an Evolving Profession

July 1, 2014

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EXECUTIVE SUMMARY

Several recent publications have discussed the current state of oral health and the dental profession in the United States, the challenges ahead, and the role of dental support organizations (DSOs) therein.[1,2] According to the American Dental Association (ADA), more than 181 million Americans will not visit a dentist in 2014.[3] Like physicians aligned with management services organizations (MSOs),[4] dentists supported by DSOs are able to focus on treating their patients and providing affordable care – particularly for underserved populations such as working – age adults, the young, and the poor.[5] MSOs and DSOs allow physicians and dentists, respectively, to be more attentive to patient care and allow knowledgeable business professionals to assist with the "non-clinical" administration of the practice. By spending their time more efficiently, dentists who hire DSOs are able to deliver dental services at lower prices, thereby increasing the accessibility of dental care to wider segments of the communities in which they practice.

DENTISTS HOLD RESPONSIBILITY FOR PATIENT CARE

The thousands of dentists who choose to practice in a DSO model maintain the same requirements and professional standards as dentists who perform administrative and business tasks themselves or with the assistance of multiple service vendors and consultants. As the AGD noted, "[r]egardless of who holds the responsibility for business decisions, dentists hold the responsibility for their clinical and ethical decisions, whether before a state dental board, a court of law, or the court of public opinion,"[6] and "regardless of practice modality, the ultimate responsibility for compliance with state laws and regulations falls upon the practicing [licensed] dentist."[7]

The ADSO Code of Ethics specifically outlines six principles of member company conduct that are consistent with a dentist's responsibility. These include:[8]

1. act with integrity,
2. focus on meeting the needs of dentists,
3. never interfere with dentists' clinical decision-making and treatment services (including never set quotas),
4. employ qualified staff and use proven methods to deliver effective support,
5. provide a variety of business support services to meet the needs of dentists, and
6. support dentists as they meet needs at home and abroad through charitable activities.

When referencing DSOs, certain commentators cloud the discussion through the use of inflammatory phrases such as "corporate dentistry" or "private equity."[9] These critics infer that a dental practice hiring a DSO violates its legal, moral, and ethical duties by transferring responsibility for all patient care decisions to the DSO. To the contrary, at all times, dental practices in a DSO – like many sole practitioner arrangements – are owned entirely by licensed dentists who are expressly responsible for patient care therein.

Mandates in the Affordable Care Act, state laws, as well as the innovative nature of dentistry, are moving the profession to invest in electronic health records, CAD/CAM technologies, digital diagnostics, etc. – all of which benefit patients. Unless a dentist is independently wealthy or has the means to afford bank loans to fund these investments, the dentist and his/her patients may have to do without such technologies. DSOs are able to invest in innovative technologies and in new practices on terms that dentists of even moderate means can now afford. These financial resources help promote greater

efficiency and expand access to care for the benefit of patients and dentists alike and without requiring tax dollars to accomplish these objectives. Private equity represents a free-market solution within the dental profession – as it has with hospital companies, ambulatory surgery centers, and others – at a time when government reimbursement for dental care is significantly lower than for general healthcare services.

CLINICAL VS. NON-CLINICAL

Every state's dental laws set forth a demarcation between matters that are "clinical" (matters of patient care that are fully reserved to dentists licensed in that state and regulated by its dental board) and "non-clinical" (operational tasks that can be performed by any individual). How the dentist-owner of a practice chooses to handle administrative needs is left to the individual. Some choose to outsource all or a portion of their administrative needs while others address these tasks internally, either by themselves or by practice employees. Regardless of how a dentist chooses to address the administrative needs of his/her practice, the fact remains that the decision has no bearing on how the dentist addresses matters of patient care in the practice.

Both DSO-supported and traditional dental practices commonly utilize the services of non-dentists for a wide range of operational tasks, such as accounting and tax preparation; payroll administration and processing; payor relations, billing, and collections; human resources; etc. The fundamental difference between dental practices supported by DSOs and those not supported by DSOs is not the type of administrative services performed by the licensed dentist; the difference is that the former outsource administrative and other non-clinical services through a single source, while the latter use either internal resources and/or a number of outside vendors and consultants to perform such tasks and services.

THE "SILENT EPIDEMIC" and INCREASING ACCESS TO CARE

Former Surgeon General David Satcher noted the "silent epidemic of oral diseases is affecting our most vulnerable citizens – poor children, the elderly, and many members of racial and ethnic minority groups."[10] In the national fight against oral disease, DSO-supported dentists already play a pivotal role. A 2012 policy brief estimated that DSO-supported dentists provided more than one-fifth of dental care services to children in Medicaid in 2009.[11] According to the author, the DSO business model is "able to reduce operating costs" and provide flexible scheduling that recognizes the "impediments that many low-income families face with transportation and work arrangements."[12]

In providing dental care to children in Medicaid, DSO-supported dentists not only increase access to care but also provide value to taxpayers. In a review of Texas Medicaid data from fiscal year 2011, the cost per patient per year at DSO-supported clinics was $483.89, compared to $711.54 at non-DSO-supported practices – an annual per patient savings of nearly one-third.[13] Lower overhead costs enable DSO-supported dentists to accept insurance from a broader range of payors, both public and private, and has helped open states to managed care plans.[14] Cost savings provided by DSO-supported dentists and practices have also been identified beyond the Medicaid setting. A 2012 study found that DSO-supported practices charged, on average, 11% less than traditional practitioners.[15] Additionally, DSO-supported dental practices are frequently located in underserved areas, providing lower-income populations with treatment options close to home. At the same time, patients of DSO-supported practices have consistently given their patient experience high marks on patient satisfaction

surveys. For example, patients of practices supported by the country's largest DSO, Heartland Dental, consistently rank their experience in the top quartile of all dental patients nationwide based on the nationally recognized Press Ganey Patient Satisfaction Survey.[16]

IMPACT ON THE DENTAL PROFESSION

The challenges of governmental regulations, along with rising supply and technology costs and reductions in employer-sponsored dental insurance coverage, are producing dissatisfaction among dentists with the business side of their profession. These caregivers are increasingly tasked to manage student loan debt, requirements for asepsis, malpractice liability, and practice compliance rather than prioritize the needs of their patients. The central demand in the profession seems singular: practice management relief. In fact, many of the factors identified by the results of the ADA's 2012 Group Practice Survey – work-life balance, flexible schedule, guaranteed salary, and less interaction with insurance companies – also appear to be perceived benefits of relief from some of the time and effort spent on managing a traditional solo practice or partnership.

DSOs offer an important additional choice for dentists faced with these practice management challenges. Many will continue to opt for the independence of a traditional solo practice, while others are likely to consider DSO models for meeting their personal and professional needs.[17] In a free market economy, dentists who choose to focus more time on patient care than on the challenges posed by practice administration should have the ability to consider the arrangement best suited to their objectives.[18] Specific examples of dentists who can benefit from practicing in a DSO environment include: 1) dentists who desire flexible schedules; 2) recent dental school graduates with significant student loan debt and a need to improve their clinical competency in an accountable and structured practice model; and 3) dentists with limited business acumen who have an appetite to learn from proven business methodologies rather than anecdotal experience of the traditional solo practitioner. For these individuals, the DSO model represents a valuable new pathway into the profession.

CONCLUSION

The dental profession is faced with significant challenges while the United States contends with a national oral healthcare crisis. Dental support organizations offer vital assistance in the fight against oral disease, providing dentists with a single source for practice administration and development resources, training, financing, and other non-clinical services that would otherwise involve numerous vendors or hours of the practitioners' valuable – and limited – time. Today's dentists must navigate mounting debt from student and practice loans as well as increasing liability and compliance requirements. DSOs provide a way for dentists to reduce the time, expense, and stress associated with the administrative aspects of their practices provide care for a wider community base including patients who have been previously underserved. Through collaboration with the ADA, the AGD, and other leading professional organizations, the ADSO is committed to assisting dentists in a common goal – the improvement of oral health in the United States through the accessibility of high-quality dental care. Put another way, the DSO model enables dentists to focus their time on patients – not paperwork.

COMPLETE PAPER

Toward a Common Goal: The Role of Dental Support Organizations in an Evolving Profession

July 1, 2014

INTRODUCTION

The publication of "A Proposed Classification of Dental Group Practices" by the American Dental Association (ADA) and "Investigative Report on the Corporate Practice of Dentistry" by Academy of General Dentistry (AGD) have initiated a great deal of discussion and debate on the current state of oral health and the dental profession in the United States, the challenges ahead, and the role of dental support organizations (DSOs). The Association of Dental Support Organizations (ADSO) agrees with the ADA, AGD and others that the dental profession is in transition – the number of group practices in the United States is increasing, and the evolution is of great interest to all involved. As a key stakeholder in the discussion taking place, the ADSO has prepared this white paper to both educate and more importantly to underscore the common mission shared by the ADA, the AGD and the ADSO: the improvement of oral health in the United States through access to high-quality dental care as well as the critical role of DSOs in this mission. [19]

OVERVIEW

While providing a unique healthcare service, dentists are similar to other licensed healthcare providers – such as physicians, optometrists, and others – in that their practices include both *clinical* and *non-clinical* functions and responsibilities. Dentistry – as is the case with healthcare services in general – is often in short supply across the United States, and certain areas of the country have very limited or even no access to dental care due to geographic and socioeconomic factors. According to the ADA, more than 181 million Americans will not visit a dentist in 2014.[20]

There is a general crisis in access to healthcare in the United States, including dentistry.[21] Other healthcare professionals have found ways to help alleviate that crisis. For decades, physicians and other healthcare professionals have formed or engaged entities such as management services organizations (MSOs) for assistance with the "administrative challenges associated with running their business. MSOs take advantage of economies of scale to provide the practice with a heightened level of expertise and to help the practice obtain better results at lower cost."[22] In a similar fashion, DSOs address the *non-clinical* aspects of practice management in order to enable dentists to focus on the *clinical* side of their practices. As utilization of dental care declines among working age adults, particularly the young and the poor[23] and more Americans experience financial barriers to care,[24] the benefits of the administrative services provided to dentists by DSOs – like those provided to physicians by MSOs – represent an important option to help ensure the long-term financial viability of dental practices, and by extension, the continued access to affordable dental care in the communities served by those dental practices.

Like physicians aligned with MSOs, dentists who affiliate with dental practices supported by DSOs are able to concentrate on providing care to their patients while benefiting from professional support for the administration of their practices. MSOs and DSOs allow physicians and dentists, respectively, to focus on the *clinical* side of their practices during the entire workweek, rather than taking some of those hours out of the "healthcare pool" to address *non-*

clinical tasks. By spending their time more efficiently on providing dental care, dentists who hire DSOs (like their MSO counterparts) are able to increase the amount of time available for the delivery of dental services and at lower prices, thereby increasing the accessibility of dental care to wider segments of the communities in which they practice.

DENTISTS HOLD RESPONSIBILITY FOR CLINICAL DECISIONS

Dentists who choose to outsource all or part of their administrative and business tasks to any contractor – including dental support organizations – meet exactly the same requirements and professional standards as dentists who chose to perform those tasks themselves or with the assistance of multiple service vendors and consultants. As the Academy of General Dentistry states in its Investigative Report, "[r]egardless of who holds the responsibility for business decisions, dentists hold the responsibility for their clinical and ethical decisions, whether before a state dental board, a court of law, or the court of public opinion,"[25] and "regardless of practice modality, the ultimate responsibility for compliance with state laws and regulations falls upon the practicing [licensed] dentist."[26]

The ADSO Code of Ethics specifically outlines six principles of member company conduct that are consistent with a dentist's responsibility. These include:

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5. provide a variety of business support services to meet the needs of dentists, and
6. support dentists as they meet needs at home and abroad through charitable activities.[27]

THE "OWNERSHIP" RED HERRING

Certain commentators cloud the discussion through the use of inflammatory phrases such as "corporate dentistry" or "private equity" when referencing DSOs.[28] These critics seek to create the inference that a dental practice that hires a DSO violates its legal, moral and ethical duties by transferring responsibility for all clinical decisions in that dental practice to the DSO.

The structure and legality of the DSO arrangement with respect to the corporate practice of dentistry prohibition is no different than many sole practitioner arrangements. A professional corporation or other professional entity owns the dental practice. Pursuant to state law, the shareholders of this professional corporation must be licensed dentists. This means that the dental practices are owned entirely by licensed dentists. This professional entity then employs or contracts as independent contractors the dental service providers. The shareholder dentists or dentist-owners are at all times responsible for the care rendered by the dental practice. This professional entity then also contracts with a DSO for administrative services. At all times, dentists (not a lay corporate entity) are responsible for the dental care provided by the dental practice. The dental practice employs or contracts with all dentists. DSOs do not employ dentists or contract for dental services. As a result of these factors, the term "corporate dentistry" in no way describes a dentist's use of a DSO any more than a physician's use of an MSO.

Much the same as with the term "corporate dentistry," these commentators further attempt to disparage dentists who hire DSOs by noting that

many DSOs are owned by "private equity" or perhaps other investors who then "control" the dentist who has just hired the DSO. Private equity typically consists of funds (similar to, and including, mutual funds and pension plans) in which many investors pool their monies to invest in companies that are not listed on a national stock exchange. The investors in private equity funds include people from all walks and stations in life – such as a teacher's union pension plan which recently invested in a DSO. Most companies in the United States are not listed on public stock exchanges, although private equity funds may also invest in publically traded companies. In other words, many Americans are invested in funds that have investments in DSOs which certain commentators attempt to demonize as "private equity."

Mandates in the Affordable Care Act, state laws as well as the innovative nature of dentistry in general are moving the profession to invest in electronic health records, CAD/CAM technologies, digital x-rays, etc., all of which benefit patients. New, fully-equipped dental practices often require start-up capital in excess of $700,000. Unless a dentist is independently wealthy or has the means to afford bank loans to fund these investments, both the dentist, and his/her patients, may have to do without these new technologies. DSOs are able to help dentists bridge the access-to-care gap by providing for new technologies and the development of new practices, on terms that even dentists of moderate means can now afford.[29] These financial resources help level the access-to-care playing field to the benefit of patients and dentists alike…and without relying on tax dollars. Private equity represents a free-market solution within the dental profession at a time when government reimbursement for dental care is significantly lower than general healthcare services. It should be noted that private equity has played a similarly vital role in supporting organizations across the full healthcare spectrum including hospital companies, pharmaceutical and life sciences companies, home health and hospice providers, ambulatory surgery centers, medical device manufacturers, behavioral healthcare providers and other groups that also face the pressures of rapidly escalating technology costs.

CLINICAL VS. NON-CLINICAL

For decades, other health professionals, such as physicians, pharmacists and optometrists, have successfully organized their practices by making their own decisions as to how to (and who should) handle the *non-clinical* activities within their practices while they concentrate on what they have been trained and licensed to do: address all *clinical* activities and matters in their practices.

Every state's dental laws set forth a demarcation between matters and tasks that are "clinical" (which are fully reserved to dentists licensed in that state) and "non-clinical" (which can be performed by any individual, including a dentist). How the dentist-owner of a practice choses to handle his/her practice's administrative needs is left to the dentist-owner. Some dentist-owners may choose to outsource all or a portion of their administrative needs (to one or more contractors) while other dentist-owners may choose to address these tasks internally, either by themselves or by employees of their practice. Regardless of how a dentist-owner chooses to address the non-clinical administrative needs of his/her practice, the fact remains that the decision has no bearing on how the dentist addresses clinical matters in the practice.

The ADA's "Proposed Classification of Dental Group Practices" confuses the universal truth that all clinical decisions are left to the dentist by attempting to define a dental practice by how it handles its non-clinical needs. The ADA's attempt to define and distinguish between a *Dentist Owned and Operated Group Practice* (which the ADA defines as a dental

practice that is completely owned and operated by dentists) and a *Dental Management Organization Group Practice* (which the ADA defines as having contracted with a DSO, while choosing to remain silent to the fact that those practices are also completely dentist owned and operated) fails to address the fundamental fact that dental practices that hire DSOs to handle their practice's administrative needs remain *dentist owned and operated.* State dental laws and regulations prohibit the ownership of dental practices by non-dental professionals in all but a handful of states, and even in those limited exceptions, the law is clear that clinical decisions are the exclusive purview of the licensed dentist. The ADA does note, however, that "[n]o practical system for classifying group dental practices can be precise, since there are unique variations among group practices even within general categories."[30, 31]

In every state, there exists a demarcation between *clinical* activities, which are regulated by a state's dental board (or equivalent state body), and *non-clinical* activities which are not considered professional matters (and over which the dental board has no authority). Licensed professionals are free to choose from a number of vendors, consultants, and professionals with respect to how best to structure their practice for the delivery of clinical services. What is common in all states, however, is that only a licensed individual can perform certain defined functions, while both licensed and unlicensed persons can perform the administrative and operational activities that are considered non-clinical in nature. A general sample of functions identified as clinical versus non-clinical is provided below.

CLINICAL ACTIVITIES
(Can only be performed by a dentist)

- Patient evaluation and diagnosis
- Determination of treatment options
- Patient Treatment
- Hiring/firing/employment (including compensation) of dental professionals
- Hiring, training and supervision of dentists and hygienists
- Preparation and ownership of patient treatment records
- Clinical protocols
- Clinical QA and peer review activities

NON-CLINICAL ACTIVITIES
(Can be performed by anyone, including a dentist)

- Bookkeeping, accounting and tax preparation
- Payroll administration and processing
- Payor relations, billing and collections
- Banking and financing
- Creation and placement of dentist-approved advertising, promotion (social media), marketing
- Information technology
- Human resources
- General office management
- Property management
- Housekeeping
- Risk management: legal and regulatory, compliance, insurance

State dental boards guard and enforce their existing statutes prohibiting non-licensed individuals from performing or even attempting to perform a clinical function reserved for licensed professionals. What is equally clear is that activities on the non-professional side of the clinical/non-clinical line do not involve the practice of dentistry and, as such, do not require a license to practice dentistry to perform. The sanctity of the clinical/non-clinical line

also applies in alternative practice arrangements, such as non-profit and insurer-provider entities as well as government-related entities. In an effort to create a distinction where one does not exist, the ADA and AGD identify elements from the *non-professional* side of the clinical/non-clinical line – such as how a dental practice chooses to address its billing, human resource and other administrative matters – as illustrative of differences on the *professional* side of the clinical/non-clinical division. The problem with this, of course, is that what happens on the non-clinical side does not change the duties of licensed professionals on the clinical side. Regardless of how a licensed *professional* chooses to address or outsource the administrative aspects of his/her practice, the professional's clinical duties and obligations do not change. "[Dentists] supported with DSOs have professional support, but still lead their offices and make decisions regarding their patients and teams. In that regard, there's really no difference between a DSO-supported office and a non-supported office, except for the extra support and training DSOs offer."[32]

Both DSO-supported and traditional dental practices commonly utilize the services of non-dentists for a wide range of important administrative and operational tasks, such as bookkeeping, accounting and tax preparation; payroll administration and processing; payor relations, billing and collections; banking and financing; creation and placement of dentist-approved advertising, promotion (social media), marketing; information technology; human resources; general office management; property management; housekeeping; and risk management, including legal and regulatory, compliance and insurance. The fundamental difference between dental practices supported by DSOs and those not supported by DSOs is not the types of administrative services actually performed by the licensed dentist; the difference is that the former outsource administrative and other non-clinical services through a *single source,* while the latter use either internal resources and/or a number of outside vendors, consultants, and professionals to perform the myriad tasks and services.

The use of terms such as "corporate dentistry" only confuses this issue. As the ADA states, "there is no definitive, accepted framework for classifying the alternative practice models that would fall under the umbrella of 'group practice,' 'corporate practice' or 'retail dentistry'."[33] Similarly the AGD also notes that "universality in the terminology in this field has not yet been achieved."[34] If the provision of non-clinical services to dental practice owners by non-dentist employees and contractors implicates the corporate practice of dentistry, then many non-DSO-supported dentists, in both solo and group practice settings, are aiding and abetting the corporate practice of dentistry. Within this context, it is debatable how many dental practices can justly claim to be utilizing a traditional solo practice model.[35]

In 2011 when legislation was proposed in the North Carolina House of Representatives that would serve to "significantly undermine the DSO model" after more than 30 years of successful operation in the state, the United States Federal Trade Commission noted the value of the model in a letter to a North Carolina State Representative.[36] In addition to emphasizing the benefit to consumers from competition among healthcare professionals, the FTC countered the position that restricting the DSO business model is necessary to ensure quality of service,[37] citing an FTC report which noted that "'the majority of studies find quality to be *unaffected* by licensing or business practices' and in 'some cases quality actually decreases' in response to the restrictions."[38, 39]

Within the larger healthcare context, it should also be noted that the Affordable Care Act enacted in 2010 contained provisions for the establishment of

Accountable Care Organizations (ACOs) in the Medicare program "by encouraging doctors, hospitals and other health care providers to form networks which coordinate patient care and become eligible for bonuses when they deliver that care more efficiently."[40] In an era when increased efficiency, value and quality are mandated by government and private payors and demanded by consumers, can the dental profession limit its own options through restrictions placed on the DSO business model?

THE "SILENT EPIDEMIC"

For the past several years the national dialogue on healthcare has focused on availability and outcomes. Instead of creating artificial distinctions between dental practices based how they obtain non-clinical services, discussions regarding dental health should similarly focus on access to care, quality of care and impact on the dental profession.

In 2000, former Surgeon General David Satcher released *Oral Health in America: A Report of the Surgeon General* , which described how the "silent epidemic of oral diseases is affecting our most vulnerable citizens—poor children, the elderly, and many members of racial and ethnic minority groups."[41] Ten years later, current Surgeon General Regina M. Benjamin noted that despite some progress, disadvantaged communities – especially children, the elderly, and racial/ethnic minority groups – remained disproportionately at risk for oral diseases.[42] In May 2010, the ADA issued a report to Congress detailing the efforts made by Action for Dental Health: Dentists Making a Difference, a nationwide, community-based movement launched by the ADA with the goal of ending the nation's dental health crisis. The report highlighted numerous promising examples of progress made in Action for Dental Health's inaugural year, but the challenge remains clear: "Many people face barriers to achieving good health…Something has to change."[43]

INCREASED ACCESS TO CARE

In the national fight against oral disease, DSO-supported dentists already play a pivotal role. A 2012 policy brief authored by Burton L. Edelstein DDS MPH, Professor of Dental Medicine and Health Policy & Management, Columbia University and Founding Chair of the Children's Dental Health Project, estimated that DSO-supported dentists provided more than one-fifth of dental care services to children in Medicaid in 2009.[44] According to Dr. Burton, the DSO business model is "able to reduce operating costs" and provide flexible scheduling that recognizes the "impediments that many low income families face with transportation and work arrangements."[45]

In providing dental care to children in Medicaid, DSO-supported dentists not only increase access to care but also provide value to taxpayers, according to a comparative review of DSOs authored by noted economist Arthur B. Laffer. In a review of Texas Medicaid data from fiscal year 2011, the cost per patient per year at DSO-supported clinics was $483.89, compared with $711.54 at non-DSO practices – an annual per patient savings of nearly one-third.[46] If, as a nation, we are truly committed to addressing the "silent epidemic" of oral disease, DSO-supported dentists should be recognized for their contributions to the effort. As Patrick Gleason pointed out in Forbes, "[l]awmakers that want to rectify the problem this country has with access to care should be touting the DSO model, not harassing it without warrant through the legislative and regulatory process. In short, DSO-supported dentists reduce costs, increase access to, and improve the quality of, care."[47]

Lower overhead costs enable DSO-supported dentists to accept insurance from a broader range of

payers, both public and private, and have helped open states to managed care plans.[48] Cost savings provided by DSO-supported dentists and practices have also been identified beyond the Medicaid setting. A 2012 study conducted by Dr. Donald H. Taylor, an associate professor at Duke University's Sanford School of Public Policy, found that DSO-supported practices charged, on average, 11% less than traditional practitioners.[49] Moreover, DSO-supported dental practices are frequently located in underserved areas, providing lower-income populations with treatment options close to home. At the same time, patients of DSO-supported practices have consistently given their patient experience high marks on patient satisfaction surveys. For example, patients of practices supported by the country's largest DSO, Heartland Dental, consistently rank their experience in the top quartile of all dental patients nationwide based on the nationally recognized Press Ganey Patient Satisfaction Survey.[50]

Conversely, the imposition of statutory and regulatory restrictions on DSOs appears to have a direct and negative impact on access to dental care. The state of North Carolina has historically placed stringent limitations on DSOs, the results of which were described in detail by the FTC:[51]

In 2010, there were approximately 4,180 dentists practicing in North Carolina. This amounts to 4.4 dentists per 10,000 people, compared to an average ratio in the United States of 5.7 dentists per 10,000. The state has historically ranked near the bottom of the fifty states in terms of dentist-to-population ratio.[52] In 2007, for example, forty-six states had a higher ratio of dentists-to-population than North Carolina.[53] All or portions of 78 out of 100 counties in North Carolina are listed as Dental Health Professional Shortage Areas,[54] and four counties have no actively practicing dentists.[55]

The Academy of General Dentistry recognizes the fact that placing new regulations and restrictions on DSOs is unnecessary, stating "states do not need to create revolutionary laws…Corporate practices in dentistry that comply with state laws and regulations…are functional modalities of dental practice."[56]

IMPACT ON THE DENTAL PROFESSION

Healthcare professionals work in a stress-filled environment, and dentists are not immune. Writing in the Journal of the California Dental Association, Dr. Richard T. Kao states "[e]ffective practice management has become progressively more difficult for solo practice owners. Increased government regulations, rising supply costs and competitive labor markets have made practice overhead difficult to contain."[57] These challenges, along with rising technology costs and reductions in employer-sponsored dental insurance coverage, are producing dissatisfaction among dentists with the business-side of their profession. Kao adds, "[f]or many years, dentists have complained that the biggest challenges to being a dentist have nothing to do with clinical aspects."[58] He notes that while dental students have been taught to diagnose and treat dental disease, "little time is spent preparing these students to own and operate a small business, even though the majority of dentists eventually do own and manage their own practices."[59]

Recent research underscores this issue. In November 2013, the Dental Economics/Levin Group 7th Annual Practice Research Report noted that "[o]ne-third of survey respondents indicate that their greatest challenge is finding ways to increase practice production and profit. Another third of dentists report that inefficient practice systems are the primary barriers to success."[60] The survey also reported that more than a third of general practice dentists utilize the assistance of consultants or coaches for assistance in practice restructuring and

development.[61] The central demand in the profession seems singular: practice management relief. In fact, many of the factors identified by the results of the ADA's 2012 Group Practice Survey – work-life balance, flexible schedule, guaranteed salary, and less interaction with insurance companies, also appear to be perceived benefits of relief from some of the time and effort spent on managing a traditional solo practice or partnership.

Dental support organizations offer an important additional choice for dentists faced with the practice management challenges described above, and individual dentists should be free to decide the path they will follow. Many will continue to opt for the independence afforded by a traditional solo practice, while others are likely to consider DSO models as the avenue for meeting their personal and professional needs.[62] In a free market economy, dentists who choose to focus more time on patient care than practice management should have the ability to consider the arrangement best suited to their objectives.[63]

Significant increases in the number of female dentists entering the profession coupled with the heightened debt of all dental graduates have produced a dramatic shift in the career paths of dentists in the last 10 years alone. The availability of DSO affiliation represents a critical option to enable new and veteran dentists alike to reduce the time and expense associated with practice operations and, instead, focus more time on patient care. Specific examples of dentists who can benefit from practicing in a DSO environment include:

Part-timers – Dentists who prefer to practice only on a part-time basis can easily find employment in a practice supported by a DSO. This often is an attractive alternative to female dentists who desire to start a family, or a dentist who is closer to retirement and who does not desire to practice 40 hours a week. Women are more likely to practice on a part-time basis, defined as less than 30 hours a week (20% versus 12% for men).[64]

Recent Dental School Graduates – For new dentists, DSO affiliation represents a viable option for opening their own practices earlier in their careers rather than practicing as a veteran dentist's associate. A community is better off with two dental practices owned by competing dentists than it is with a single practice that employs both dentists. Three primary funding options exist for new dentists seeking to finance a new dental practice: (1) self-funding; (2) arranging financing through banks or other lenders; and (3) utilizing financing options through a DSO. Today, dentists increasingly begin their practice careers with significant debt from student loans – more than $215,000 on average in 2011.[65] Some dental school graduates are simply unwilling or unable to take out a loan to finance a new practice on top of already significant student loan obligations.[66] As the U.S. economy continues its slow rebound, DSO financing provides a viable option at a time when industries are looking for investors and capital and states are looking for new avenues of job creation and increased access to dental services.

Dentists with Limited Business Acumen – Dental schools provide comparatively little training with respect to the challenges of owning and operating a small business. Skilled dental practitioners who may have not been successful as small businesspersons can now own practices with the non-clinical support they need to be successful.

In general, trends among new dentists favoring the option of working with a DSO-supported dental practice parallel trends among young physicians who are more than 30 times more likely to choose hospital employment over solo practice, according to a Merritt Hawkins survey.[67] Like young dentists, young physicians worry about the risk and expense entailed in starting their own practice in the face of

massive student loan debt.[68] Young physicians are increasingly gravitating toward the stability of hospital employment, and physicians looking to start families place considerable importance on work-life balance.[69]

CONCLUSION

From declining numbers of patients with employer-sponsored dental insurance to dramatic increases in education costs, the dental profession is faced with significant challenges while the United States contends with a national oral healthcare crisis. Dental support organizations offer vital assistance in the fight against oral disease, providing dentists with a single source for practice administration and development resources, training, financing and other non-clinical services that would otherwise involve numerous vendors or hours of the practitioners' valuable – and limited – time. Through collaboration and cooperation with the American Dental Association, the Academy of General Dentistry and other leading professional organizations, the Association of Dental Support Organizations is committed to assisting dentists in a common goal – the improvement of oral health in the United States through the accessibility of high-quality dental care. Put another way, the DSO model enables dentists to focus their time on patients, not paperwork.

CONTRIBUTORS

The Association of Dental Support Organizations (ADSO) is a non-profit association of leading Dental Support Organizations (DSOs) and Industry Partners dedicated to solving America's dental access crisis by expanding patient access to high-quality, cost-effective, community-based dental care. ADSO's mission is to communicate the benefits and resources that dental support organizations bring to dentistry, which enable participating dentists to focus on increasing accessibility to high quality dental care.

Dentists for Oral Health Innovation (DOHI) is an organization of thousands of dentists who have joined together to expand access to affordable, quality dental care for patients through the use of advanced models and methods. DOHI is committed to advocating for quality patient care, Continuing Education on the latest dental technologies, and initiatives that actively give back to our communities at home, across the country and around the world.

Waller, a leading provider of legal services to the healthcare, financial services, retail and hospitality industries, is headquartered in Nashville, Tenn. with offices in Birmingham, Ala., Austin, Tex., and Memphis, Tenn. With approximately 200 attorneys, Waller helps clients navigate a diverse range of complex transactional, regulatory and litigation issues. Waller is one of the country's leading law firms in the area of dental practice management and dental groups. For more than 20 years, we have counseled on a daily basis dental support services companies (DSOs) and dental groups operating throughout the United States – from startups to to public companies. We understand the unique legal issues faced by companies devoted to dental services.

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