



Journal *of the* American College *of* Dentists

MANAGEMENT
PERSPECTIVE ON
PRACTICE

WINTER 2015
VOLUME 82
NUMBER 1



Journal of the American College of Dentists

A publication advancing
excellence, ethics, professionalism,
and leadership in dentistry

The *Journal of the American College of Dentists* (ISSN 0002-7979) is published quarterly by the American College of Dentists, Inc., 839J Quince Orchard Boulevard, Gaithersburg, MD 20878-1614. Periodicals postage paid at Gaithersburg, MD. Copyright 2015 by the American College of Dentists.

Postmaster—Send address changes to:
Managing Editor
Journal of the American College of Dentists
839J Quince Orchard Boulevard
Gaithersburg, MD 20878-1614

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All claims for undelivered/not received issues must be made within 90 days. If claim is made after this time period, it will not be honored.

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For bibliographic references, the *Journal* is abbreviated J Am Col Dent and should be followed by the year, volume, number, and page. The reference for this issue is: J Am Col Dent 2015; 82 (1): 1-36.

Member Publication
AADEJ
American Association of Dental Editors & Journalists

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- D. To encourage, stimulate, and promote research;
- E. To improve the public understanding and appreciation of oral health service and its importance to the optimum health of the patient;
- F. To encourage the free exchange of ideas and experiences in the interest of better service to the patient;
- G. To cooperate with other groups for the advancement of interprofessional relationships in the interest of the public;
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FROM THE EDITOR

THE SEPARATION OF TREATMENT FROM MANAGEMENT

The new elephant in the room is “corporate dental practice.” I have intentionally placed the term in scare quotes. The idea is frightening precisely because no one knows exactly what we are dealing with.

Big changes are coming, although perhaps not as pervasive as insurance, where over 99% of American dentists participate, or social media that gives virtually all dentists a public comments page whether they want it or not. There will be much good that comes from these trends; and there is potential for significant harm.

My second editorial in this journal in 1995 raised concerns over the emerging trend for dentists to work for other dentists, and I am still worried. In 2001, the journal profiled one of the first dental service organizations. But today we are choking in a dust cloud of vague euphemisms designed to hide true responsibility, and there is manifest motivated misunderstanding on the part of others who have closed their minds to change before learning what is on offer.

Some have characterized shifting times in terms like large group practices, DSOs, or commercialism. The structure matters a lot, but primarily as it privileges new values and blocks others. A solo practitioner can embody barefaced greed; a large network of centralized practices can lead the way in quality, patient

satisfaction, and cost reduction. The test is a simple question: when there is a conflict, which values (income or patient outcomes) will take precedence. No ties allowed, full transparency required.

A more meaningful way of framing what is happening now is to notice the separation of treatment from management. Dentistry has always been a healing art and a business, with necessary requirements in both domains. What is new is separating these functions to permit a situation where neither the dentists at chairside nor a legal fiction is responsible for both. There is nothing inherently evil in this arrangement other than the opportunity it presents for some dentists who are practitioner/owners to be double-minded about their values and to speak from whichever perspective is convenient.

The profession is experimenting with exchanging one model of dentistry for another. Traditionally, dentistry is what is known in management circles as a “professional services organization.” (This is something quite different from a medical services organization or a dental support organization.) Notice the first word. Professional service organizations provide highly customized, knowledge-based services, typically by a group of professionals who share a common set of goals and ethical standards. Lawyers, accounting firms, real estate agents, and medical offices (but not hospitals) are examples. Clients or patients seek help for personal problems, usually in a long-term relationship grounded in trust and free from the kinds of advertising claims for

price or other features that are obvious to the customer.

Professional service organizations do not operate on the same financial basis as manufacturing, banks, or service industries such as retail or hospitality. Economy of scale and leverage of capital are minimally effective. There are only two ways to increase the profit in a professional services organization: delegating to lower-paid individuals and selling more services—and it is usually easier and more rewarding to extend extra services to existing customers than to provide basic services to first-time customers. Growing the business by increasing the number of full-privileged professionals will not improve profits because each expects to be equally compensated.

Much has changed in the past 50 years that has made dentistry spectacularly successful by any measure one would choose to use. The purchasing power of patients for oral health services has doubled because insurance allows employers and the government to chip in. University research and industry development have given dentists and patients more choices of better and longer-lasting treatment options. The number of auxiliaries and the scope of their responsibilities have expanded dramatically and currently account for most of the difference in dentists’ incomes. These are exactly the success criteria for a professional services organization.

It is very possible that the evolution of dentistry has reached a point where further profits are not possible without moving away from the traditional model. Certainly, the flattening of dentists' incomes that began about a decade ago is consistent with this interpretation. We are in new territory; we need to find landmarks.

Perhaps the interest in "corporate" models is a disguised recognition of this fact. There could be some advantages in separating the management aspects of the oral health business from the traditional functions of delivering care at chairside. Breaking off management as a separate activity seems to entail, in various combinations, at least the following prospects: (a) efficiencies of scale and rapid diffusion of best practices; (b) getting oral health care to cost-sensitive patients and those in low-density population areas; (c) capital formation for purchasing larger equipment and opening new offices; (d) bridge financing for the transition from school to practice, (e) intrusion of commercial values into a profession causing moral conflict at chairside; (f) aggregation of data to reveal opportunities for quality improvements; (g) infusion of money and expectations from market investors into dental practice; (h) better serving practitioners' trade needs for insurance, CE, and lobbying than voluntary dental organizations can; (i) "delegation" or hiding and dodging moral responsibility under corporate "personhood"; (j) recruitment of excellent management

talent; (k) freeing dentists who have little interest or ability in the management direction to work 100% at chairside; (l) devaluing comprehensive and continuous care as treatment ideals; (m) allowing groups of patients and insurance companies to negotiate with groups of dentists rather than one-to-one; and (n) giving those who are not compensated entirely for treating patients a voice in practice policy.

None of these changes would be attractive to everyone; there are contradictions among them, some seem to favor one group at the expense of others, and certainly all of them will not be quickly achieved. The greatest danger is to give them all one name and then an up-or-down vote. We need to evaluate each on its own merits and customize the best possible combinations or fragments into plural models.

One of the effects of separating treatment from management is the creation of two groups, one to handle treatment by traditional professional standards and one to handle management functions by commercial standards. I am not convinced by the talk that each side fully respects the integrity of the other. There seem to be attractive features in dentists contracting for and controlling support services to better develop their practices. The other relationship, where firms with

Today we are choking in a dust cloud of vague euphemisms designed to hide true responsibility, and there is manifest motivated misunderstanding on the part of others who have closed their minds to change before learning what is on offer.

Models for Group Dental Practices that May Separate Treatment from Management

1. Group practice in the traditional professional service organization model.

Multiple dentists working from the same general office policy and sharing some resources, perhaps at more than one location. Dentists hire all management services (paid on salary) other than legal and accounting. Although there are alternative legal forms of ownership, treatment and management responsibility are not separated.

2. Groups with contracted management services.

Practitioners own their practices and retain control over the management services they use. Various independent organizations are retained for fixed fees or percentages to bring expertise and efficiency into the management function of the practice. Dentists can hire or fire the services.

3. Corporate dental practice.

Treatment and management functions are performed by separate but overlapping legal entities. Although practice dentists have full legal liability for individual patient care, their voice in the policy of managing the practice is limited. Individuals with a financial interest in the management organization have direct or indirect hiring or firing authority over practice dentists and distribution of equity, including acquisition and sale of practices. The management organization also has say over hours of operation, equipment and supplies, opening new locations, and so forth.

4. Insurance provider clinics (variations on closed panels).

Ownership is through an organization that both sells and administers insurance and manages the provision of care. While treatment and management are separate functions, they are under a common legal structure.

5. Not-for-profit.

Treatment provided by salaried or volunteer dentists in facilities owned and managed by nonprofit organizations, such as the uniformed military services, the Indian Health Service, FQHCs, dental school faculty practices, and charity organizations. While treatment and management are separate functions, they are under a common legal structure. The mission of the organization prominently includes values beyond exchanging services to individual patients for economic reward.

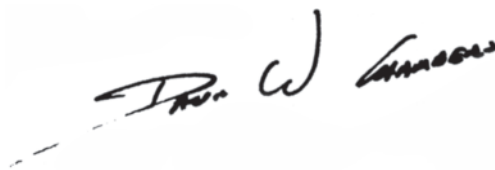
commercial motivations hire dentists and control the practice protocol, will need to be explained to me.

What matters in the end is responsibility for patient care. The laws in America are interpreted differently when a professional person is responsible and when a business entity contracts "someone" to hold that responsibility. This can be verified by checking bankruptcy laws, tort statutes, and the types of sanctions that can be placed on individuals who bend the rules compared with businesses that bend the same rules. Or we may see this by reflecting on the concept of "too big to fail." The concentration of resources has tremendous prospects for enhancing

efficiency and stimulating growth. It also strengthens the hands of a few in negotiating contracts, retaining good lawyers, and lobbying to get favorable rule changes.

I have developed my own classification system for dental models that separate management from treatment (see sidebar). The rationale for offering an alternative to those systems developed by the ADA and the AGD is to highlight the operational details of the difference between management and treatment.

In this issue of the journal, there are six papers written by individuals involved in delivery models that separate management from treatment. The writers all reflect the management perspective. There are descriptions of programs representing four of the five models. Despite repeated requests, I was unable to get a representative to write on the record for model #3—the corporate model. There are two additional papers focusing specifically on dental support organizations, groups that concentrate on the management segment of the separation of management from treatment. The next issue of the journal will feature discussions of these models from the chairside point of view.



GROUP PRACTICES AND PARTNERSHIPS

A TRADITIONAL MODEL THAT FITS MANY SITUATIONS

Stephen R. Pickering, DDS, MSD, FACD

ABSTRACT

The traditional group practice model can take many forms, including general practitioners, specialists, and combinations, as well as solo practitioners sharing space and staff, partnerships, and other legal entities. These practices may share some or all staff functions, including contracting for some functions. The essential characteristic is that those treating patients also have full control over and often direct management of the business aspects of the practice. The most important requirements for success in this model may be a common philosophy of patient care and mutual trust regarding business matters.

A group dental practice can follow the traditional model where the dentist who provides the professional care for patients also manages the business aspects of the practice. The solo group practice and the partnership are examples where several dentists individually provide treatment while sharing oversight for hiring, equipment and supply purchases, patient relationships, payroll, physical office space, and other management functions. The same people who are responsible for patient care are also responsible for and directly involved in office management.

I am a periodontist, but I was a general practitioner for 20 years before embarking on my periodontal residency program at the University of Washington. I have practiced both general dentistry and periodontics using two different traditional group practice models—the solo group practice and the partnership.

THE SOLO GROUP MODEL

After graduating from dental school, I worked in a general dental practice. This practice had three practices that shared a facility, general supplies, and some staff and hygienists. Operatory equipment, some chairside supplies, associates, and the chairside dental assistants were paid by the individual dentist. I was hired by one of the dentists as an associate. After one year, I bought the practice that I was working in. I stayed with this

practice for two decades and sold it when I returned to specialty school in periodontics. By the time I sold my interest in the practice, we had two large dental practices sharing the facility (one later moved to a nearby town).

I would describe this practice model as a solo group practice. It allows individual practices to share overhead expenses. Another benefit of this approach is that the individual dentists can discuss treatment, products, techniques, and just about anything related to running a dental practice with colleagues. These peers are only a few steps away and their work is known. There was no official written agreement with our solo group practice. We filed our own taxes.

This model is a common model in traditional general dental practices, though there are probably as many variations as to the specifics of each arrangement as there are practices. We did not own the building we practiced in. An individual dentist had his or her own practice, made individual decisions regarding incorporation or other legal forms of business, chose the materials to use, and determined how many days and hours to work.

Common business decision making in our solo group was achieved during



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The same people who are responsible for patient care are also responsible for and directly involved in office management.

after-hours meetings of the dentists involved. We usually had combined office social occasions (e.g., holiday party, office picnics). We, at times, worked with practice management firms, but more often than not, we made all decisions ourselves. Some decisions were made for the benefit of the group while others were made by the individual dentists based on personal practice style. Marketing was done by each individual practice. Though we shared hygienists, we kept track of which practice each patient belonged to and paid the hygienist accordingly. Associates were brought in, usually with the intent of eventually buying out one of the practices.

One aspect of my solo group practice that made this a successful practice model was that we became good friends. This model will work even if you are not close friends, as long as you have respect (personal and professional) for the other dentists. It would be difficult for me to imagine this model being successful if there was a divergence of practice philosophies or even silent partners making decisions about patient care coming from views or serving values that were not held in common.

THE PARTNERSHIP MODEL

After completing my residency, I joined a periodontal group practice. This is a more formal group practice model. We are a partnership, with a legal partnership agreement. We have a fictitious business name and do most of our marketing as a group. We invite new periodontists into the practice after intensive searching and vetting. They are brought in as full partners. There

is an entrance and exit plan for each periodontist in the practice. A partner may choose to retire after the age of 64. The practice can require a partner to retire after the age of 68 (this has never been enforced). The sale price of the exiting partner's interest in the practice is spelled out in the partnership agreement, as a new partner's buy-in. We have an agreement where we help out the new partners financially for several years, however repayment is expected (required) over time. This partnership arrangement, like my general dental experience, allows for sharing of practice expenses and knowledge among the partners.

The partners share equally in rent, utilities, some general office supplies, staff, hygienists, office remodeling, and office marketing endeavors. The hygienists work for the partnership, so the expenses and profits from this department are shared equally by the partners. Other supplies (mostly surgical supplies) are paid by each partner based on monthly production. Professional organization dues, subscriptions, continuing education, insurance premiums, and some marketing expenses are paid by the individual partner. Chairside surgical assistants are also paid by the individual partner (though an individual surgical assistant may work with different partners on different days). We have a staff position somewhere between bookkeeper and accountant that handles our employee benefits, keeps track of business expenses and provides our accountant with all needed information.

A partner may buy into the ownership of the building up to his or her estimated square foot usage, but this is optional. The transitions including new partner buy-in and retiring partner buyout are covered in the partnership agreement. We at one time ventured into

a second (satellite) office, but made the decision after four years to consolidate back to the primary office.

The partners are scheduled to meet regularly for meetings, where practice issues are discussed and decisions are made. We have found that dividing up the lead role in practice projects works best. One partner may oversee the numbers of the practice, one may oversee the staff, and one might arrange for office remodeling (though all partners are kept informed and have a say in all aspects of the practice). We are currently limited to three partners due to the size of our office. I believe that as long as we follow the partnership agreement, and have personal and professional respect for each other, a larger periodontal partnership (more partners) would provide additional benefits. If this should occur in the future, there will be additional (non-partner) levels of management needed to deal with the increased volume of decisions to be made.

Marketing is done primarily for the partnership, not for the individual partner. However, each partner does have his or her individual practice in the group. The referral slip to our practice has a check box for the referring dentist to indicate which partner the patient is to see. We have an additional box labeled "First Available." We let our referring dentists know that we prefer them to check the "First Available" box, but many work exclusively with one of the partners. We have a professional relations staff member who handles our marketing on a day-to-day basis and helps run our study club. An example of her marketing activity is that she will take a pizza lunch or a box of cookies randomly to referring offices throughout the year.

Several years ago we worked with a well-known practice management firm to help shore up our practice vision, systems, patient interactions, and staff interactions. This was extremely worthwhile and helped the partnership on many levels. Of course, all expenses related to this endeavor were shared equally by the partners.

Any group practice model with shared ownership and leadership has its pros and cons. I have mentioned many of the pros above. Sharing of overhead expenses, sharing of decision making, sharing of professional ideas and techniques, mentoring of newer practitioners, and ability to enter a practice without incurring an initial heavy financial burden can all result from practicing as a group.

PROS AND CONS OF A TRADITIONAL GROUP PRACTICE

One's mindset going into such an arrangement needs to be similar to entering a marriage. There will always be unforeseen problems and disagreements. The key to success is respect between the parties involved. A shared professional vision and open communication are essential. Those who cannot establish a common practice philosophy or work with colleagues must work alone, suffer a difficult career, or pay others to run their practices for them.

In the age of e-mail, all partners do not have to be present physically to share information and concerns on a daily basis. I have been fortunate to have benefited significantly from both group practice models that I have participated in. Now that there are corporate models as well as single dentist offices, the solo group or partnership models may represent the right fit for many practitioners between doing everything

alone and giving up control over decisions that are important.

There are potential negative aspects to the group practice models I have practiced in. A basic fact of life as to the success of a group practice is the ability of all partners to communicate with and have respect for each other. Like a marriage, a partnership can be a wonderful arrangement, but it can also have pitfalls. Decisions made by a majority of the partners, may not sit well with the minority. I have found that as long as there is mutual respect, these disagreements fade over time. There will be differences in treatment details, and an individual partner may want to incorporate new directions of treatment (e.g., laser, CT guided surgery, or alternative gingival grafting techniques). However, if the basic philosophy of care is to do what each partner feels is best for patients, we all work in harmony. We actually find that as we watch a technique or product that one partner incorporates into his or her practice, the others often follow suit.

Dentistry has always been a profession of entrepreneurs, who come into dentistry liking the idea of "being their own bosses." Solo groups and partnerships can achieve this, and at the same time add to the experience. They may be the appropriate model for a substantial portion of the profession. ■

Looking for the Right Balance Between Dentist as Manager and Dentist as Care Provider

Akhil Reddy, DDS

ABSTRACT

In the quest to understand the implications of separating management and treatment, we must first examine the forces driving management decisions. By defining ownership and equity interest, we are able to isolate a critical factor in the decision-making process. Evaluating the spectrum of the different models of dentistry gives us insight into potential advantages as well as disadvantages that can arise. In private practice, an owner typically wants to see the business grow over a lifetime, while, on the other end of the spectrum, corporate dental companies may be prioritizing dividends, investment returns through speedy packaged sales, or other means of reporting progress to investors. Interestingly, each model of dentistry has shown strength and growth, but there is no clear path to what is deemed ideal.

Starting the Search
My first exposure to the dynamics of separating management and treatment occurred many years ago as I was interviewing toward the end of dental school. Like most of my peers in San Francisco, my primary goals as a graduating student were growing my skills as a dentist and servicing my sizable student debt. After finding that the jobs offered by large corporations in California would present difficulty in reaching my financial goals, I set up interviews in my home state of Texas. Some trusted friends and an advisor offered a few tips: try to avoid HMOs, due to the conflicts of interest in care and ownership; be wary of dentists promising equity upon their retirement, and be especially comfortable with employers when performing Medicaid-type work.

Seemingly general in nature, these remarks had little relevance during my journey toward employment. My interview experience involved a wide spectrum of practice models. I learned to approach each interview by categorizing key considerations, including the competitiveness of the contract, the fit with the managing dentist, and the interviewer's ability to clearly articulate the goals of the practice (of particular importance in the event of interviewing with a non-dentist).

Each discussion offered insight into the separation of management and treatment. My first interview was with a large corporation that subsequently

merged with another large DSO and went public. The head of recruitment, a non-dentist, was very polite and charming, and we even bonded over our Eagle Scout rankings. However, I found the offer, which consisted of a base pay with bonuses contingent upon predetermined targets, to be unimpressive in terms of year-end income and the work environment. Another interview involved a solo practice owner with a PPO and cash patient base. Impressed by my academic credentials, he encouraged me to join his church and network with his community upon offering me a position. Unfortunately, this practice did not seem to have enough patients for two dentists and thus no clear path to sufficient income. Next, I spoke with an owner of a dentist group that focused on Medicaid in low-income areas and reported high patient volume. Despite the potential for high income, the offer seemed low in terms of percentage of production and exuded an unwelcoming vibe.

I also interviewed with a non-dentist recruiter from a five-office dental group that focused on hygienist treatments, whitening, Invisalign, and cosmetic crowns, in addition to a large orthodontic base. As a soon-to-be new graduate, this office seemed like heaven—that is until the discussion turned technical in nature. I enthusiastically spoke about



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dentistry and cosmetics as I presented one of my large-unit cases from dental school on PowerPoint. The interviewer did not seem to have a clue as to what I was talking about nor did he show any interest. This was my first encounter with a clear disconnect between management and treatment.

Finally, I spoke to a dentist who co-owned three practices with a PPO, cash, and Medicaid patient base. He and his partner seemed transparent about expectations and compensation, while giving associates full autonomy with treatments. The office I interviewed in was far from fancy, but I quickly noticed that the staff and associates seemed very happy. Eventually, I signed with this group due to the transparency, at-will nature of contract and the opportunity to meet my financial goals.

THE PREFERRED MODEL

With a year of practice under my belt, I decided it was time to explore ownership. I found the general business and operations side of dentistry to be very compelling. Though I contemplated owning a practice myself, I ultimately decided to partner with my employer. He would manage the bulk of the backend work and supply regional staff to run the offices while I would build the offices clinically and internally in addition to developing the community contacts. Under this arrangement, my expertise would both expand and diversify through practice, training associates, and managing several aspects of the business but not having it all on my shoulders.

Our organization is an all-dentist equity model consisting of a central management office and many practices. Each practice is a separate legal entity in which owners are compensated through partnership income and employment income when they are practicing dentistry. Practices have similar equity structure, but they are not limited to a set structure between partners. Associate dentists are compensated exclusively as employees.

The central management company only provides services to the practices under the group umbrella and does not own any part of the practices. Having decided to drive the business via vetted internal dentists and ensure that central management could keep up with internal growth, it was important to keep management closed to outside dentists. The CEO (a dentist) and his dentist partners serving as central management executives realize their income through equity in their co-owned practices and not through central management. As a generally nonprofit company, the central management office does not own any part of the practices and functions only as an extension of the office network, creating efficiency in time and money that would be lost by confining business operations within each practice. In addition, the partner dentists are able to spend more time serving patients and adding practices to the group.

Without an operating dentist owner physically present at the practice, we believed the quality of care could diminish along with standard metrics of productivity-revenue, patient satisfaction, recalls, exam-to-treatment conversion, and employee work ethic.

In simplified terms, the leadership of each practice consists of an operating dentist owner, a managing partner dentist, and the central management CEO. Generally, the operating dentist owner works clinically on a full-time basis while training and monitoring associate dentists, training back-office staff, maintaining high patient satisfaction, guiding local marketing efforts, and ensuring high productivity. Without an operating dentist owner physically present at the practice, we believed the quality of care could diminish along with standard metrics of productivity—revenue, patient satisfaction, recalls, exam-to-treatment conversion, and employee work ethic. Relative to a dentist owner, the managing dentist is a more senior dentist that serves as a liaison to central management while practicing on a part-time basis and managing some aspects of business that are not covered by central management. Senior dentists' duties include training and managing the operating dentists, helping with all aspects of the business as needed, and generally managing their groups of practices. At the top of the pyramid, the CEO focuses on driving growth by dictating strategy and leading central management.

CENTRALIZED MANAGEMENT

The central management office consists of several departments that have grown significantly over the years: finance/operations, legal, HR, billing/collections, credentialing, compliance, marketing, administration, supplies, and IT. The CEO manages department executives. At present, non-dentists occupy the positions of president, CFO and COO.

These individuals all have healthcare backgrounds. The executives are compensated mainly with salaries, but they are eligible for bonuses based on overall group metrics.

Several examples of interactions between management and treatment highlight the larger systems at work. The compliance department conducts chart audits that inform dentists as to whether chart notes and billing numbers merit concern. Specific outliers, such as a dentist reporting higher than average productions per patient, are brought to the attention of ownership for review. The operations department reviews key metrics such as new patients, recall, supply spending, marketing spending, and specialist productivity with each owner and central management leadership, offering recommendations for improvement and addressing individual office needs. The billing/collections department summarizes insurance company rules and procedures while keeping dentists notified of any adjustments or nonpayment. The marketing department recommends methods for increasing recall appointments or how more orthodontic or Invisalign treatments can be accepted. The legal department makes recommendations on new promotions as they pertain to state and federal law. These are just some of the multitude of interactions present on an ongoing basis.

THE ROLE OF THE ASSOCIATES

Our dentists are paid a percentage of production and, in some cases, a base salary. Production-based compensation seems to be prevalent—and, in my opinion, for good reason. It allows the associate dentists to partake in the upside of a busy practice while encouraging them to embrace a sense of ownership. Having a sense of ownership seems to drive quality of care and internal referrals through satisfied patients.

Regarding clinical matters for which associates need help, our owners are always present to offer assistance. At the same time, we provide associates with full autonomy on treatment planning. If there is ever an instance where a senior or operating owner dentist deems a treatment plan to be not ideal, we discuss it with our associates. We also conduct clinical and patient satisfaction monitoring on all associates in conjunction with protective protocols; for instance, the front desk is not allowed to bill until the dentist executes the respective chart note and verifies the ledger on treatments performed.

A significant component of our management strategy is interoffice collaboration. Whether it be sharing treatment cases through a Facebook group or engaging in continuing education together, we have found these group activities to be extremely helpful in encouraging growth in skills and overall quality of treatment.

WHAT DOES THIS MODEL ACHIEVE?

Several advantages result from the adoption of external-to-dentist model. First, if management creates more efficiency in time, the treatment outcomes and patient satisfaction naturally improve. If a dentist has more time, he or she is theoretically less prone to making mistakes. Second, the creation of sophisticated systems for monitoring analytics of dentists across the group allows larger practices to prevent or stop potentially aggressive or substandard care. Third, the separation of management facilitates more overhead efficiency through the increase of management players and their respective skill sets. The rise in innovative methods and services in management may increase dentists' profits and decrease patients' costs.

On the other hand, potential conflicts arise from the separation of management and treatment. If management is driven by production numbers, its incentives may not be in alignment with the appropriate standards of medical care. For example (albeit on the extreme end of the spectrum), a dental group may instruct dentists employed on the basis of an H1 Visa to perform root canals on every crown or otherwise get called on by a regional manager. In this case, the dentists would feel obligated to comply so as to avoid complications with sponsorship. Perhaps more frequently, conflict between management and treatment arises over supply costs or different treatments that increase profit margins. On a global scale, if non-dentist management grows, as in traditional medicine, dentists are subjected to the possibility of being squeezed out of larger group management altogether.

Is This Model Scalable Into the Future?

Access to care will continue to increase in no small part due to the adoption of various models of dental practice. Many of our clinics were built in suburbs, towns, and cities where the demand for dentistry far surpassed that of their urban equivalents. This task proves extremely difficult when performed by a solo provider or small group, especially without an infrastructure built to support raising capital, setting up HR systems, hiring dentists, build-outs, and operations management. Generally, scaling has many inhibiting factors, but the scaling of larger groups has shown increased access to care in outlying areas. Along with the increasing number of practices, competition seems to be

decreasing what some patients spend. Though the price decreases are generally associated with promotions in items such as exams, X-rays, whitening, and orthodontics, other complex factors may also be at play.

There are clear issues inhibiting growth for every group. External factors will undoubtedly affect our business through the fluctuation of disposable income and employer-provided insurance coverage. In addition, group-specific factors such as the ability to partner with qualified dentists, access to capital, and the acquisition of fitting locations will require intermittent attention by the individuals dictating strategy.

The landscape of dentistry has changed quite a bit in the last decade with little indication of slowing down, especially on the business and management side. Rapid development of enterprise software, cloud computing, and digital marketing, in addition to the advent of Yelp and other review systems, are dramatically changing the quality of care and transparency—all welcome changes. When considering Moore's Law, which postulates that computing power doubles every two years, it is evident that access to technology will create more efficiency in our industry. Cheaper technology and business tools can also facilitate the consolidation of management. Furthermore, bold new tools such as artificial intelligence designed specifically for insurance billing promise to brighten our future as dentists. ■

Having a sense of ownership seems to drive quality of care and internal referrals through satisfied patients.

MANAGING FOR QUALITY RATHER THAN PROFIT

David S. Gesko, DDS

ABSTRACT

HealthPartners is a collection of medical, dental, pharmacy, hospital, and health promotion and research units in the upper Midwest. The dental component includes 24 dental clinics and a network of 2,500 dentists in a PPO plan, supported by a quality management team. An important feature of this network of clinics and dentists is the opportunity for pooling and analyzing data on oral health-care outcomes. These data are used to mentor the entire office team, to drive systemwide improvements in treatment protocols, and as part of providers' compensation. The management function is centralized but entirely within our very large group practice.

Founded in 1957, HealthPartners is the nation's largest consumer-governed medical and dental collaborative organization. Based in Minnesota, HealthPartners includes a medical group and comprehensive medical plan and a dental group and dental plan. Also part of the HealthPartners family is pharmacy, an expansive (multiple) hospital system, including a Level I trauma center, Health Promotion, and an independent HealthPartners Institute for Education and Research.

Don Berwick, a longtime leader is the quality movement in medicine, coined the phrase Triple Aim as a goal for all health care. The three aims are to enhance patient's experience of health, to improve the health of our population, and to lower per capita cost of health care. He referred to the organizational "integrator," one that "accepts responsibility for...at least five components: partnership with individuals and families, redesign of primary care, population health management, financial management, and macro system integration. The HealthPartners family of companies is well suited for an approach of this design and has made significant efforts to impact the quality of care delivery by enacting a multifaceted definition and approach.

Pursuing a vision for the highest quality in patient experience, healthcare outcomes, and affordability (Triple Aim), HealthPartners Dental Group (HPDG) has established many innovative

programs and initiatives in line with quality aims. These initiatives stand to benefit a sizeable population of patients. HPDG consists of 24 HealthPartners dental clinics across the seven-county greater Twin-Cities, Minnesota, metropolitan area and serve more than 125,000 patients. It is an interdisciplinary, multi-specialty group practice of some 75 dentists in our "internal" clinic structure. In the broader community of the upper-Midwest, more than 2,500 dentists participate in the HealthPartners Preferred Provider Organization (PPO) network and practice throughout Minnesota, Wisconsin, North Dakota, South Dakota, and Iowa.

INTEGRATION IS KEY

Although this "theme issue" of the *Journal* is focusing on "separation of management and treatment" our model at HealthPartners in some ways defies that trend. Certainly, all of our providers have the autonomy and empowerment to act on their own relative to diagnosis and treatment planning of care. That said, we are indeed a "group practice," and we see that very differently from a "group of practices." The former relies on a common philosophy-of-care and a shared agenda regarding the approach to care in a systematic manner. Layer



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on the fact that we are also a dental plan and a research institute and you begin to see the multidimensional nature of our integration.

We believe that through active participation in research, including practical, chairside research conducted through the National Dental Practice-Based Research Network (NDPBRN), allows us the opportunity to better understand “how” to define and deliver quality care. Oral health and dental research has contributed uniquely to the HealthPartners research portfolio and the profession’s body of knowledge, but has also positioned HealthPartners dentists to be a part of the research process and for HealthPartners Dental Group to facilitate research findings and products into practice where appropriate. As an example, a recent study competitively awarded with federal funds examined a tool to support computer-assisted tobacco intervention in HealthPartners dental encounters. Patient-centered outcomes helped to illustrate the competency of both dentists and dental hygienists in implementing strategies outlined in the U.S. Public Health Service clinical practice guideline for healthcare providers on treating tobacco use and dependence. Another research project allowed for independent and scientifically rigorous examination of the quality of restorations placed by dentists when compared with dental assistants and hygienists with special training to place select restorations (when certified

and under the supervision of a dentist). Again, the examination of competency in HealthPartners expands to include not only an individual dentist, but also the entire dentist-led team of clinicians delivering treatment. It is, after all, this collective expertise that benefits the individual patient and his or her comprehensive treatment needs.

An opportunity for not only HealthPartners practitioners, but also dentists and hygienists across the nation, is participation in practice-based research. The NDPBRN is a consortium of participating practices and dental organizations committed to advancing knowledge of dental practice and ways to improve it. The network promises “practical science done about, in, and for the benefit of real world, everyday clinical practice.” The major source of funding for the nation’s network is the National Institute of Dental and Craniofacial Research (NIDCR), part of the U.S. National Institutes of Health (NIH). HealthPartners was involved in early efforts in dental practice-based research and enthusiastically supports and participates in the national network. HPDG’s under-lying motivation to support practitioners’ involvement is that in order to continuously evaluate competence and quality of care it is critically important to have high-quality practice-based research findings and subsequent evidence-based practice guidelines as a baseline for comparison.

We are indeed a “group practice,” and we see that very differently from a “group of practices.”

A privilege and subsequent responsibility of this orientation is to continuously evaluate those systems and to put into place performance metrics that ensure high quality care.

In turn, as a dental plan, we learn from our long history of providing care and measuring all aspects of that care and strive to integrate those learning's into creative plan design and innovative ways to finance care. We believe that with this structure, we are well positioned to deliver Triple-Aim results to the members and patients that we serve.

INTEGRATED MANAGEMENT

Our non-clinician leadership partners on a constant basis with our clinical team members. With a goal to allow our clinicians to perform at their very best, our management structure is integrated throughout our system. In this highly complex world of compliance, with its multiple regulators and payment systems, our management system functions to support the delivery of care and allow maximum efficiency. Although very important, compliance with all the regulations can distract from quality care if both providing and monitoring care trends are performed only one chair at a time. We have non-clinical as well as clinical leaders that partner to oversee all aspects of our practice, allowing providers of care to focus on the patient and their needs. This support allows all to deliver their best and divide responsibilities relative to expertise to maximize overall outcomes.

DEFINING AND UPHOLDING A CARE AGENDA

A systems-based (integrated) approach is both afforded and demanded by a large-group, multiclinic system. A privilege and subsequent responsibility of this orientation is to continuously evaluate those systems and to put into place performance metrics that ensure high quality care. The emphasis on continu-

ous quality improvement is partially a function of the ownership model of HealthPartners. We serve a generally fixed population and expect to provide care to them on a continuous and comprehensive basis across their lifetimes.

Evidence-based decisionmaking has been an underpinning value in the development of HealthPartners' care delivery agenda. Responsiveness to authoritative guidelines is therefore expected of clinicians. For the sake of transparency, HealthPartners makes its guidelines publicly available and continues to update them based on current best evidence (www.guideline.gov, keywords: HealthPartners Dental Group). Annual performance evaluation in the dental group adheres to this principle. Clinical metrics pulled from a well-established and comprehensive electronic dental record system allow for administrative reporting that informs review of a dentist's compliance with expectations for regular risk assessment and preventive intervention, appropriately consistent treatment planning (with reasonable variation expected according to patients' individual needs and desires), and record-keeping. Subjective evaluation rounds out the performance evaluation with specific attention devoted to other equally critical competencies: patient communication, responsiveness, flexibility, respectful workplace attitudes and behaviors, positive participation in work-related activities, and even an opportunity to participate in research.

While data regarding individuals remains confidential, aggregate results are reported back to clinic teams including dental assistants, dental hygienists, dental therapists, clinic supervisors, and regional managers. The competence of the entire team is improved with this strategy. As an example, systemwide risk assessment for caries, periodontal disease, and oral

cancer (which requires the collaborative effort of both dentists and hygienists) is reported regularly. Consistently, 90% of HPDG patients in a category of moderate or high risk for caries, periodontal disease, and oral cancer are provided with appropriate interventions to mitigate this risk. Monitoring of this process of assessment and intervention is conducted in an ongoing fashion and providers are kept abreast of expectations regarding this measure.

HEALTHPARTNERS DENTAL GROUP DENTIST-DENTIST MENTORING

A new dentist is, in the eyes of our professional organization, someone ten or fewer years out of dental school. On the generous side of that equation, one could be fully one-third through his or her career and still warrant the label. Certainly context also plays a role. Dentists in a new practice setting are faced with the challenge of understanding and engaging their new colleagues and patients, comprehending new systems, and refreshing or developing new skills.

Understanding one's place in the social and clinical milieu of a large group practice is supported at HealthPartners through dentist-dentist mentoring of all newly hired dentists. Part of this mentoring includes an evaluation of and structured conversation about clinical and organizational decision making, guideline-oriented risk assessment and treatment planning, patient communication, record keeping, referral principles, coding, lab use...the list goes on. With human resources a highly valued asset (as they are in any practice), staff relations and expectations and clinic-related policies and procedures are also discussed and explained. Often the conversation about *why* one needs to

know is as critical as *what* specific knowledge and skill set are expected.

Mentoring is organized by the chief of professional services at each clinic or by the group's associate dental director, all of whom would agree they too benefit from and renew their own competencies in the process. In that same spirit, dentists more experienced in their career at HealthPartners can also benefit from mentoring as professional challenges and situations requiring better expertise present themselves. As anyone engaged in such a process can testify, if you wish to learn something better yourself, try teaching it to someone else. Very quickly, one realizes that concepts, principles, and details must be clarified in one's own mind in order to best articulate information to another. The process is therefore a mutually beneficial one for the individuals involved, as well as a systems-improvement opportunity.

Mentoring goes far beyond imparting a clinical quality aptitude; it is also a vehicle to call attention to the "experience" dimension of the Triple Aim. Clinicians will generally believe that "quality care" is the same as "technical quality" and that it flows from their years of training. To be sure, this belief is in part correct. A patient's view of "quality care" will expand on the clinician's perspective and include the manner in which the care is delivered or in other words, their "experience" throughout the care continuum. In our integrated system, we also believe this perspective is key to overall success.

A shadowing program has been developed whereby clinicians are observed and suggestions offered by nonclinician-trained observers on how to deliver exceptional patient experience at each and every patient contact. Improving this aspect of the care experience allows provider and patient to better connect and improves communi-

cation and ultimately outcomes of care by way of compliance with preventive treatment recommendations.

QUALITY ASSURANCE

Quality assurance in HealthPartners dental clinics is a formalized process that involves ongoing random chart audits. All 75 HealthPartners dentists, along with the nearly 80 Dental Hygienists and now three Dental Therapists, participate in chart review. A new provider may, in his or her first month of employment, be asked to review the charts of a more senior colleague. The process is a participatory and equitable one, meant not to be punitive, but to establish expectations for all that are fair, reasonable, and useful in assuring and improving quality. Findings from chart audits are organized, evaluated, and advised on quarterly by a Quality Assurance Committee of approximately eight representative dentists and hygienists. All dentists in the group rotate through the Quality Assurance Committee, allowing for not only the opportunity to provide input but also full comprehension of the process.

MEASURING QUALITY/HEALTH OUTCOMES

As mentioned earlier, we have learned to make a habit of measuring everything. For 15 years we have used an electronic record system and for as many years we have captured diagnostic codes with all diagnoses. With as large a patient base as we have, this results in a vast database allowing extensive research opportunities that have allowed us to become a learning organization and to continuously evaluate and improve quality. Partnering is key in our organization both within and beyond our integrated system. We have been

A patient's view of "quality care" will expand on the clinician's perspective and include the manner in which the care is delivered or in other words, their "experience" throughout the care continuum.

involved with the Dental Quality Alliance since its inception and are firmly committed to leading in the development of nationally agreed upon and certified metrics of measuring quality in dental care.

Currently, we measure compliance with our care guidelines and link that with our dentist's compensation. An example of this is relative to the early, nonsurgical, management of incipient carious lesions. Through the use of our diagnostic coding system, we can identify early on any enamel carious lesions. Couple this with our firm belief in risk assessment and our electronic record and we have the ability to follow and monitor the entire spectrum of care from diagnosis through the management of those diagnoses. We can determine if the evidence to treat an early lesion on a low-risk patient is indeed being done through conservative remineralization or invasive surgical restoration.

In addition, all of our dental group patients receive systematic and reproducible risk assessments on periodontal disease and oral cancer as well. Identifying the risk for the major disease entities we treat allow us to develop customized treatment plans and recommendations based on individual risk and apply evidence-based interventions focused on mitigating that risk. In addition, measuring risk for so long has now allowed us to quantify and report the *change* in risk over time. We see this truly as an outcome measure and a step in our journey to measure and report quality.

Affordability and Total Cost-of-Care Management

I have elaborated on strategies we employ in this model of care delivery/management and financing that impact health outcomes, the pinnacle in my opinion, of the Triple Aim. Affordability is also integral to the Triple Aim and is essential as one simultaneously manages these goals. Recently, we have made great strides in our ability measure the total cost-of-care (TCOC) within our "internal" care system (HealthPartners Dental Group/HPDG) along with the TCOC of our network provider groups. That analysis has produced an affirmation that not only can our internal Dental Group deliver great health outcomes, but also they can do it at a significantly more affordable rate.

Conclusion

Integration rather than separation is key to our success. Clearly, the delivery of dental care is evolving in this country. Management complexity increases daily because of regulation, payment, and compliance issues. Our model of group practice strives to address these challenges by allowing clinicians to focus on what they do best—deliver care consistent with the Triple Aim. Through integrated management support and research connection, we believe our model of care is well positioned to address the dynamic market we currently face as well as into the foreseeable future. ■

NYU'S DENTAL FACULTY PRACTICE

PRIVATE PRACTICE OPPORTUNITIES FOR FACULTY, CARE OPTION FOR PATIENTS, AND A MINI RESIDENCY FOR DDS STUDENTS

Cosmo V. DeSteno, DMD, PhD, FACD
Barbara Donofrio

ABSTRACT

The New York University College of Dentistry's Dental Faculty Practice operates two clinics in Manhattan, staffed by specialists from multiple disciplines who hold teaching positions at the college. These facilities service several populations, ranging from students to patients with very complex dental conditions. The practices are managed by the school with a view to financial stability while allowing faculty members to focus on their advanced professional skills.

New York University College of Dentistry (NYUCD) expanded its patient care services in 1997 with the opening of a Dental Faculty Practice in Greenwich Village. The mission of this faculty practice is to offer New Yorkers, including members of the NYU community, access to the expertise and skills of distinguished NYUCD faculty in an attractive, state-of-the-art, private practice setting. NYU's philosophy is that the best interests of patients are served by using the expertise of our faculty consisting of general dentists, endodontists, oral and maxillofacial surgeons, orthodontists, periodontists, and prosthodontists, all working collaboratively through a multidisciplinary approach to oral health. The faculty practice motto is "where academics meets excellence."

NYUCD further expanded its patient care services in 2001 with the opening of a second faculty practice located at the NYU Langone Medical Center in Midtown Manhattan. Known as Faculty Practice North, this facility is staffed by faculty with special expertise in oral medicine who comprise an oral medicine group, thereby complementing and extending the private-practice services offered by the original NYU dental faculty practice in Greenwich Village.

HISTORY AND RATIONALE FOR NYU'S DENTAL FACULTY PRACTICE

The primary objective in establishing a dental faculty practice at NYU was to enhance NYUCD's ability to recruit

additional highly-qualified clinical and research faculty nationally and globally by providing an opportunity for them to practice privately without the cost and time burdens of establishing their own practices and building a patient base. They can focus their advanced-level expertise on providing care.

NYU's Dental Faculty Practice offers the opportunity for faculty members to ensure that their clinical skills are maintained and that their knowledge is current; increase their earning potential (thereby making their academic salaries more financially competitive with other academic opportunities and close to or greater than would be possible in private practice exclusively); encourage retention of faculty through the professionally rewarding experience of providing patient care and the increased income realized from the revenue derived; and encourage dental professionals to consider academic dentistry as a full-time or part-time career.

In addition to providing a venue for NYUCD faculty to practice privately,



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objectives of the NYUCD Dental Faculty Practice include giving private-practice patients the added value of access to dentists who all having teaching positions at NYUCD, thus marrying clinical expertise with academic authority, expanding access to care by offering and providing dental care to all NYU faculty, staff, and students; and providing an additional clinical site for predoctoral student education.

Notably, NYU's Dental Faculty Practice supports NYU's Student Health Services Program by raising awareness that dental care is an essential component of student wellness and is a benefit of being an NYU student. In conjunction with the Student Health Services Program, the Dental Faculty Practice provides urgent care to any and all NYU students, not just those in the dental school, who experience pain, swelling, bleeding, or trauma at no cost to the student. Another dental benefit for all NYU students through the faculty practice is Stu-Dent, a capitation plan purchased by NYU students for an academic year with on- and off-menu procedures.

CRITERIA AND CONDITIONS FOR PROVIDER PARTICIPATION

All full-time and part-time faculty members who are licensed in the State of New York are eligible to participate in the faculty practice. Full-time faculty who do not have a New York license can be granted a certificate by New York State to participate. Recommendation for this is required from the chair of the faculty member's clinical department. Approval for participation is required from the dean of NYUCD and the chief

operating officer of its Dental Faculty Practice (associate dean for clinical affairs). Dental faculty practice providers may participate during times when they are not assigned to teaching, research, or administrative duties at NYUCD. Participation usually begins at one-half day per week, with additional time assigned of up to one day per week as appointment scheduling necessitates additional chair time. Ad hoc reservation of chair time in addition to the assigned one day per week is contingent on availability. A degree of flexibility is required by the faculty practice and the faculty provider as teaching responsibilities change.

DUE DILIGENCE

NYUCD visited several faculty practices across the United States and also interviewed dental administrators at annual ADEA meetings about the structure and finances of their practices. The intent of our model is to provide a management structure that frees highly skilled practitioners to concentrate on providing care while administrative, business, marketing, and other services are performed by professionals in those areas with a goal to operate at a financially sound basis while providing the maximal oral health benefit possible. The group structure focuses multiple resources while ensuring fiscal stability.

We found that, in general, faculty practices having their own facilities outside of a dental school were subsidized by the dental school and lost money. Most faculty practices were operated on an informal basis, with no consistent hours of operation. Some faculty practices had beautiful facilities that were underutilized and irregularly scheduled. Also, faculty practices were isolated and were not integrated into their universities, either physically or culturally. We determined that in order to make the NYUCD Dental Faculty Practice a profitable model, additional sources of

income would be required. These include the Stu-Dent Plan, the Urgent Care Program operated in conjunction with the NYU Student Health Services Program, and the judicious sharing of operating expenses with faculty providers.

BUSINESS MODEL GOALS AND ACHIEVEMENTS

NYUCD's Dental Faculty Practice goals and achievements are as follows:

Goal: Create a destination practice where patients receive best practice and state-of-the-art dental care.

Achievement: NYU's Dental Faculty Practice operates in two locations, with 34 providers from seven specialties, serving private patients from the greater New York area as well as members of the NYU Board of Trustees and vice presidents, deans, and faculty. Appointments are available from 8 am to 8 pm, thereby accommodating patient availability and enabling faculty to practice with minimal impact on their academic/research/administrative responsibilities.

Goal: Provide a high-end professional dental facility in a highly desirable location with the most up-to-date equipment and technology.

Achievement: The main location in the heart of Greenwich Village has a beautiful, elegantly appointed reception area, twelve patient-friendly, completely digitalized, patient care areas, and on-site sterilization and laboratory facilities.

Goal: Provide a highly skilled professional team to support faculty providers in delivering dental care and ensuring a positive patient-care experience.

Achievement: Each clinical staff member has a minimum of eight years of experience in private dental practice and receives ongoing training in the latest techniques. Our business staff is trained in billing, insurance, and, importantly, in customer service.

Morning briefings and continuous communication keep everyone informed of priorities as the day progresses.

Goal: Encourage NYU to support a capitated student dental care plan and to include an urgent care component into the university's student health care plan.

Achievement: This goal is met through the creation of the Stu-Dent Plan, whereby NYU students are treated by fourth-year NYU dental students and students from the NYU dental hygiene program supervised by NYUCD faculty, and an Urgent Care Program which provides emergency care for any NYU student at no charge. Procedures that are considered off menu can be performed in many instances by students in the Stu-Dent program, with more complex procedures referred to the faculty providers. When student patients are referred to dental faculty practice providers, the faculty practice fee schedule is used with a 20% discount applied.

Goal: Enable NYU dental students the opportunity to experience the "private practice model" by participating in the dental faculty practice.

Achievement: Thirty fourth-year NYU dental students annually are chosen to spend one full day per week at the Dental Faculty Practice treating students enrolled in the Stu-Dent Plan as well as NYU employees using their dental insurance benefits. All support functions and faculty supervision are provided. The opportunity for on-site interaction with general practitioners and specialists makes this a "mini-residency" for our students. The opportunity for predoctoral dental students to have a private-practice experience as part of their clinical training is believed to be unique to NYUCD. Although they are still students, the participants are nevertheless

expected to assume many of the responsibilities of a practicing dentist. For example, any student who cannot make it to the practice is responsible for finding another student in the program to cover for them. We also expect students to be familiar with the dental faculty practice fee schedule and to be comfortable discussing it with patients.

FINANCIAL BENEFITS OF Multiple REVENUE SOURCES

The dental faculty practice is owned by NYU College of Dentistry but operates as a separate and self-sustaining cost center. Ultimately, it serves the mission of the university. Management of the system is the responsibility of the associate dean for clinical affairs acting as the dean's designee and the senior director of the program responsible for its fiscal, administrative, and support functions.

Revenue is received from three sources: faculty practice fees; Stu-Dent Plan annual enrollment fees and additional off-menu treatment charges; and the urgent care program subsidized by NYU's Student Health Services Program. NYU's Dental Faculty Practice fees are competitive with private practices in Manhattan; our Stu-Dent fees are based on fees at the NYUCD; urgent care treatment is comprehensive and is performed by students when appropriate and by faculty when advanced procedures are needed, all at no charge to the patient. Our combined practices had a total of 15,000 patient visits last year.

Common expenses are paid based on chair utilization (five chairs for faculty providers; seven chairs for the Stu-Dent Plan). These expenses include personnel costs, including benefits; facilities charges and upgrades, supplies, laboratory costs, and equipment. Faculty providers are

The primary objective in establishing a Dental Faculty Practice at NYU was to strengthen NYUCD's ability to recruit additional highly-qualified clinical and research faculty nationally and globally by providing an opportunity for them to practice privately without the cost and time burdens of establishing their own practices and building a patient base.

At year's end, 95% of surplus is returned to faculty providers using a formula that returns the percent of their contribution to the total revenue back to the faculty provider, with the remaining five percent paid to NYUCD.

paid 35% of their collections monthly with the remaining 65% of faculty payments used to defray common expenses. At year's end, 95% of the surplus is returned to faculty providers using a formula that returns the percent of their contribution to the total revenue back to the faculty provider, with the remaining five percent paid to NYUCD. There has been a surplus consistently for the past 15 years, which has historically raised the faculty provider portion to between 42% and 49% annually for both faculty practices. The key to success in this regard is to operate on the principle that faculty practices are a business like any dental practice, and, as such, must be managed in a fiscally sound way that ultimately rewards faculty, patients, and the academic institution.

ADVANTAGES OF SEPARATING MANAGEMENT AND TREATMENT FUNCTIONS

There are multiple advantages in using this model. Providers (currently a total of 34 in both locations who practice between two and 14 hours a week) are responsible for diagnosis and treatment planning, discussing treatment options, fees, and payment plans with patients, and for sequencing of treatment and tentative timelines for treatment, in conjunction with the front desk support staff, as well as providing the care or supervising students treating patients. The front desk support staff is responsible for making appointments, managing cancellations and rescheduling patients, and updating providers with changes to their schedules. The front desk staff is

also responsible for financial arrangements, billing, and collections, thereby freeing providers to focus on treatment.

Referral of patients for specialty care outside the dental faculty practice is discouraged except for urgent care, when and if it cannot be provided in a timely manner by a faculty provider or for procedures that are not performed by one of the faculty providers.

Conclusion

The NYUCD Dental Faculty Practice model offers many opportunities for success:

- NYUCD can offer an additional financial opportunity when recruiting faculty.
- Patients can be treated in a state-of-the-art environment where specialties are represented by faculty who are experts in their fields and are located under one roof; and patients are charged fees that are competitive within the area.
- Faculty providers have a "turnkey" practice that is well managed and financially profitable.
- NYUCD students have access to a private practice experience.
- NYUCD benefits both financially and culturally, in being closely integrated into the fabric of University life.

In short, the model is a win-win for all.



DENTAL SUPPORT ORGANIZATIONS

Quinn Dufurrena, DDS, JD

ABSTRACT

The Association of Dental Support Organizations is a recently formed association of 33 companies representing a range of management and support services for dental practices. These organizations do not engage in the practice of dentistry, although in some cases they operate as holding companies for practices that do, thus separating the legal responsibility of providing treatment from the management and flow of funds. This report summarizes some of the recent trends in oral health care and dentists' practice patterns that are prompting the increased prevalence of this model. The general functioning of the DSO model is described, including some common variations, and the core values of ADSO are featured.

In July 2014, the Association of Dental Support Organizations (ADSO) and the Dentists for Oral Health Innovation (DOHI) released a white paper entitled, "Toward a common goal: The role of Dental Support Organizations in an evolving profession." The paper highlights the important role of dental support organizations (DSOs) in fighting the "silent epidemic of oral diseases" in the United States. There are significant challenges facing the dental profession given the current state of oral health of Americans. With the American Dental Association (ADA) reporting that more than 181 million Americans will not visit a dentist in 2014, it is vital that the profession adapt and immediately embrace potential solutions to the problems, and the DSO model is a promising solution.

It is widely recognized that DSOs are part of the solution and important participants in finding new and innovative answers to access to care issues in dentistry. DSOs, like management service organizations (MSOs) for physicians, allow dentists to focus more time and attention on patient care. Further, DSOs comprise business professionals with expertise in developing efficiencies for the administrative components of health care. A 2012 study found that DSO-supported practices charged, on average, 11% less than traditional practitioners. While DSOs clearly provide significant benefits to dentists and patients, they understand more is needed by all stakeholders to ensure the demand is met.

In fact, dentists in DSO-supported dental practices desire to collaborate with other dentists in other business models to fight the silent epidemic happening in America. The rest of the profession and DSOs cannot truly come together though until there is an understanding by all dentists of the value provided by DSOs and a commitment to work together. DSOs have reached out to state dental boards and dental associations, increasing transparency, and partnering on addressing their concerns.

The separation of the clinical from the nonclinical aspects of dentistry has been the cornerstone of the DSO model since its inception. In the white paper, ADSO and DOHI clarify the structure, role and function, and ethical imperatives for ADSO members and the dental practices they support.

It cannot be ignored that the number of dentists seeking to engage and work at DSO-supported offices is increasing each year. These increases would not be happening if dentists in the environment could not deliver quality patient care in what is considered to be an ethical manner.



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The U.S. Federal Trade Commission (FTC) has given input on DSOs. In a letter regarding a 2012 bill in North Carolina, the FTC wrote that dental support organizations would potentially increase efficiency and allow entry by new dental practices, which may lead to lower dental prices, expanded access to services and greater choices for consumers (www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-letter-nc-representative-stephen-laroque-concerning-nc-house-bill-698-and-regulation/1205ncdental.pdf).

ADSO members have experienced the changing demographics noted by the ADA. The ADA reports, in their “Dental Medicaid—2012” report, that 38% of newly active practicing dentists are female, compared to 22% of all practicing dentists. Sixty percent of dentists age 44 and younger are women. In addition, women are more likely to practice part-time and are less likely to be owners (41% women to 28% men). The DSO-supported model is attractive to women in that part-time schedules are viable. Multiple dentists at one location lends itself to a supportive environment where dentists are able to cover for each other without closing the office or inconveniencing patients whether such practices have relationships with DSOs or not.

Further, the debt load for new graduates has grown. This is one of many reasons why more dentists are likely to forego solo practice. Dentists who have completed their education within the past ten years are three times more likely to be part of a larger organization than those that completed their education more than ten years ago (Guay et al, 2012). This is consistent

with the experience of ADSO member companies. The numbers of applicants for positions at group dental practices are increasing. Currently, about 8,000 dentists are working at ADSO member supported practices. The positions held by practitioners in groups that are supported by DSOs may range from associate to managing dentist to owner. Certain ADSO member organizations include in their package of services programs developed to attract and help new graduate dentists partner with mentors and find quality training classes. Many DSOs attend and support events across the nation at and sponsored by dental schools. And the attraction of an office affiliating with a DSO is not limited to its impact on new graduates. Of those responding to a 2009 survey by the ADA’s Health Policy Resources Center, 32.5% of whom are affiliated with a DSO are 40 years old or older (unpublished ADA report listed in AGD’s findings—see Chambers, 2013).

Group forms of dental practice are growing. According to the ADA Health Policy Resources Center, in two years the number of large group practices has risen 25%. The proportion of solo practitioners is falling. In 2010 69% of dentists were in solo practice, compared to 76% in 2006. Other data from the ADA supports this finding. The ADA reports that in 1990, almost 93% of dentists chose private practices. By 2009, the number had dropped to 86%. New dental school graduates are three times more likely to seek employment in a large group practice than they were a decade ago (Fox, 2013).

The DSO Model

ADSO is composed of 33 member companies, each of which may have a different legal structure. Overall, however, there is one basic level of legal framework. The DSO-supported dental practice forms a professional corporation or

professional association to conduct business, similar to private practices. Practices contract with DSOs for dental support services. The ownership and management structure of a group dental practice is distinct from the ownership and management structure of any DSO they may contract with, although there is potential for interlocking management and distribution of profit.

The principle contribution of a DSO is support services, with the primary characteristic being the employment of support staff. The administrative staff is employed by the DSO. Dental support services may include the following:

1. Ownership, leasing, or otherwise making available any asset used by a dental practice, including real property, furnishings, and equipment, but not including dental patient records
2. Employment or contracting for the services of personnel other than licensed dentists; provided, however, the practicing dentist shall assume and be given all functional responsibility for dental hygienists and dental assistants rendering clinical care at the direction of the dentist
3. Management or conduct of the business or administrative aspects of a dental practice other than the clinical practice of dentistry, which includes but is not limited to the following:
 - a) Advice and consulting services with respect to regulatory compliance
 - b) Track, maintain, own inventory, serve as the purchasing agent and arrange for the purchase of equipment, supplies, and instruments as directed by the dental practice
 - c) Purchase, ownership, and maintenance of information systems,

including but not limited to hardware and software

- d) Store, maintain, backup, and assist in the production of patient records pursuant to the dental practice act of a state for dental services provided by a dental practice, provided, however, such patient records shall be owned by the dental practice at all times
- e) Subject to any limitation in the dental practice act of a state and further subject to approval of the dental practice, implement or arrange for a third party to implement marketing, advertising, and public relations programs
- f) Provide financial services, including selection and maintenance of one or more institutions for banking services
- g) Provide accounting, bookkeeping, monitoring, and payment of accounts payable processing and reporting
- h) Facilitate and coordinate arrangements to provide third-party financing for the dental practice for dental services and products provided to patients
- i) Provide payroll or benefits administration services
- j) Provide billing and collection for dental services and products used in a dental practice; provided, however, the dental practice shall maintain the ability to pull an account out of the collection process at any time
- k) Report federal or state income taxes, personal property, or intangible taxes on behalf of a dental practice
- l) Administer interest expense or indebtedness incurred to finance the operation of the dental practice
- m) Administer insurance such as malpractice and general liability, including arranging for the purchase of insurance products and managing claims activities

DSOs also consult and engage in other activities or services to enhance productivity, efficiency, and cost management of a dental practice. DSOs are unapologetic about their efforts to maximize the use of a dentist's valuable time. DSOs benefit the industry, patients, and the dentists they support by making dentists more productive. This increased productivity directly addresses the access issue.

The two entities—the dental practice and the dental support organization—may overlap to varying degrees, but they are distinct entities. Only dental practices can provide patient care, whether associated with a DSO or not. The practice employs or contracts with licensed dentists to provide dental services to patients. The practice collects all revenue generated from dental services. It is also the practice that pays a fee to the DSO for the services provided by the DSO. The practice owns the records. The practicing dentists retain legal and professional responsibility for the quality of care provided. A dentist may additionally be a managing member of the DSO in which he or she works and may receive financial compensation in that capacity. Individuals who are not chairside dentists may participate in management and share in the profits of a DSO although they are not practicing dentistry and have no direct liability regarding care given in the practice. Non-dentists can be owners of DSOs and these organizations can issue stock.

Certain DSOs will facilitate the acquisition of equity interest in an existing dental practice. This would entail the purchase by a professional corporation of the dental practice, with the physical assets and facilities being

The ADSO member DSOs are committed to ethical conduct and behavior and encourage the same from non-member DSOs. There is a strong recognition that DSOs are implored to simply provide business services and economies for the dental office. DSOs are not to interfere with a licensed dentist's independent clinical judgment.

purchased potentially by the DSO. This would mean that in a corresponding sale, the proceeds would be allocated similarly.

VARIATIONS ON THE THEME AND CORE VALUES

DSO models vary in several respects. Some of the main differences are discussed below. While not an exhaustive list, the variations highlight the significance of permitting dentists to make choices about their practice.

First, DSO-supported dental practices may operate in one location or many locations. Some DSOs support one dental professional corporation operating from one to as many as 50 locations in a state. Other DSOs support one dental practice per location—a one-to-one model. Yet other DSOs use a combination approach of the one-to-one model and multiple locations.

Another variation concerns whether the dentists that work in the individual locations become owners or shareholders of the professional corporations. Some DSO-supported dental practices choose to simply employ other dentists as associates. In both situations, the associate may be the sole practitioner at a location or there could be multiple dentists working at the location.

Some DSO-supported dental practices engage one or more dentists to perform specialty dental services at the location. This leads to efficiencies for the dentist, office, and patients. Patients are able to see specialists for care at their local office. They are familiar with the office and staff, and complete records are readily available. This one-stop approach is convenient and attractive to many patients. And there are some DSOs that focus solely on a single specialty,

such as orthodontics or pediatric dentistry.

Further variation includes whether a brand name is used to identify the practices. Branding adds efficiencies in advertising and marketing, alerting consumers to the quality components of the practice.

There is one very important commonality among ADSO member DSOs. All agree and concede that they should never interfere with a licensed dentist's independent clinical judgment in matters of individual patient treatment. A list of prohibited acts has been developed to highlight the commitment of the member organizations to sustaining this principle. ADSO DSOs agree they will NOT interfere with a licensed dentist's clinical judgment by doing any of the following:

- a. Limiting or imposing requirements on the length of time a licensed dentist spends with a patient or performing dental services
- b. Placing conditions on the number of patients a licensed dentist must treat in a certain period of time, or the number of specific types of procedures a licensed dentist must complete in a certain time period
- c. Limiting or imposing requirements on the decision of a licensed dentist regarding a course or alternative course of treatment for a patient or the manner in which a course of treatment is carried out by the dentist
- d. Limiting or imposing requirements on the manner in which a licensed dentist uses dental equipment or materials for the provision of dental treatment
- e. Limiting or imposing requirements on the use of a laboratory or the supplies, instruments, or equipment deemed reasonably necessary by a licensed dentist to provide diagnoses and treatment consistent with the standard of care

- f. Limiting or imposing requirements for the professional training deemed reasonably necessary by a licensed dentist to properly serve the dentist's patients
- g. Limiting or imposing requirements on the referrals by a licensed dentist to another licensed dentist specialist or any other practitioner the licensed dentist determines is necessary
- h.. Interfering with a licensed dentist's ability to access patient records for treatment-related purposes
- i. Interfering with a licensed dentist's decision to refund any payment made by a patient for dental services performed by the licensed dentist
- j. Limiting or imposing requirements on the advertising of a dental practice if it would result in a violation of the dental practice act by the dental practice
- k. Limiting or imposing requirements on communications that are clinical in nature with the licensed dentist's patients

The ADSO member DSOs are committed to ethical conduct and behavior and encourage the same from nonmember DSOs. There is a strong recognition that DSOs are implored to simply provide business services and economies for the dental office. DSOs are not to interfere with a licensed dentist's independent clinical judgment. The ADSO Code of Ethics and Conduct includes the following principles: ADSO-member companies

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 setting 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
6. Are dedicated to supporting dentists as they meet needs at home and abroad through charitable activities

On the clinical side, DSO-supported dental practices often benefit from extensive oversight from other clinicians, access to reporting from multiple locations, and technological advances. Systems are deployed to monitor outcomes and increase consistency in the care delivered to patients. The nature of the environment lends itself to more self-reporting of deficiencies. In a more isolated environment, staff may be hesitant to report a dentist engaged in destructive conduct such as drug and alcohol use. The DSO-supported practice is tied to a larger organization and thus open reporting is encouraged and championed.

SUMMARY

DSOs are not dental practices; they are management structures in which practices, usually group practices, can, under the right conditions, operate as maximal efficiency practices. There is a wide variety of business models, but generally speaking, dentists, regardless of the model, are responsible for the clinical decisions, their schedules, their fees, and treatment plans. DSO-supported dentists outsource their administrative tasks to a single entity while solo practitioners contract with separate business professionals.

DSOs simply provide dentists with another choice. DSO-supported practices often offer more flexible hours—open Fridays, longer days, and sometimes on weekends. Because of the economies of scale they also participate in more dental plans, including Medicaid, providing

much needed access to the most vulnerable and needy. The FTC letter stated that though only 6.4% of dentists are affiliated with a DSO, DSO-affiliated dentists provided 21% of the care received by children in Medicaid. Due to the additional administrative burdens associated with participating with managed care plans, particularly Medicaid, dentists supported by DSOs benefit greatly from the experience DSOs have with centralized contracting and the application process. Where few solo practitioners want to participate and be open extended hours, patients respond well to those who do when offered the choice. In addition to helping dentists treat more patients, DSOs also help dentists serve more patients who cannot afford care by their participation in various activities, such as ADA's annual Give Kids A Smile in February to international missions in other countries like Ethiopia and Haiti and mobile dental clinics traveling across their county providing pro bono dentistry to the neediest in their communities.

Patients may also be responding well to DSO-supported practices because of the amenities they offer. Many have the latest technology—from digital radiography and electronic charting to CEREC® CAD/CAM (same day restorations). Or it could be due simply to the beautiful locations and contemporary décor.

While the recent focus on them might make one think otherwise, DSOs have been supporting dentists for decades. Their growth may scare some, but it should be embraced by organized dentistry because they appear to be just what we need. At a time when more patients are covered, thanks to the Affordable Care Act, fewer are actually seeing a dentist. It is DSOs that invest heavily in patient education, marketing, and advertising. From billboards to

search engine optimization, more patients are being informed of their need to see a dentist and the value of good oral health. And many DSOs are on the forefront of systemic oral health, identifying the benefits of good oral health to the overall health of a person, monitoring and partnering with dental plans and the ADA's Dental Quality Alliance. Some companies are even implementing their own quality improvement programs headed up by dentists or committees of dentists. By embracing this business model, it's clear that everyone wins.

To learn more about DSOs, please visit www.theadso.org. ■

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WE HAVE YOUR BACK

Jim Baker, DDS

ABSTRACT

Healthcare delivery in the United States, including dental services, has changed rapidly in the last few years, and will continue to change in the years to come. Oral and Maxillofacial Surgery Partners (OMSP) was initially formed to specialize in the unique issues of running the business aspects of an oral surgery practice. Over the past 17 years we have grown to the point of including 25 practices, in most specialty fields, primarily solo practitioners and small partnerships. The need for this service is a direct function of the increasing requirements for and complexity of the business aspects of small businesses and the need to ensure quality standards in health care.

HOW DOES OUR MODEL WORK?

We divide our service model into two components: service center operations and back office services.

Service centers were originally called billing and collections, but have evolved to include much more. Billing and collections means oversight to produce a “clean claim,” and, once that is done, the office staff should not have any further involvement with that encounter. Service center work also includes aged accounts receivables, patient and insurance refunds, and backup coding expertise for practice-based personnel.

Credentialing is a related service that has evolved in our service centers and includes contracts with insurance companies, staff privileges at hospital and surgery centers, and licenses at the state and federal level for controlled substances. Organizations that interact with healthcare professionals are increasingly requiring that documentation be provided attesting to the qualifications of providers.

The service centers also perform a yearly fee analysis using a zip-code-specific fee analyzer for each practice. We then make recommendations as to fee changes suggested for the practice. The practice ultimately makes the decision to change any or all of their fees.

Back office services include human resources, regulatory compliance, cash flow management, accounts payable processing, information technology,

consulting, and accounting. There are many components to all of these services. A few are highlighted below.

Human resources now includes assistance with employee acquisition and termination of employees, payroll, and employee/employer benefits—to include development and maintenance of 401(k) plans or other more sophisticated benefit plans such as defined benefit plans, when appropriate. Other services include helping to regulate workplace standards to minimize potential legal issues, OSHA matters, and consulting for appropriate staff levels to optimize personnel (overhead).

A good deal of effort is now required to be sure all practices are properly insured against the risks inherent in running a small business. We oversee and maintain this variety of policies.

Management accounting and reporting services provided can be comprehensive to include everything from monthly profit and loss statements to the business and personal tax returns. Other clients may choose to have outside accounting support and we provide the information necessary to the practice’s certified public accountant.

We maintain our own proprietary information technology (IT) system which is Web-based and includes a robust electronic medical record



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(EMR). This system brings together the revenue cycle and the expense cycle under one roof to allow more coherent practice management.

We have 17 years of experience building an infrastructure to provide these services with coherency and an economy of scale. Our model is conservatively structured to economically provide all necessary services for an office to turn the business practices over and spend time producing high quality care. Clients can choose the service model that fits their needs, and the cost of delivery is divided between these two functions. The service center service fees are 7% of collected revenue and the back office service fees are 2.5% of collected revenue. This division is designed to yield approximately 1% profit to OMSP on each of these service areas or a 2% profit on the collective 9.5% fee.

Our Model

Oral and Maxillofacial Surgery Partners (OMSP) does not own practices or employ dentists as associates; we provide a management service on a contract basis. Dentist owners of group practices have authority to retain or terminate our services and which ones to use. Because our fees are based on a percentage of collections, the service is conveniently scalable to groups of various sizes. We have built an infrastructure that is ideal for solo practitioners or small partnerships with two or three dentists. This allows them to practice independently, but with the safety net of a large, well-managed back office to support them.

Advantage of the Model

For patients, we are invisible and they never know we are in the back office doing much of the heavy lifting. This lack of noticeable presence is our goal; this relieves the office to be attentive to the patients' needs for the time they are in the office. The disadvantage is that, if there is a problem, the practitioner's office staff may seem to have a lack of knowledge of the problem. It takes open communication between office personnel and corporate personnel to minimize potential problems. The main area this impacts is the billing and collections function. This requires the office staff to "buy in" to our model, which simply means turn the billing over to us and take it out of the office. This is different from the model they may have been used to, and occasionally it creates resistance. This communication breakdown usually results in a patient hearing inconsistent answers to the same question, and this is an undesirable outcome. The office staff that accepts our model and uses our billing service as designed leads to satisfied patients. Our model is designed to provide consistent high quality billing and third-party payor management. This in turn leads to more consistently satisfied patients.

Our managers are at the corporate level, so the advantages and disadvantages are not always immediately apparent. Good managers can handle

A good deal of effort is now required to be sure all practices are properly insured against the risks inherent in running a small business.

We are best suited for start-ups that want to grow and for practices that are too busy as a result of their own success.

several practices. But if they are given inaccurate information from a practice they cannot produce an accurate result. We give advice, not orders. Our client practices are truly independent and can take our advice or choose not to follow it. It does occasionally happen that our advice is not taken and we spend more time solving the problem that has been created. We do not get paid “extra” for this “extra” work. It is important to us for the success of the practice and our client relationship.

For the dentist, the advantages revolve around having high quality consistent business practices in place. There is no crisis when billing and collections staff leaves a practice. We provide a depth of personnel with expertise that a solo or small partnership cannot afford. This increases the constancy of satisfied patients and referrals.

This benefit is experienced differently for a startup practice and an established practice. For start-up new graduates, we can fill in the substantial business and management gaps in their education. We have a track record of start-ups that have been able to grow their practices more quickly than their peers due to their hard work and our back up. Established practices require a leap of faith that our model will produce superior results compared to what they have been doing. If a practice does not have a certain scale this is not a model the dentist is likely to accept because of the cost. We are able to demonstrate the value of spending the 9.5% of collections, but for a practice with less than a low seven-figure gross collections, the value proposition is more difficult. We are best suited for start-ups that want to grow and for practices that are too busy as a result of their own success.

The advantage for the profession is that we have a model that is designed to

perpetuate private practice, not corporate ownership. We do this with sharing of high quality business practices. If there is a disadvantage, it is that continuing the classic “cottage industry” model with no shared services is ill-suited to our model. We would argue that the rules of health care have changed and will continue to change making the truly stand-alone practice more difficult.

Why ARE MANAGEMENT SERVICES of INTEREST Now?

Seventeen years ago we did not foresee the current complex regulatory environment and pace of change in healthcare delivery. But we did suspect that things were changing in ways that made it difficult for a single practitioner to adapt.

The current requirements related to HIPAA are an example. A commercial engagement to have some assurance a practice is HIPAA-compliant involves an audit component and an implementation component. They are typically priced at \$2,000-\$2,500 per office. In addition, each of our practices undergoes an annual workers' compensation audit. Regulatory requirements go on and on and will continue to get more time-consuming and laborious within healthcare delivery environments. We have experience and are equipped to handle OSHA inspections, state use and sales tax audits, Medicaid audits, third-party payor audits, as well as Internal Revenue Service examinations.

In today's dynamic information technology environment, especially with Web accessibility to the general dentists, referral sources, insurance companies as well as governmental agencies, we are involved with HIPAA compliance reviews, identity theft protection (regulation S-ID), cybersecurity protection and reviews, as well as protection of confidential and protected patient health and financial information. As a long-time oral and maxillofacial surgeon

myself, I really want to spend my time at what I am best qualified to do and what gives me the greatest personal satisfaction: treating patients. This is becoming exceedingly difficult with the additional demands of today's highly complex business and regulatory environment.

The evidence is accumulating that the non-patient care portion of running a practice as an individual without outside expertise is no longer realistic.

DOES THE DELEGATION OF MANAGEMENT SERVICES AFFECT TREATMENT?

The case is very simple: patient care and business functions must be done to a high standard. Dentists are trained and usually most interested in providing top quality patient care. That really cannot be delegated. But management services often can be delegated, if done right.

Social and economic forces that control the growth of our model are complex. Health insurance is now considered a right. The Affordable Care Act has now become part of our lives. Its partial implementation in dentistry seems to have increased regulatory issues without an improvement in the access to dental care, although there is some evidence that it has had an effect on slowing the rate of medical costs. The overlap between medicine and dentistry is more conspicuous in the case of oral and maxillofacial surgery. The new requirement that all dentists must "opt in" or "opt out" of Medicare means more changes are coming that will require regulatory and management adaptation. This means all fields of dentistry will now be involved at a higher level than in the past with the federal healthcare system.

Another big economic issue is the level of debt faced by dentists beginning their practices. Finishing four years of dental school and four to six years of

residency is not inexpensive. Student loans of \$200,000–\$400,000 are common. Now the new graduate needs to borrow \$500,000 to open an office and still has a family with no house. There is no room for error. Nor is it feasible to "ease into" a low volume start-up practice with such large debt service obligations.

My prediction is that, in 20 years, 50% of practicing oral and maxillofacial surgeons will have at least some shared services. Most of the rest will be in large group practices. Perhaps 10-20% are likely to remain in the "cottage industry" model.

HOW DOES OMSP FUNCTION?

In addition to my OMSP role, I am a full-time practicing oral and maxillofacial surgeon in private practice for 35 years. I have also been fortunate to include teaching positions throughout my career.

My management responsibilities involve oversight of a staff of approximately 35 people, and I deal primarily with the senior managers of our areas of service. As chairman, I have a board that supports me including oral and maxillofacial surgeons with a range of subject matter expertise. I coordinate the triage of practice level issues with the appropriate manager or board member. This may include day-to-day issues or long-range planning. I oversee practice transitions and growth opportunities for our client practices as well as our new graduate startups.

My initial attraction to this work came from interacting with many practitioners around the country to find those "best practices" that would help us all. The changes in health care that occurred in the mid-1990s piqued my interest in the business delivery of oral and maxillofacial surgery. We strive to integrate these best practices in the continuing evolution of the way we do business in our practices. This helps to

mitigate the damaging effects and increases the practitioner's adaptive capacity as the landscape of healthcare delivery changes.

What we did not do is also important. At one point, the thought of becoming a public company was very attractive. We did not go that route as our collective opinion remains that healthcare delivery at the practitioner level is not suited to a stock exchange. We determined that our best energies were directed at facilitating the traditional private practice boutique model with shared services.

We have had some surprises. I continue to be amazed at the ability of dentists to literally forget how they receives a paycheck in private practice: Revenue – Overhead = Compensation. Seems simple, but the separation of management and treatment may make this easy to forget. Our experience shows us that fuzzy thinking increases with the number of practitioners in a large group. It also increases if we allow our client dentists to disengage from the business of their practice. Our communication to our clients has to be continuous and accurate.

CONCLUSION

We continue to position our company to be the shock absorber of adaptive change in health care. I cannot predict the changes that are coming, but I am certain our practices are better equipped to handle them than they would be as stand-alone practices. We are striving to create an environment to allow these dentist-managed practices to collectively adapt to change while maintaining a focus of high quality oral health care. ■

CHEATING

WHO DOES IT REALLY HURT?

Debra A. Peterson

ABSTRACT

It is easy enough to proclaim that cheating is wrong and to explain it as yet another example of trends in this country elevating the big bluff or the apparently sincere apology as means of getting off. The question is what should a professional do when witnessing what appears to be a colleague's unethical behavior? A scenario is analyzed where a dental student observes what appears to be cheating on an examination. Important steps in the process include diagnosing the moral culture of the school, determining who else might have witnessed the event and what they might do about it, and being willing to accept personal responsibility for any action taken.

Anyone who has ever survived the rigors of dental school knows that it is an arduous journey, pitting an accelerated pace of study and development of skills and techniques against the finite number of hours in a day. Multiple projects, deadlines, and cramming information into an already saturated brain only to regurgitate it in an accurate, cogent nature for the next test all contribute to push students to the breaking point. The stressful elements served up in school are dichotomous—a microcosm of life given in heaping, steaming piles of success and failure and the temptation to take a short cut in order to arrive at the diploma stage without doing the work needed to achieve mastery of skills is ever present; skills that include the discipline of proper conduct and competency within our chosen profession. If an individual falls into moral compromise during the critical professional formative years of dental school, this same individual might find it justifiable to fall back on such habits in the professional arena. For this reason, it is paramount that cheating in the dental school setting be dealt with in a swift, compassionate, and uniform matter.

THE DENTAL SCHOOL CONTEXT

Cheating is lying, whether to one's self, one's peers, or an institution. While this statement may seem unequivocal to the reader, I believe that cheating has gone from a clear issue of right and wrong to

one that has varying degrees of blame, stigma, and consequence. Punishment for cheating varies it seems as each situation is analyzed, defended, and rationalized against the circumstances and character of the cheater. As a dental student, what would you do if you saw a classmate openly cheating on a test or project?

Competition can be unnecessarily brutal between classmates and even within ourselves as we strain against the pressures of school to grow and succeed. Mettle is tested, skills are molded, and personalities tempered by the forces necessary for transforming us into the competent professionals we strive to be. The process is meant to be comprehensive, and dental students are well-qualified for the arduous challenge. Having survived the winnowing process that is required for admission, dental students are not strangers to success. We have fought hard to win our seats in class and are programmed to expect earlier successes from undergraduate school to continue throughout our post-baccalaureate years. Personal failure might be measured objectively or subjectively. Regardless, dental students



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This paper was a winner of the 2014 Ozar-Hasegawa Prize for student ethics essays sponsored by the American Society for Dental Ethics.

are likely to encounter both clinical and didactic failure during their four years of school. It is the fear of failure and the time-consuming remediation it causes in an already time-critical environment that promotes the temptation to cheat. The culture of your school determines your course of action when confronting a cheating classmate and that culture embodies a variety of attitudes, behaviors, and interactions between students and faculty that must be considered before embarking on a course of action.

THE SCENARIO

Sitting down in the simulation lab, you nervously adjust your unit to prepare for the practical examination. All students have been given the objectives and clear rules for the exercise. All typodonts have been checked for occlusion, teeth are clearly unprepared, and all stations have been scanned to ensure that nothing except the prescribed armamentarium and score sheets remain. As you take a deep breath and look toward the clock to check the start time, you notice that a classmate is furiously scribbling something on the test sheet. Before averting your gaze, you see the crib notes in your classmate's hand barely concealed under the instrument table. The proctor calls out that the examination is beginning and you observe your peer carefully slide the paper into the white coat.

When preparing teeth, there are multiple objectives that will make or break a prep. Dental students have dozens of criteria that must be met in order to accomplish a clinically acceptable final product. Procedures in clinical dentistry, out of necessity, follow a strict protocol and sequence. Any deviation from either will compromise the end result. Additionally, any deficiencies along the way have a tendency to affect subsequent objectives; the earlier the issue the more calamitous the result. Students are taught zero tolerance from required criteria. While students may be encouraged to write down personal reminders during a practical, referring to a covertly prepared "cheat sheet" during the test is clearly wrong. Having observed the aforementioned activity, you must how deal with this situation.

THE ANALYSIS

Confronting the issue of cheating will have far-reaching effects for both the cheater and the person reporting the cheating. Certainly, there is some degree of interdependence, for better or worse, with our classmates for the duration of our school years. "Ratting out" a classmate for unethical behavior can

The culture of your school determines your course of action when confronting a cheating classmate and that culture embodies a variety of attitudes, behaviors, and interactions between students and faculty that must be considered before embarking on a course of action.

and will have repercussions for both parties. Classmates may ostracize either or both, and mistrust can permeate the group as the class divides into the camps of “accused” and “accuser.” If cheating goes unreported, class rankings will be skewed as the cheater is scored inaccurately relative to classmates who receive accurate grading results for their abilities and efforts. The profession suffers as a whole because dentists who take shortcuts in practice very likely have done so throughout their lives.

In order to find resolution to this dilemma, I would immediately consult with a trusted advisor at my institution. Before giving details, I would ask for clarification regarding the school’s policy regarding cheating and what my responsibilities would be if I suspected someone of cheating. I would use this information as the basis to proceed. If I knew I was the only one who had witnessed the incident, I would know that by divulging my classmate’s name I will have set myself up for a “my word against yours” scenario which could have a detrimental effect on me and my reputation in the eyes of my classmates.

By remaining discrete and keeping the accused anonymous, yet in registering my concerns with a faculty member,

I can choose to not confront the person directly. This transfers responsibility for the issue to the faculty member and places him or her in a “my word against yours” situation. There is a possibility that more than one person saw the incident and if anyone else comes forward, I could be accused of complicity if I did not report.

If I felt comfortable with my relationship with my classmate, I may choose to mention, in a non-threatening manner, what I thought I had seen. With no hint of condemnation, I would tell my friend that his or her behavior might be construed as cheating and that the next time it might be someone less tolerant that sees him or her. I am not required to tell my classmate that I have alerted faculty and there is no reason for the suspected cheater to take offense. Either they were cheating or they were not. If they were, they know at least one person saw them and if not, they know to be more circumspect in future behavior to avoid suspicion. No threats, no blame, just a compassionate heads up that the behavior has been noted. If more than one person steps forward and corroborates the accusation, faculty will interview all parties involved and render a decision or back away if witnesses are not willing to speak publicly.

In order to make an ethical decision in regards to a cheating classmate, I would use the ACD test (assess, communicate, decide) for making ethical decisions. I would question whether there could have been any other possible reason for the student to be writing

before the start of the practical. Knowing that there was a slim chance that what I had seen was something I may have misinterpreted; I still communicated my concerns to an advisor. Speaking with the advisor, I would have to admit to the possibility that maybe what I had seen was not what I thought I had seen, thereby staying true to the assessment portion of my decision and leaving an opening for an alternative explanation. I decided not to divulge the name of my classmate or to confront him or her. Taking into account how classmates would respond and the very real possibility of negative repercussions, I felt that this was the best course of action. While this decision is a moral compromise because the incident would likely never be investigated, I know that the ramifications for my divulging my classmate’s identity would overshadow any beneficence gained for my school.

THE SOCIAL CONTEXT

The stance of ethicists is that ethics provides the baseline for determining a course of action that is good and just within the spirit or intent of a rule. The rule may or may not be good and just and the dental provider must be comfortable making independent moral arguments for ethical decisions as to what needs to be done and why something should be done. It is essential that these critical thinking skills are practiced

and improved in the dental school setting because the issues of ethics and morality do not disappear after graduation; they multiply. Almost every decision made in the dental office is guided by some ethical principle and these decisions are critical to the aim of providing service to patients—the reason why we become dentists. Cheating undermines the moral growth of the student by preventing honest introspection and stifling ethical challenges within oneself for decisions made. If one cannot be honest with oneself, how can one be honest with patients?

In days past, society would hold us responsible when people were caught lying or cheating through the use of guilt, shame, and consequences. Regrettably, cheating in our society has become a means to an end. As our small inner voices, ingrained from parental admonitions and fear of retribution, are washed out by the daily cacophony of news stories about people who cheat and are successful. Guilt and shame are no longer powerful deterrents to cheating. The rewards can be huge and it is difficult not to be seduced by a false sense of security when blatant cheaters are rewarded. Lauded and respected, we all know these characters, seemingly always on the right side of the law yet obviously running afoul of the spirit or intent of it. While consequences doled out to those “caught” can be salacious and overly entertaining, society’s response is more about “forgive and forget” than any lasting condemnation.

A tearful apology or a sizable contribution to a worthy cause can allow the most egregious of sins to evaporate into thin air. And we as a society are also guilty of either not wanting to get involved or making excuses for the malevolence of people we like and admire. This popular cultural stance must not be tolerated in the dental setting because it undermines professionalism as ethics are thrown out and replaced with a “feel good” attitude of benign forgiveness.

If society has lost the moral compass used to hold people responsible for their actions, we as dental professionals have an obligation to monitor our own and send the message that cheating will not be tolerated in dental school, as it will not be tolerated in clinical dentistry, as it should not be tolerated in life. Cheating is lying and should be treated as such. We need to identify instances of cheating and as a profession address cheating as we would any other ethical dilemma—with uncompromising veracity, a deep commitment to nonmaleficence and the distribution of fair and consistent justice.



The rewards can be huge and it is difficult not to be seduced by a false sense of security when blatant cheaters are rewarded.

NO MATTER THE SCALE

Courtney Killough

"I'm a student no more,"
She thought as she sat,
Diploma in hand,
Tassel on hat.

"Four years of hard work,
Soaking up skills like a sponge,
Private practice awaits me.
It's time to take the plunge."

Flash forward six months,
It's a jam-packed treatment day,
New patients, multiple recalls,
And of course, some x-rays.

Her schedule, however,
Doesn't seem quite so tight.
Building a patient pool, she found out,
Doesn't happen overnight.

People hate change.
A new dentist is no exception.
So she sets out to prove them wrong,
To change their perception.

"Mr. Jefferson is in chair four!"
The assistant proclaims.
She's thankful to see a familiar face,
To hear a familiar name.

"Is that crown holding up?
Is the shade just right?
Does it bother you at all
When you speak or when you bite?"

He shakes his head "no,"
With a grin that lights the room.
She pats herself on the back
For earning his trust, she presumes.

It's back to the treatment plan.
She checks what's next on the list.
Two amalgam restorations,
With no apparent tricks or twists.

"Sir," she begins
As her chair spins around,
"Your bottom teeth are my next priority
Remember that enamel, all broken
down?"

She pulls up his radiographs,
Making sure the stories match,
19-MO, slot prep on 31-MO,
She will tackle in the same batch.

As the appointment winds down,
Mr. Jefferson interjects,
"Are you taking new patients?
I know some people who'd like to
connect."

"Why yes, of course," she exclaims,
So he offers up his plan,
"Heck, I've enjoyed being your patient
so much,
I'm recommending you to everyone
I can!"



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This paper was a winner of the 2014 Ozar-Hasegawa Prize for student ethics essays sponsored by the American Society for Dental Ethics.

She is hopeful her pool will grow,
Will fill up drop by drop.
One thing of which she is certain,
Word-of-mouth is no trivial prop.

So they set a date for treatment,
December 21st,
“No more than an hour, Mr. Jefferson,
And I promise it won’t hurt!”

When Monday morning rolls around,
Her voicemail light is flashing.
There are messages and inquiries,
Mr. Jefferson’s promises in action.

“I’m so lucky,” she recognizes,
To have a patient who trusts me enough,
To recommend my services,
To all the ones he loves.

Sure as the rising sun,
The tides begin to change.
Her newfound success is quite exciting,
At times stressful, almost strange.

Then that cold December day
Rolls in with a punch
And the fateful restorations,
Are to happen after lunch.

As she sits chatting chairside
To let the lidocaine diffuse
She takes a mental break just long
enough
For a few things to be confused.

Although the restorations
Go off without a hitch
Her heart drops to her stomach,
When she grasps what she switched.

19-MO, slot prep on 30-MO,
They’re staring her right in the face
“How could I be so careless?
How can this be erased?”

As she gathers her thoughts,
Preparing to admit her mistake,
A devil on her shoulder,
Jumps out and pumps the brakes.

“Are you sure that fessing up
Will work in your best interest?
You’re trying to build your name,
Your place as a dentist.

With student loans to pay,
With bills stacking high,
If only for the sake of honesty
Forget it. Just lie.”

Her mind clouds with confusion,
She’s stuck on what to do,
But is it really lying,
To not admit what’s true?

Mr. Jefferson won’t be the wiser,
He’s a businessman not a doc,
But armed with the truth of her mistake,
He might punch her time clock.

Since missteps are seen as failures
In our profession by and large,
Admitting seems terrifying,
Like a dishonorable discharge.

But she knows the road to veracity
Is one she has to walk.
She takes a breath, taps his arm,
And just begins to talk.

“Mr. Jefferson, I’m so sorry.
I must admit my mistake,
I drilled and filled the wrong tooth,
But there are no retakes.”

She holds her breath and waits,
For his thoughts on it all.
Instead of anger or disappointment
There is an air of calm.

“Well thank you,” he begins,
“For your honesty is rare,
What is life for anyways,
If not to learn when you err?”

Despite her hunger for success,
And the pressures of new-dentist life,
She knows deep down that what he says
Is a perfect tidbit of advice.

A non-truth is a lie,
No matter the scale.
But representing her work truthfully,
Ensures honesty and growth prevail.

“I’m a student for life,”
She thought as she sat,
Shaking Mr. Jefferson’s hand,
His head donned with a hat.

SUBMITTING MANUSCRIPTS FOR POTENTIAL PUBLICATION IN JACD

Manuscripts for potential publication in the *Journal of the American College of Dentists* should be sent as attachments via e-mail to the editor, Dr. David W. Chambers, at dchambers@pacific.edu. The transmittal message should affirm that the manuscript or substantial portions of it or prior analyses of the data upon which it is based have not been previously published and that the manuscript is not currently under review by any other journal.

Authors are strongly urged to review several recent volumes of *JACD*. These can be found on the ACD Web page under "publications." In conducting this review, authors should pay particular attention to the type of paper we focus on. For example, we normally do not publish clinical case reports or articles that describe dental techniques. The communication policy of the College is to "identify and place before the Fellows, the profession, and other parties of interest those issues that affect dentistry and oral health. The goal is to stimulate this community to remain informed, inquire actively, and participate in the formation of public policy and personal leadership

to advance the purpose and objectives of the College."

There is no style sheet for the *Journal of the American College of Dentists*. Authors are expected to be familiar with previously published material and to model the style of former publications as nearly as possible.

A "desk review" is normally provided within one week of receiving a manuscript to determine whether it suits the general content and quality criteria for publication. Papers that hold potential are often sent directly for peer review. Usually there are six anonymous reviewers, representing subject matter experts, boards of the College, and typical readers. In certain cases, a manuscript will be returned to the authors with suggestions for improvements and directions about conformity with the style of work published in this journal. The peer review process typically takes four to five weeks.

Authors whose submissions are peer-reviewed receive feedback from this process. A copy of the guidelines used by reviewers is found on this site and is labeled "How to Review a Manuscript for the *Journal of the American College of Dentists*." An annual report of the peer review process for *JACD* is printed in the fourth issue of each volume. Typically, this journal accepts about a quarter of the manuscripts

reviewed and the consistency of the reviewers is in the phi = .60 to .80 range.

Letters from readers concerning any material appearing in this journal are welcome at dchambers@pacific.edu. They should be no longer than 500 words and will not be considered after other letters have already been published on the same topic. [The editor reserves the right to refer submitted letters to the editorial board for review.]

This journal has a regular section devoted to papers in ethical and professional aspects of dentistry. Manuscripts with this focus may be sent directly to Dr. Bruce Peltier, the editor of the Issues in Dental Ethics section of *JACD*, at bpeltier@pacific.edu. If it is not clear whether a manuscript best fits the criteria of Issues in Dental Ethics, it should be sent to Dr. Chambers at the e-mail address given above and a determination will be made.



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