Understanding and Evaluating Associateship Opportunities

This course is no longer offered for Continuing Education credit.

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Intended Audience: Dentists, Dental Students, Office Managers
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Disclaimer: Participants must always be aware of the hazards of using limited knowledge in integrating new techniques or procedures into their practice. Only sound evidence-based dentistry should be used in patient therapy.

Introduction
Most general dental graduates eventually become associates in either private practice and/or dental support organizations (DSOs) or in a government agency such as the military or health service. Some will eventually buy-into or buy-out dental practices in which they associate. Associateships encompass a number of foundational variables, ranging from employment agreements to payment of laboratory expenses to practice valuation to assignment of patients. This course explores these and other key parameters in associateships. A special section addresses large group practices and DSOs. The course concludes with a detailed vetting process for evaluating associateship opportunities.

Conflict of Interest Disclosure Statement
• Dr. Dunning served as the lead editor of a textbook, Dental Practice Transition (Wiley, 2016). Six of the 26 chapters from this textbook are cited in this course among dozens of other references plus many additional websites.
• Dr. Madden reports no conflicts of interest associated with this course.
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Overview

Depending on the dental school and geographic region, approximately 50 to 70% or more dental graduates will, within one to two months of graduation, enter into an associateship arrangement in a general dental practice, and even more following residency specialty training. Students as well as dentist-owners can both benefit from an overview of the nuances of associateship employment in general dental practice. This course draws on a variety of resources, including practice experience in guiding both dental students and dentists in associateship careers. Inasmuch as humanly possible, our motivation is to provide a fair and balanced treatment about associateships.

Major sections developed in this course include: current market trends, philosophy of practice as a foundation, why owners may want an associate, why consider an associateship, reasons associates fail, features of successful associateships, compensation considerations, personal budgeting, contracts matter, employee vs. independent contractor, suggestions for looking for an associateship, suggestions for recruiting associates, large group practices/DSOs—special considerations, practice valuation issues, tips on creating a strong CV, proof book or portfolio, tips on effective interviewing, transition etiquette, and evaluating associateship opportunities.
**Learning Objectives**
Upon completion of this course, the dental professional should be able to:

- Describe the importance of a philosophy of practice and its bearing on associateship opportunities.
- Discuss 3 emerging market trends in dental practice.
- Explain 4 reasons a dentist-owner may want to hire an associate.
- Analyze 4 key factors in considering an associateship opportunity, including the lifestyle of millennials.
- List 12 reasons that associateships may fail.
- Identify 4 features of successful associateships.
- Discuss the importance of personal budgeting as part of the associateship opportunity.
- Specify 6 compensation considerations for associateships.
- Identify typical sections of an associateship agreement.
- Describe 3 commonly troublesome areas in associateship agreements.
- Summarize two strategies/options for selecting professional advisors.
- Define “employee” in the context of associateships.
- Define “independent contractor” in the context of associateships.
- Discuss 6 ways to look for an associateship opportunity.
- Discuss 5 ways to recruit an associate.
- Differentiate between DSOs and large group practices.
- Describe recruitment strategies, tips and interview questions associated with DSOs.
- Analyze practice ownership options/implications among DSOs.
- Discuss the importance of when and how a practice should be valued in the context of an associateship, including 3 commonly used methods of valuation.
- Define normalization in the context of practice valuation.
- Distinguish between a resume and a CV and identify their respective sections.
- List 6 recommendations and tips for developing a resume or CV.
- Describe the purpose of a cover letter and identify its components.
- Review the importance and role of a proof book or portfolio in the context of associateships.
- Specify 5 recommendations and tips for successful interviewing.
- Describe 6 recommended “dos” in practice transition.
- Describe 5 recommended “don'ts” in practice transition.
- Identify 3 current trends in associateships.
- Discuss 3 recommended topics/steps in an initial associateship meeting and 1 recommended topic to NOT discuss.
- Define 9 major variable categories needing to be researched and addressed when vetting an associateship.
- Identify 2 interview questions to answer or ask related to philosophies and personalities when vetting an associateship.
- List 3 business parameter/systems variables important when vetting an associateship.
- Specify 4 key patient-related variables to vetting an associateship.
- Discuss 2 issues pivotal to buy-in/buy-out issues when vetting an associateship.
- Differentiate 8 foundational compensation topics when vetting an associateship.
- Identify 3 variables related to physical facilities and technology.
- Specify 2 variables about staff when vetting an associateship.
- List 2 recommendations about restrictive covenants when vetting an associateship.
- Discuss work week expectations when vetting an associateship.
- Apply 2 recommendations about technology when vetting an associateship.
- Identify 1 recommended topic to NOT discuss about the community and surrounding area when vetting an associateship.
- Differentiate 8 foundational compensation topics when vetting an associateship.
- Identify 3 variables related to physical facilities and technology.
- Specify 2 variables about staff when vetting an associateship.
- Define work week expectations when vetting an associateship.
- Discuss 2 clinical topics and 1 associate interpersonal skill when vetting an associateship.
- Identify 2 interview questions to answer about the community and surrounding area when vetting an associateship.

**Glossary**

A/R – Accounts receivable.

CP – Collection/production ratio (percentage of billable production received as revenue in a practice).

DSO – Dental Support Organization.

Normalization – Identifying and removing from
(or possibly adding to) a practice’s overhead numbers based on the business perks available to an owner, perks which a new owner may or may not have.

**Practice philosophy** – Beliefs, values and principles serving as a foundation for a dentist.

**Practice valuation** – The process and accompanying documentation to establish the asking price for a dental practice.

**Practice vision** – A one paragraph written statement describing a practice’s purpose and values in areas such as dental care, customer service, teamwork and community engagement.

**Philosophy of a Practice as a Foundation**

Prior to entering into an associateship, it is essential to invest time to develop and put into writing a practice philosophy. As busy practitioners/students, it is difficult to find time to reflect on the work being done and why it is being done. Yet dentists are continually confronted with making decisions, consulting, delivering treatment, managing, leading, and striving to find ways to improve. In doing so it is understandable a practice philosophy may be overlooked. Nevertheless, articulating a practice philosophy is a vital tool for a successful practice.

What is a practice philosophy? Philosophy can be defined as a set of beliefs, values and principles relating to a particular field or activity. It is a method of thinking based upon rationalism, striving to make no unexamined assumptions or leaps of faith. Philosophy is the rational investigation of the truths and principles of being, knowledge or conduct which together form the basis for core values and life.² Many core values may have been established by guidance from parents and life experiences prior to entering dental school. During dental school, daily challenges surface around a rigorous curriculum and the various disciplines involved in earning a dental degree. Professors also espouse their philosophies; and dental schools reflect either stated and actually practiced values. Students soon discover what they like and dislike about the dental profession and themselves. Most importantly, individual students develop rational reasons answering the “whys” of their likes and dislikes. These beliefs gradually become incorporated into a unique practice philosophy for each person. Beliefs and values represent part of who we are as healthcare providers.

According to a study conducted at Case Western University School of Dentistry, and published in JADA,³ an associateship relationship is more likely to be compatible when these variables align between the associate and owner-dentist:

1. Graduated from the same dental school.
2. Are of the same gender.
3. Have similar outside interests.
4. Have a similar practice philosophy.

When you stop to think about having similar practice philosophies, it's logical the influence of having attended the same institution would no doubt be a major influencing factor. The development of diagnostic and treatment modalities would likely be in concert with one another. Furthermore, general practice management concepts would likely be compatible.
Why is a Practice Philosophy Important?

Significance
Your philosophy is significant in that it forms a framework and provides meaning as to your identity as a dentist. It provides significance through values and understanding which are motivational to staff and fellow dentists within the practice. Your philosophy will exemplify the standards and desire to provide the best professional care and do so at the highest level of service culture imaginable.

Relationships
Relationships are built on emotional intelligence, the ability to seek and understand the views of others, in addition to the essential ability to build trust. Sharing your philosophy allows you to engage with others on a level of understanding that is built upon sound principles and strong core values.

Aspirations
Each of us must decide what is important to us in life in a manner in which reflects who and what we aspire to become as a professional. That means at times in our lives we must do some self-reflection. Those periods of self-reflection may likely occur while we are still in dental school, again when we graduate and again in private practice. A reality check on who we are and what we want to become should encompass your philosophy. Envisioning the future takes courage, skill, and the ability to explore future possibilities. It may even lead to the discovery you were wrong in assessing your personal and professional aspirations.

Interview Preparation
While interviewing for a positon as an associate dentist, you will no doubt be asked about your practice philosophy. Be prepared. Take the time to put your philosophy in writing. Share it with your family, friends, and mentors prior to your interview. It is nice to have one question you about your philosophy prior to being asked about it by a potential employer. In a similar manner you should investigate the philosophy of the potential employer. Ask yourself if you are comfortable with this individual’s principles and core values. Do they complement yours?

Sample Philosophy
“At Smith Lake Dental Group we realize we are in a position of awesome responsibility to the people in our care. We work hard to attain and retain your trust in order to provide you the quality general, cosmetic, and reconstructive dental care you and your family deserve.”

Additional information on developing a philosophy can be found at: Linda K. Chase Professional Portfolio. Further, literally thousands of dental philosophies can be viewed by simply doing a search for “dental philosophy.”

Current Market Trends in Dental Practice
“Adapt or perish, now as ever, is nature’s inexorable imperative.” — H. G. Wells

The future for dentists remains incredibly bright. Most dental schools still have the luxury of choosing students from highly talented and intellectually blessed candidates. General dentistry was ranked by U.S. News and World Report respectively in 2015 and 2016 as the #1 and #2 career, with orthodontics displacing general dentistry in 2016.4,5

However, the dental practice landscape has also been marked by major, permanent changes, necessitating a vigilant need to constantly monitor the greater economic environment.6-8 Dunning and Lange, for example, assert the formerly termed “platinum age” of dentistry has now been somewhat tarnished.6 Why?

First, the expenditures ($) for dental services appear to have flattened and may not rebound amidst the ebb and flow of economic conditions. Meanwhile, utilization (those going to the dentist for services) has increased for children and
dropped for adults.\textsuperscript{3,11} Further, and brace yourself for some sobering statistics, the total number of dental care visits in the United States, across all settings, decreased by 7% between 2006 and 2012. There were approximately 271 million dental care visits nationwide in 2006 compared with 252 million in 2012.\textsuperscript{9} By way of a staggering, summary statistic: this means approximately 19 million fewer dental visits in 2012 vs. 2006. Over this same time frame, the US population increased by 5.3%, and the number of practicing dentists increased by 9.4%. As a result, average dental care visits per capita and per dentist decreased substantially. Even though more people now seem to have dental coverage of some kind, such as Medicaid, preferred-provider, etc., patients still struggle to access care and still need some expendable income for any deductibles or co-pays.\textsuperscript{12}

Second, dental student debt has skyrocketed, prompting studies about its influence on recruiting students and impact on career decisions. As of this writing, average debt hovers around the $225,000 area, with lower averages for public dental school graduates and higher for private dental school graduates.\textsuperscript{13} [Some argue that as of this writing the average dental student loan debt is approaching approximately $270,000.\textsuperscript{7}] The lower average debt of $225,000 at a blended 6.5% rate over 10 years results in a monthly payment of $2,555. Without factoring in rather strict limits on the tax deductibility of student loan interest and income taxes owed on with after-tax/ take-home income, a recent graduate would need to earn on average $30,660 in annual income just to make a $2,555 monthly payment ($2,555 x 12). This indebtedness redefines the economic landscape for associateship positions and for obtaining practice purchase loans. From another perspective, if an associate earned 33% of collections, s/he would need to generate $93,000 in annual revenue just to make student loan payments ($93,000 x .33 = $30,690), without factoring-in limits on tax deductibility on student loan interest or income taxes owed on gross income.

Fourth, decreased reimbursement schemes from some dental insurance companies are putting increased pressure on practice profit margins, presenting an ongoing challenge to dentists.\textsuperscript{12} Summarizing an aggregate data set, Boechler asserts that although the dentists and hygienists are working more hours on average each month, their net production per hour and per patient represents a smaller percentage of the gross.\textsuperscript{16} This is due to the increased use of insurance as payment, leading to higher adjustments and a smaller percentage of net production.\textsuperscript{b} Unfortunately, for dentists, with the ACA [Affordable Care Act]...this trend is likely to continue into the future. In other words, dentists can expect to work longer hours and realize increasing pressure on profit margins.

Why Owners May Want an Associate
Dr. Richard Callan outlines five main reasons a dentist-owner may want to hire an associate:\textsuperscript{17}

1. being too busy/too much patient demand for service;
2. planning to retire and/or sell a practice;
3. wanting to slow down/reduce hours;
4. having extra available operatories/space; and
5. fulfilling a desire to mentor. We have divided these five main reasons into two categories: best reasons; and other reasons.

Best Reasons
1. In spite of lower utilization rates and market pressures on profitability, many successful dentists still report being too busy or having too much demand to meet all their patient treatment needs. Such blessed dentists are obviously in a situation in which they need additional help which an associate should be willing to provide.
2. Many owner-dentists view a potential associateship as an opportunity to sell their practices and eventually retire. Dr. Steve Wolff serves as a broker and as of this writing a current officer in ADS Group (adstransitions.com), the largest independent dental brokerage firm in the United States. Dr. Wolff calls the associateship-owner retirement transition “the 5% solution,” suggesting such a transition actually succeeds about 5% of the time.\textsuperscript{18} Whatever the percentage in actual experience, the transition from associate to owner is complicated business. Several
sections later in this course address specific reasons that associateships may fail and offer suggestions for successful associateships.

In our opinion, the best reasons create the most optimal situation for a successful associateship, particularly one involving the associate working as an employee vs. an independent contractor—this distinction will be addressed later.

Other Reasons
3. As dentists advance in age, many may want to slow down or reduce their hours. Doing so creates an opportunity for an associate to fill the gap in dental services. The current average retirement age of dentists is 70 with a projected increase from one source to 75 within the next 5 to 10 years.7 Other people are observing lower retirement ages as practice performance improves along with the general economy. In the end, there may be fewer full-time and more part-time associateship opportunities over time. At least some dentists will be working more years on the one hand; on the other, there may be increasing numbers wanting to slow down or to reduce their chair time.

4. Some dentists have facility resources which exceed the practitioner’s needs—namely, unused, equipped operatories or perhaps unequipped operatories. This space creates at least a place for a potential associate to practice. Depending on patient demand in the area and the respective goals of an owner and an associate candidate, this space could be utilized by an associate as an employee or, arguably more likely, by an independent contractor-associate who could potentially build a second practice within the same facility. A later section differentiates employment vs. independent contracting in the context of dental associateships.

5. At least some dentists have a deep and abiding interest to mentor younger dentists. Mentoring and the associated professional collegiality can be a powerful, meaningful experience for both the owner-dentist and associate. Mentoring is infrequently mentioned in associateship agreements/contracts, but should probably be described in writing or at least discussed during the hiring process. Mentoring can embrace clinical, interpersonal and business aspects of practice.

Our view is that the second “other reason”—having excessive facility resources, may lend itself more favorably for an associate working as an independent contractor. In effect, the associate would be building his/her own practice in the same location(s) as the current owner.

Why Consider an Associateship?
Why would a dental graduate or later career dentist consider entering an associateship?

- One key point for the associate candidate to ponder very judiciously is this: am I looking only for a probably short-term job OR am I looking for a career track? The distinction is fundamental to the reasons for seeking an associateship. Clearly, having a job is a good outcome! Bills have to be paid, including student loans. Some life situations may necessitate a “job-only” mentality—for example, a spouse’s education or career constraints or other life goals such as having children may lead an associate to view a potential associateship as a short-term job with no expectations beyond 1 to 3 years. Conversely, a career track implies long-standing employment in a practice and probably, for most dentists, a future ownership position in a practice(s). A career-track focus necessitates a much more rigorous vetting process in evaluating a potential associateship opportunity such as addressing the long list of items/questions discussed toward the end of this course.

- A widely common reason for pursuing an associateship, especially immediately upon graduation, is to have the opportunity to grow in clinical/technical skills in a variety of disciplines while also increasing speed/efficiency. While widely variable based on education and motivation, it has been our experience in talking with many dentists that associates right out of school can produce approximately 60% of what an experienced dentist can do in the same amount of time, and upwards of 75% after a year in practice. While current students find this almost impossible to believe, experience shows this is a reasonable expectation. To some extent,
work time does expand and compress as needed to get the job done. Most associates will need to add a second chair for patient care (not counting hygiene “checks”) within a few short months after graduation. The associate, in essence, is getting paid to learn how to perform more dentistry in less time.

While less commonly discussed, an associate also has a fantastic opportunity to learn about the business of dentistry from an owner-dentist or DSO. Particularly important in this regard are: developing a keen focus on key practice indicators (such as production per day or per chair per day); learning how to hire and supervise staff; participating in daily morning huddle business meetings; and developing expertise in vital business systems which take good practices to great practices (such as scheduling, collecting, customer service and internal marketing).19

• A career goal of becoming a co-owner/partner or solo-owner of a dental practice is certainly a vital reason for entering an associateship. Working alongside another dentist and with the dental team and observing areas of strength and systems needing improvement affords a long-term experiential evaluation of practice. Beyond the formal valuation of a practice to be discussed later, working as a dentist in a practice probably affords the best perspective from which to make an informed judgement about purchasing a practice.

• Much has been written about values and priorities of every generation, including millennials (see, for example, reference 20). While individual differences must be acknowledged, as a group millennials value teamwork, growth in careers, collaboration, and perhaps most importantly here, work-life balance and flexibility. A well-structured associateship with clear expectations in a team-based dental practice is well-suited to millennials. Associates have an opportunity to make a good living with some flexibility in schedules AND without the primary burden for the business aspects of dental practice.

More will be discussed about compensation issues in another section of this course, but the pressures of making student loan payments and the increased competitiveness in the marketplace due in part to DSOs have resulted in higher levels of compensation for associates in many markets.

Reasons Associateships Fail
Dr. Eugene Heller wrote what we consider to be a classic article detailing ten reasons associateships fail.21 In this section of the course we summarize Dr. Heller’s ten reasons and added a few more. The focus here is particularly on a career track associateship leading to buy-in or buy-out.

1. **Not discussing purchase price before an associateship begins.** The owner-dentist and associate approach the issue of practice valuation and the associated purchase price from opposite ends of a continuum. The owner-dentist usually prefers the practice be valued after the associate has worked for a period of time and be valued just prior to purchase. The associate typically prefers the practice to be valued before or soon after starting to work as an associate. Neither is right and neither is wrong, and there are strategies to reasonably discount associate “sweat equity” or increase a practice’s value based on growth besides what the associate adds to the practice. However, the ADA advises in its associateships book the discussion of valuation should take place prior to the associate beginning to work.22

Drawing from hundreds of cases, the statistic
cited by Dr. Heller is staggering on this issue: in 75% of the cases, associateships leading to ownership will succeed when the purchase price has been established before the associate begins working. Even more startling, in 90% of the cases the transition to ownership will fail if purchase price has not been determined when the associate begins working. Clearly, it is in the best interest of both parties to discuss purchase price before the associate begins working.

2. **Not defining buy-in/buy-out terms/process.** The more details of the future buy-in/buy-out that are discussed and committed in writing prior to or soon after the associate joins a practice, the greater the likelihood the associate will become an owner/buy the practice. This can include sections in an associate employment agreement and in a letter of intent to purchase, which can detail the process and timing of the purchase. In most situations it may be beneficial to include a timeline framework with some flexibility for the buy-in/buy-out (for example, between 6 and 18 months of the associateship). While a deadline date is needed (buy no later than), it is necessary to understand that practice dynamics and other variables may make it beneficial to both parties to execute the buy-in before the deadline date.

3. **Inadequate patient base.** While experts may have well-informed and varying opinions about exact number of patients needed, most suggest 1000–1200 active patients (patients seen within the last 18 months for care other than emergencies) for EACH practicing dentist. At least 1500 to 1800 patients will be needed for a one-dentist practice to take on an associate to ensure sufficient demand for services to keep the associate busy. Hygiene maintenance appointments are a fairly reliable way to estimate the number of active patients in a practice (number of patients due for a maintenance appointment). Take the number of patients seen in a given six month period of time multiplied by a factor of 1.5. With almost all practices now enjoying software programs, a report query can likely ascertain rather quickly the number of active patients in a practice.

4. **Incompatibility of clinical skills between practitioners.** This can be incompatibility in a number of different areas or ways: skill levels by different disciplines, clinical speed/pace (or lack thereof), types of treatment being diagnosed (dentists may see things differently), types of care proposed/provided, and even philosophy of treatment. For example, one dentist may believe that CERAC and CBCT imaging are essential features of a modern practice, while another does not. One dentist may want to provide care to all children who qualify for Medicaid, while another wants to limit this, if allowed by law, to only children within the county in which the practice resides. These clinically-based issues can result in a failed associateship.

5. **Not executing buy-in/buy-out when agreed upon.** While related to item #2 in this section, it is definitely worth delineating by itself this reason for failure. Suppose the associateship agreement or letter of intent to purchase specifies a drop dead date of March of 2018 by which the associate must purchase the practice. The owner-dentist might be unwilling to sell at that point for a myriad of reasons; alternatively, the associate might not be willing to buy for many reasons. In any case, failure to execute by one of the parties, even for possibly “good reasons” may sink the deal.

6. **Inadequate or unfair patient assignment.** Does the owner-dentist share existing and new patients with the associate? This is often a contentious issue that could be addressed in a well-crafted associateship agreement/contract. We have heard of horror stories in which the owner-dentist provides care for all the better patients needing higher-end fee procedures, and shifts less expensive preventative care and single restorations to the associate. In other instances, an associate might be assigned the practice’s entire roster of Medicaid patients, resulting in potentially lower compensation if being paid on the basis of collections. A specific strategy for managing this area of conflict is to have all new patients assigned to the associate (if the owner is already fully booked/busy) or having every other new patient assigned to the associate unless the patient requests a specific doctor for treatment.

7. **Unwillingness or inability of owner to “let go.”** Here is the reality: a dental practice—patients, team members—is the owner’s
“baby” so to speak. Being unwilling to turn-over challenging clinical cases to the less experienced associate, or being unable to take the steps needed to finally sell a practice and “abandon” patients and staff can be very troublesome from an emotional standpoint for the owner-dentist. Some owners may be in a situation where their financial assets have not performed as expected, and so this could also play a role in not being willing or fiscally able to sell and retire.

8. **Incompatibility of business and/or practice philosophies.** If these fundamental values and principles clash, it is very probable that an associateship will fail. These clashes could encompass issues of third party insurance, integrity (“gray” tax write-offs, for example) and transparency or lack thereof (something very important to millennials). The owner may wish to avoid all dental insurance, including preferred provider “participation,” while the associate, eager for clinical experience and business growth of the practice, may instead wish to invite all preferred provider plans and patients into the practice. Remember the previously cited study emphasized compatible philosophies as a marker of successful associateships.

9. **Incompatibility of personalities.** It is sometimes said that, as a group, dentists don't play well together when actually having to work in the same practice. Whether an accurate characterization or not, personalities often collide. For example, one dentist may be boisterous and expressive, and another may be quiet and reserved. It doesn't take much of an imagination to see how this will conflict in a team business meeting. Similarly, as is the case of a majority of dentists, the owner-dentist may be highly structured in terms of schedules and organizations, and the associate may be spontaneous and “go with the flow.” Whatever the differences, personalities at combat may lead to a failed associateship.

10. **Conflicts among advisors such as attorneys.** Professional advisors, including attorneys, potentially can sink an associateship before it has even started or after it has commenced. Contracts or agreements are incredibly nuanced legal documents, for example, and what the owner-dentist's attorney believes is a reasonable and enforceable restrictive covenant, for example, may be in sharp contrast with the associate's legal counsel. The brokers or other transition consultants may have very different opinions about the value of a practice in what is essentially an unregulated industry with multiple methods of valuation utilized in multiple ways. This is a proper place to remind you that an attorney and an accountant are your ADVISORS, but they should not be making your well-informed decisions for you. That responsibility is your professional expression.

11. **Inadequate interpersonal skills.** An associate's interpersonal skills appear to be as important as technical skills in successful associateships. These skills range from how to talk with patients successfully about treatment, motivating patients and staff, encouraging team members and managing conflict. If an associate has deficits in these types of foundational interpersonal skills, an associateship may be short-lived.

12. **Inadequate clinical skills.** Just as weak interpersonal skills may portend a failed associateship, insufficient clinical skills may do the same. Commonly cited clinical skill issues for associates include: diagnosis, slowness and, frankly, procedures completed below standard (for example, compromised margins). While patients may have a limited understanding of an associate's clinical skills other than whether a tooth hurts or not or a crown lasts long enough, an owner-dentist typically brings a wealth of experience in judging whether dental treatment meets expectations.

13. **Staff/patient conflict.** While related to interpersonal skills, conflicts with staff and patients are worth mentioning as a separate line-item. An associate's pattern of creating and failing to manage conflict with staff and/or patients will often result in a failed associateship, just as conflict often results in other failed or broken relationships in life.

14. **Family members working in the practice.** This is a controversial issue to be sure. However, having spouses or other family members of a dentist working in the office often creates perceptions of inequity and often results in more stress potentially both
in the office and at home. Suppose, for example, that a woman dentist's spouse is also the office manager charged with patient assignment within the office. The scenario is potentially rife with conflict. If the associate believes that patients are not being equitably assigned, to whom does the associate turn to work this out? The owner-dentist and office manager have an inherent conflict of interest and may not be able to overcome biases.

15. **Work Ethic.** Although based only on many anecdotal reports, there may be inconsistencies between the work ethic of the owner-dentist and that of the new associate. In certain cases, the owner dentist may perceive that the new associate lacks the drive, motivation and work ethic to put in the quality time to build the practice and provide the best dental care.

**Features of Successful Associateships**
A successful associateship can be broadly defined as one meeting the career goals of both the associate and the owner-dentist. Some associates may not have an interest in ownership, and so a long-term associateship would be considered successful in such a situation. Most dentists still have an interest in an equity position in a practice—partial or complete ownership. Consequently, we will focus on the associate to owner transition in addressing a successful associateship while acknowledging that this does not always apply.

Clearly, it is necessary to address the previous reasons associateships fail in order to pave the road toward a successful associateship, including initial conversations establishing compatible philosophies. Several other building blocks deserve special mention.

The first building block for a successful associateship is a thorough written agreement detailing expectations for both parties. Even if you have known the owner-dentist your whole life, you should never, ever enter an associateship without a thorough written agreement or contract. A later section outlines contractual elements and potentially troublesome areas. Associateship agreements or contracts vary in length—some may be as few as two pages and some may be dozens of pages. It is simply not possible to establish clear expectations in a two page document. Typically an 8 to 20 page document, if well written, may address the essential expectations, though we are aware of agreements in excess of 60 pages.

A second building block for a successful associateship is sufficient compensation for the associate. Note that we did not say “impoverished” or “exorbitant” compensation. Every associate will present with a unique set of lifestyle and financial parameters. Compensation will be covered in more detail in the next section. Our advice to any associate candidate is quite basic when it comes to compensation: determine your basic personal/family budgetary needs (also discussed in more detail later), and negotiate toward that amount.

The third building block for a successful associateship is to acknowledge the need for risk-reward balance for the owner-dentist. The owner may have to equip additional operatories, will probably have to share patients in some equitable manner, and will have increased overhead costs (both fixed costs such as additional staff and variable costs such as supplies). To some extent, just as “associates” at Wal-Mart are from a certain vantage point a type of profit center for the corporation, so, too, a dental associate is within reasonable levels of a profit center for the owner-dentist. The owner-dentist should not be put in a position of financial loss for having an associate, at least not over the long-term. Owners may incur a loss for the first few months an associate works in the practice, but a loss is obviously not sustainable in the long-term.

What is the fourth building block? Having reasonable advisors providing competent professional advice—the flip-side of the tenth reason for associateship failure in the previous section. Given the complexities involved in associateships and in practice valuation/purchase, both parties must have at least an attorney and an accountant in their respective corners to give insights and to provide for a legally and financially sound transition. This is an ideal place in the course to mention that some consulting firms offer “dual-party representation.” This means the same consulting firm espouses
a philosophy of providing professional advice to both the owner and the associate candidate. It is our opinion an associate should retain the right to select his/her own independent advisors even if offered by a consulting firm offering dual-party representation. To a certain extent, bias can enter into any negotiation and relationship, and biases must be managed.

Many associateships present and require management of unique circumstances. These can potentially include a long laundry list of items such as: the role of family members in the negotiations or actually working in the practice, staggering of office hours if the facility lacks a sufficient number of operatories for the dentists and hygienists, firm contractual commitment from the associate especially when the owner incurs significant expenses to build and/or equip additional operatories in which the associate will work, how any lab-related “redos” will be handled (sometimes the additional laboratory expense must be paid by the associate), history of substance abuse on the part of one of the dentists.

Finally, while not designated as building blocks in this section, a number of key practice variables greatly facilitate a successful associateship. These are discussed in the section on vetting an associateship opportunity and include: desirable overhead levels (~60% +/-), minimum active patient base (1500–1800+, the more the better), and adequate revenues to support both the owner and the associate: ~$900,000 to $1,000,000.

### Personal Budgeting

#### Need for a Detailed Personal/Family Budget

An associate’s personal/family budget situation plays a foundational role in negotiating for a position, be it “only” a job or a career track. In view of rising student loan debt and the practice market trends discussed earlier, it is arguably now more important than ever that an associate develop a detailed, retentive personal/family budget so s/he knows fairly precisely what compensation is necessary to meet personal/family needs. Our advice is associate candidates develop a budget before beginning to look for a position. Additional information on personal budgeting is available elsewhere (for example, 23) and websites such as http://feedthepig.org.

A sample budget template is presented in Table 1. Many templates are available online, including Meet Every Dollar.\(^24\) The essential point is this: develop a detailed budget using this template or another one! And realize the budget amounts are AFTER TAX dollars, meaning the amount you actually get to “take home.” You may have a guaranteed base of $100,000, but after state and federal income tax and other taxes, you may take home only $75,000.

As any financial advisor would assert: it is vital that a “liquid” (cash available) emergency fund of 3 (for single individuals) to 6 months (for those with dependents) be established as an overall strategy in budgeting.

### Table 1. Personal/Family Monthly Budget.

<table>
<thead>
<tr>
<th>Item</th>
<th>$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated take home monthly income</td>
<td></td>
</tr>
<tr>
<td>Automobiles</td>
<td></td>
</tr>
<tr>
<td>Gasoline</td>
<td></td>
</tr>
<tr>
<td>Repairs/Tires</td>
<td></td>
</tr>
<tr>
<td>Taxes</td>
<td></td>
</tr>
<tr>
<td>Insurance</td>
<td></td>
</tr>
</tbody>
</table>
Table 1. Personal/Family Monthly Budget. (continued)

| Category                                      | Cost  
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Loan Payment</td>
<td></td>
</tr>
<tr>
<td>Car Replacement Savings Fund</td>
<td></td>
</tr>
<tr>
<td>Clothing/Shoes</td>
<td></td>
</tr>
<tr>
<td>Food</td>
<td></td>
</tr>
<tr>
<td>Nonfood (household cleaning supplies, shampoo, etc.)</td>
<td></td>
</tr>
<tr>
<td>Gifts and Stamps/Postage</td>
<td></td>
</tr>
<tr>
<td>Personal Debt (credit cards, dept. stores, etc.)</td>
<td></td>
</tr>
<tr>
<td>School Debt</td>
<td></td>
</tr>
<tr>
<td>Child Care</td>
<td></td>
</tr>
<tr>
<td>House/Apartment (30%)</td>
<td></td>
</tr>
<tr>
<td>Phones</td>
<td></td>
</tr>
<tr>
<td>Water</td>
<td></td>
</tr>
<tr>
<td>Electricity</td>
<td></td>
</tr>
<tr>
<td>Natural Gas/Propane</td>
<td></td>
</tr>
<tr>
<td>Waste and Recycling Services</td>
<td></td>
</tr>
<tr>
<td>House Maintenance (repairs, etc.)</td>
<td></td>
</tr>
<tr>
<td>Mortgage Loan Payment or Rent</td>
<td></td>
</tr>
<tr>
<td>Escrow for insurance/Real Estate Taxes</td>
<td></td>
</tr>
<tr>
<td>Cable/Internet</td>
<td></td>
</tr>
<tr>
<td>Replacement Funds (furnace, roof, carpet, furniture, etc.)</td>
<td></td>
</tr>
<tr>
<td>Other Insurance (could be a work benefit)</td>
<td></td>
</tr>
<tr>
<td>Health insurance and out of pocket expense</td>
<td></td>
</tr>
<tr>
<td>Life</td>
<td></td>
</tr>
</tbody>
</table>
Student Loan Debt Management

We would be remiss if we failed to address student loan debt management in the context of associateships. The length and interest rates of educational loans for dental school can vary greatly depending on type, but a blended average interest rate of 6% is used here for illustrative purposes only. Your situation will be individually fact-dependent. The ADEA website has excellent modules posted on loan repayment, including possibly more affordable income-driven repayment options developed and narrated by Dr. Paul Garrard. We highly recommend you review these modules for more in-depth information. (ADEA modules.)

Below is a table with the approximate monthly payments for the listed loan amounts and the number of years to pay off the loan listed on the left.

Table 1. Personal/Family Monthly Budget. (continued)

<table>
<thead>
<tr>
<th>Table 1. Personal/Family Monthly Budget. (continued)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability</td>
</tr>
<tr>
<td>Identify Theft</td>
</tr>
<tr>
<td>Entertainment (movies, eating out, etc.)</td>
</tr>
<tr>
<td>Allowances</td>
</tr>
<tr>
<td>Vacation Fund</td>
</tr>
<tr>
<td>Giving to Charities</td>
</tr>
<tr>
<td>Savings/Retirement (could be a work benefit)</td>
</tr>
<tr>
<td>Miscellaneous (newspaper, magazines, haircuts, sports, school expenses for children, etc.)</td>
</tr>
<tr>
<td>Continuing Education (could be a work benefit)</td>
</tr>
<tr>
<td>Contribution to Emergency Fund if Not Fully Funded</td>
</tr>
<tr>
<td>TOTAL MONTHLY BUDGET</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Monthly Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>$50,000 $100,000 $150,000 $200,000 $250,000 $300,000</td>
</tr>
<tr>
<td>10 Years $967 $1,933 $2,900 $3,867 $4,833 $5,800</td>
</tr>
<tr>
<td>25 Years $322 $644 $966 $2,181 $1,611 $1,933</td>
</tr>
</tbody>
</table>

Below is a table with the approximate monthly payments for the listed loan amounts and the number of years to pay off the loan listed on the left.

Monthly Payments

<table>
<thead>
<tr>
<th>$50,000</th>
<th>$100,000</th>
<th>$150,000</th>
<th>$200,000</th>
<th>$250,000</th>
<th>$300,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 Years</td>
<td>$967</td>
<td>$1,933</td>
<td>$2,900</td>
<td>$3,867</td>
<td>$4,833</td>
</tr>
<tr>
<td>25 Years</td>
<td>$322</td>
<td>$644</td>
<td>$966</td>
<td>$2,181</td>
<td>$1,611</td>
</tr>
</tbody>
</table>

Rising Tuition Costs
A portion of the interest on these loan amounts may provide a tax deduction in the first year or two for some recent graduates. However, that deduction phases out at higher income levels and disappears completely once taxable income exceeds a certain threshold (as of 2016, $80,000 in adjusted gross income for single tax payers and $160,000 for married tax payers). See this IRS link for more information: Student Loan Interest Deduction.

As a rough rule of thumb, figure you will need to make these student loan payments with AFTER tax income and any other taxes such as social security. Your gross (before taxes) income will need to be about 20 to 30% more than your monthly payment amount. For example, to make a monthly payment of $2,000, you will need to make approximately $2,400 to $2,600 in gross (before tax) monthly income. The standard period for paying off education loans is 10 or 25 years, though other options are available (see the ADEA modules mentioned above).

If allowed, should you pay off your student loan earlier than required by the lender or by law? This is a very complicated question highly fact-dependent on your individual/family situation. Generally speaking, at today’s interest rates for other loans, 6% is fairly high. In the long-term, if you could realize a greater rate of return on investments in a tax qualified retirement account (no income tax on the amount contributed and no income tax on your investment growth until you take money out upon retirement), you might be better served to invest in tax qualified retirement plan through your dental practice rather than pay-off loans earlier than required. Of course, there is no guarantee your retirement account investments will yield a rate of return that would exceed your 6% student loan rate; on the other hand, contributions to a tax qualified retirement account will reduce your income tax.

As with any major financial decision, you should consult with a trusted and highly competent financial planner and a certified public accountant when deciding about options for paying off student loans early vs. investing in some other way such as practice or a retirement account.

**Goal Setting**

Setting specific longer-term financial goals takes monthly/yearly budgeting to the next level of sophistication. For example, are you still driving that 1999 Toyota Corolla with 187,000 miles on it? Someday that tired car (with no intended offense to the Corolla!) will have to be replaced. Your choices: save and pay all or a portion in cash; or finance a newer car. In either case, setting a goal will help ease your mind as you work toward achieving your goal over time. Developing written goals in financial and other areas of life facilitates success.

**Production Considerations to Achieve Needed Income**

As an associate candidate, have you ever asked yourself various scenarios under which you need to make enough income or generate enough revenue as an associate to meet your budget? Compensation schemes are discussed in the next section. But, for now, if you have a yearly budget requiring $80,000 in net/take-home income, then your guaranteed salary must be in the broad range of $100,000 to $110,000 to cover estimated taxes.

If you are going to be paid ONLY on a percentage of collections, the revenue you need to generate in the practice becomes more complicated. Let’s assume you are going to make 32% of collections, the owner-dentist will cover 100% of the lab bill, and the practice collects 98% of billable production. With a take-home annual budget need of $80,000, the numbers look like this:

\[
\text{Billable Production} = $350,000 \\
\text{Collection (98%)} = 0.98 \times 343,000 \\
\text{Billable Production} = ($343,000) \times \text{Compensation rate (32%)} = 0.32 \times 109,760 \\
\text{Estimated take-home:} = 82,320.
\]

So, if you as an associate realize $350,000 in billable production annually, you would slightly exceed your budgetary needs by $2,320.

Another approach to determining needed production to meet income needs is this formula:
Production Needed = Pretax Income/Compensation Rate (33%)/Collections/Production Ratio (CP) (98%)

$100,000 divided by 33% = $303,030 divide by 98% = Production needed of $309,215

Assumptions:
Necessary (after tax) Income: $80,000
Necessary Pretax Income: $80,000 + 25% (for taxes) = $100,000

The lower the CP ratio the higher the production needed to attain the same compensation.

The Production necessary at various CP ratios for $100,000 of pretax income at 33% of collections as compensation.

<table>
<thead>
<tr>
<th>CPI Ratio</th>
<th>Production</th>
</tr>
</thead>
<tbody>
<tr>
<td>98%</td>
<td>$309,215</td>
</tr>
<tr>
<td>95%</td>
<td>$318,979</td>
</tr>
<tr>
<td>90%</td>
<td>$336,700</td>
</tr>
<tr>
<td>80%</td>
<td>$378,788</td>
</tr>
</tbody>
</table>

Guaranteed Flat Level Percentage
A less popular method of compensation is to provide a flat level of produced or collected revenue based on the associate's work. Ranges here vary widely from ~27% to ~34% depending on benefits provided and responsibility for the laboratory expense. Offering only a guaranteed flat level percentage for compensation makes it very difficult for an associate to make an informed financial decision. Associate candidates may not be able to answer with any certainty the fundamental question: Will the income meet basic budgetary needs?

Guaranteed Based Compensation plus Percentage
Another common and desirable compensation package consists of a base compensation with a collection or production percentage which replaces the base amount when associate-generated revenues exceed a dollar amount per month or per quarter (three months). For example, the associate is guaranteed an income of $7,750. Once monthly collections exceed $25,000 per month (realize that $25,000 x .31 = $7,750), the associate then earns 31% of all his/her generated revenue.

Tiered Compensation
Roger Hill suggests an innovative twist to the “plus percentage” system. Namely, he suggests that associateship compensation could also be based on a tiered, stair-step system in which the associate earns a higher percentage based on higher revenue targets. Here is an example simply for illustrative purposes:

<table>
<thead>
<tr>
<th>Associate Revenue</th>
<th>Percentage Received by Associate</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0 - $25,000</td>
<td>31%</td>
</tr>
<tr>
<td>$25,000 - $30,000</td>
<td>33%</td>
</tr>
<tr>
<td>$30,000 - $35,000</td>
<td>35%</td>
</tr>
<tr>
<td>$35,000 or higher</td>
<td>37%</td>
</tr>
</tbody>
</table>

This system recognizes that, for the most part, the owner-dentist's fixed costs for the associate...
do not necessarily increase as the associate's productivity increases, but variable costs such as supplies and laboratory do increase as the associate produces more. Nevertheless, the owner-dentist realizes a higher profit as associate-generated revenue increases, and this system allows an associate to share in some of that additional revenue.

**Hourly Rate**
While less common, an associate might be compensated at a flat hourly rate which often is in the range of $56+/-.27

**Production or Collections?**
Should an associate be paid on the basis of billable production (after any third-party adjustments such as from Medicaid or dental insurance) OR on the basis of actual collections? The correct answer is whatever is agreed upon in the contract! If the collection/production ratio is high as it will be in well-run dental offices, this question becomes much less of an issue. Associates may have little control over collection systems in a dental office, and so this may factor-in to the production vs. collections decision.

**Lab Bill—Who Pays, and How Much?**
Nuances of the laboratory bill are discussed in the next section on contracts.

**Benefits**
Employee associates will obviously receive legally mandated benefits of an employer match for social security/Medicaid of ~7.65%, unemployment insurance and workers compensation. Associates in dental offices can have widely varying benefit packages beyond what is legally required. Commonly given benefits include malpractice/professional liability coverage and free dental work for self and immediate family (with patients paying for the laboratory bill). Less common but certainly negotiable benefits could include health care insurance, a continuing education allowance, moving expenses, paid time off for vacations or sickness, and retirement contributions. Some contracts even occasionally include a signing bonus. Disability insurance is usually paid with AFTER tax dollars because, should a claim become necessary, benefits will be subject to income tax if premiums are used by a business as a tax deduction. Generally speaking, benefits within a corporation tend to be applied equally to all employees; some benefits may become available after a defined length of employment such as becoming eligible for retirement benefits.

Associates working in DSO-affiliated practices and in public health clinics typically enjoy a richer benefit package compared to associates in private practices. DSOs and public health clinics more closely follow competitive “corporation” benefit packages that could include paid time off (vacation and wellness or sick leave) and health insurance. In most cases, private dental offices may elect to not offer these benefits in an effort to manage costs/overhead. Some federally mandated benefits are required when employers reach certain thresholds for the number of employees (for example, 50 or more full time employees); thus, additional benefits could be required in a DSO organization.

**Independent Contractors**
Independent contractors have NO benefits and thus incur a higher tax burden, having to pay approximately 15.3% of income for social security/Medicaid tax (the combined percentage owed by both the employer and employee). Plus, state and federal income taxes will still be owed. So, compensation for independent contractors will usually be proportionately higher to cover this increased tax burden with flat percentage rates probably in the mid to upper 30s range, assuming the independent contractor does NOT have to pay for any other expenses such as the laboratory bill, staff and supplies. As recommended later, an independent contractor would be wise to form a corporation to mitigate increased tax burdens.

**Contracts Matter!**
We have all heard the phrase, “Get it in writing,” and the reason is simple: If parties fail to document their business and or employment agreement in writing, then there always exists room for possible future disagreements. More often than not, failure to get good legal counsel on such matters can lead to serious and expensive disputes. Contracts provide guidance for each of the parties involved in the contact. When disputes arise, and they frequently do, courts and jurors seek some form of guidance.
upon which they can decide the case. Contracts provide that road map. Without such guidance, courts and jurors are forced to make tough decisions. The toughest decisions are in those circumstances where the parties at dispute have provided no clear rule for the court and jury to apply to the facts before it. For this reason, professional legal counsel is strongly advised in the construction of any business agreement. It is essential to say what you mean and mean what you say, and to do what you say you will do. The person with the training and experience to construct such an agreement is a labor law attorney. Successful and wise people know what they do not know. Be very weary of any professional arrangement in which one member of the party says, “We don’t need a written agreement; we don’t need to get the lawyers involved. Our word and handshake should be good enough.” As former President Ronald Reagan asserted: “Trust, but verify.”

The objective of a written agreement or contract is to provide a legal agreement between the dental associate and the dental practice and/or owner. It should be in written form and binds both parties to the mutual covenants defined in the written agreement. It should serve to protect both the associate and the dental practice and/or owner by defining the terms of their relationship.

An associate agreement or contract may consist of two parts. The first part of the business contract is the employment contract for the prospective associate. If the possibility exists for a buy-in or buy-out of the practice, then if there is an intent to purchase or a purchase agreement then a second part can be drawn up and become part of the associate agreement or contract or as separate documents. If a practice buy-in/buy-out is a possibility, then the practice needs to have a valuation performed. Valuation issues will be addressed in a later section.

While there may be many components that can go into an employment agreement, the following are considered to be critical components in any dental associate employment contract.

**Critical Components of a Written Agreement**

1. Status of the associate dentist (employee or independent contractor)
2. Schedule and location of services
3. Professional liability insurance
4. How the associate is to be compensated
5. Duties for the owner and the associate
6. Business related expenses
7. Patients charts and records
8. Restrictive covenants
9. Confidentiality of business trade secrets
10. Associate’s right to buy-in/buy-out
11. Indemnification of parties
12. Attorney’s fees
13. Cross insurance of parties

**Non-compete/Restrictive Covenants**

There are some areas in the dental associate written agreement that can pose difficulty. A non-compete/restrictive covenant can be an issue of concern. In some states restrictive non-compete covenants are not enforceable. It is highly recommended you first check with your respective state laws to see if non-compete covenants are legal and enforceable. If they are, such covenants must be reasonable in duration and geographic area. They must be in the best interest of the public to be enforceable. It is worthy to note violations of non-compete covenants can carry rather hefty fines and penalties.

**Supervision of Hygiene**

What if any compensation an associate receives for supervising dental hygiene remains a contentious issue. An owner-dentist may argue that s/he is paying the dental hygienist and the associate, and therefore all hygiene-related production should be credited to the owner-dentist. From the perspective of the associate, his/her license and liability are literally on the line.
when supervising dental hygiene. Further, an associate misses treatment time to do “hygiene checks,” thus, some argue the associate should at least receive credit for the dental exam and perhaps a percentage of radiographic fees. As with other potentially troublesome areas in the contract, the worst course of action is to ignore hygiene supervision issues in the contract. Instead, the contract should state plainly if the dental associate is to receive credit in his/her revenue for at least performing the check/dental exam. Alternatively, if the dental exam is to be credited to the practice (not the associate), the contract should state this. Failure to address the issue and operating on the basis of assumptions on the part of the doctor or the owner simply paves the way for unnecessary conflict which could contribute to an unsuccessful associateship over time.

**Dental Laboratory Expenses**

Dental laboratory expenses can also pose a problem. Under most circumstances laboratory expenses should be considered part of overhead and thus treated the same for all doctors within the practice. That being the case, no special consideration in the agreement needs to be made. On occasion, a doctor may insist their new associate pay their own lab bills. Under this scenario, conflict as to what percentage of compensation will be fair becomes an issue for negotiation. Questions as to how the lab expense will be deducted from gross income will need to be negotiated and agreed upon as well. For example: The written agreement states the associate will receive 30% of their production and pay their own lab bill. For illustrative purposes, assume the associate’s production for the month is $50,000.00. Thirty percent of the production, $15,000.00, is paid to the associate. From that $15,000.00 the monthly lab expense of $3,500.00 is deducted, thus leaving the associate with a gross income of $11,500.00 before taxes. Another way of looking at this arrangement might be the following: Once again the associate’s production is $50,000.00. However, this time the lab bill is subtracted from the gross production. This leaves the associate with production gross of $46,500.00. From this gross production, the associate is paid 30% of the remaining gross production. In this case, $13,950.00 would be the associate’s income before taxes. As you can see, there is a substantial difference, $2000.00, in the amount the associate is paid depending upon when the lab expense is deducted. Which one is fair? Obviously, this area needs to be negotiated and clearly stated in the written agreement. Sometimes examples need to be added for clarity.

**Patient Assignment**

Patient assignment is another area that can be of conflict if not clearly stated in the contract agreement. Do the doctors share the new patients equally? What about treatment of existing patients in the practice? Are they permitted to see the new associate if they specify no preference in dentists? What about difficult case types? How will staff member handle various patient allocations so as not to cause conflict within the office? As you can clearly see, this area needs careful attention by all concerned parties. Sometimes a dental practice transition expert may need to be consulted as an attorney may not be familiar with these particular circumstances.

**Guaranteed Bases and Percentages**

Sometimes associates are compensated with a guaranteed base, with or without a bonus, which replaces the base when associate generated revenue exceeds an agreed upon threshold. However, in these situations, what happens if the associate generated revenue is short of expectation for several months, as is fairly
common with a recent graduate? Does the associate owe the accumulated shortfall before the percentage system kicks-in? To illustrate, an associate earns a guaranteed base of $8,000/month, but when associate generated collections exceed $25,000/month, the associate is then paid 32% ($25,000 x .32). Suppose the associate generates $18,000 in month one, $24,000 in month two and then reaches $25,000 in months three and beyond. Does the associate then owe the owner $6,000 for month one and $1,000 for month two? Or does the owner allow this variance as a cost of doing business. Neither situation is right or wrong! What is critical is that the contract specify how this scenario will be addressed. That way both parties understand the rules for handling the associate’s compensation.

How to Find the Professional Help You Need

Transitioning from the academic environment of dental school, graduate school, or residency program carries with it a great deal of uncertainty and anxiety when it comes to entering private practice. Having spent years learning and perfecting their clinical skills, many young dentists enter into the world of private practice naïve of what awaits them in the business world. While in dental school, students have repeatedly been told to find a good attorney and accountant before signing any employment document or sale agreement. But how do you go about finding good professional help? The selection is an important one which may carry with it years of ramifications. The bottom line in the selection of anyone who is going to represent you is this: You don’t want them to be learning on you! Look for someone who has had experience in dental transitions and or associateship arrangements. Dental transactions are not a common event for most attorneys and accountants. You want someone who has been there done that numerous times.

Word of mouth can be a good starting process. Upon interviewing prospective attorneys and accountants, be specific on what you want them to do for you. Next ask them how many dental associate agreements/dental practice sales they have transacted. Ask for references. Likewise with the accountant, ask them how many dental clients they represent. Are they familiar with the industry business norms for dentists? Have they been involved in dental sales or associateship arrangements? Once again ask for references.

Our professional organizations, the ADA for example, may be of assistance as well. Likewise, state and local dental associations may be able to provide names of those who are familiar with dental associateship agreements and purchase agreements.

Perhaps one of the better ways of finding someone who is familiar with the legal and accounting needs of dentists is to utilize a dental transitions broker. Dental transition brokers will know of attorneys who can construct solid dental employment and or purchase agreements. Furthermore, they will be familiar with accountants who are members of the Academy of Dental CPAs to handle the accounting issues. The largest independent nationwide network of dental transition brokers is www.adstransitions.com.

A practical word of advice for both associate candidates and owner-dentists: We have seen many cases in which important points of agreement developed informally between would-be associates and owner-dentists are somehow revised or removed from formal contracts drawn up by professional advisors. In other words, it is fairly common for contractual-related information to not get successfully communicated to an adviser or for someone to make a mistake in codifying agreed-upon points. For example, the two parties agree on a base compensation of $110,000 with the owner covering all of the laboratory bills. When the associate candidate receives the contract, it specifies $95,000 in base compensation and calls for the associate to pay 1/3 of the laboratory bill. Such situations can obviously create unnecessary conflict. If this “failure to communicate” occurs for either party, it is best to resolve this in a calm and orderly fashion by talking with (NOT texting or emailing) the parties involved in a straightforward business manner. Use of conversation vs. electronic communication allows for a reading of nuanced nonverbal cues and a higher likelihood of successful management of the issues involved.
Employee or Independent Contractor?
Should an associate be classified as an employee or an independent contractor? Under most circumstances the associate dentist should be classified as an employee. Generally, businesses and or business owners must withhold income taxes, withhold and pay Social Security taxes and Medicare taxes, and pay unemployment tax on wages paid to employees. Employers generally do not have to withhold or pay any taxes on payments paid to independent contractors. In many cases owner dentists are looking for ways to avoid having to pay payroll taxes, unemployment insurance, pension contributions, etc. Thus, it is advantageous financially for an employer to designate an associate as an independent contractor. An attempt to classify an associate as an independent contractor in the long run may prove to be costly to all parties concerned. As far as the IRS is concerned, employment agreements carry no weight in the determination as to the status of the individual performing the services. How does the IRS differentiate an independent contractor and an employee?

Determining Whether the Individuals Providing Services are Employees or Independent Contractors
Before an employer can determine how to compensate someone, it is absolutely necessary to analyze the business relationship that exists or will exist between the employer and the person performing the services. For the purposes of this course, the person may be classified either as an independent contractor or a common law employee. As a general rule, according to the IRS, an individual is an independent contractor if the payer has the right to control or direct only the result of the work and not what will be done and how it will be done. The earnings of a person who works as an independent contractor are subject to Self-Employment Tax (the total amount of social security/Medicare tax as discussed in a previous section, ~15.3% up to an income threshold which increases from time to time). In determining whether the person is an employee or independent contractor in the eyes of the Internal Revenue Service, a preponderance of the evidence defines the business relationship that exists between the employer and the person performing the services. All information that provides evidence of the degree of control and independence must be considered. The facts that provide evidence of the degree of control fall into three categories.

1. Behavioral: Does the company control or have the right to control what the worker does and how the worker does his or her job?
2. Financial: Are the business aspects of the worker's job controlled by the payer? (These include items such as how the worker is paid, whether expenses are reimbursed, who provides tools/supplies, etc.) Will the relationship continue and is the work performed a key aspect of the business? Finally, does the person work for other businesses?

IRS Form SS-8 delineates the lengthy list of questions to be answered in determining employee vs. independent contractor status.

The key is to look at the entire relationship, consider the degree or extent of the right to direct and control, and finally, to document each of the factors used in determining the relationship. If classification as an independent contractor is desired, the following steps need to be taken. First, both the owner and the associate need very good legal counsel. It is probably best to secure the services of employment or labor law attorneys. Next, each party should form a corporation if not already incorporated. Many dentists still practice as non-incorporated solo practitioners, thereby exposing their personal assets to potential lawsuits. By law, corporations may not be treated as employees, and corporations provide a veil of protection for personal assets such as houses, retirement holdings, cars, etc. The associate's corporation then contracts with the owner's corporation for services. These arrangements need to be carefully executed and documented as harsh penalties exist for both the owner and the associate should the IRS determine an employee relationship exists and not that of an independent contractor. This type of an arrangement can carry with it advantages and disadvantages for both parties. Legal counsel will be able to provide those details.
As a practical matter, there are two long-term consequences for both parties to consider should an associate work for the owner as an independent contractor. First, structuring a reasonable and enforceable non-compete/restrictive covenant (in states where this is enforceable) can be quite a legal challenge when applied to independent contractors. So, attorneys specifically experienced in this precise area should be involved in crafting contracts. In most cases, restrictive covenants do not readily apply to independent contractors. Applicable state law and counsel from a labor law attorney are definitely needed. The second consequence correlates with the first one. Namely, an independent contractor is, in fact, developing his/her own dental practice, possibly “under the roof” of the owner’s practice and/or at other locations. In any case, if the independent contractor builds a thriving practice in two to four years, the independent contractor may have no interest in buying out the owner or in forming a partnership because the independent contractor already has a strong equity position in a successful dental practice. Owner-dentists considering developing an independent contractor relationship with an associate need to carefully consider these two long-term consequences.

Finally, any associate practicing as an independent contractor MUST form a corporation and, in turn, be hired by his/her own corporation. There are two main reasons for this. First, being incorporated provides at least a shield of protection against potential lawsuits, affording much more protection for personal assets such as retirement accounts and real estate. Second, tax strategies are available to mitigate legally and ethically the increased tax burden in a corporation context, especially the 15.3% self-employment tax.

**Suggestions for Looking for Associateship Opportunities**

It is critical to first create a philosophy of practice, establish short- and long-term goals, decide where you want to live, the type of practice in which you would like to work and your expectations for compensation!

1. Check the online postings available through dental schools.
2. Check state dental association newsletters/websites. Attend dental association state and/or district meetings. The ADA career website is http://careercenter.ada.org/.
3. Network with brokers such as those listed in www.dentalsalescareers.com, ADS Transitions, and on opportunities such as those in MD & DDS Resources and Dental Word of Mouth. 3RNnet also lists openings nationwide and by state.
4. Contact vendors, especially dental supplier representatives, in the area in which you wish to practice (such as Patterson, Henry Schein, Benco, Goetze) representatives). (Schein’s online list of openings for dentists).
5. Contact alumni from your dental school in the area in which you wish to practice. The ADA publishes a directory of members listing individuals by city/town and state, and possibly year of graduation.
6. Consider the opportunities of larger group practices and DSOs such as Midwest Dental, Pacific Dental, and Heartland. This is not an endorsement of these potential opportunities. Larger group practices and DSOs sometimes include higher levels of compensation, richer benefits, and possibly longer hours of work per week.

7. Network with school faculty, with your hometown dentist, etc.

8. Research the economic viability of the state/city/town/county through state offices of economic development, chambers of commerce (and their web sites) and city-data.com to get detailed information about the community.


10. Opportunities are also available through public health clinics, the Indian Health Service, the military, government institutions/clinics and clinics associated with individual American Indian nations/tribes. Some programs exist which offer loan repayment opportunities in, for example, federally qualified health clinics.

**Suggestions for Recruiting Associates**

The owner(s) of a practice are best served by having already developed a clear practice mission and philosophy to communicate to the would-be associate. The owner(s) should also be thinking about both short and longer term plans, including facilities and strategic financial targets into the future. Having provided such a foundation makes for a clearer framework for hiring an associate.

Here are some suggestions for recruiting associates:

1. Network with colleagues in dental education, particularly those from your alma mater.
2. Post the opportunity through dental schools. This is often free or a nominal fee.
3. Advertise through your state dental association newsletters/websites.
4. Leverage newer web-based recruiting methods, such as Zip Recruiter which has the capability of advertising through social media.
5. List your opening with brokers, such as ADS Transitions and other websites such as Nationwide Dental Opportunities (Schein’s on-line list of openings for dentists).

6. Network with vendors, especially dental supplier representatives.

**Large Group Practices and DSOs: Special Considerations**

In 1964, song writer Bob Dylan penned the song “The Times They Are a-Changin.” The song has remained popular for over 50 years. Many music critics cite the song’s lasting popularity to its everlasting message of change. For the most part, people are reluctant to embrace change because it carries with it a disruption to everyday routines. Those who wish to maintain the status quo, over time, will gradually and most assuredly be left behind in their respective field of endeavor. As W. Edwards Deming inimitably quipped, “It is not necessary to change. Survival is not mandatory.” Change has come to define our world in the 21st century. Transformations in the healthcare professions are exemplified by demographic shifts, educational competencies, degree requirements; technology and practice settings.

During the past decade, the types and number of group practices have grown. Today, increasingly more dentists practice as corporate employees, as opposed to associates in traditional practice settings. Similarly, there has been growth in the number of dentists in partnerships or multiple-ownership arrangements. The percentage of dentists in traditional solo practice has declined to approximately 85%, and some would argue that the percentage is now more likely between 65 to 75%.

What accounts for these changes, and are they likely to continue? Listed below are a number of reasons why changes have come to dentistry and will likely continue.

1. Future growth in the U.S. population will continue to come disproportionately from racial and ethnic minorities and immigrants.
2. Non-Hispanic white births are less than 50% of all births in the U.S.
3. Americans covered by commercial dental insurance peaked in the late 1990s and has continued to decline in the 21st century.
4. Total U.S. expenditures on dental care services have plateaued over the past five years.
5. The number of dental graduates now exceeds the number of dentists leaving the workforce each year.
6. New dentists are increasingly graduating with higher debt levels.
7. New graduates have a greater interest in work-life balance than previous generations of dentists.
8. Due to debt load and life style balance, more young dentists prefer salaried positions as employees than have past generations of new dentists.

How has the dental marketplace shifted in responding to these changes? In part, these fundamental changes have contributed to the continued growth of large practices, group practices (multiple dentists working in the same or multiple locations) and Dental Support Organizations (DSO). Both enjoy the benefits of economies of scale when compared to solo practices. Dr. Roger Levin, a noted dental practice consultant, author and lecturer, astutely commented about DSOs and their competitive advantages: “these businesses pose stiff competition for traditional solo practices by promoting a lower-priced alternative and accepting more insurance” and they “have the potential to transform a geographic market virtually overnight.” Nevertheless, Levin concedes that “traditional practitioners can remain competitive by focusing on building value, through personal attention, and strong customer service, extensive experience, community involvement and uniqueness.”

One additional major advantage traditional solo practitioners have is the stability of doctors and auxiliary personnel. As stated in the beginning of this section “people do not like change.” This is perhaps especially true of healthcare providers. For this reason, the solo practitioner will still maintain a profitable niche in our delivery system for healthcare services.

Large group practices offer some advantages with regard to economies of scale over the solo practitioner. However, DSOs enjoy much greater capital structure, economies of scale, and national presence. Large group practices tend to be a more localized model, whereas DSOs tend to be more regional/national. The formation of large group practices seeks to take advantage of maximum use of facility and staff. Large groups often are able to enjoy purchasing discounts with regard to dental supplies and laboratory expenditures. While this may pose an advantage over a solo practitioner, the advantages posed by the national DSOs far outweigh the competitive advantages of large group practices.

**Interview Questions**

While it is difficult to know exactly what questions you will be asked during the interview process, prepare by considering various scenarios. Some questions you may be asked include:
1. What is your practice philosophy? How does it reflect with the goals and mission of the DSO?
2. What is your leadership style?
3. What is your ability to work as a team member?
4. What are your strengths and weaknesses?
5. What are your qualifications? Certifications?
6. What is your overall knowledge of dentistry? How have you demonstrated an openness to new ideas?
7. What are your past work experiences?
8. Describe your good work ethic? What evidence can you give the interviewer?
9. Why should we hire you?
10. Do you know how to fail forward?
11. Are you open, positive, and mentally flexible?
12. Do you know you can make a difference? Be prepared to state how.
13. Are you a flexible communicator and are you genuine? Do you have a sense of humor?

**Ownership Implications**

Founder of Heartland Dental, Dr. Rich Workman, asserts: “DSOs are often connected with the ‘corporate dentistry’ or ‘private equity’ stigma when referenced or discussed. With these phrases, detractors infer that dental practices and practitioners give up control—that in choosing to be supported by a DSO, they illegally transfer all clinical decisions and duties made in their practices to DSOs.” All related dental decisions and clinical care are the providing dentist’s sole responsibility. The DSO provides services such as marketing and all administrative responsibilities as the owning dentist corporation deem necessary to run the practice.

In structure, typically, a dentist-owned professional corporation contracts with a DSO-corporation to provide administrative services for that office. This
is in compliance with many state laws which require that only licensed dentists can own a dental practice. Accordingly, ownership options, if available among DSO-affiliated practices, typically take the form of stock in the local affiliated dental practice or possibly as stock in the larger corporate DSO. Thus, some type of an equity or ownership position may be available to dentists in a DSO-affiliated career track.

This philosophy of managed healthcare has emerged in other healthcare delivery systems, such as pharmacy, medicine and optical. For decades, health professionals, physicians, pharmacists, and optometrists, have successfully utilized outside sources for nonclinical responsibilities. This evolution has taken place because the laws of medical boards have continually modernized to fit the current needs of these healthcare professionals. With this modernization, a clear distinction between clinical and nonclinical services has been made with regard to these healthcare sectors. In dentistry many of the laws governing the profession have not been modernized to accommodate the new industry trends and shifts. Many of these governing laws have not been updated since the early 1940s. The clear distinction between clinical and nonclinical services supplied by the DSO in dentistry has not been made by governing boards. Consequently, many misunderstandings have occurred because of this failure to clearly define roles and responsibilities. These misunderstandings or misinterpretations do not necessarily originate from whether or not the DSO model is right or wrong, but more from a lack of education about what DSOs actually do for a dental practice.

**Practice Valuation Issues**

**When Should a Practice be Valued?**
The answer to this crucial question may depend on whether you are the owner-dentist or the associate. The owner-dentist, taking on the risk of adding an associate, might prefer to have the practice valued after the associate has worked for a couple of years or longer in the practice. The associate will likely want the practice valued before or right after commencing an associateship. As was discussed earlier in regard to reasons associateships fail, the general consensus is that it is best to have the discussion of practice valuation, and arguably the price, determined before the associateship begins. The chances of a successful transition—namely, the associate becoming an owner, significantly increase if this fundamental issue is settled beforehand. Failure to settle it in advance results in a failure of transition in most cases. Establishing the value of a practice before or right after the associate begins working avoids sticker shock for the associate and serves as a reality check for the owner about the practice’s worth and the fiscal viability of a potential associateship.

So long as both parties agree, the value of a practice could reasonably be adjusted to a higher amount when the associate actually buys-in, in order to account for: major tangible equipment upgrades, at a fair market value; and for increases in practice value attributable to the owner’s production or an inflation rate such as the Consumer Price Index.

**What Valuation Methodologies are Commonly Used to Establish Value?**
Practice valuations are very complicated and can involve multiple methods by people with highly variable experience. The main driver of valuations remains the actual revenue or collections in the practice and related owner profit (which obviously takes overhead into account) using practice financial data for the
past 3 to 5 years. In our opinion, multiple valuation methods should be utilized, including capitalization of earnings, excess earnings and asset summation. While a thorough discussion of practice valuation issues clearly exceeds the scope of this course, a brief overview of the three methods just mentioned, plus a commonly misused “ballpark” approach, will enable you to have a greater appreciation for the complexity of practice valuation issues.

- **Capitalization of earnings** involves calculating a rate of return on the practice’s profits, with the rate of return referred to as the “cap rate.” What dollar amount is used to determine the rate of return? The “excess earnings” of the practice which, simply defined, is the cash remaining AFTER paying all expenses PLUS a reasonable compensation for dentist-related labor costs (often in the neighborhood of 25% of generated revenue +/- 5 to 10%). The cap rate or rate of return is somewhat subjectively determined by an appraiser but often hover in mid-twenties range. A potential buyer must recognize the cap number greatly influences the asking price. The lower the cap rate in the formula, the higher the valuation and vice-versa. The formula appears fairly simply, but arriving at the values to enter into the formula represent a complicated process:

  For example, if the excess Earnings = $100,000 and the Cap Rate = 28%, the practice value would be $357,143 ($100,000 divided by .28 = $357,143). Note if the Cap Rate drops to .25, the practice value would be $400,000 ($100,000 divided by .25 = $400,000).

- **Excess Earnings.** This is a cousin to Capitalization of Earnings. The goal here is to determine how much debt excess earnings would allow a new owner to pay off. This is analogous to a home loan amortization schedule. At 6% interest over a 7 year period, a buyer would have to make the payments of $5,843 per month for a $400,000 practice. The question would then be: are there sufficient revenues being generated in the practice in order for the owner to cover all the overhead costs plus have enough revenue for working capital and to meet personal/family budgetary needs? Lenders may answer this question by a debt- to-service ratio—simply stated, this compares excess practice earnings to personal budgetary needs. The practice revenue must cover the overhead and practice loan payment to guard against potential unexpected business or personal expenses. For example, if a buyer has to realize a minimum of $100,000 annually for his/her personal budget, excess earnings from the practice should usually be ~1.25 above $100,000—namely, ~$125,000.

- **Asset Summation** is a very sophisticated process in which practice appraisers research, assign a value to, and sum all assets in a practice. Assets are assigned values for variables such as computer systems, radiology equipment, patient records, location, demographics, profitability, staff experience/loyalty and cash flow.

- **Revenue Multipliers.** Most general dental practices will sell, ON AVERAGE, in the range of 60% to 70% of revenue averaged over the past 3 to 5 years in metropolitan, non-costal locations, but the range varies widely and could exceed 100% on the East or West coast. Further, rural owners may not realize a sales price of even 50% of average revenue. So, in a city in the Midwest, a practice generating $800,000 annually may sell for $480,000 to $560,000 ($800,000 x .6 or .7). Practitioners will often use this “rule of thumb” to get an idea about practice value. Revenue multipliers are NOT actual valuation methods because, among other reasons, overhead and profit are ignored. We fully agree with Dr. Steve Wolff that revenue multipliers should only be used as a ballpark benchmark to gauge the overall reasonableness of a practice’s value.

It should also be mentioned that another legitimate valuation method involves comparable sales of similar practices within a given geographic area. Importantly, most competent appraisers will utilize multiple methods and create an asking price based on a combination of methods. And bear in mind the last 2 or 3 years of practice financial data may...
be assigned a weighted value above the data from 4 or 5 years ago. Valuations are typically valid only for the very short term, perhaps 2-3 years at most.

**Normalization**
A thorough practice valuation will include normalization of the overhead. Normalization involves identifying and removing from (or possibly adding to) a practice’s overhead numbers based on the business perks available to an owner, perks which a new owner may or may not have. These perks may include, on the one hand, legitimate but optional business expenses claimed on taxes by owners—for examples, charitable contributions given through the practice, retirement contributions and expensive continuing education trips to exotic locations. On the other hand, an owner may have a spouse working in the office without compensation or with below market compensation. Whether a legitimate expense or an avoided expense, an appraiser will adjust the overhead of the practice by removing legitimate but optional business expenses or potentially adding back into the overhead realistic but avoided costs. A specific line-item to evaluate as part of normalization is the lease/rent expense. An owner may also own the building in which the practice is housed and the building will most likely be owned by another corporation formed by the owner such as a limited liability company. The lease/rent may be lower or higher than the market would typically bear depending on the owner’s tax strategy, in effect, paying a lease/rent to him/herself.

Just as real estate values depend on the old adage of “location, location, location,” a practice’s value and loan approval will hinge in part on cash flow, cash flow, cash flow. In the end, a lender will require a practice valuation to be reasonable based on revenues, cash flow and profitability. As previously mentioned, if the practice does not generate sufficient debt-to-service ratios (enough money for the would-be owner to cover his/her personal/family budget, make the loan payments, and have a decent cushion of additional money), the loan will not be approved. For owners and potential buyers, dental supply companies may be willing to provide an estimated value of the tangible assets such as equipment and supplies. As a final comment, as with real estate, the listing/asking price for a practice may include a “fudge” factor for negotiating toward a final sales price.

**Creating a Strong Resume or CV and Cover Letter**
Confusion often arises when answering the question: “What is the difference between a resume and a curriculum vitae (CV)?” Further, which is most appropriate for my career track? In deciding which one to use you will need to determine which of them most appropriately meets the criteria provided by the employer who will be reading your application. Frequently, the application instructions will state whether a CV or resume is requested. If you are unsure, it is worth your time to contact the prospective business and ask which would be most appropriate for the position.

**What is the Difference: Resume vs. CV?**
A typical resume is a general and concise introduction of your experiences and skills as they relate to a particular position you are seeking to acquire. As such, resumes have to frequently be modified for each position for which you are applying; thus, emphasizing those skills most pertinent for the position. For example, you would not submit the same resume for a position as a director of a community health center as you would for a position as a practicing dentist in a group practice. Obviously, different skill sets need to be emphasized for each career track.

A typical resume will include the following sections:
1. Name and Contact Information
2. Education
   a. List all your degrees, dates, and educational institutions attended.
3. Work Experience
   a. Name of companies or organizations you have worked for, location of each, dates, job title, and duties performed.

The information written in each section should be organized chronologically. Resumes are usually no more than one page in length and are accompanied with a cover letter. A cover letter
provides a permanent written record of the transmittal of the resume (what is being sent, to whom it is being sent, and who sent it).

A CV, in contrast, is a detailed overview of your life accomplishments, especially those which are most relevant for the position. It is wise to view your CV as a living document that will frequently need to be updated. In the beginning of your career, the CV will likely be fairly short, perhaps two to three pages in length. A more seasoned applicant may have a CV that may run into double digits. Like a resume, the information in the various sections is typically provided in chronological order.

A typical CV will include the following information:
1. Name and Contact Information
2. Areas of Interest
3. Education
   a. List all degrees earned or in progress
   b. Institutions attended accompanied by dates
   c. Dates of graduation for each degree earned
4. Grants, Honors, and Awards
5. Publications and Presentations
   a. List all published articles and books
   b. List all presentations given at meeting or conferences
6. Employment and Experience (including leadership experience)
7. Scholarly or Professional Memberships
   a. Include offices and positions held
8. References
   a. List all persons who write letters of recommendation for you, include their contact information (or indicate “Available upon request”).

Regardless of whether you are submitting a resume or a CV, it should be neat and easy to read. Use common sense in formatting. There is no universal guide as to formatting, but many examples and templates are available online. You should print preview the document to make sure it is not misaligned. You will also be able to evaluate the consistency in use of space in the document.

As far as fonts and font sizes, it is recommended you use something easy on the eyes such as Times New Roman, Calibri or Arial when creating a resume or CV. Remember: you do not want the reader to be distracted from the content; you want them to read it. You want them to easily focus on your accomplishments. A size 10-12 font is also recommended.

It is always a good idea to have someone read your CV or resume. Is it easy to read and grammatically correct? Does it present well to the reader? Is it consistent in listing of content? If photos are used, are they easy to view? Are the photos appropriate for the content of the document? A personal professional photo is recommended.

**Tips in Writing a Resume or CV**
1. Match your CV or resume for the position. Highlight your education, work experience and skills as they relate to the position.
2. Use keywords from the job description. This will show the employer you are an ideal fit for the position.
3. Edit, edit, and re-edit your document. Make sure there are no spelling or grammatical errors. Make sure your format is uniform. For example, if you use bullet points in one job description make sure they are used in all of the job descriptions.
4. Review your document and make sure you have included everything.
5. Be honest and accurate with your achievements, employment, etc.
6. Get permission from your references.
7. Expect background checks to be done by the employer.

Samples of resumes and CVs can be viewed online. One website you might wish to view is: http://jobsearch.about.com/od/sampleresumes/a/sampleresumes.htm. Additional tips on writing resumes/CVs along with a sample can be viewed at: https://asdanet.org/cv/.
The Cover Letter
A cover letter is sent along with your resume or CV, the purpose of which is to provide detailed information about your skill and experience. In short, a cover letter explains why you are qualified for the job. Employers use cover letters as a means by which to identify candidates for interviews. Generally your cover letter will be an employer’s first exposure to you as an applicant. You want to make a good first impression with your cover letter.

A typical cover letter will consist of three paragraphs.
1. The first paragraph will focus on why you are writing and how you heard about the position. Include the name of any contact person associated with the practice. Briefly state how your skills and experience match with the company and the position.
2. The second paragraph will explain why you are interested in the position and why you are the ideal candidate for the position. Mention the specific skills listed in the job posting and explain how you meet those qualifications and skill sets. Also, address your knowledge of the practice and how you may be of benefit to the practice as an employee. Do not simply duplicate your resume or CV. However, do offer specific examples that demonstrate your abilities.
3. The third paragraph will be your closing. In this paragraph restate how your skills make you a perfect fit for their company. Conclude by requesting the opportunity to interview or discuss potential employment. Explain what and when you will do as a follow-up. Thank the employer for their consideration.

As with the resume and CV, proofread your cover letter. Make sure you have the correct name and spelling of the company and the person to whom the letter is being addressed. And follow the previously recommended fonts and sizes.

Proof Book or Portfolio
Most dental schools incorporate one or more case presentations or more comprehensive portfolio reviews as part of their assessments of dental students. Accordingly, an associate candidate may be wise to have these available when looking for an associateship position. Obviously, care must be taken to secure releases from patients or to otherwise protect patient privacy information. A portfolio can provide visual evidence of the clinical skills demonstrated by an associate candidate.

Tips on Effective Interviewing
Today's dental associate marketplace is extremely competitive. Approximately 2,500 to over 3,000 graduates per year may be looking for some form of associate or employee relationship. The resume or CV you send to a prospective employer is one of dozens, perhaps even hundreds, subject to review. If you are fortunate enough to be granted an interview, you will still be facing some tough competition for the position. That's where performing well during the interview process becomes extremely important.

An Interview Misconception
The biggest misconception you can make about an interview is thinking the interview will be primarily about talking about yourself. It is not. Going on an interview involves talking about how you fit into the corporate mission and culture of the practice company with which you’re hoping to work. You will need to do your due diligence with regard to the practice or company.

In an ideal world we would all be judged by our experience and the quality of our professional skills. Unfortunately, we live in the real world which is far from ideal. Regardless of gender, appearances do make a significant difference to employers. The bottom line is they see what
the public is going to see. You get only one chance to make a good first impression. Your appearance must reflect you as a professional healthcare provider. You must not only be the part–you must look the part!

**What to Wear**
A good rule of thumb to follow is to dress one step higher than you think is necessary. A good rule of thumb to follow for men would to be to wear a business suit or conservative sports jacket. Obviously a nice shirt and tie would accompany the suit or sports coat. Shoes should be shined. For women, a business suit would be appropriate. In both instances choose a conservative look. Navy blues and dark gray are always appropriate colors for a business setting. Part of your appearance also includes having a nice haircut/style. Finally, make sure your hands are clean and finger nails manicured. It goes without saying that you should have a healthy looking smile!

**When to Arrive**
Always be on time! That means arriving 20-30 minutes prior to the interview. If someone tells you that you are early, tell the staff member being early is one of your faults. Tell them you are always early! It is likely to make a favorable impression. Arriving early affords you the opportunity to meet and greet reception personnel. Don't kid yourself: receptionists will be asked by the employer what they thought of you. By arriving early it will allow you to get to know key people in the business. Be gracious and respectful to everyone you meet. Carry on a friendly conversation. Compliment the employees on how nice the office looks and the friendliness of the staff members. By arriving early you will become comfortable with the environment and thus be more relaxed for the interview. Upon exiting from the interview, make it a point to once again address the people at the reception area. Tell them how impressed you were with the staff, the office, and the doctor. And clinch your exit with a sincere, “Thank you!”

**What to Bring to the Interview**
It is highly recommended you turn off your cell phone. Better yet, leave it in the car. This is not the time for interruptions in this crucial period in your life. Make sure you have all the necessary documents with you. They should include the following:
1. Your resume and/or CV
2. Reference letters
3. Diploma, state license, DEA license
4. Written questions to ask the employer
5. Note pad and calendar

**Tips for the Interview**
Prepare mentally for questions you will almost certainly be asked such as: “Tell me about yourself?” “What are your goals in the next 3 to 5 years ... 10 years?” “Tell me about your clinical experiences and skills.” “What are some areas of expertise you plan to improve in the next two years?” “What are your core values and beliefs, and how do these influence your practice of dentistry? Give an example.” “Describe a difficult case you've encountered and how you managed it.”

1. Be open to a variety of opportunities.
   a. The laws of supply and demand dictate the market place.
2. Be open to other locations
   a. Consider locating in communities outside of communities with dental schools.
   b. Rural communities can be very profitable and offer great living conditions.
3. Production numbers
   a. Have some proof that you can do dentistry in a timely fashion.
   i. This may be a letter from an instructor at your dental school stating your proficiency in delivering care.
4. Prepare a “proof book”
   a. This may include photos of cases you have done while in dental school or in a graduate residency program.
   b. Letters of recommendation with regard to clinical and interpersonal skills.

In summary, do your due diligence relating to the practice or the DSO you are considering. Know your resume or CV inside and out. Look the part and be the part. Never bring up the topic of compensation unless the potential employer brings it up. As previously discussed, this means you need to know your personal budget. You also need to know your nonnegotiable deal makers and breakers with regard to the position. Last but not least - ask for the job!
Thank You, Thank You
After leaving the interview, take time to reflect on your performance. Write down what you think you did right and what you did poorly. These pieces of information may be useful to you in the future.

Take time to write a thank you note to the prospective employer. Make this an “old school” thank you sent via snail mail, not an email or a text. Remember your potential employer is likely to be someone 20-30 years older than you. Additionally, corporate interviewers will be impressed by the hand written note. Why? Because that is what they expect out of you when you send thank you notes to your patients! It shows you have class as a dental professional and just may land you the job!

Etiquette in Practice Transition
As you consider offering an associateship position or evaluating an associateship position, remember that your actions should reflect professional ethics: autonomy; beneficence; justice; veracity. Here are some suggestions to guide your actions.

Some Dos
• Focus initial discussions on compatibility of personalities and philosophies of practice, not on numbers or about salary/compensation or practice performance indicators. Use open-ended questions, listen, and allow time for the owner and associateship candidates to talk. For examples, “Ideally, how would you describe your practice 5 years from now?” “Tell me about your philosophy of practice ... of staff management/teamwork?” “How would you describe an ideal associate in your practice?”
• Keep information confidential as mutually agreed upon. The owner and associate will both likely need feedback from professionals such as an attorney and an accountant and perhaps others. Make sure this information sharing is acceptable with the practice/dentist/candidate/organization with whom you are negotiating.
• Explore in greater detail practice information in proportion to the developing relationship of the parties involved.
• Associateship candidates should find out as much as possible about the community, county, state as you can before getting into details of each opportunity.
• Inform one another in a timely manner of continued interest in an opportunity or lack thereof.
• Request over time more detailed information needed to make an informed decision.
• Remain cordial, calm; maintain a business focus.
• Be willing to negotiate; if you don't ask, you may not get what you want.
• Thank and provide feedback to those who provide you with referral opportunities and professional advice.
• Monitor the involvement of family members. Extended family members may create unreasonable barriers to reaching an agreement.
• Watch how you are treated because this may be predictive of the future.
• Be clear about your short-term and long-term intentions and plans.
• Fulfill promises, such as meeting deadlines for written materials, e.g., employee agreements.
• Discuss practice valuation issues, such as timing and process prior to an associate begins working.

Some Don’ts
• Play people/opportunities against each other, particularly practices/dentists in the same city/county/area.
• Gossip.
• Share practice-specific information with others unless you have clear permission to do so.
• “Burn bridges” with potential colleagues/peers.
• Break an associateship over comparatively small issues such as 10 days for vacation instead of 12 days or a difference in salary of $10,000/year or a CE benefit of $2,000 vs. $2,500 a year.
• Be surprised by or pass judgment on others based on generational differences. For examples: a 76 year-old practitioner may have limited technology in a practice; soon-to-graduate associateship candidates may have limited experience in treating dental emergencies or in specific technical skill areas such as endodontics and implants.
Current Trends in Associateships

With DSOs having approximately 15% of the market share, it is understandable more and more dentists in transition; especially recent graduates are considering associateship DSO opportunities. DSOs have a reputation for a higher base, guaranteed compensation, richer benefit packages, and considerable continuing education opportunities. Combined, these match up well for students saddled with increasing student loan debt. It is our observation the presence of DSOs have also created a competitive increase in overall compensation packages being offered by private practitioners. This is good for associates but also puts a potential squeeze on the profit margins of employing dentists in private practice.

For some context before considering negotiation issues for an associateship, here are some additional trends based on surveys conducted by Insurance Solutions and the ADA:27

• Most recent graduates are in associateship positions as employees, with fewer as independent contractors.
• The vast majority of recent graduates are not owners or co-owners of practices.
• Male dentists tend to be owners compared to women dentists. This could be because of lifestyle/child rearing choices. Also, over time it is reasonable to expect this previously observed gender-gap in ownership close, if indeed it hasn't already, in part to the work schedule flexibility offered by multi-practitioner models.
• Dentists are more likely to move into ownership positions over time (that is, fewer remain as associateships over the long-term of a career span).
• Forty-six percent of associates work with a one-owner dentist; 25% work with one owner-dentist and multiple associates; 11% work as a one associate with multiple owners; 9% work with multiple associates and multiple owners; 7% work for non-dentist owners with multiple associates; and <2% work as individual associates for non-dentist owners.

Some Considerations for Initial Conversations

Exploring a potential associateship involves due diligence on the part of both the candidate and the owner(s). Checklists such as the one offered later in this course can be very helpful in working you through details of the negotiation process; however, initial conversations help to build a relationship and establish a framework for future negotiations.

In most cases, details defining an associateship such as compensation and benefits, while clearly important, will need to wait until after a few initial and foundational critical conversations. Over the years, we have been asked many times a more general question about how to approach initial, exploratory meetings between a candidate and an owner-dentist. These meetings often involve lunch or dinner, include significant others, and tend to be informal.

The following are several recommendations for participating in these types of initial meetings. Remember, if an associateship is being negotiated with the services of a consulting firm, the company may have its own protocol and/or process. These suggestions are geared toward a traditional associateship in a general practice.

1. Arguably, the most important task is to assess the compatibility for practicing together, particularly as related to practice philosophy. Both parties should ask open-ended questions such as, “Tell me about your practice philosophy...about managing patients...about dental treatment...about staff management.” As Dr. David Neumeister, a practitioner in Vermont advises when talking with patients: stay curious, ask open-ended questions with an open mind and withhold judgment when listening.

An owner might even bring a copy of the practice's mission and philosophy, and ask some open-ended questions about how the candidate might fit into such a practice.

In the end, there should be some sense of the extent of overlap in practice philosophies of the two parties.

2. Similar to the discussion of practice philosophy, how do the personalities of the dentist-owner and the candidate mesh? Are the personalities complementary and compatible? Some key areas to consider in comparing personalities are those measured
by the Myers-Briggs Type Indicator: extent of introversion vs. extraversion, a “sensing” nuts and bolts focus (common among dentists) vs. a theoretical “big idea” focus, a “thinking” vs. a “feeling” orientation, and an emphasis on structure and organization vs. go with the flow spontaneity. One of these personality measures could even be used as part of the initial conversations.

The goal is for you to get a sense of the unique personalities of each person, and how these may complement each other or potentially be in conflict. Further, how might the associate’s personality align with and contribute to the broader dental team?

3. Are the short- and long-term goals of the owner-dentist and candidate compatible? Again, ask open-ended questions such as “Where do you see the practice in two years?” Or, “In five years, where do you see the practice?” “Describe the kind of relationship you are hoping for?” and, assuming this is a potential mutual interest, “How do you envision a future buy-in/buy-out?”

The goal is for you to get a sense of the overlap of your career goals with those of the owner-dentist.

4. To reiterate, in most cases, we would recommend NOT discussing in this initial meeting issues related to compensation, benefits, patient assignment, or other specifics related to a future associateship contract. These issues are usually best reserved for future meetings. Also, the owner-dentist may already have a contract in mind with these issues delineated. Exceptions may of course exist, such as a situation in which the parties have known each other for years, the associate candidate worked for the owner-dentist for years as a dental team member in the past, etc.

5. Pay keen attention to the communication process up to and including the initial meeting. Are both parties timely in their follow-up or does someone need to be prompted to follow-up or follow-through? These subtle but critical early signs may point toward future opportunities or potential problems.

6. Importantly, rely at least in part on your “gut” or intuition and that of a significant other. If something doesn’t seem right, this may forecast future problems that would be better avoided than confronted.

7. Answer each other’s questions in honesty and completeness.

8. Obviously, professional demeanor and attire should be displayed. A later section discusses specific interviewing tips.

Vetting an Associateship Opportunity
As part of due diligence, an associate candidate should do his/her “homework” about the dental practice and the contract. Further, the candidate should also have a labor law attorney review an employment agreement before signing it.

Vetting an associateship opportunity needs to reflect career intentions. “Only a job” is much different than having intentions to buy or buy-into a practice. The list of items below becomes more important in situations of an associateship leading to future ownership (buy-out or buy-in).

Similarly, an owner-dentist may utilize this list in preparation before hiring an associate, thinking through the vital issues involved.

The following is a generic list of questions/concerns grouped by major categories. While admittedly not exhaustive, the detailed items provide for a solid framework for examining a given associateship opportunity.

Philosophies and Personalities
1. Have the would-be associate and owner-dentist discussed their philosophies of practice in areas such as patient care, managed care/dental insurance, staff management?

2. Are the personalities of the would-be associate and owner-dentist compatible, and how will the would-be associate’s personality “fit” within the existing dental team? Personality testing such as the DISC or Myers-Briggs Type Indicator might be helpful in answering these questions.

3. Will the owner serve as a mentor in terms of clinical skills and business skills? Is the owner willing/available to do this or will schedules be staggered to maximize facility efficiencies?
4. Does the practice have a clearly articulated and communicated vision statement?

5. If a previous associate worked in the practice, does the owner encourage the associate candidate to talk with the previous associate about their experiences? If this is the first associate working for the owner-dentist, realize there may be a learning curve for both parties.

**Business Parameters and Systems**

1. What are the key performance indicators (KPI) being routinely targeted for goal setting and measured in the practice? Many potential variables are involved here, including these with ranges of recommended targets.

   - Business overhead (55-70%)
   - Collection/production ratio (98%+/-)
   - Third-party involvement in practice (no more than 30 to 50% of total gross production, depending on market conditions)
   - Accounts receivable as a fraction of average monthly collections (1.0+/-)
   - New patients per month (15 to 20 per dentist)
   - Dental hygiene maintenance/recall % (total due/total seen) per month (90% or higher)
   - Utilization of chair as a % of time/appointments available (90% or higher)
   - Dental hygiene as a percentage of overall production (25% to 33%)

   Leading experts may have varying opinions about what these and other KPI numbers should be. The pivotal question is: are goals/targets being set for these variables and are they being routinely tracked in the practice?

2. Practices typically need to be generating ~$900K to $1 million in total revenue for a one-dentist office in order for an associate to earn a living in situations where the other dentist plans to keep working at previous levels. If the other dentist will by contract reduce hours, the revenue may be proportionally reduced. Further, overhead plays a major role in evaluating needed revenue per dentist. The higher the overhead, the higher revenue is necessary.

3. What business systems are in place for sound practice management? Included here would be scheduling, internal marketing, external marketing (especially a sophisticated website), customer service, financial arrangements for patients, morning huddle/business meeting. Practices with sophisticated management systems will have implemented scripted conversational strategies aimed to achieve results.

4. An associate candidate should get credentialed by all third-party carriers involved in the dental practice prior to starting work. And this appears to be an increasingly difficult task to achieve. So, it is best to start the credentialing process as early as possible.

**Patient-related Variables**

1. How many new patients are coming into the practice per month? If entering a practice as the second dentist, a new patient flow of approximately 15 to 25+ per dentist per month will be needed in most cases.

2. How far out are patient's booked? This gives an indication of demand for services; the longer, the better for the associate candidate.

3. How will patients be assigned? It is usually helpful if patients are assigned to the first appointment opening available in the schedule unless they request a specific provider.

4. What is the active patient count? **At least** 1500-1800 patients are recommended for a two-dentist practice.

5. How will emergency appointments be managed outside of normal office hours? Shared equally? Some associates may wish to cover disproportionately more emergencies to help meet more patients.

**Buy-in/Buy-out Issues**

1. Is the employer incorporated? If so, this will have significant tax implications if the associate ever buys into the practice. An experienced team with an attorney, accountant and practice transition consultant can help manage the tax implications.

2. What is the value of the practice now? Has a valuation been done? Will the associate have to pay for any “sweat equity” built into the practice?

3. If the value has been established prior to an associate working in the practice, can the owner adjust the value of the practice due to legitimate reasons, such as the fair market value of added equipment when the associate buys-into the practice?
4. If the associate intends to buy or buy into the practice, it is in the best interest of both parties to include a contract section to that effect or an accompanying letter of intent addressing the option to purchase within a reasonable time framework—for example, 6-24 months after starting an associateship position.

5. Are terms and conditions of the buy-in/buy-out clearly and specifically defined?

**Compensation Issues**

1. How will the associate be paid: guaranteed base, base plus “bonus,” production vs. collections, etc.? Refer to the earlier section for more detailed information.

2. Is there a history of clinical production available from previous associates? If so, does the information confirm that the income needs of the would-be associate will be met?

3. What benefits will be offered, if any? Benefits required by law for employees include: employer's portion of social security/Medicare tax (≈7.65% of salary up to a threshold income cap), worker compensation (≈2-5% of salary), unemployment insurance (≈2% of salary). Benefit packages vary widely in associateships. Associates sometimes receive malpractice insurance coverage and some vacation time. Disability coverage, health care and continuing education benefits are less common.

4. Does the practice have an office policy/employment manual covering issues, such as asepsis, financial policies, safety training, benefits, etc.? If so, acquire and study the manual. If not, request that these be developed soon.

5. Will the associate owe a portion of the laboratory bill? If so, how/when will this percentage be calculated? If responsible for a portion of the lab bill, ask that the laboratory portion be taken out of the **total amount** of generated collections/production **before** any collections/production percentage is applied, e.g., $30,000 in monthly collections minus $3,000 in lab bills = $27,000 in collections $27,000 x .34 = **$9,180 monthly income** vs.

$30,000 in monthly collections X .34 = $10,200 $10,200 minus $3,000 in lab bills = **$7,200 monthly income**

The difference is significant, obviously.

6. Will the associate receive any compensation for supervising dental hygiene? From the associate's standpoint, it is reasonable to negotiate for at least the examination fee to be credited to your collection/production and perhaps for a percentage of certain procedures such as radiographs.

7. Remember, an associate is to some extent a profit-center for the owner—it is his/her business, after all. Don't be surprised if the owner realizes 20-25% of profit for each dollar generated for the practice.

8. Consider the possibility of a guaranteed base salary to meet minimum monthly budget requirements including student loan payments. This assumes the associate has developed a detailed personal budget. With increasing student loans, an associate may need to realize a gross salary of $20,000 to $30,000 or more JUST to make student loan payments, depending on the schedule of payments.

9. Consider the possibility of a stair-step compensation system in which the associate earns a higher percentage for higher levels of revenue (as previously reviewed in the compensation section earlier). An example based on monthly associate-generated collection/production might look like this: Up to $30,000 = 30% $30,000 - $35,000 = 32% $35,000 - $40,000 = 34% >$40,000 = 36%

10. Will the associate have any continuing education benefit or allowance paid by the owner-dentist? If so, is this clearly defined?

11. If the associate will be working as an independent contractor, s/he should receive a much higher percentage of collections/
production in order to cover the additional taxes owed by independent contractors. In this case, it may be wise to consider establishing a corporation to mitigate the tax consequences of being an independent contractor. The corporation could act as an independent contractor, and the associate could be employed by his/her own corporation. Remember, independent contractors receive no employment benefits, not even unemployment insurance or workers compensation.

Physical Facilities and Technology
1. Are the facilities adequate for the number of dentists and staff? A newly graduated associate will need at least two operatories within just a few months into practice. Are the operatories of adequate size for modern technology, roughly 10 x 12?
2. What technology is currently in place and is planned for the near future? Included here would be: dental software, including patient communication and education, type of digital radiology, a panoramic unit, Cerac, CBCT.
3. Will the associate have the materials and equipment needed to do the technical work expected?

Staff
1. What role will the associate have in supervising, hiring, reviewing dental assistants? Will the associate have the chair-side help needed from assistants and the front-office support needed for collections and scheduling?
2. Is the associate responsible to pay for any staff or for any supplies? If so, the compensation package must account for these increased costs to the associate.
3. What practical leadership experience does the associate candidate possess?
4. Is a detailed Office/Procedural Manual in place which outlines policies?

Restrictive Covenant
1. Are restrictive covenants enforceable within your state? If so, what is considered “reasonable” in terms of: solicitation of patients, staff; length of time and geographical distance?
2. It is strongly recommended for both the associate and the owner-dentist that a restrictive covenant begin AFTER a “waiting period” of 60-90 days after the associateship begins working. This way the associate and owner have an “out” if the associateship position is not meeting expectations of either party.

Work Week Expectations
1. What are the expected days/hours of work (chair side, completion of paper work and administrative duties)?

Clinical and Interpersonal Skills
1. Is there some way for the owner-dentist to gauge the clinical skills of the associate candidate? Perhaps the associate has prepared a clinical portfolio of cases to discuss with the owner-dentist?
2. How do the clinical skill sets of the associate and the owner-dentist complement each other?
3. What evidence of consistently competent interpersonal skills does the associate present or demonstrate, particularly in regard to: patient communication; staff communication; and conflict management?

Community and Surrounding Area
1. Does the community and surrounding area offer the livability features needed for an associate candidate and his/her family to achieve short- and long-term life goals? These goals could include: healthcare, education for children, recreational options, cultural experiences, shopping, and so forth.
2. What is the past, current and projected economic health of the community and surrounding area? This would include: cost of living, demographic trends, unemployment rates as well as major employers whose downsizing or upsizing could significantly impact demand for dental services and dental insurance availability.
Conclusion
Associateships in dental practices present some challenges and opportunities for the associate and the owner dentist. This course overviewed key variables and dynamics to be addressed, from recruiting, to interviewing, to vetting an opportunity. We trust a thorough review of this course will aid both associates and owners in developing long-term, favorable outcomes for all parties involved in this particularly nuanced career option for dentists.
Course Test Preview

1. Considerations of a practice philosophy in the context of the relationship between an owner-dentist and an associate, involve most fundamentally which variables ___________.
   a. values
   b. marital status
   c. principles
   d. political party affiliation
   e. A and C

2. Current market trends in dental practice include which of the following ___________.
   a. significantly higher demand for dental services
   b. stable to decreasing student educational debt
   c. historically high interest rates for borrowing money to purchase a practice
   d. lower reimbursement levels/schemes from third party insurers
   e. decreasing numbers of dental graduates

3. An owner-dentist may be interested in hiring an associate for many reasons, including ___________?
   a. being too busy/too much patient demand for service
   b. wanting to work more hours
   c. having extra available operatories/space
   d. wanting to increase contributions to retirement accounts
   e. A and C

4. One of the fundamental, key issues involved in deciding to pursue an associateship is to determining if you are interested in a short-term job vs. a career track.
   a. True
   b. False

5. It is estimated that a newly graduated associate can produce how much dentistry within the first year of practice compared to the owner-dentist?
   a. 30% to 40%
   b. 40% to 50%
   c. 60% to 75%
   d. 80% to 85%
   e. 85% to 90%

6. In what percentage of the cases will an intended transition from associate to ownership fail if purchase price has not been determined when the associate begins working?
   a. 40%
   b. 60%
   c. 70%
   d. 80%
   e. 90%
7. Which of the following is a reason for failed associateships __________?  
   a. inadequate patient base or unfair patient assignment  
   b. compatible personalities and compatible philosophies  
   c. an owner's being very willing to “let go”  
   d. solid associate clinical skills and strong associate interpersonal skills  
   e. defining in documents specific buy-in/out terms/process

8. In what percentage of the cases will an intended transition from associate to ownership succeed when the purchase price has been established before the associate begins working?  
   a. 60%  
   b. 65%  
   c. 70%  
   d. 75%  
   e. 80%

9. You are planning to work as an associate with a dentist you have known for many years. He simply wants an associateship based on a handshake of trust and no written agreement/contract. It is recommended that you accept these terms of employment and begin working as an associate.  
   a. True  
   b. False

10. A successful associateship arrangement must acknowledge a risk-reward balance for the owner-dentist so that s/he earns at least some reasonable profit as a result of hiring an associate.  
    a. True  
    b. False

11. You are considering an associateship opportunity. The owner-dentist's consulting firm prohibits you from seeking independent advice from your own selected accountant and attorney. In this situation, you should continue negotiation without your own advisers.  
    a. True  
    b. False

12. When should an associate-candidate first develop a detail personal budget?  
    a. Before starting the process of looking for an associate position.  
    b. During contract negotiations with the owner-dentist.  
    c. After receiving a contract/agreement from the owner-dentist.

13. As a rule of thumb, you can plan on being able to deduct student loan interest for many years because of generous federal tax law provisions and so can make your student loan payments with pre-taxed dollars.  
    a. True  
    b. False
14. An associate requires an annual gross income of $105,000 based on a thorough budget. She is considering a position in a practice with a 96% CP ratio of billable production, a 32% compensation level (of actual collections), and the owner-dentist will pay 100% of the laboratory bill. What is the minimum billable production the associate must generate in this scenario to earn $105,000?
   a. $324,000
   b. $331,000
   c. $336,000
   d. $343,000
   e. $348,000

15. Which compensation system allows an associate to earn more income as associate revenues reach higher targets/thresholds?
   a. Base compensation
   b. Flat percentage
   c. Base plus flat percentage
   d. Tiered system
   e. Hourly rate

16. In general, what benefits would an owner-dentist be obligated by law to provide an associate?
   a. Retirement
   b. Social security/Medicare employer match
   c. Unemployment insurance
   d. Worker’s compensation
   e. B and C

17. Compensation packages for independent contractor associates tend to be __________ compared to associate-employees.
   a. lower
   b. about equal
   c. higher

   a. True
   b. False

19. One of the contentious issues in associateships, particularly in contracts, relates to what income if any associates receive for overseeing hygiene examinations and services.
   a. True
   b. False

20. If an associate is contractually required to pay a portion of the lab bill/fees, it is in the associate’s best financial interest to have this amount taken “off the top” from total associate-generated revenue/collections.
   a. True
   b. False

21. Patient assignment does NOT need to be defined specifically in an associateship contract.
   a. True
   b. False
22. An associate candidate and owner-dentist have several meetings and agree on certain variables in a transition. However, it is fairly common for some of these areas of agreement to differ in documents generated by the owner-dentist's attorney or other adviser.
   a. True
   b. False

23. As a general rule, according to the IRS, an individual is an independent contractor if the payer [owner] has the right to control or direct only the result of the work and not what will be done and how it will be done.
   a. True
   b. False

24. It is recommended that an independent contracting associate function as a “solo practitioner” from a tax standpoint, having no need to incorporate as a business.
   a. True
   b. False

25. Looking for an associateship includes which of these recommendations?
   a. Networking with dental suppliers
   b. Reviewing opportunities posted on websites
   c. Networking with faculty and alumni
   d. Researching economic variables of the area in which you plan to live/practice
   e. All of the above.

26. What differentiates large group practices from DSOs?
   a. Large group practices have greater economies of scale and negotiating power.
   b. DSOs have greater economies of scale and negotiating power.
   c. Large group practices tend to be local or regional, whereas DSOs tend to be more regional or national.
   d. A and B
   e. B and C

27. Which strategies are likely to enhance employment with a DSO?
   a. Research the company with which you wish to interview.
   b. Dressing in business-professional attire when attending recruiting events.
   c. Begin looking for a position two months before graduation.
   d. Develop a good relationship with the recruiter.
   e. All of the above except C.

28. Ownership options, if available among DSO-affiliated practices, typically take the form of stock in the local affiliated dental practice or possibly as stock in the larger corporate DSO.
   a. True
   b. False

29. Practice valuations should consider all of the following EXCEPT?
   a. Multiple methods of valuation.
   b. Consideration of the owner's overhead and profit.
   c. The fact that a valuation should be valid for 3 to 5 years.
   d. Financial data from the practice for the past 3 to 5 years.
   e. Using a revenue multiplier only as a means of seeing if a valuation is in reasonable ballpark.
30. __________ involves identifying and removing from (or possibly adding to) the overhead adjustments based on the business perks available to an owner, perks which a new owner may or may not have.
   a. Valuation
   b. Appraisal
   c. Normalization
   d. Centralization of expenses
   e. Itemizing deductions

31. **Comparing resumes and CVs, which statements are correct?**
   a. Resumes will usually be longer than CVs.
   b. CVs will grow in length as you have more career experience.
   c. A resume is more likely to be adapted to fit a specific job opportunity application.
   d. B and C
   e. A, B and C

32. **Which font and size combination is recommended for resumes, CVs and cover letters?**
   a. Old English Text and 8
   b. French Script and 10
   c. Calibri and 11
   d. Rockwell Condensed and 9
   e. Shocard Gothic and 12

33. **Which of the following is inconsistent with the recommendations for interviewing?**
   a. Know your resume or CV inside out.
   b. Study the mission and other information about the practice/company before the interview.
   c. Arrive 5 minutes early for the interview.
   d. Prepare mentally ahead of time for questions you will likely be asked.
   e. Dress in business attire.

34. **As a part of transition etiquette, it is important to not be surprised by or pass judgment on others based solely on generational differences.**
   a. True
   b. False

35. **Which of the following is NOT a current trend in associateships?**
   a. Most associates are independent contractors, not employees.
   b. Most recent graduates are not owners or co-owners of practices.
   c. Male dentists tend to be owners compared to women dentists.
   d. Over time, more dentists become owners of practices.
   e. 46% of associates work in one-owner dentist practices.

36. **Initial conversations about associateship opportunities should focus mainly on compensation issues and practice financial information.**
   a. True
   b. False
37. An associate is considering an employment opportunity with an owner-dentist. Which of the following variables should be most troublesome to the associate?
   a. Hygiene production at 30% of total practice revenue.
   b. Accounts receivable at the equivalent of 1 month's collections.
   c. Overhead level of 63%.
   d. Chair utilization at 80% of available time.
   e. Manage care/third party carriers constituting 20% of all revenue.

38. An associate is considering an employment opportunity with an owner-dentist. Which of the following variables should be most troublesome to the associate?
   a. Active patient base of 1275.
   b. 35 new patients per month.
   c. Annual collections of $1.1 million.
   d. A CP ratio of 98.5%.
   e. Managed care/third party carriers constituting 25% of all revenue.
References
18. Wolff S. Seminar handouts and lecture/discussion. University of Nebraska Medical Center, School of Dentistry. 2016.
36. Ibid.
41. Crist R. Madden, R. Practice valuations. Seminar power point slides and notes. University of Nebraska Medical Center, School of Dentistry. 2016.
45. Willis D. Dental Practice Management Simulations is the financial analysis program in the "Strategic Challenge" version of the simulation includes an excel file that computes ratios when practice data is inputed. 2011. Accessed December 30, 2016.
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Dr. Madden is a 1975 graduate of the University of Nebraska Medical Center, College of Dentistry. He has practiced as an associate, as a solo practitioner in a rural community, and as partner in a large metropolitan practice. He currently maintains a solo practice in Littleton, Colorado. Dr. Madden earned a Master’s in Business Administration from the University of Colorado in 1989. He has served as a dental consultant to several senior citizen healthcare facilities. Dr. Madden served as a dental consultant to the Head Start Program for Children in Denver from 2004 to 2008. Dr. Madden also mentors new dentists on the topic of overhead control in the Denver metropolitan area. He is also a member of a recently created alumni career advisory team organized to assist our students with career decisions. Dr. Madden served for 25 years as an ADA Success Seminar Speaker. He has spoken in dozens of dental colleges throughout the U.S. In October of 2011, Dr. Madden was nominated and elected, by a council of his peers, to become a Fellow in the American College of Dentists. Dr. Madden’s interests outside of dentistry include skiing, fly fishing, theater, art, bicycling, and reading. Dr. Madden is the father of two sons. The oldest, Trevor, currently works as an associate with Heartland Dental in Texas. His youngest son is an attorney in Denver. Dr. Madden is a co-owner in a Canadian fishing lodge in Northern Saskatchewan. He has sponsored dental continuing education at this lodge for over 25 years.

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