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**Issue Brief**  
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**Changes in Practice  
Settings of Iowa  
Dentists, 1997-2013**

**Third Brief in a Series**

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## Background

Recent changes in the health care system emphasize increased coordination of services and improved health outcomes, which have contributed to the transition toward more physicians practicing in large group or hospital-based settings. However, similar trends in dentistry have not been as pronounced. As of 2012, only 18% of physicians nationwide worked in a solo practice,<sup>1</sup> whereas in 2010, 69% of private practice dentists were practicing solo.<sup>2</sup> Although changes in the dental care system have not kept pace with changes in medicine, the proportion of dentists nationwide who work in solo practices is slowly declining.<sup>2</sup>

Concurrently, there has been an increase in the number of dentists nationwide who practice in public delivery settings such as federally qualified health centers (FQHCs).<sup>3</sup> This is likely to continue while the public delivery system undergoes changes as a result of the Affordable Care Act.

The aim of this issue brief is to examine changes in the practice settings of Iowa's dentist workforce from 1997-2013 and to make comparisons with nationwide trends.

## Approach

Data from the Iowa Dentist Tracking System (IDTS) were used to examine dentist workforce trends. The IDTS is part of the University of Iowa's Office of Statewide Clinical Education Programs, which tracks the workforce of five health professions: physicians, pharmacists, dentists, physician assistants, and advanced practice nurses. The dentist tracking system was established in 1997. Since then, all active Iowa dentists have been contacted biannually for updated information regarding individual and practice characteristics.

In this issue brief, group practices are defined as practices with two or more members, as well as single- and multi-specialty associations. In 2011, the IDTS began to track corporate practice arrangements separately from group practices. The IDTS defines corporate practices as "offices with a centralized organizational structure that may or may not be based in the state of Iowa" with "standard protocols as dictated by their corporate headquarters." Dental practices self-identify their practice setting category based upon IDTS definitions.

In our examination of the public dentist workforce, we include dentists practicing in community health centers (CHCs). CHCs include FQHCs and other community dental clinics serving primarily low-income patients.

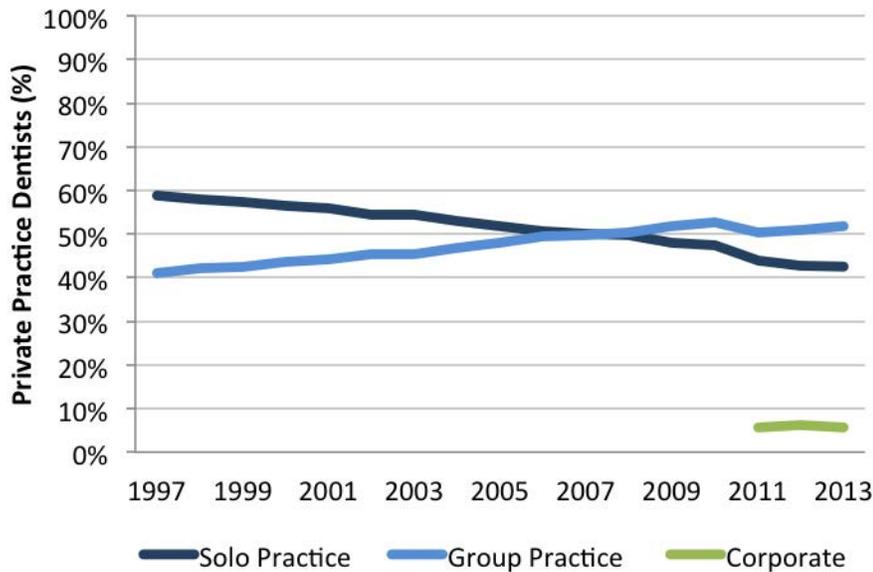
## Results

### Trends in Solo and Group Practice

From 1997-2013, there was a marked increase in the proportion of Iowa private practice dentists who worked in a group practice (41% to 52%), and a concomitant decrease in the number of dentists in solo practice (59% to 43%) (Exhibit 1). A small proportion (6%) worked in corporate practice from 2011-2013; however, a clear trend has not yet been identified due to the limited time frame under which this information has been collected. The slight dips observed in solo and group practitioners in 2011 are likely related to the addition of the 'corporate' category that year.

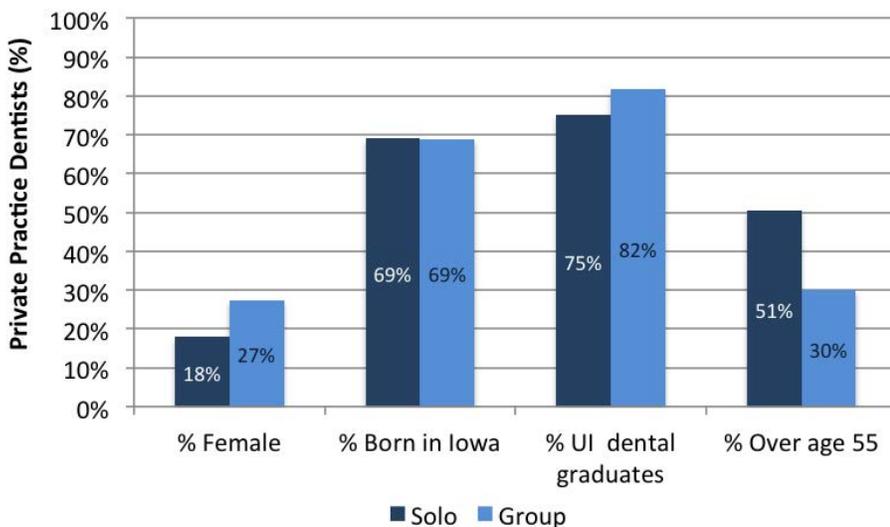
This increasing trend in group practice is seen nationally, as well. Younger dentists are more likely to practice in a group setting than in previous generations.<sup>2</sup>

**Exhibit 1. Practice setting of Iowa private practice dentists, 1997-2013**



In 2013, comparisons between solo and group practitioners revealed higher proportions of group practitioners were female and University of Iowa College of Dentistry graduates (Exhibit 2). However, half of the solo practitioners were over age 55 compared to 30% of group practitioners. Data for corporate practitioners are not included here due to the low number in this category (n=77).

**Exhibit 2. Characteristics of Iowa private practice dentists by practice setting, 2013**



## Iowa's Public Dentist Workforce

The number of dentists working in Iowa's CHCs has increased more than eightfold from 1997-2013, from 5 to 43 providers (Exhibit 3). This is related to the 2001 Health Center Growth Initiative, which grew the health center program nationwide by funding both the expansion of existing centers and the construction of new ones. From 2001-2007, this initiative funded the construction of 716 new centers the expansion of 520 existing centers nationwide.<sup>4</sup>

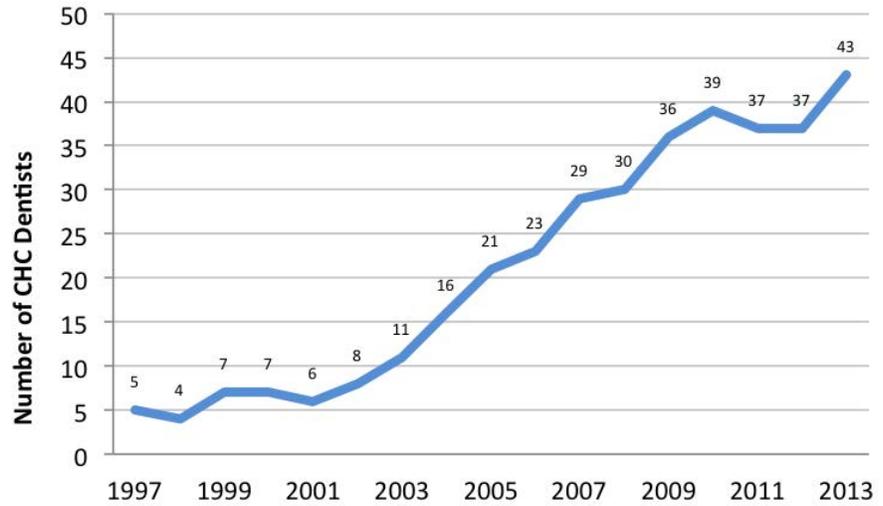
The Health Resources and Services Administration (HRSA) tracks FQHC staffing

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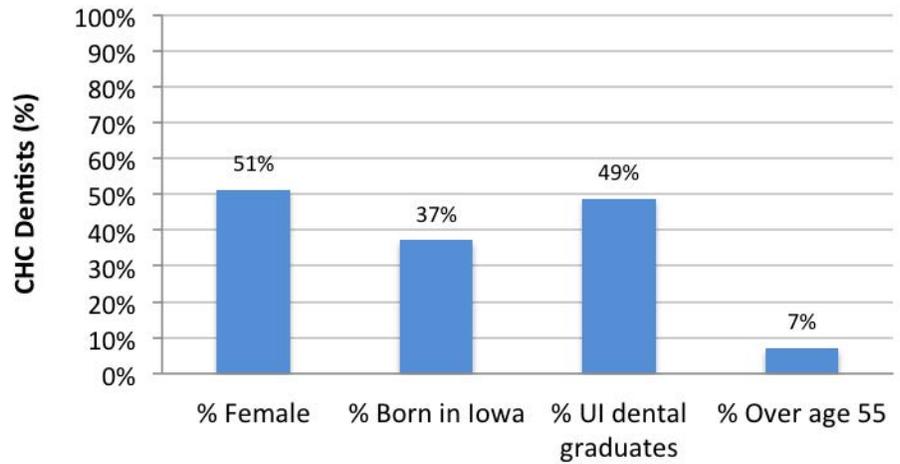
and patients served. From 2005-2014, the total number of dental staff FTEs employed at Iowa's FQHCs, including dentists, hygienists, and assistants, grew from 50 to 135.<sup>5</sup> This increase in the capacity of Iowa's public dental safety net resulted in dental care for more low-income Iowans. From 2000-2014, the number of patients served by Iowa's FQHCs also increased eightfold, from approximately 7,600 to 61,000.<sup>6,7</sup>

**Exhibit 3. Iowa CHC dentist workforce, 1997-2013**



In 2013, more than half of CHC dentists were women, (Exhibit 4), which corresponds to the national CHC workforce, where 55% were female in 2013.<sup>8</sup>

**Exhibit 4. Characteristics of Iowa's community health center dentist workforce, 2013 (n=43)**



*In 2013, more than half of CHC dentists were women*

## Conclusions & Policy Implications

Over the past 17 years, the predominant practice arrangement in Iowa has shifted from solo to group practice, a trend that is also seen nationally as large group practices become more common. Corporate dental practice is also becoming more common nationally; thus, future monitoring should continue to assess changes associated with this phenomenon.

The public dental workforce has grown considerably during this time and reflects investments made at a national level to increase the capacity of the nation's CHCs. This growth has been accompanied by an increase in allied dental staff employed in these settings as well as more patients being seen at Iowa's CHCs.

## Author Information

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## Endnotes

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