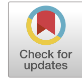
EDITORIAL

The business model of oral medicine—new market disruption of the practice of dental medicine



Oral medicine is defined by the American Academy of Oral Medicine as the discipline of dental medicine concerned with the oral health care of patients with medically complex conditions, including the diagnosis and management of medical disorders that affect the oral maxillofacial region.[1] This field of oral health care has advanced worldwide in the past 80 years. Accredited training programs with established goals, competencies, and experiences now exist in several parts of the world. As members of an interdisciplinary team, oral medicine practitioners must be knowledgeable of the principles of internal medicine, dermatology, rheumatology, infectious diseases, and pharmacology, among others, to be able to provide appropriate care to complex cases.[2] Our training provides opportunities to work in changing environments in a medical center, in an educational institution, or in private practice. Many of us merge our clinical skills with a passion for teaching and research. Although this has been an established model for oral medicine practitioners, morphing patient populations, increasing medical complexities, and evolving compensation patterns (i.e., bundled payments, value-based payment) in the medical/dental field have attracted a new group of young clinicians who are interested in the clinical practice of oral medicine in a community setting. We observe these fledgling dentists and junior residents approaching us at professional meetings with a genuine drive toward pursuing oral medicine training. A common question they pose is "What will I do as an oral medicine clinician?" Not everyone enjoys or wants an academic career. Some of our colleagues relish clinical practice and would love to establish themselves in their community as referring oral medicine providers. This scenario presents a significant challenge to the field because we believe that growth of our field demands that these individuals be able to inform and educate multiple stakeholders on the value-added proposition of our practice to overall health care. We believe that dentists with oral medicine training are now in high demand, not only in the academic and hospital environments but also in clinical practice. It is in clinical practice that translational discoveries presented in scientific forums move to population-level scenarios. Moreover, health care systems need clinicians who are able to uphold the patient's comprehensive and continuous health care and act in an interprofessional collaborative manner to enhance the patient's health status and quality of life.

Therefore, we see an increased interest in young clinicians to establish practice opportunities for oral medicine that may include management of chronic pain, salivary gland disorders, medically complex cases, and mucosal diseases. As senior academic oral medicine clinicians with a combined clinical experience of more than thirty years, we view this as an opportunity to prove the value of interprofessional team practice to third-party payers, organized dentistry, and our communities. However, as with any enterprise, we must address the viability of such a proposal in light of massive student and personal debt that our young colleagues may accrue during training. What is the future of private practice of oral medicine? Is it sustainable, and how is the compensation algorithm established and forecast done for growth and maintained return? This editorial will address the basic tenets of what we consider is the business model for this diagnostic discipline. We hope to provide fundamental principles to consider when establishing a practice model for oral medicine.

Before we consider a business model for oral medicine, we must assess standard models for dental practice. Most general practices assume a business-to-consumer (B2C) model, where the oral health professional offers multiple services and comprehensive oral care to target markets. These markets may be neighborhoods, professional societies, age-segmented markets, or others. Specialty practice uses the business-to-business model (B2B), where specialists cater to general practitioners and other specialists for referrals. Given the interprofessional nature of the field, one might think that oral medicine may fit into this model. But does it?

Oral medicine may, in fact, be in the perfect position to pave the way to a new disruptive paradigm. This paradigm merges the demands of both existing market (s) and stakeholders and creates a new market sustained by a new set of core values as its founding pillars: integration of general medicine and dental medicine, personalized medicine/dental medicine and collaborative care practice—translated outside the walls of the academia.

The theory of "disruptive innovation" developed by Clayton Christensen (Kim B. Clark Professor of Business

Administration at the Harvard Business School) encapsulates the basic principles of modern entrepreneurship, so often seen in these century's successful startups with a social conscience.[3]

After 2015, the United Nations Eight Millennium Development Goals gave rise to 17 Sustainable Development Goals (SDGs). Health-related SDGs are crucial streamers that should be monitored to enforce National and Global accountability on the well-being of the global population. The World Health Organization defines health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." We consider oral medicine specialists not only as the oral health "avant-garde" who provide the health care system with competent technicians but also as health care professionals with a holistic perspective of the patient and the responsibility for both oral and general health.

Bearing this in mind, we must take into consideration how our long experience can break down "silos" across academic campuses and lead the education of interprofessional teams to maximize our clinical skills, often creating new and collaborative settings within all aspects of health care.

Several studies have profiled the sources of referrals to oral medicine clinicians in the United States.[4,5] These sources include not only dental practitioners but also those from multiple medical specialties, including otorhinolaryngology, dermatology, and internal medicine. As a diagnostic discipline, oral medicine differs from traditional dental practice in compensation paradigms. Current payment schemes for dental practice focus on procedural codes, with some effort made to include diagnostic codes in recent years. Oral medicine may assume a fee-for-service schedule, where the practitioner targets a specific population on the basis of income level or ability to pay. Another approach is to establish a conversation with third-party payers to gain acceptance to enroll as medical billers or to create alternative packages that may include value-based pricing. Both options require a deliberate effort to educate multiple stakeholders on the importance and nature of our services. In the United States and beyond, there are increasing numbers of patients with medically complex conditions a significant burden of illness from chronic pain, and an almost 3% prevalence of autoimmune disorders with significant oral health implications. These conservative figures lead us to believe that the time is right for a "blue sky" assessment of the business of oral medicine.

Any fledgling enterprise considers the target market, how to access it, and how to become successful in it.[6] This involves the demand for and supply of our products, the size of the industry, our core objectives, customer attributes that we are trying to satisfy with our business, the activities necessary to achieve these objectives, and the available/necessary resources. These items form the basis of a business plan. The business plan will incorporate keen knowledge of our target population, any segmentation we would like to achieve, and how can we deliver needed attributes to our customers with the available resources. The initial analysis precedes the formulation of a robust value chain and profit logic that decreases waste, maximizes customer delivery, and guarantees revenue.

From a conceptual standpoint, as with any industry, we can use Professor Michael Porter's "five forces analysis" to assess viability.[7] These forces include (1) the threat of entry, (2) rivalry or competition, (3) the power of suppliers, (4) the power of customers, and (5) the threat of substitute products. Each one of the forces represents a low, medium, or high level of risk. First, we will consider the threat of new entry. As a distinct upcoming field within the practice of dental medicine, oral medicine as a business is in its infancy. We believe our field is broad enough to create "niche" areas where an individual can excel and become competitive. The development of such an area depends significantly on local geographic, economic, and practice characteristics of existent dental/medical providers. We do recognize the challenge in developing scale for the practice of oral medicine. A few specialized medical centers have done this with great success and have become models for others. The future will tell us if such enterprises, developed by community or solo group practices in the field, will move forward. Still, in a "disruptive model," such as that described by Christensen, we are expected to think and act outside the existing business environment, and because we inhabit different value networks, we are able to pursue innovate methods and approaches and provide services designed for a new set of customers.

Oral medicine will undoubtedly benefit, at this point, by the entrance of new practitioners who can increase access to care for our patients. Indeed, a significant threat to new entry into the field is to establish a recognized presence in medical, allied health, and dental groups and establish best care pathways for reimbursement of services. Once such a presence has been established, new entry into the field for young clinicians will be similar to entry into other specialized fields of dental medicine, except without the heavy burden of large capital costs or significant overheads associated with other fields. The intensity of rivalry or competition, in our opinion, is modulated by a careful differentiation of a practice that is distinct from surgical specialties or general practice. Customers of oral medicine services are usually desperately searching for appropriate care. On many occasions, we are the third or fourth clinician who has seen this patient. What

better definition could we have than what Clayton Christensen described as a "new market disruption," that is, targeting customers who have needs that are not met by existing incumbents?

What many industries define as bargaining power of customers is a low risk for a tertiary care field of practice such as ours. A similar outcome appears from the bargaining powers of suppliers because at this point, oral medicine clinicians are few and far apart. At least in the United States, most clinical practices are located in the east and west coast states, with less than a handful in the middle of the country. Suppliers in our industry may be defined as referring clinicians, and the majority of sensible practitioners, either in dental medicine or medicine, will gladly refer their challenging cases to individuals they trust and consider adequately trained to provide the necessary care to their patients. Substitute products for our model would require individuals who deliver the same services that we do. We do have overlapping practice characteristics with other specialized fields in dental medicine, like dental sleep medicine and orofacial pain.

Nevertheless, the astute clinician interested in a profitable enterprise will do his or her due diligence in searching out "peers" in the area to assess how to develop a competitive advantage in comparison with their practice characteristics. This may be interpreted as a more aggressive marketing strategy, a widened scope for reimbursement (enrolled in all carriers), or a focused target market segmentation (addressing the specific needs of a significant customer population). This is more challenging in the traditional specialty areas with a more limited scope. We consider that in our field, there are sufficient niche areas to accommodate many combinations of clinicians. Again, the dentist interested in oral medicine may want to explore geographic areas with less concentration of oral medicine providers or those with a demonstrated need for such services. We adapt. Our training provides us with a broad set of skills to do so.

We believe oral medicine is ripe for a demonstration of the utility of interprofessional activities. After all, interprofessional activities are at the crux of it. We exhort current training programs to include principles of business modeling into their already busy clinical training and invite successful community and institutional practitioners to share pearls of wisdom from their current practices. Although oral medicine began as a mainly academic field, we believe that clinicians interested in access to care and practice will benefit from research and can aid in educating the public, as well as our colleagues in dental medicine and general medicine, about the value-added services we can provide to patients. New market disruption in oral medicine occurs in many additional forms, such as local delivery of mucosal medications, telemedicine, stem cell therapy for pain, and vector-guided delivery for salivary hypofunction, to name a few already in the works. New market disruption will be possible only with the help of clinical oral medicine dentists who can test innovative ideas at a greater scale. After all, we are all health care providers who strive to offer only the best outcomes to our patients.

Andres Pinto, DMD, MPH, MSCE, MBA, FDS RCS(Edin)
Rui Amaral Mendes, DMD, PHD
University Hospitals Cleveland Medical Center and Case Western Reserve University, Oral and Maxillofacial Medicine and Diagnostic Sciences, Cleveland, OH, USA

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