PMM news
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To Review

In the June issue we started exploring associateships and began a review of the findings of Oral Health America, a non-profit advocacy group working to inform the American public about the vital importance of oral health to overall health.

Desirable Qualities of an Associate

There are definite differences between an associate and a partner. An associate is hired to provide clinical services, but may not be involved in practice management. Once the associate begins to buy into the practice, he/she becomes a partner with a financial and usually a management obligation that is much greater than that of an associate.

Senior doctors who contemplate bringing in an associate may wish to have the candidate tested psychologically to make four determinations:

1. Is there satisfactory interpersonal compatibility? Do the two doctors have similar interests, standards, mores and humor? Are they sensitive to staff members, respectful of patients, able to work well with diverse people and each other?
2. Is the level of dominance or aggression of the entering doctor acceptable to the senior doctor and vice versa? Is the senior or young doctor so aggressive that he/she will overpower or alienate the other? Or is the prospective associate so docile and unassertive that he/she will be unable to keep the practice healthy when the senior departs?
3. Does the young doctor have a high sense of integrity? Can you rely on his/her word? Is his/her word as important, or perhaps more important, than a contract might be? Such evidence of integrity is vitally important even though an associateship is, in my opinion, mandatory.
4. Does the prospective partner have a strong work ethic? Is he/she "hungry?" Is he/she willing to work extended hours, take call, limit vacation? A successful doctor knows that when the door is closed at night the problems of the practice do not disappear. He/she takes them home, worries about them, works on their resolution and plans for future development. Will the prospective associate be able to work at such a level?

Perhaps a keyword in choosing the right associate is continuity for the practice. After a dynamic leader reduces workload or retires, the level of enthusiasm and excellence that the senior doctor initiated during earlier years will have to be maintained. Can an associate who is to become a partner continue and even enhance all that has been built?

What Makes an Associateship Work?

The decision to hire an associate is often a difficult one for the dentist and perhaps his/her family and staff. Personal/emotional and administrative issues must be clarified. The administrative issues, including practice statistics, staff retention, shared practice management, physical facility and layout and business systems, can be worked and agreed upon fairly and objectively.

The emotional concerns are much more difficult to address. However, the personal and emotional agendas of the dentists involved must be discussed and understood. Successful associateships *feel* good. Both the senior and junior dentists enjoy peace of mind and a sense of security that comes from having the right person with whom to practice.

Dr. Peter Wylie, a consultant providing advice on business partnerships, discusses aspects of associateships with some interesting comments. He suggests a simple exercise for the dentists to help clarify the emotional level of the relationship between prospective associates/partners. He calls his method TRAC –Trust, Respect, Affection and Confidence.

Dr. Wylie advises the senior doctor to think about the prospective associate. Rate him/her in each of these categories according to your perceptions:

Trust
1 2 3 4 5 6 7 8 9 10
Respect
1 2 3 4 5 6 7 8 9 10
Affection/Likeability
1 2 3 4 5 6 7 8 9 10
Confidence
1 2 3 4 5 6 7 8 9 10

If you scored the prospective associate less than 10 in any of these four categories, ask yourself these questions:

- If the score I gave is less than 10, why?
- What does the doctor have to do to get a 10?
- Do I believe the doctor could/would make those changes?

The thoughtful answers to these questions will allow the dentist(s) to decide if this is a professional with whom associateship and/or partnership seems feasible.

What Does a Prospective Associate Need to Know About a Practice He/She is Joining?

The prospective associate will also have concerns during his/her search for a position. Is this the right doctor with whom to practice? Can this practice support two (or more) dentists? What about staff?

Obviously all of these questions will not be asked during the initial interview. However, this is the type of information an associate should ask and the senior doctor should be prepared to answer as the interviewing process and negotiations proceed, and before a final associateship contract is signed:

1. Review for me the main characteristics you are searching for in an associate.
2. Describe your practice:
   - Age
   - Location(s)
   - Number of doctors
   - Number of staff
   - Distribution of staff
     Business: Clinical:
   - Number of operatories
   - Any additional equipment to be added for an associate
   - Number of days/week worked
   - Office hours
   - Plans for expanding hours
   - Adequate parking
   - Number of phone lines
   - Computer system
   - Incorporated
3. Will the current staff remain employed and can they support another doctor, or will more space and staff be added?
4. How willing will current staff be to work with a new dentist?
5. Will an additional hygienist have to be hired? Is there room for him/her or will more equipment have to be added? Will I be required to help purchase any additional equipment?
6. Is the entering associate to absorb patient overflow or build his/her own patient base?
7. Will I get to see/treat new patients as well as restorative and recare? If not, do you have a time frame in mind when I can treat the full scope of patients?
8. What is the approximate number of active patients (seen within the last 18 months in pediatric dental practice)?
9. What is the average number of new patients per month coming into the practice?
10. What is an average number of restorative and recare (hygiene) patients seen monthly?
11. Outline the mix of services offered in the practice; which services are consistently referred to another office?
12. How many patients per month leave the practice?
13. How often are charts purged?
14. What kind of marketing (education) efforts are used to strengthen patients' home care regimen and to build the practice?
15. What is the primary referral source?
16. Describe your recare system.
17. What percentage of the practice is insurance? Do you wait on insurance assignment?
18. How is insurance processed? What happens to insurance claims that are not paid within four to six weeks?
19. Are collections a problem?
20. What is the collection percentage rate? (Collection percentage rate is calculated by dividing collections for a given period by production for the same period.)
21. Do you treat managed care patients (welfare, other)? If so, what percentage is each of the patient load? Will the new associate be expected to absorb all managed care patients?
22. How frequently are fees reviewed?
23. What is the general profile of the patient load? Are there enough young patients to assure the practice has not aged out?
24. How much vacation do you take? How will my vacation be allotted?
25. How many continuing education courses do you attend yearly? How many may I attend?
26. Describe your work pace and schedule.
27. Have you had an associate before? May I ask the

circumstances of his/her departure (or buy-in if the associate is a partner)?

28. Will there be a large up-front cash outlay for the entering associate?
29. Which expenses will the entering associate be expected to pay?
30. Will the associate be salaried or receive a percent of his/her collections (production)?
31. How long before a buy-in situation might be offered? Do you want an associate for one year, two years or longer? Would you welcome a buy-in partner following a successful one or two year associateship?
32. If a buy-in is to be offered in a year or two, how and when will the practice be appraised?
33. How would a buy-in situation be structured?
34. What if the association does not work? Will a restrictive covenant be included in the contract? If so, what conditions will seem fair?
35. What is the general profile of the community? Is it growing?
36. Who are the major employers?
37. What is the general climate of the dental community?
38. Does the local dental society meet regularly? Do you participate?
39. Does your accountant meet with you regularly to plan for the practice?
40. May I see the most recent year's income and expense statement or at least be apprised of expenses (overhead) once our negotiations are in the final stages?
41. What is your time frame for taking an associate?
42. I know I will need your input and advice as we begin working together. Will we be able to meet regularly?

While young dentists interviewing for associateships may be reluctant to ask so many questions, this is the type of information needed to make a wise choice. Before an interview, the questions can be pared, combined and written so that there is no doubt that the interviewee has thoughts and details in order.

Oral Health America—continued

The article, "The Disparity Cavity–Filling America's Oral Health Care Gap," published by Oral Health America, offers a wealth of information and vital statistics on the importance dental health plays to overall essential good health. With permission from Oral Health America we have reprinted portions of the article.[1]

The Barriers: Why Some People Don't Get Care

Greater insurance coverage is no guarantee more people would receive care, for other barriers exist. About 90 percent of the nation's dentists are in private practice and don't work in inner cities and rural areas where poor and underserved people live. An impending dental manpower shortage and a drop in the numbers of minority dentists threaten to make this barrier even greater. Also, though dental treatment for Medicaid-eligible children is mandated by law, many dentists don't accept Medicaid patients because low reimbursement rates do not cover costs of care and they consider Medicaid, with its rules and regulations an administrative "nightmare".

Less easy to document, priorities and attitudes also keep people from getting or giving care. To most people, other health conditions seem far more important than dental health when time and money are limited, especially since the link between dental health and overall health is not widely understood. Nor is the fact that medical and dental care are different. Everyone needs regular dental care, though only certain groups–the very young and the very old and those with chronic conditions – need regular medical care. The belief that oral diseases are inevitable also keeps many from preventive care. Some cultures simply accept, as a given, that the loss of some or all of their teeth is part of life.

Who Pays for Care?

More than 150 million Americans, 55 percent of the population, have no dental insurance. Dental care accounts for a minute portion of the nation's trillion-dollar health care bill. In 1997 a total of $50.6 billion was spent for dental care and nearly half, or 47 percent, was paid directly by patients. A 1997 survey, by the American Dental Association, showed nearly half of all dentists provided some uncompensated care. The total amount of charitable care is an estimated $2 billion a year, most for the poor and near poor.

Because dental care for 20 million Medicaid-eligible children through age 18 is mandated by law and the new Child Health Insurance Program (CHIP) provides dental coverage for an additional 4 million low-income children, in theory at least, needy children should be able to get dental care. Despite the legal requirement, Congress has never provided enough money to carry out the program. "We have a program that made the promise but didn't deliver," reports Dr. Burton L. Edelstein.

Who Will Provide Care?

The current access problems will only become more acute in the future as the supply of dental manpower declines. Many have worried that dental education is approaching a crisis with declines in applicants as well as graduates. The decline

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started when dental schools reduced their enrollment by about 30 percent in the 1980s and went from about 5,200 to the current 4,000 graduates a year. During that same time, six dental schools have closed and others face financial difficulties.

What Can Be Done?

Some of the solutions are self-evident. Dr. Howard Bailit, for instance, thinks "a relatively modest increase" of $3 billion in the $152 billion Medicaid budget would provide basic dental services for the entire Medicaid-eligible population and would make a significant difference in the access problem–as long as program administration improves and reimbursement levels increase.

None of this will happen until the public demands it, but there is no organized and vocal constituency for oral health. Even senior citizens have not lobbied for dental coverage through Medicare. "The general societal view is that dental care is not as important as medical care," worries Dr. Howard Bailit. "There's not a constituency out there screaming for it."

That could change as the public becomes more aware of the strong link between good oral health and good overall health. The release of the Surgeon General's groundbreaking report on Oral Health and the ambitious goals for reducing disparities in care that are in Healthy People 2010, the government's health goals for the nation of the next decade, should push the issue to the forefront of public attention.

Preview

In the next issue, we will focus on personnel administration and the art of motivation.

1. "The Disparity Cavity," published by Oral Health America and the W.K. Kellogg Foundation (June 2000). Reprinted with permission from Oral Health America, 410 N. Michigan Avenue, Suite 352, Chicago, IL 60611, 312-836-9900, 312-836-9986 (fax), www.oralhealthamerica.org.

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