AAE Advocacy & Professional Issues Survey Report

Prepared by Whorton Research August 6, 2026

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Executive Summary

Methodology

Following a pretest period, the survey was launched with an invitation email on July 9 with reminders to non-respondents on July 15, 21, and 27 with a final deadline of August 3. Separate reminders were sent to individuals with incomplete surveys to encourage them to return to the survey and complete more of the survey.

The universe was 4,191 unique member email addresses. There were 112 undeliverable addresses and another 36 who opted out of participation. A total of 732 individuals responded, a response rate of 17.9%. The completion rate was 69% but our analysis includes almost all incomplete surveys.

Most Important Issues

We use two metrics to help prioritize the importance of challenges and opportunities affecting endodontists' patient volume over the next several years—the percent who assigned the highest possible rating ("extremely important") and an average score calculated from a 5-point scale.

- **Tier 1**: While overall levels of insurance reimbursement (4.41 average score/64% extremely important) is clearly rated most important, three other issues cluster with almost as high an average score—workforce issues: ability to recruit/retain qualified employees (4.20/44%), managing overhead costs and profitability (4.18/42%), and insurance down-coding or not covering specific codes (4.15/51%).
- **Tier 2**: Three other issues cluster around 4.0 in average importance—insurers limiting treatment options (4.02/44%), increasing influence of private equity (4.01/40%), and growth and influence of corporate dental practices (3.99/38%).
- **Tier 3**: Another three issues cluster considerably lower, between 6%-8% lower average importance compared to Tier 2. These include choosing and spending for necessary technology (3.75/20%), level of competition in my area of patients (3.66/25%), and increasing administrative burden (3.66/22%).
- **Tier 4**: The remaining six issues constitute a clear lowest tier, with at best 9% lower importance compared to Tier 3. These include regulatory compliance/changes (3.40/16%), lack of access to endodontic care for underserved individuals (3.15/11%), ability to leverage AI for practice operations (3.10/11%), ability to leverage AI for clinical treatment (2.63/7%), ability to use mid-level providers for some of our work (2.04/5%), and telehealth treatment options (1.81/1%).

Insurance

Respondents answered up to three questions regarding specific insurers. They indicated which insurers they are in network with today, with which insurance providers/types they are no longer in network, and if they indicated current or past status in network, rating each for the ease of submitting claims and receiving payment now or in the past on a 5-point scale from excellent to poor.

Currently in Network

- Delta is by far most likely to be in network (74%) and a majority reported Cigna and Aetna in network as well.
- MetLife, Guardian, and BCBS are in network for more than 40% while UHC, United Concordia, and Humana are in network for at least one-third.
- Ameritas (25%) and DentaQuest (12%) round out the most common; Physicians Mutual, Medicaid, and Spirit Dental were each in network for 4%-9%. Other insurers were mentioned by 9% and another 9% indicated none as being predominantly cash customers.

	Now In-network N=498	Out of network N=420	Average ease N=503
Delta Dental	74%	20%	2.72
Cigna	55%	20%	2.83
Aetna	52%	20%	2.91
MetLife	46%	24%	2.64
Guardian	42%	20%	2.71
BlueCross Blue Shield	41%	25%	2.52
UnitedHealthcare	37%	20%	2.55
United Concordia	34%	25%	2.58
Humana	34%	20%	2.58
Ameritas	25%	20%	2.72
DentaQuest	12%	26%	2.19
Physicians Mutual	9%	22%	2.50
Medicaid	6%	34%	2.13
Spirit Dental	4%	26%	2.33
Other	9%	5%	2.29

Out of Network

- There is much more consistency in the proportion who no longer carry or are in network. Other than Medicaid (34%), all other insurers are no longer in network for 20%-26% each, highest for Spirit Dental and DentaQuest. Another 25% of respondents indicate not dropping or becoming out of network for any of these carriers, and only 5% indicate not becoming out of network within the past five years.

Average score

- Perhaps the most telling statistic in this area is a mean score of 2.55 across all insurers. AETNA (2.91) and CIGNA (2.83) are rated highest, followed by Delta and Ameritas (2.72) and Guardian (2.71).
- At the other extreme, Medicaid (2.13), DentaQuest (2.19), and Spirit Dental (2.33) are rated lowest. Six insurers are rated between 2.50-2.64 including MetLife, United Concordia, Humana, UHC, BCBS, and Physicians Mutual.
- It should be noted that many respondents had no context or bases for rating their insurers. As a straight line (unweighted) averaged across insurers, an average of 40% have no opinion. The distribution shows the highest proportion (21%) rate their insurer as the midpoint, or "average." Poor (16%), good (12%), fair (9%) have fewer rating them at these levels, while excellent (2%) has a far lower proportion checking this.

Tracking Quality Measures

- Only 6% indicate they are currently tracking any quality measures. Within this very small base, by far the highest proportion (57%) indicate Delta requires them to submit quality measures while 21% each indicate that BCBS, Cigna, UHC, and Medicaid require them.

Advocacy Priorities

	Avg score	Extr. Import
Promoting specialty recognition so endodontists are recognized for their advanced training	4.49	64%
Combating misinformation to address false narratives about root canals and reinforcing importance of saving natural teeth	4.47	61%
Promoting tax/small business reform (tax deductions allowing endo to reinvest in practices)	4.24	46%
Dental plan advocacy: virtual credit card reform, non-covered/disallowed services, Silent PPOs	4.15	41%
Reducing administrative and regulatory burdens	4.06	36%
Pushing for transparency in dental loss ratio	4.02	32%
Promoting scope of practice protections from non-dentists	4.02	39%
Implementing liability and tort reform	3.94	31%
Addressing workforce shortages	3.87	32%
Promoting dentist mental health & wellness	3.79	31%
Promoting use of quality measurements	3.78	26%
Advocating for reductions in the debt burden of dental students/recent graduates	3.77	32%
Increasing oral health funding	3.71	23%
Promoting water fluoridation	3.65	25%
Supporting interstate compact legislation to allow easier practice mobility	3.42	22%
Expanding Medicare and Medicaid coverage	3.17	15%
Teledentistry	2.19	4%

- Overall, these priorities have an average score of 3.8, driven by an unweighted average with many extremely (33%), very (28%), and somewhat important (22%), and fewer rating them somewhat unimportant (8%), not at all important or no opinion (4% each).
- **Tier 1**: The highest average scores were reported for promoting specialty recognition so that endodontists are recognized for their advanced training (4.49) and combating misinformation to address false narratives about root canals and reinforcing importance of saving natural teeth (4.47).
- **Tier 2**: Promoting tax/small business reform such as tax deductions for small businesses to allow endodontists to reinvest in their practices (4.24) and dental plan advocacy: virtual credit card reform, non-covered and

disallowed services and Silent PPOs (4.15) are also rated well above 4.0 or the numeric equivalent of extremely important.

- **Tier 3**: Reducing administrative and regulatory burdens (4.06), pushing for transparency in dental loss ratio, and promoting scope of practice protections from non-dentists (4.02 each).
- **Tier 4**: Implementing liability and tort reform (3.94) and addressing workforce shortages (3.87).
- **Tier 5**: Five issues rated between 3.65 to 3.79, highest for promoting dentist mental health & wellness, promoting use of quality measurements, advocating for reductions in the debt burden of dental students/recent graduates, increasing oral health funding, and promoting water fluoridation.
- The lowest priorities are expressed for supporting interstate compact legislation to allow easier practice mobility (3.42), expanding Medicare and Medicaid coverage (3.17), and teledentistry (2.19).

Single Highest Priority

- The single highest advocacy priority was most often combating misinformation (25%), promoting specialty recognition (23%), and dental plan advocacy (15%). Combined these priorities were primary for 62% of members.
- Promoting tax/small business reform (8%), addressing workforce shortages, and advocating for reductions in student/resident debt burden (6%) account for another 20% of members.
- All remaining issues are regarded as single highest priority by 18% combined.

Advocacy Involvement

While 23% indicate no involvement is AAE activity and another 18% have none but considered it, while the slight majority who indicate some involvement report an average of just over two activities.

- These often included accessing and shared patient outreach materials (36% of the total), supporting AAE Save Your Tooth Month (33%), and supporting other aspects of Worth Saving public awareness campaign (20%).
- Fewer visited the AAE Advocacy Action Center online for grassroots organizing resources or supported AAE Dental Plan & Government outreach (14% each), or served on or participating in state dental boards (12%).
- The proportion who are involved in other advocacy related activity most often are involved in advocacy with their ADA state affiliate and/or local dental society (30%), while fewer are involved with ADA (national) advocacy activities (16%), or are involved in advocacy with other specialty or general dental organizations (15%).

Professional Profile

Practice—Almost all respondents work in private practice (81%). DSO (14%) is the one other setting reported by a substantial number, while 3%-4% each work in academic practice, public practice such as government, or are fully or semi-retired. Only 1% each are inactive or in transition, or work in other settings.

Employment Status—While a plurality are sole owners (44%), substantial numbers are partner/partial owner (28%) or an associate/employee (22%), with fewer independent contractors (8%) or faculty/teachers (6%).

Private Practice Description—A majority report working in a practice with a single-dentist owning and operating (61%). Fewer work in a practice with multiple dentists who own/operate individual practices with shared space/costs (31%), while some indicate other (10%) often giving more detail as to their staffing structure, anticipating a question we ask later in the survey. Interestingly, despite all three of these profile questions sometimes used as screeners for subsequent questions and response items are multiple-choice in format, between 2% and 8% of respondents check more than one option for each question.

Future Priorities—When asked to describe their priorities over the next five years, respondents indicate an average of 2.6 of them.

- By far the most common is a “stay the course” answer—maintaining a steady practice with a consistent territory, referral patterns, and staffing level (71%).
- Three answers represented more active choices, including increasing patient volume through referrals, digital marketing, and other techniques (39%); increasing efficiency with better use of technology and AI (30%); and

increasing their total endodontists (23%). Retirement or semi-retirement (27%) was also indicated by more than one-fifth.

- Other activities anticipated by a smaller number include selling all or part of their practice (14%) or considering academia (10%); while some want to increase other (non-endodontist) staff including hygienists, assistants, and/or administrative (11%); add one or more new offices (9%), broadening their territory of operation into new communities or metro areas (8%), buying into/partnering in a practice (8%), or starting a practice of their own (5%).
- Very few plan to change jobs or move to a different practice (4%), reducing the size of their practice with fewer staff or cutting back on hours (1%), or indicated another action (4%).
- Although many of these response options were conditional on the current state of the respondent (such as employees only being asked if they want to start their own practice), we reported each option as a percent of total respondents to ensure a fair comparison of how prevalent each potential priority is among U.S.-based endodontists.

Desired Future Practice—Among those who plan to start a practice from currently being an IC or associate or who plan to change jobs or move to a different practice, there is no clear consensus. Between 25%-35% each indicate planning to enter solo (35%) or group private practice (27%), or a specialized endodontic practice (25%), while a few indicate an academic practice (6%), DSO or a practice working with some general dentists (4% each).

History—Respondents are a mean of 51.2 years of age, with means of 18.4 years since completing their endodontic training, 16.1 years as the owner of or 10.6 years working in their current practice, and 19.9 years of AAE membership.

- Almost all of the median/midpoints are similar to the means, except for years in current practice among non-owners, which is only 5.0 years, with the mean driven by some outliers among them who have been in their current practice setting for much longer.
- Segmented by decade of experience, those with 0-10 years (32%) are a larger cohort than those with 11-20 years (28%), 21-30 years (23%), or those with more than 30 years (17%).
- By age range, fewer are younger than 40 years old (18%) while similar proportions are in their 40s (29%), 50s (27%), or are 60 or older (26%).
- AAE membership shows similar frequency by decade—about the same number have 0-10 years (26%), 11-20 years (28%), or 21-30 years (27%) while the remaining 19% have more than 30 years.
- By years in their current practice, a substantial number have been in position or owner for 0-5 years (31%) while similar quartiles have 6-15 years (25%) or 16-25 years (26%) and a smaller number have more than 25 years (17%).

Location—A plurality of respondents indicates working in a larger metro area, which we defined as having more than 500,000 people (41%).

- This is much more common than those working in a larger city with 100-500,000 (29%) or a smaller city under 100,000 (28%), and predictably rural areas with fewer than 20,000 people (3%).
- Although we did not ask it in this survey, we appended results from the 2025 Referral Patterns Survey regarding how respondents assessed endodontist supply relative to demand in their market. While 37% say the number aligns well with how many are needed there, a similar proportion say there is some oversupply (38%) and some say there is a substantial oversupply with far too many endodontists (17%).
- Only 7% say there is some and 1% a substantial undersupply in their market.
- Eleven states had at least 20 responses. The most common was California (89 or 12%), followed by Texas (8%), Florida, New York, and Illinois (6%), Pennsylvania (5%), Ohio and Colorado (4% each), Massachusetts, Tennessee, and Washington (3% each). Combined, they account for 60% of all respondents.
- By Census Area, South (32%) has the most followed by West (27%), Midwest (22%), and Northeast (19%).

Patient Population—On an average week, respondents say that they see a mean of 34.9 and a median of 32 patients, while their practice sees a mean of 66 and a median 50 including other dentists in the count.

- Asked somewhat differently (and perhaps redundantly), total patients seen per week counting each person as one despite any repeat visits were a similar mean of 64.4 and a median 45. The total procedures performed per week was a mean of 49.4 and median 30.
- Dividing this response by total dentists (endodontist or general) reported in the staffing section showed that the mean patients per dentist per week was a mean 33.0 and median of 30, while weekly procedures were a mean of 24.5 and a median 20.

Staffing—Respondents have a mean 11 and median 7 total full-time equivalent staff.

- Mean total endodontists (including the respondent) was 2.1, and more total dental assistants (4.6) and administrative staff (3.9), and far fewer general dentists or other specialists (0.2) and dental hygienists (0.1).
- Segmenting responses by total FTE shows about one-third each have 1 to 5 (36%), 5.1 to 9 (34%), or more than 9 FTE staff (30%).
- Over the past 12 months, 65% of practices had had at least one open dental assistant positions, 44% had at least one open administrative position, and 2% had an open position for dental hygienist.
- Those who had vacancies generally regard them as difficult to fill. They rate administrative staff (2.35), dental assistants (2.24), and dental hygienist (2.00) very difficult on a 5-point scale.
- Dental assistant hires were regarded as either extremely (30%), very (28%), or somewhat difficult (32%) while only 10% felt it was somewhat or very easy.
- Administrative staff had fewer regarded as extremely (22%) and more very (32%) or somewhat difficult (35%) and 10% rating it easy.
- Dental hygienist hires were rare but more than 40% indicated it was extremely difficult to hire.

Changes Over Time—Respondents indicated whether key metrics increased, decreased, or stayed the same over the past five years.

- Unsurprisingly, total expenses are most likely to increase, reported by 83%. Gross revenue (61%) increased for fewer, while fewer report an increased patient volume and FTE staff (42% each), and only 10% have increased total locations.
- While very few report a decrease in expenses (2%) or locations (5%), more report a decrease in FTE staff (14%), revenue (19%), and patient volume (24%). Very few (1%-3% each) indicated not knowing.
- The net number of practices (increased minus decreased) is highest for expenses (81%) and much lower for gross revenue (42%), FTE staff (27%), patient volume (18%), and total locations (5%).
- Mean estimated change in total staff and expenses (19% each), gross revenue (17%), and locations (12%) seem modest over a 5-year period, particularly considering that net patient volume (31%) increased by far more.

Management Structure/Ownership Changes—More respondents (53%) indicate not considering or making a change in management structure or ownership in the past several years, while some made changes (23%) and an equal number combined considered but did not make a change (17%) or planned a change (6%).

Demographics—Overlays of AMS data show that 71% each of respondents are male and white.

- Females are 29% of the total, while Asian (15%) are second most common and 3%-4% each are Hispanic, Middle Eastern, Black, or some other ethnicity or race.
- The degrees held by respondents most commonly consist of a DDS (63%) with fewer DMD (36%), and some indicating an MS (24%) or MSD (11%). Degrees such as PhD, MDS, BDS, MPH, or other are indicated by 12%.
- Membership category is generally Active (77%) with some Life (13%), 1st or 2nd year (6%), or FDHS (3%).

Future Priorities

When asked to describe their priorities over the next five years, respondents indicate an average of 2.6 of them.

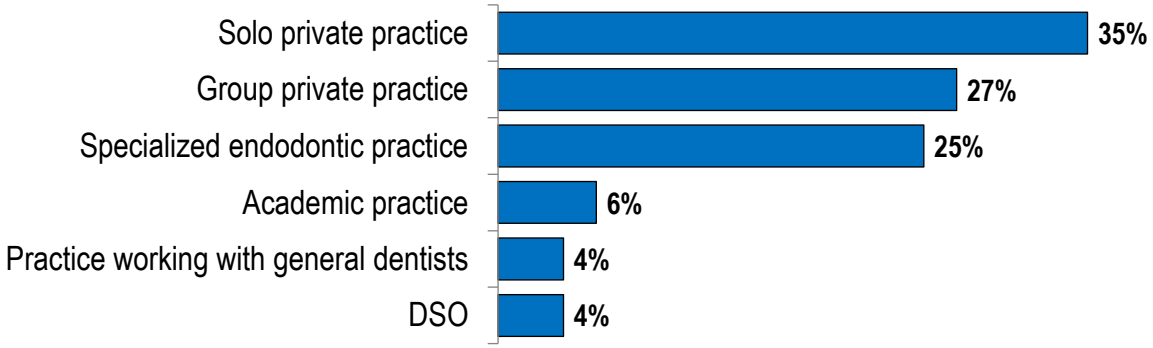
- By far the most common is a "stay the course" answer—maintaining a steady practice with a consistent territory, referral patterns, and staffing level (71%).
- Three answers represented more active choices, including increasing patient volume through referrals, digital marketing, and other techniques (39%); increasing efficiency with better use of technology and AI (30%); and increasing their total endodontists (23%). Retirement or semi-retirement (27%) was also indicated by more than one-fifth.



- Other activities anticipated by a smaller number include selling all or part of their practice (14%) or considering academia (10%); while some want to increase other (non-endodontist) staff including hygienists, assistants, and/or administrative (11%); add one or more new offices (9%), broadening their territory of operation into new communities or metro areas (8%), buying into/partnering in a practice (8%), or starting a practice of their own (5%).
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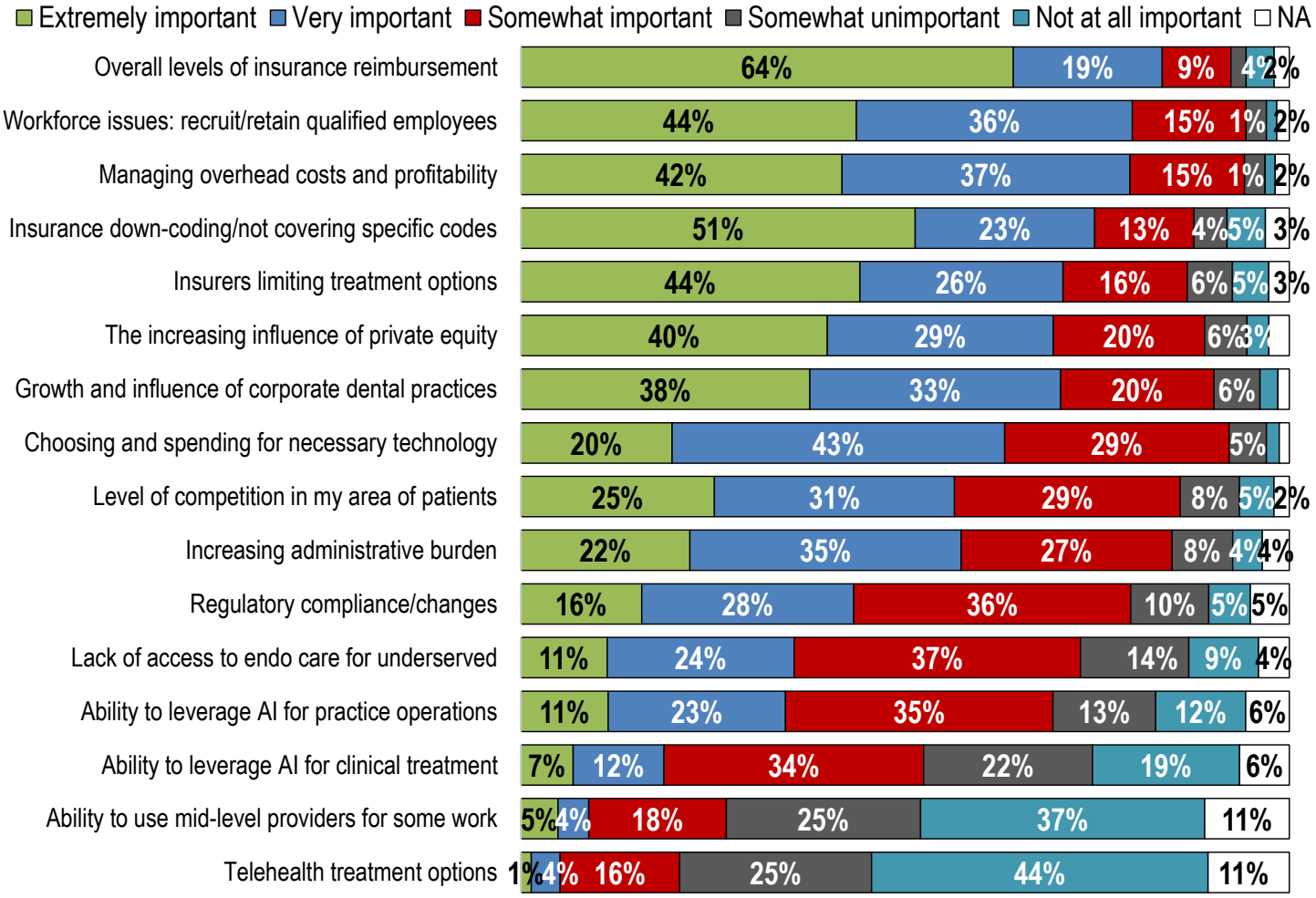
Desired Future Practice

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Most Important Challenges/Opportunities

We use two metrics to help prioritize the importance of challenges and opportunities affecting endodontists' patient volume over the next several years—the percent who assigned the highest possible rating ("extremely important") and an average score calculated from a 5-point scale.



- **Tier 1**: While overall levels of insurance reimbursement (4.41 average score/64% extremely important) is clearly rated most important, three other issues cluster with almost as high an average score—workforce issues: ability to recruit/retain qualified employees (4.20/44%), managing overhead costs and profitability (4.18/42%), and insurance down-coding or not covering specific codes (4.15/51%).
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Challenges/Opportunities by Segment

Doing a slightly deeper dive reveals a number of cross-sectional trends in who perceives the greatest challenges or opportunities.

- An unweighted aggregate average score shows that those in academic practice (3.77) and public practice (3.71) rate issues as more important than those in DSOs (3.52) and private practice (3.50) with the latter closely resembling the overall average since they account for more than 80% of respondents.
- Variables that have minimal impact include age range, geographic location, and years of experience.
- Where there is some variation, faculty members, female respondents, those with 11-20 years of membership and who work in larger practices defined by FTE dentists rate overall importance higher. Respondents who indicated an oversupply of endodontists in their market and/or who work in large metro areas rate overall importance of these issues higher.

Variations by DSO

- Specific challenges or opportunities of greater importance to endodontists in DSOs compared to private practice include key insurance issues--overall insurance reimbursement, insurance down-coding, and limiting treatment options (each rated 5% higher), along with lack of care for underserved and leveraging AI for practice operations (each 5% higher), and AI for clinical treatment and telehealth treatment options (each 11% higher) among the lower priorities.
- Perhaps understandably, challenges or opportunities seen as less important by DSO based endodontists include growth/influence of corporate dental practices and increasing admin burden (each -7% lower), managing overhead costs and profitability (-5%), increasing private equity influence and level of competition for patients (-4% each).

Variations by Academic & Public Practice

- Compared to private practice, endodontists in academic practice see far more opportunity with telehealth (+40% higher), use of mid-level providers (+36%), leveraging AI for clinical treatment (+31%) and practice operations (15%), and lack of access for the underserved (+26%).
- Public practice endodontists also place more importance than private practice on most of these factors, notably lack of access to underserved (+39%), telehealth (+33%) and leveraging AI for clinical treatment (+28%) and practice operations (17%).
- They only vary from academic practices in the low importance they assign to using mid-level providers and both practice segments rate importance much lower for competition in their area for patients.

Variations by Employment Status

In this area, we tentatively expected to see greater concern among sole owners or partners, who are often the most vocal supporters of dental advocacy within the state dental society clients we have worked with. There are only small variations in how they regard opportunities or challenges.

- Compared to the average respondent, sole owners place lower importance on AI for clinical treatment and telehealth (-6% each), and lack of care for underserved (-4%).
- Partners place less importance on lack of care for underserved (-5%) and telehealth (-4%) while they place more importance on leveraging AI for practice operations (+5%).
- Both employees and independent contractors place less importance on managing overhead costs and profitability (-7% to -8%). They place more importance of care for underserved, ability to use mid-level providers, and telehealth (each +5% to +11% per segment).

Variations by Size of Practice

Larger practices index much higher than the average respondent for leveraging AI for practice operations (+11% higher) and to a lesser degree for clinical treatment (+6%).

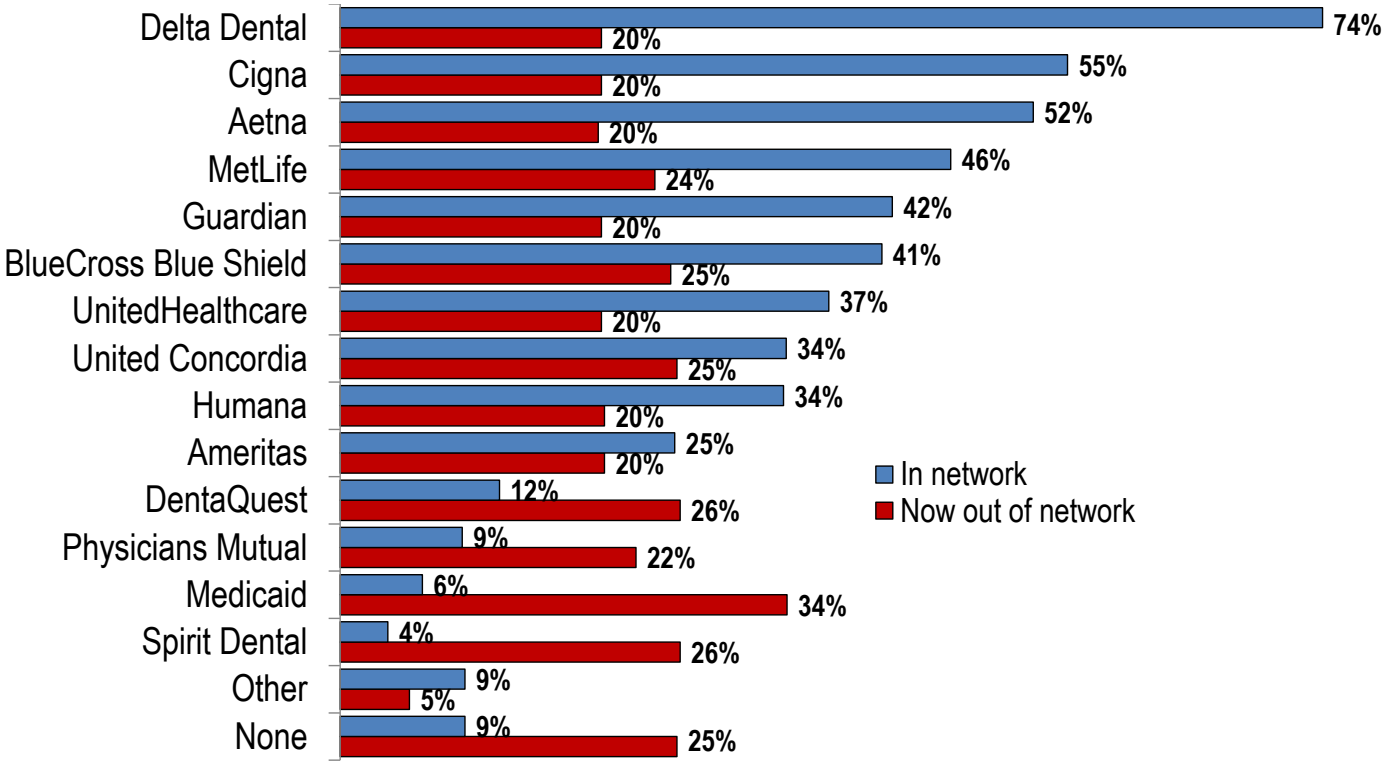
- In contrast, mid-sized practices (with 5-9 dentists) place far lower importance on both applications of AI (-8% and -10% lower), telehealth (-10%), and use of mid-level providers (-7 points). The smallest practices index lower for all four of these challenges/opportunities as well.

Insurance Networks

Respondents answered up to three questions regarding specific insurers. They indicated which insurers they are in network with today, with which insurance providers/types they are no longer in network, and if they indicated current or past status in network, rating each for the ease of submitting claims and receiving payment now or in the past on a 5-point scale from excellent to poor.

Currently in Network

- Delta is by far most likely to be in network (74%) and a majority reported Cigna and Aetna in network as well.
- MetLife, Guardian, and BCBS are in network for more than 40% while UHC, United Concordia, and Humana are in network for at least one-third.
- Ameritas (25%) and DentaQuest (12%) round out the most common; Physicians Mutual, Medicaid, and Spirit Dental were each in network for 4%-9%. Other insurers were mentioned by 9% and another 9% indicated none as being predominantly cash customers.



Out of Network

- There is much more consistency in the proportion who no longer carry or are in network. Other than Medicaid (34%), all other insurers are no longer in network for 20%-26% each, highest for Spirit Dental and DentaQuest. Another 25% of respondents indicate not dropping or becoming out of network for any of these carriers, and only 5% indicate not becoming out of network within the past five years.
- Analyzed by various characteristics shows that DSOs (average 6.1 in network/2.6 no longer in network) are much more active with insurers than private practice (4.8/3.4), public practice (2.0/2.9) or academic (3.3/2.2).
- By employment status, ICs (6.1/2.0) and partners (5.5/3.4) are more active than sole owners (4.4/3.5) or employees (4.7/3.1). Larger practices (5.2/2.8) are more active than small (4.4/3.3) or medium sized (4.4/4.3).
- Newer endos (5.2/3.3) are active with slightly more insurers than the most experienced (4.7/2.8).
- Those in larger metro areas (5.5/3.0) are active with more insurers than in small cities (3.5/3.8) and those in markets that have some oversupply of endodontists (4.6/3.3) are active with more than those whose market aligns well with need (4.0 in network/4.7 no longer in network).

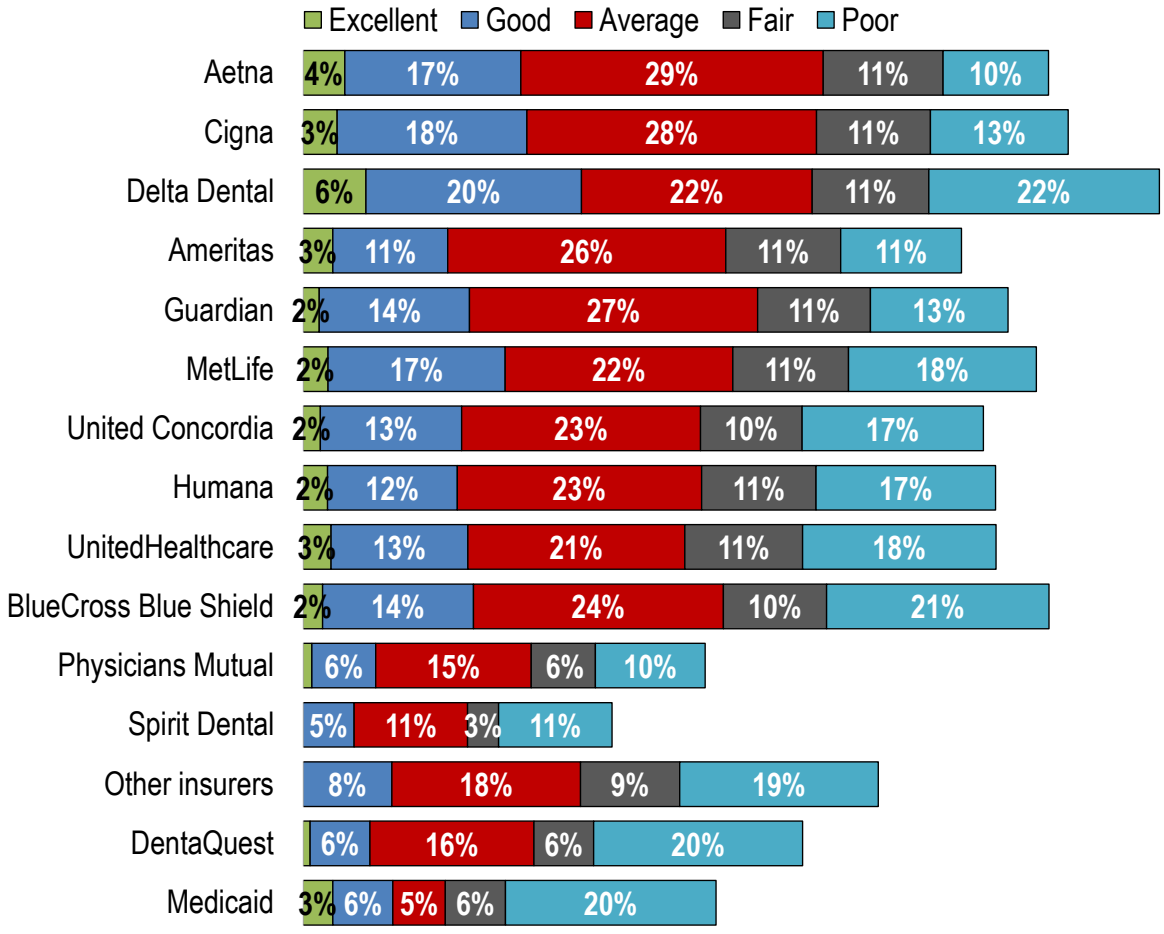
Rating Insurers for Ease of Submitting Claims & Receiving Payment

Respondents rated each of their current or former insurers for the ease of submitting claims and receiving payment. They used a 5-point scale ranging from excellent to poor, with a no opinion option that was not included in computing an average score.

- Perhaps the most telling statistic in this area is a mean score of 2.55 across all insurers. An unweighted average across all insurers shows that they had very few who rate them excellent (2%), larger proportions good (12%) or fair (9%), and the highest proportion rating them poor (16%) or average (21%) with an average of 40% having no opinion.
- The latter proportion is very high due to two reasons, our choice to display insurers that endodontists indicate no longer are in network, and respondents who indicate in comments that they are unfamiliar with the claims process. They may have a general impression expressed in other questions, but they don't know how specific insurance companies perform.

Comparing across firms, AETNA (2.91) and CIGNA (2.83) are rated highest, followed by Delta and Ameritas (2.72 each) and Guardian (2.71). These vary in terms of the distribution of scores—for example, Delta has the highest proportion rating them poor (22%) or good (20%), due in part for having the fewest (19%) with no opinion.

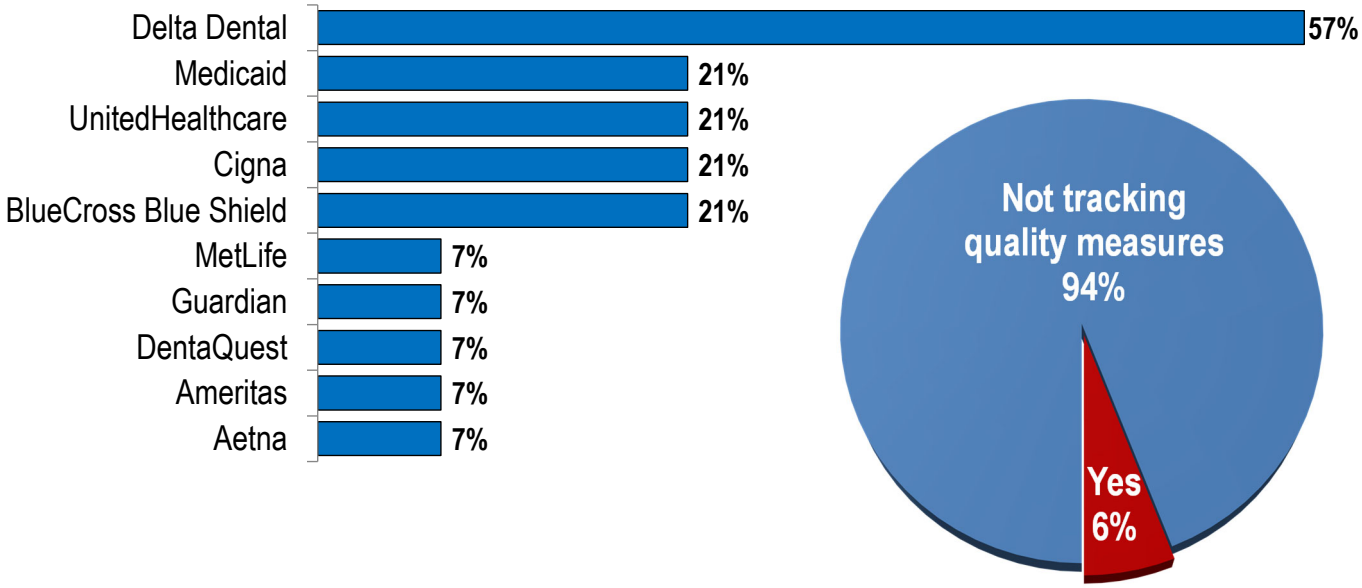
- Six insurers are rated between 2.50-2.64 including MetLife (2.64), United Concordia and Humana (2.58 each), UHC (2.55), BCBS (2.52), and Physicians Mutual (2.50).
- At the other extreme, Medicaid (2.13), DentaQuest (2.19), and Spirit Dental (2.33) are rated lowest.
- Physicians Mutual, Spirit Dental, Medicaid, and DentaQuest have a majority of respondents indicating no opinion.



Tracking Quality Measures

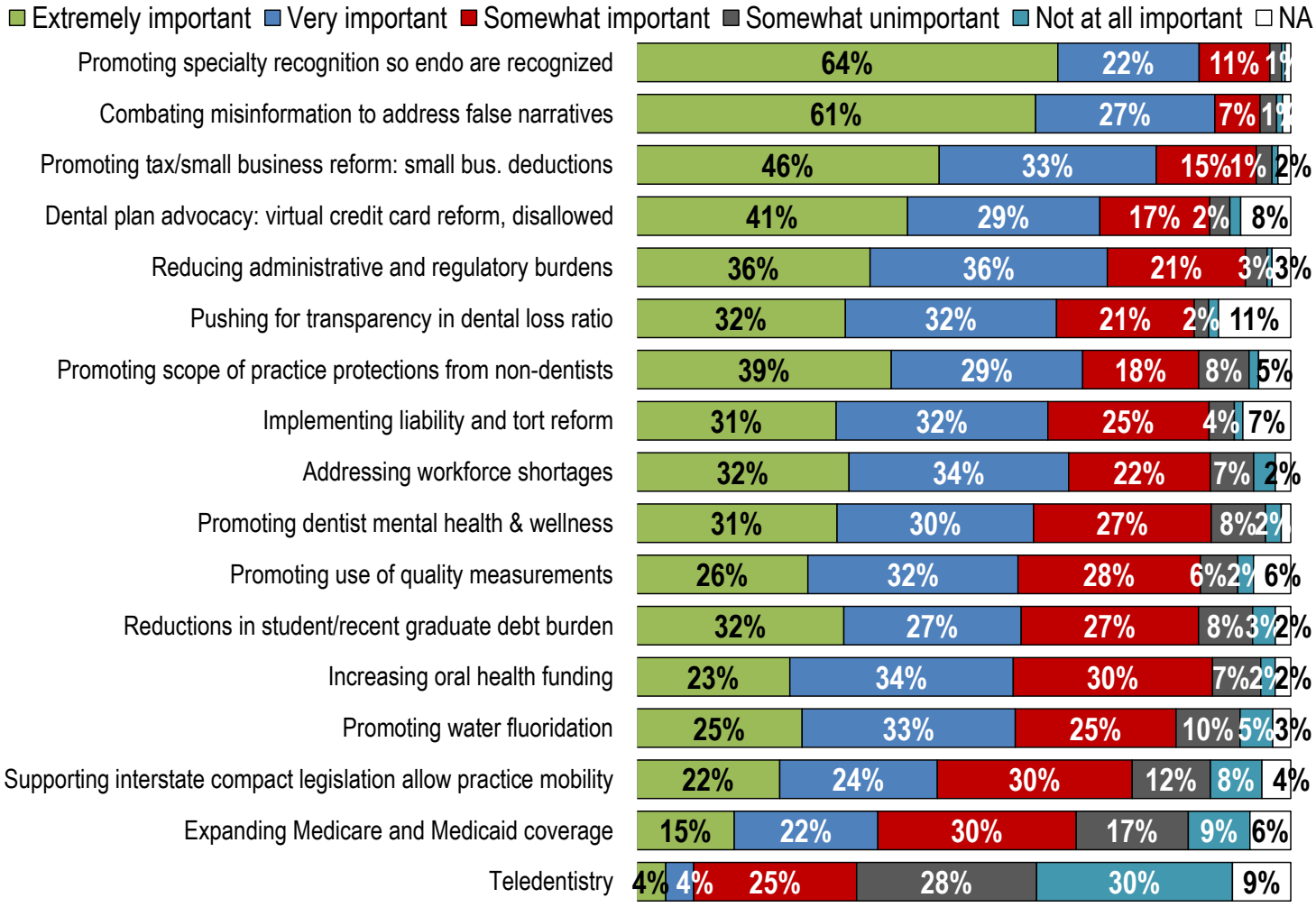
Only 6% of respondents indicate that they are currently tracking any quality measures with their insurers.

- Within this very small base, by far the highest proportion (57%) indicate Delta requires them to submit quality measures while 21% each indicate that BCBS, Cigna, UHC, and Medicaid require them.



Importance of Current Priorities of AAE's Advocacy Agenda

When rated on a 5-point scale, these priorities have an unweighted average score of 3.80, driven by a plurality rating them extremely important (33%), a fewer who rate each very (28%) or somewhat important (22%). Few rate them somewhat unimportant (8%), not at all important, or have no opinion (4% each).



Ranking these in general tiers based on their average scores suggests the following categorization.

- **Tier 1**: Highest average scores were reported for promoting specialty recognition so that endodontists are recognized for their advanced training (4.49) and combating misinformation to address false narratives about root canals and reinforcing importance of saving natural teeth (4.47). These are the only two priorities rated extremely important by a majority of respondents.
- **Tier 2**: Promoting tax/small business reform such as tax deductions for small businesses to allow endodontists to reinvest in their practices (4.24) and dental plan advocacy: virtual credit card reform, non-covered and disallowed services and silent PPOs (4.15) are also rated well above 4.0. These have at least 40% rating them extremely important.
- **Tier 3**: Reducing administrative and regulatory burdens (4.06), pushing for transparency in dental loss ratio, and promoting scope of practice protections from non-dentists (4.02 each) have at least 30% rating them extremely and almost 30% very important.
- **Tier 4**: Implementing liability and tort reform (3.94) and addressing workforce shortages (3.87).
- **Tier 5**: Five issues rated between 3.65 to 3.79, highest for promoting dentist mental health & wellness, promoting use of quality measurements, advocating for reductions in the debt burden of dental students/recent graduates, increasing oral health funding, and promoting water fluoridation.
- **Least Important**: The lowest priorities are expressed for supporting interstate compact legislation to allow easier practice mobility (3.42), expanding Medicare and Medicaid coverage (3.17), and teledentistry (2.19).

Issues in Tier 4 or lower generally have more who rate them very important compared to extremely important, excepting student/graduate debt burden and dentist mental health. Many respondents shift to rating them somewhat important, although no more than 20% regard them as unimportant until the least important issues.

Advocacy Priorities by Segment

Similar to our approach to opportunities/challenges, analysis of average importance scores in this area are somewhat revealing of how perceptions vary by type of practice, personal responsibilities, and location.

- An unweighted aggregate average score shows that those in academic practice (4.05) rate advocacy priorities somewhat higher than those in DSOs (3.90) or public practice do (3.92), and much higher than those in private practice (3.78).
- Female endodontists (3.94), those who are 60 or older (3.88), those in markets with some oversupply of endodontists (3.78), and faculty (3.99) and independent contractors (3.94) place higher importance on advocacy priorities than males (3.76), under 40 (3.73), sole owners or partners (3.76 each), and those in markets with substantial oversupply (3.64). Sometimes these variations are smaller but they do run in the opposite direction of what we might expect, as endodontists might be expected to value advocacy more as they are starting out, in competitive markets, and if they are practice owners with more "skin in the game."
- Variables with minimal impact on importance include size of practice and population of their local area.

Variations by Work Setting

- Those in DSOs place 6%-8% greater importance than the average respondent for advocating for reductions in debt burden, promoting dentist mental health/wellness, promoting use of quality measures, expanding Medicare/Medicaid coverage, and teledentistry.
- Those in public and academic practice place at least 20% greater importance on Medicare/Medicaid expansion and at least 10% more on addressing workforce shortages and supporting interstate compact legislation. Public practice also places more importance on promoting fluoridation (+16%) and increased oral health funding (+13%), while academics are also more likely but to a lesser degree (by +7% and +9%).
- There are few priorities they rate much lower, other than teledentistry among academics (-21%) and dental plan advocacy (-11%) and reduced admin/regulatory burdens (-8%) among those in public practice.

Variations by Employment Status

- Sole owners place at most +3% higher importance on some advocacy priorities, while they place slightly less importance than the average respondent for Medicare/Medicaid expansion (-7%) and teledentistry (-6%). Partners show even less variance.
- Both associates and ICs place more than +10% greater importance on debt burden reduction, while the latter also put more than 10% greater importance on Medicare/Medicaid expansion and promoting fluoridation. Associates also place more importance on dental mental health & wellness (+8%) and they place -9% less importance on promoting tax/small business reform.
- Faculty/teachers place at least +14% more importance on Medicare/Medicaid, teledentistry, interstate compact legislation, and workforce shortages.

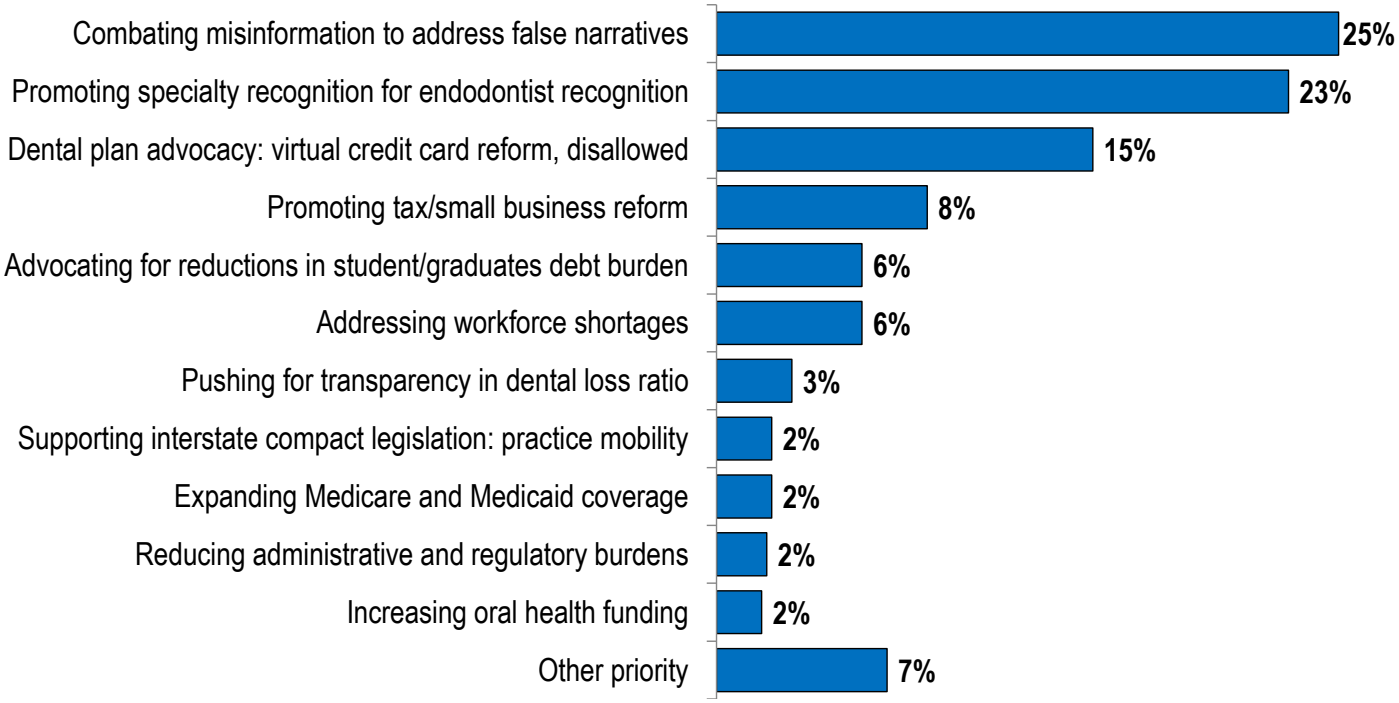
Variations by Practice Size

- The only priority that large practices vary by more than +/- 4% from the average respondent is Medicare/Medicaid expansion (-7%). Medium-sized practices also rate this lower, and they also rate teledentistry and debt burdens lower. There are almost no variations among smaller practices and the average respondent.

Single Highest Priority

The single highest advocacy priority was most often combating misinformation (25%), promoting specialty recognition (23%), and dental plan advocacy (15%). Combined these priorities were primary for 62% of members.

- Promoting tax/small business reform (8%), addressing workforce shortages, and advocating for reductions in student/resident debt burden (6%) account for another 20% of members.
- All remaining issues are regarded as single highest priority by 18% combined.



Practitioners in academic (35%) and public practice (29%) are more likely to indicate combating misinformation as the single highest priority.

- The former are also likely to rank workforce shortages (15%), debt burden reduction, Medicare/Medicaid expansion, and specialty recognition (10% each) #1. All other priorities combined were indicated by only 20%.
- The latter are also concerned with specialty recognition (24%) and tax/small business reform (18%).
- Those in DSOs are also most likely to rank combating misinformation #1 (22%) although fewer do, and almost as many rank promoting specialty recognition first (19%). They also are likely to rank #1 either debt burden reduction (13%) or dental plan advocacy (12%).

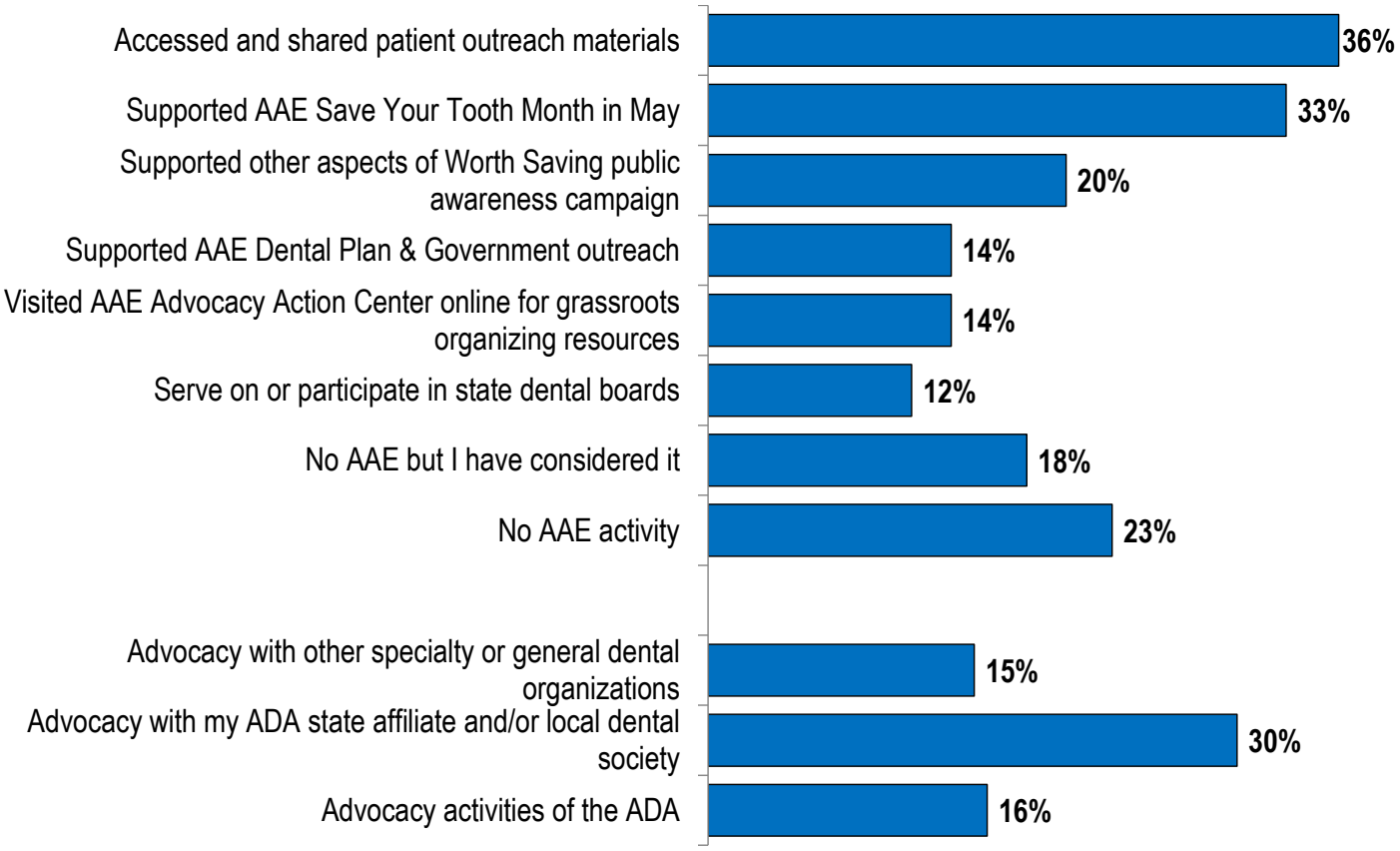
Sole owners are split between ranking combating misinformation (24%), promoting specialty recognition (23%), and dental plan advocacy (20% as most important.

- Partners are split between the first two (27% each) and far fewer rank dental plan advocacy #1.
- Only independent contractors rank something else #1, with more choosing specialty recognition (21%) than debt burden reductions (18%), promoting tax/small business reform, dental plan advocacy, and combating misinformation (15% each).

Advocacy Involvement

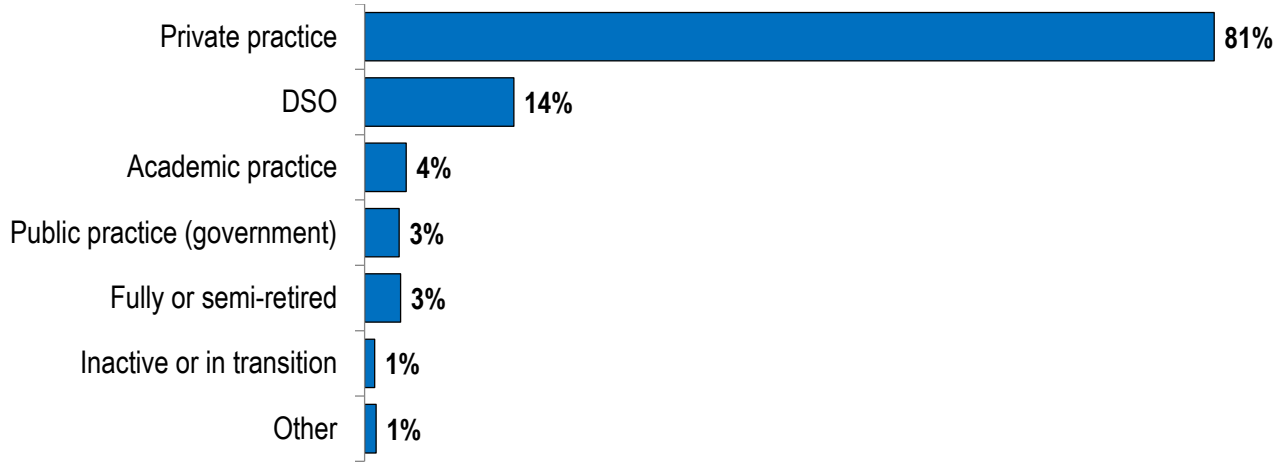
While 23% indicate no involvement is AAE activity and another 18% have none but considered it, while the slight majority who indicate some involvement report an average of just over two activities.

- These often included accessing and shared patient outreach materials (36% of the total), supporting AAE Save Your Tooth Month (33%), and supporting other aspects of Worth Saving public awareness campaign (20%).
- Fewer visited the AAE Advocacy Action Center online for grassroots organizing resources or supported AAE Dental Plan & Government outreach (14% each), or served on or participating in state dental boards (12%).
- The proportion who are involved in other advocacy related activity most often are involved in advocacy with their ADA state affiliate and/or local dental society (30%), while fewer are involved with ADA (national) advocacy activities (16%), or are involved in advocacy with other specialty or general dental organizations (15%).

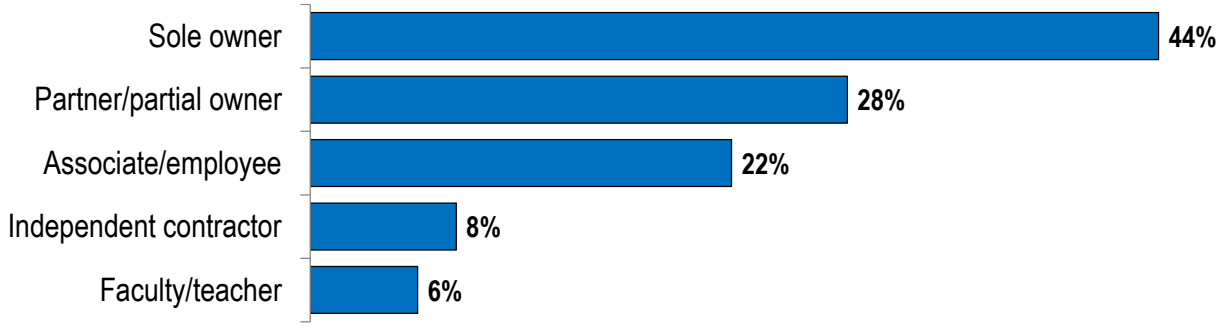


Practice Profile

Practice Setting—Almost all respondents work in private practice (81%). DSO (14%) is the one other setting reported by a substantial number, while 3%-4% each work in academic practice, public practice such as government, or are fully or semi-retired. Only 1% each are inactive or in transition, or work in other settings.

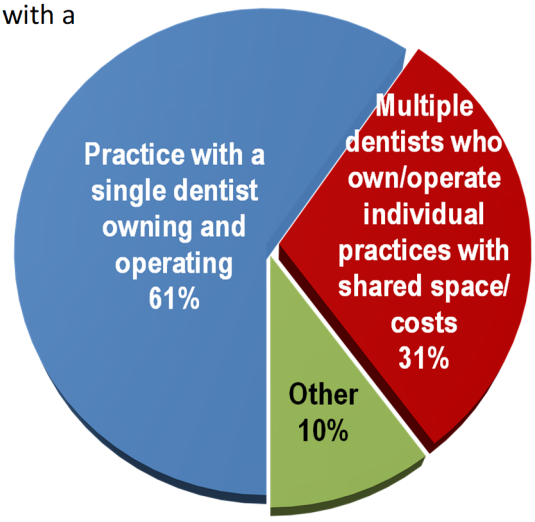


Employment Status—While a plurality are sole owners (44%), substantial numbers are partner/partial owner (28%) or an associate/employee (22%), with fewer independent contractors (8%) or faculty/teachers (6%).



Private Practice Description—A majority report working in a practice with a single-dentist owning and operating (61%).

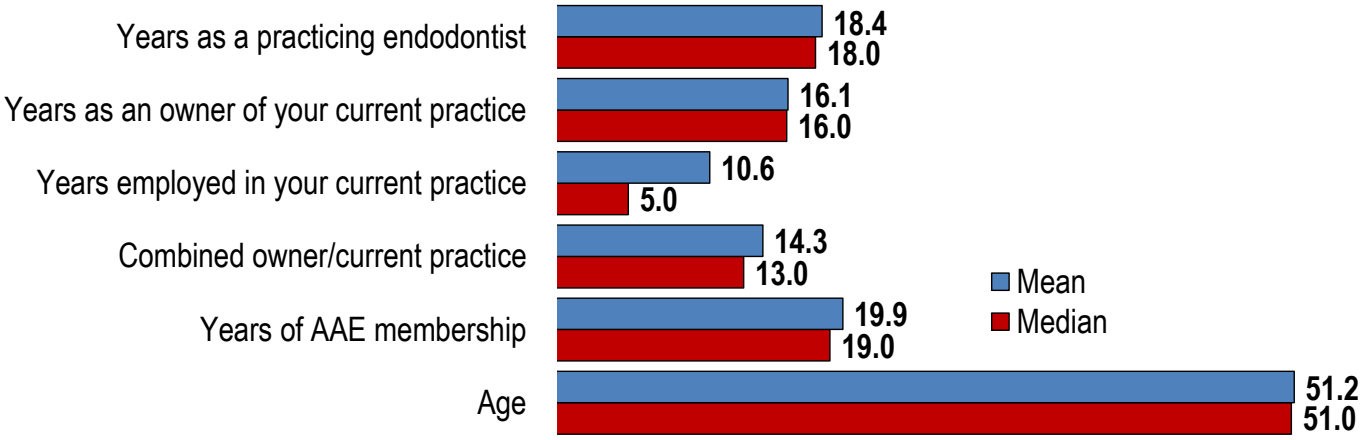
- Fewer work in a practice with multiple dentists who own/operate individual practices with shared space/costs (31%).
- Some indicate other (10%) often giving more detail as to their staffing structure, anticipating a question we ask later in the survey.



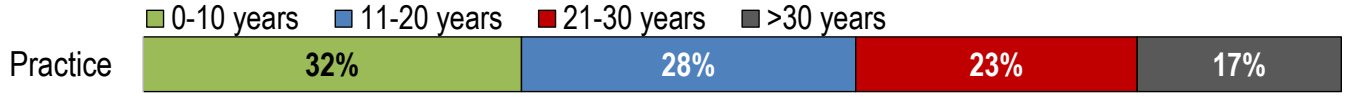
Interestingly, despite all three of these profile questions sometimes used as screeners for subsequent questions and response items are multiple-choice in format, between 2% and 8% of respondents check more than one option for each question.

Professional History

Respondents are a mean of 51.2 years of age, with means of 18.4 years since completing their endodontic training, 16.1 years as the owner of or 10.6 years working in their current practice, and 19.9 years of AAE membership.



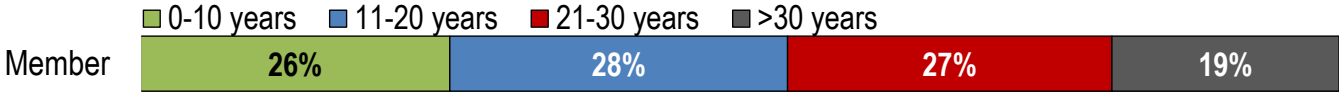
- Almost all of the median/midpoints are similar to the means, except for years in current practice among non-owners, which is only 5.0 years, with the mean driven by some outliers among them who have been in their current practice setting for much longer.
- Segmented by decades of experience, those with 0-10 years (32%) are a larger cohort than those with 11-20 years (28%), 21-30 years (23%), or those with more than 30 years (17%).



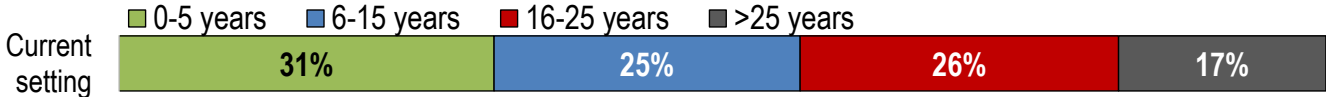
- By age range, fewer are younger than 40 years old (18%) while similar proportions are in their 40s (29%), 50s (27%), or are 60 or older (26%).



- AAE membership shows similar frequency by decade—about the same number have 0-10 years (26%), 11-20 years (28%), or 21-30 years (27%) while the remaining 19% have more than 30 years.



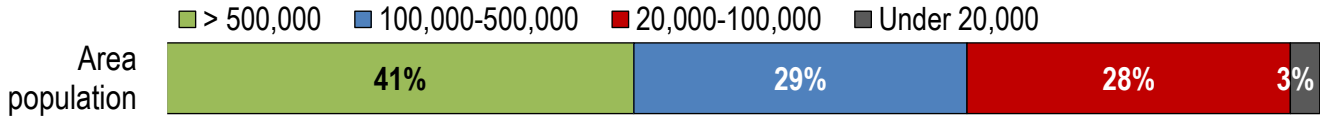
- By years in their current practice, a substantial number have been in position or owner for 0-5 years (31%) while similar quartiles have 6-15 years (25%) or 16-25 years (26%) and a smaller number have more than 25 years (17%).



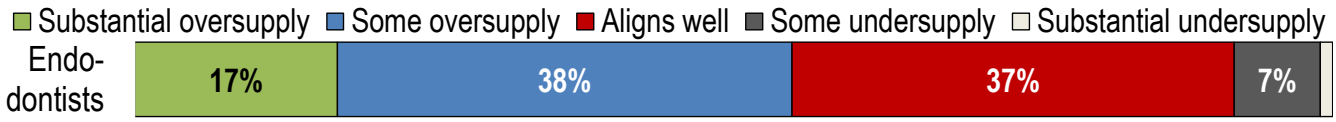
Market & Location

A plurality of respondents indicates working in a larger metro area, which we defined as having more than 500,000 people (41%).

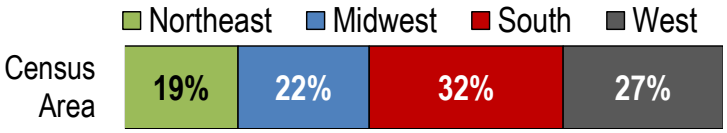
- This is much more common than those working in a larger city with 100-500,000 (29%) or a smaller city under 100,000 (28%), and predictably rural areas with fewer than 20,000 people (3%).

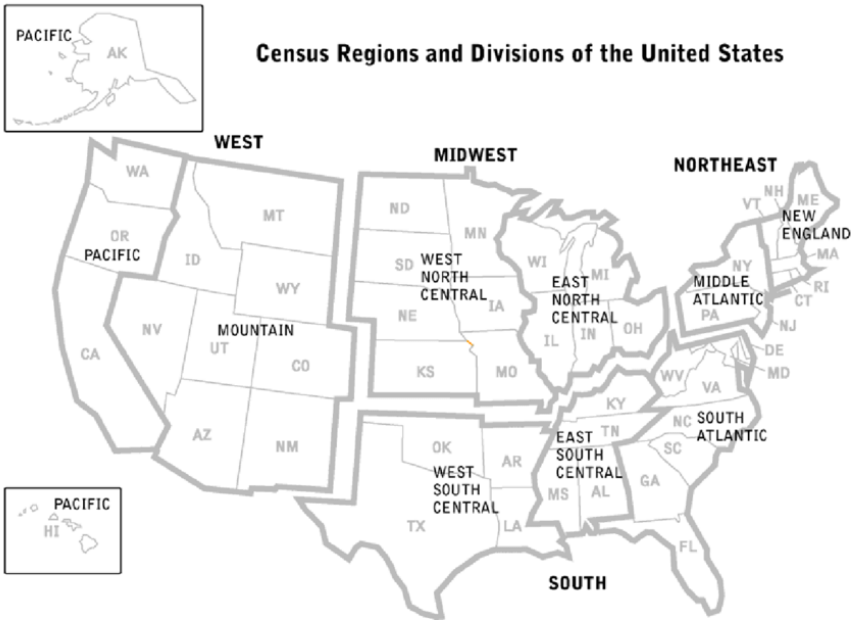


- Although not asked in this survey, results were appended from the 2025 Referral Patterns Survey regarding how respondents assessed endodontist supply relative to demand in their market.
- While 37% say the number aligns well with how many are needed there, a similar proportion say there is some oversupply (38%) and some say there is a substantial oversupply with far too many endodontists (17%).
- Only 7% say there is some and 1% a substantial undersupply in their market.



- Eleven states had at least 20 responses. The most common was California (89 or 12%), followed by Texas (8%), Florida, New York, and Illinois (6%), Pennsylvania (5%), Ohio and Colorado (4% each), Massachusetts, Tennessee, and Washington (3% each). Combined, they account for 60% of all respondents.
- By Census Area, South (32%) has the most followed by West (27%), Midwest (22%), and Northeast (19%).



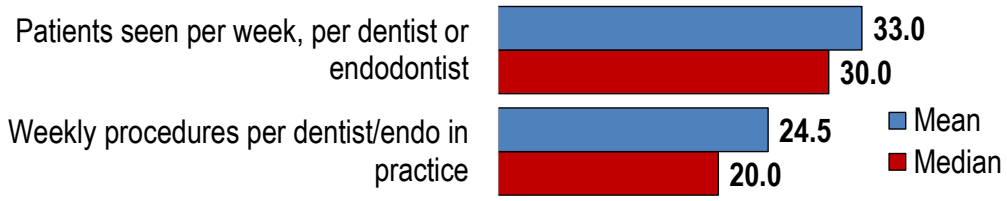


Patient Population Characteristics

On an average week, respondents say that they see a mean of 34.9 and a median of 32 patients, while their practice sees a mean of 66 and a median 50 including other dentists in the count.

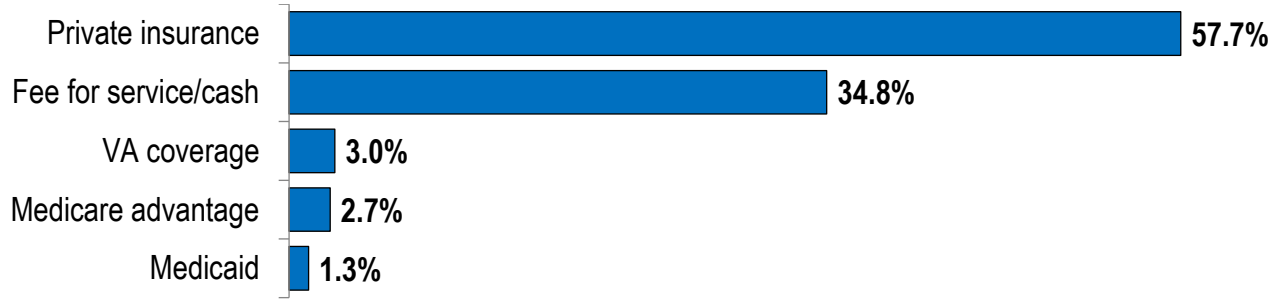


- Asked somewhat differently (and perhaps redundantly), total patients seen per week counting each person as one despite any repeat visits were a similar mean of 64.4 and a median 45. The total procedures performed per week was a mean of 49.4 and median 30.
- Dividing this response by total dentists (endodontist or general) reported in the staffing section showed that the mean patients per dentist per week was a mean 33.0 and median of 30, while weekly procedures were a mean of 24.5 and a median 20.



The average proportion of patients by their payment characteristics shows that a majority of the typical practice is using private insurance (58%).

- Fee for service/cash (35%) accounts for most of the remainder.
- A very small proportion of patients were VA (3.0%), Medicare Advantage (2.7%), or Medicaid (1.3%).



By predominant type of practice, endodontists in DSOs report a higher average proportion of patients paying with private insurance (67%) and lower proportion of patients who are fee for service/cash (27%) compared to the patients of private practice endodontists who have 57% and 35%, respectively.

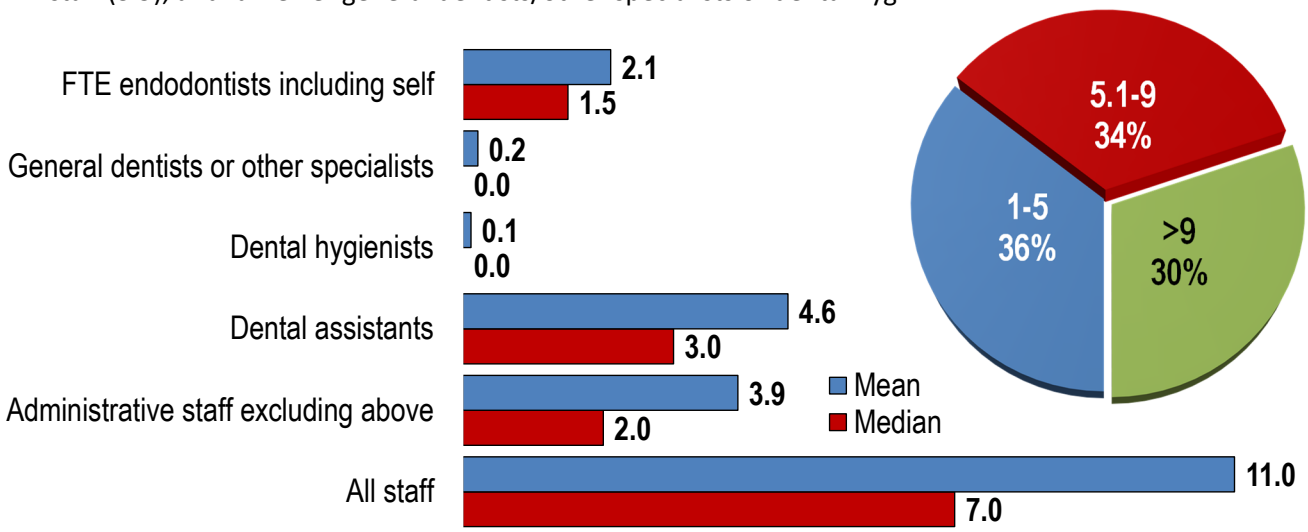
Share of patients	Private	Acad	DSO
Private insurance	57%	50%	67%
Fee for service/cash	35%	45%	27%
Medicare advantage	3%	3%	3%
VA coverage	3%	2%	4%
Medicaid	1%	0%	0%

- Academic practice endodontists have the lowest proportion who pay with private insurance (50%) and a far higher proportion who are fee for service. They also have only 5% of patients who are paying with VA coverage, Medicaid, or Medicare advantage, compared to 7% each among private practice and DSOs.

Staff Levels

Respondents have a mean 11 and median 7 total full-time equivalent staff.

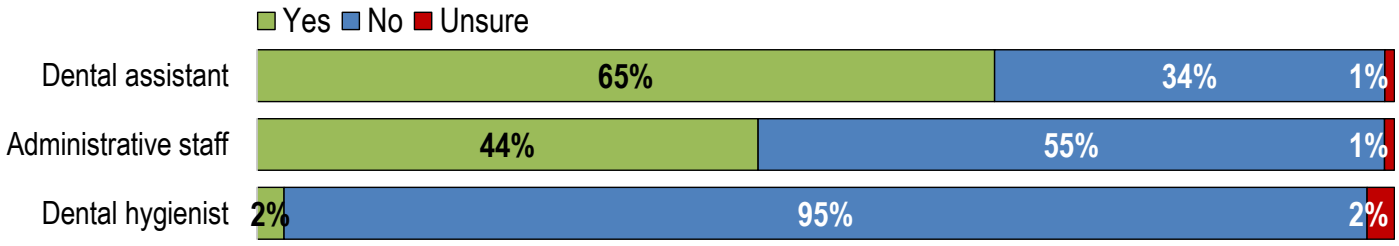
- Mean total endodontists (including respondent) was 2.1, with more dental assistants (4.6) and administrative staff (3.9), and far fewer general dentists/other specialists or dental hygienists.



- Segmenting responses by total FTE shows about one-third each have 1 to 5 (36%), 5.1 to 9 (34%), or more than 9 FTE staff (30%).

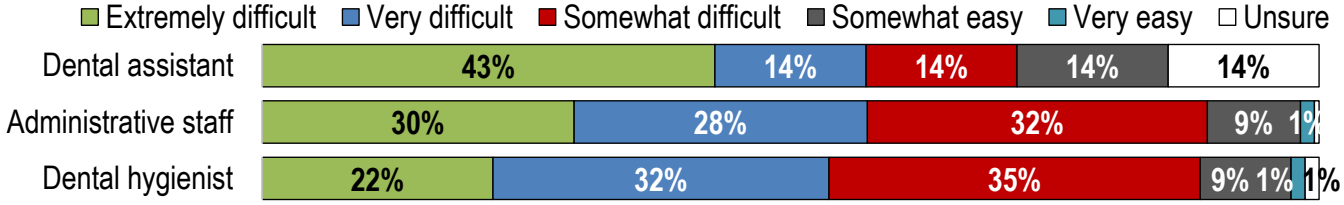
Open Positions in Practice, Past 12 Months

Over the past 12 months, 65% of practices had had at least one open dental assistant positions, 44% had at least one open administrative position, and 2% had an open position for dental hygienist.



Difficulty Filling Position(s)

- Those who had vacancies generally regard them as difficult to fill. They rate administrative staff (2.35), dental assistants (2.24), and dental hygienist (2.00) very difficult on a 5-point scale.

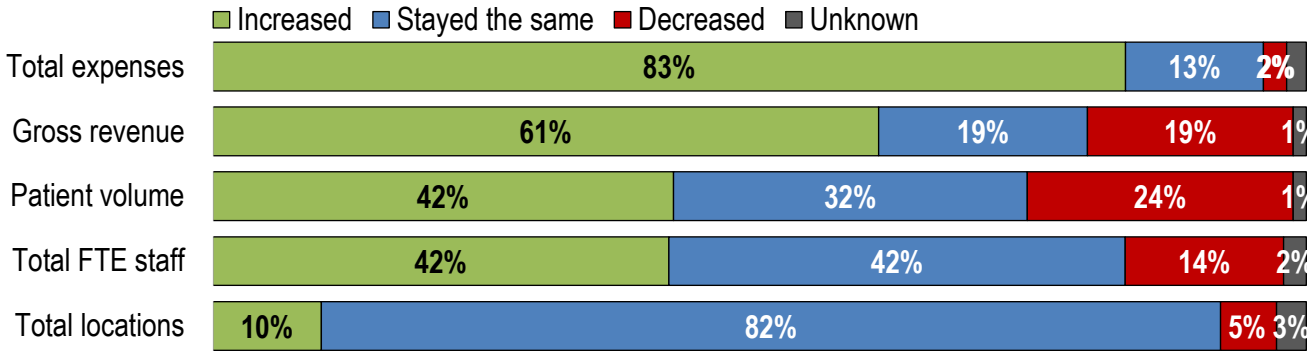


- Dental assistant hires were regarded as either extremely (30%), very (28%), or somewhat difficult (32%) while only 10% felt it was somewhat or very easy.
- Administrative staff had fewer regarded as extremely (22%) and more very (32%) or somewhat difficult (35%) and 10% rating it easy.
- Dental hygienist hires were rare but more than 40% indicated it was extremely difficult to hire.

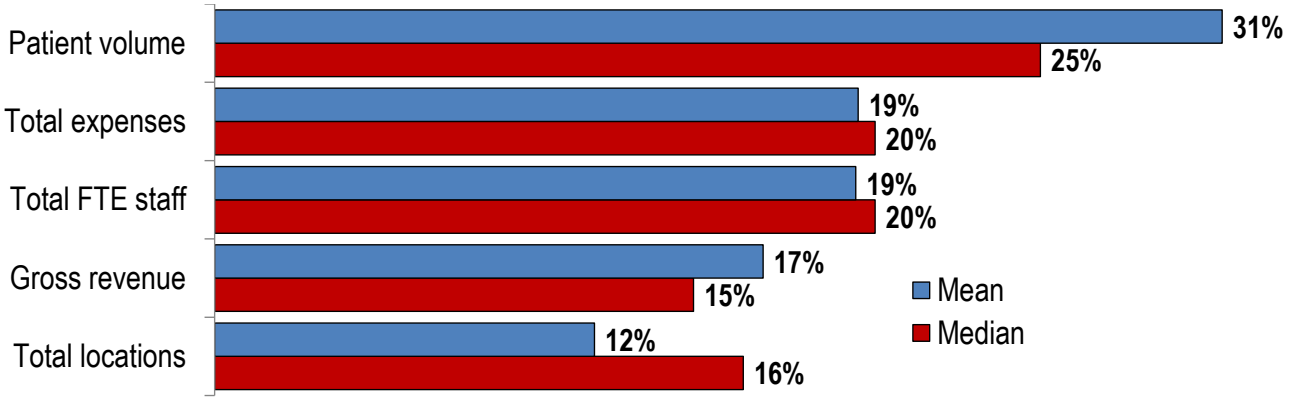
Changes in Practice Over Past Five Years

Respondents indicated whether key metrics increased, decreased, or stayed the same over the past five years.

- Unsurprisingly, total expenses are most likely to increase, reported by 83%. Gross revenue (61%) increased for fewer, while fewer report an increased patient volume and FTE staff (42% each), and only 10% have increased total locations.
- While very few report a decrease in expenses (2%) or locations (5%), more report a decrease in FTE staff (14%), revenue (19%), and patient volume (24%). Very few (1%-3% each) indicated not knowing.
- The net number of practices (increased minus decreased) is highest for expenses (81%) and much lower for gross revenue (42%), FTE staff (27%), patient volume (18%), and total locations (5%).



Mean estimated change in total staff and expenses (19% each), gross revenue (17%), and locations (12%) seem modest over a 5-year period, particularly considering that net patient volume (31%) increased by far more.

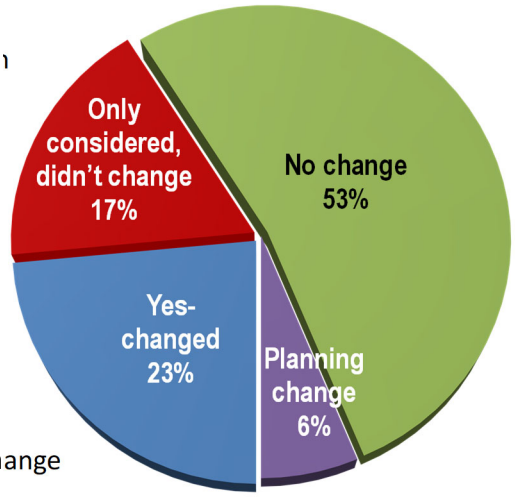


Respondents could indicate alternatively what actual amounts changed.

- Patient volume increased a mean of 27 and median 20 per week.
- Total FTE staff increased by a mean of 0.6 and median of 1.0 staff.
- Total locations increased by a mean and median of 1.0 over the past five years.
- Only gross revenue and total expenses had too few respondents to report.

- By size of practice, naturally large practices (+33%) show greater 5-year growth in mean gross revenue, compared to medium-sized (+20%) and small practices (+1%). At the same time, large practices had almost identical 5-year growth in mean expenses (+21%) compared to both medium and small (+19% each) so we can reasonably conclude that larger practices are growing more profitable while medium-sized are stable and small practices are growing less profitable in recent history.

Management Structure/Ownership Changes



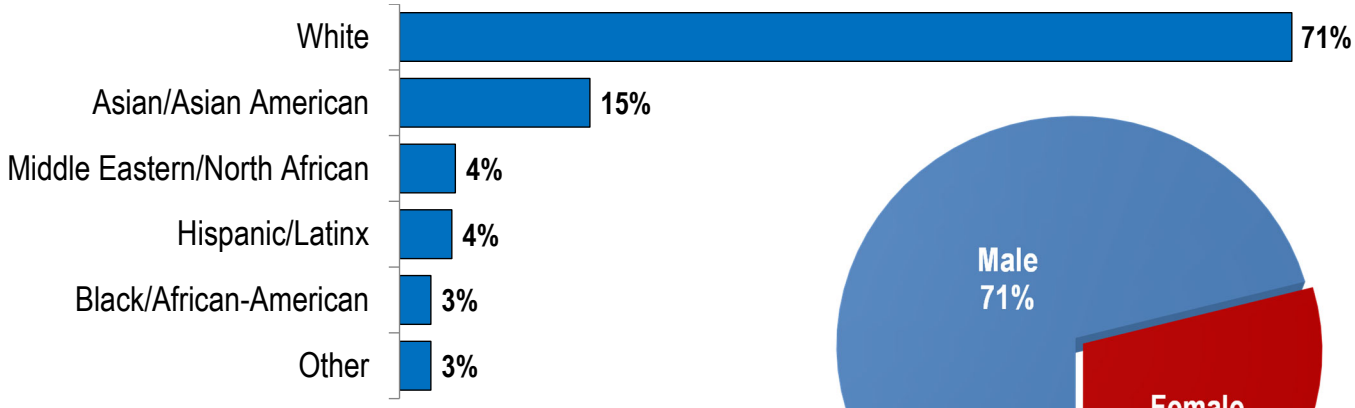
More respondents (53%) indicate not considering or making a change in management structure or ownership in the past several years.

- Some made changes (23%) while an equal number combined considered but did not make a change (17%) or planned a change (6%).
- By FTE size, large practices are far more likely to have changed (36%). They are least likely to have not done, considered, or planned a change (39%).
- Medium-sized practices are much less likely to have changed (17%) but are the most likely to have considered but not changed (22%), and 53% report no change.
- Small practices are least likely to have made (10%) or considered change (17%), and a vast majority (68%) report no change.

Personal Demographics

Overlays of AAE's AMS data show that 71% each of respondents are male and white.

- Females are 29% of the total, while Asian (15%) are second most common and 3%-4% each are Hispanic, Middle Eastern, Black, or some other ethnicity or race.
- The degrees held by respondents most commonly consist of a DDS (63%) with fewer DMD (36%), and some indicating an MS (24%) or MSD (11%). Degrees such as PhD, MDS, BDS, MPH, or other are indicated by 12%.
- Membership category is generally Active (77%) with some Life (13%), 1st or 2nd year (6%), or FDHS (3%).



Survey Comments:

What other challenges and opportunities do you see as important?

1. Corporate Dentistry, DSOs, and Private Equity

- Private equity and DSOs (Dental Service Organizations) as "destroying the specialty," prioritizing profit over patient care, and treating patients like "numbers."
- Corporate consolidation eroding independent/solo practice ownership — described as turning dentists from small business owners into "employees of the MBA class."
- DSOs use restrictive covenants that trap associates, prevent them from leaving to join independent practices.
- Corporate groups only refer within their own network, cutting off independent endodontists from referrals.
- Younger endodontists increasingly choosing to work for DSOs rather than pursue ownership.
- Some nuance: a few respondents note private equity growth could paradoxically help solo practices stand out as an alternative.

2. Insurance Reimbursement

- Reimbursement rates stagnant/declining while overhead/staff/supply costs rise sharply (post-2020 inflation).
- Specific insurers named repeatedly as problematic: Delta Dental, BlueCross Blue Shield, MetLife (one respondent cites 29.1% of income written off last year).
- Frustration that insurance "dental benefit plans" are really just discount/tooth-benefit plans, not real coverage, and patients don't understand this.
- Complaints about non-covered procedures (CBCT, pulpotomy, resorption repairs) and downcoding.
- Some call for federal-level bans on "disallow" clauses or Medicare dental out-of-network coverage.
- A few practices report moving to fee-for-service or dropping insurance networks (e.g., Delta) entirely.
- Frustration that AAE/ADA aren't advocating strongly enough against insurers.

3. General Dentists Performing Endodontic Treatment

- GPs doing root canals themselves instead of referring, often producing substandard treatment that later requires retreatment or extraction.
- Belief that GPs lack adequate training/procedure volume in dental school, leading to more failures.
- Some want AAE/ADA to publicize data on general-dentist RCT success/failure rates to educate the public.
- Patients and public largely unaware endodontists are root-canal specialists ("80% of patients don't know").

4. Workforce/Staffing Issues

- Difficulty hiring and retaining qualified dental assistants and staff.
- Childcare-related staffing shortages post-parenthood.
- Difficulty recruiting associates, especially in rural areas, and eventually finding successors/buyers for practice transitions (retirement).
- Concerns about resident debt burden discouraging practice ownership.

5. Education & Training Quality

- Dental/endodontic schools increasing class sizes ("diploma mills"), reducing training quality and procedural volume per student.
- Shortage of qualified educators in graduate endodontic programs.
- Concerns about an oversupply of graduating endodontists in some (especially metro) markets, saturating competition, alongside shortages in rural/underserved areas.

6. Technology, AI, and Marketing

- Mixed views on AI: some see promise for reducing administrative burden; others feel it's "overblown" or worry about AI-driven misinformation.
- Need to adapt marketing to compete with social media outreach and "hybrid" or "traveling" endodontists who may not use microscopes or provide full-service care.
- Rising cost of new technology (microscopes, CBCT, GentleWave, lasers) increasing overhead and case time without matching reimbursement.

7. Public Perception & Misinformation

- Concern about "fake news"/pseudoscience about root canal safety (root canal–cancer myths, etc.), amplified by influencers and social media.
- Worry this drives patients toward extraction over treatable teeth.
- Concern about Key Opinion Leaders (KOLs) taking corporate money without disclosure while promoting products/practices.

8. Regulatory & Economic Environment

- General frustration with government over-regulation.
- Broader economic pressures (inflation, wage growth outpacing reimbursement) cited often.
- A few political/economic tangents (e.g., comments about immigration, labor markets) tied to broader economic anxiety affecting patients' ability to afford care.

9. Burnout and Practice Sustainability

- Several long-tenured practitioners mention burnout, declining motivation, and phased retirement plans.
- Concerns about maintaining "highest level of care" amid competitive/corporate pressure.
- A running theme of frustration with AAE itself — several respondents feel the association isn't doing enough to advocate on insurance, corporate dentistry, or education quality.

Summary

The profession is under strain from three converging pressures—corporate/private equity consolidation, insurance reimbursement squeeze, and erosion of referral-based specialty care from general dentists doing their own endodontics. These are compounded by staffing shortages, rising costs, and uncertainty about AI's role. There's also a recurring undercurrent of frustration directed at the AAE for perceived inaction on these issues.

Theme breakdown/keyword analysis of individual responses (double-counting responses that touch multiple themes) shows insurance reimbursement (46), corporate dentistry/DSOs/private equity (35), staffing & hiring , workforce shortages assistants, associates, recruiting (28), general dentists doing endo/referral erosion (27), technology, AI & marketing social media, microscopes, CBCT, GentleWave (20), education & training quality dental/endo school class sizes, faculty shortages (19), economy/inflation/rising overhead costs (17), public perception & misinformation root canal safety myths, public awareness (13), and government regulation (10).

Key takeaways:

- **Insurance reimbursement** and **corporate consolidation (DSOs/PE)** are clearly the two dominant concerns, together touched on by more than a third of all responses.
- **Staffing** and **GP-performed endodontics/referral problems** are close behind as the next-tier concerns — both operational/day-to-day pain points rather than industry-wide structural ones.
- Smaller but notable clusters exist around **tech/AI/marketing** and **education quality**, often framed as double-edged (both a challenge and an opportunity).
- **Burnout** is likely undercounted by keyword matching alone — several other responses express fatigue/frustration without using those exact words (e.g., "I'm ready to retire," "fighting the DSO culture").

What do you see as the top administrative burdens to endodontic practices today?

Responses converge on two issues: **insurance administration** and **staffing**, accounting for a large majority of all responses. Many responses were a single word ("Insurance" or "Staffing").

1. Insurance Administration: *overwhelmingly the top burden*

Sub-patterns include:

- **Claims, denials, and appeals**: constant denials, downcoding, bundling, requests for unnecessary documentation, and the need for repeated appeals.
- **Verification/pre-authorization burden**: staff spending hours on hold verifying benefits, often getting inaccurate or incomplete information from insurers.
- **Reimbursement stagnation**: rates not rising with inflation/overhead, described by many as unsustainable.
- **Specific insurer frustration**: Delta Dental named repeatedly and harshly (one respondent calls for a class-action lawsuit against them; several call insurers "thieves" or describe the process as a "nightmare"/"shitshow").
- **New wrinkle**: a few respondents specifically flag **insurers using AI to auto-deny claims** as an emerging burden.
- **Philosophical framing**: several describe billing/insurance administration as an unpaid "free service" to patients—work that was once a courtesy and is now an expected, unfunded burden.

2. Staffing/Human Resources

- Difficulty **finding, hiring, and retaining** qualified staff (assistants, front desk, office managers).
- **Rising wage demands**—one respondent notes staff asking for nearly double what they earned four years ago.
- **Training burden**: new hires described as lacking work ethic, motivation, or people skills; several mention a generational shift in worker attitudes.
- **HR complexity**: compliance, benefits administration, and general personnel management described as a "nightmare," particularly for practices without dedicated HR staff (contrasted with corporate/DSO practices that have this built in).

3. Regulatory & Compliance Burden

- HIPAA, OSHA, cybersecurity/IT compliance, and general "government red tape" mentioned frequently as burdensome, especially for small practices held to the same regulatory standard as large corporate groups.
- A few pointed critiques of continuing education (CE) requirements as "worthless" bureaucratic box-checking rather than meaningful quality control.
- One mentions "tort reform" as a needed change.

4. Documentation & Charting

- Time spent on **chart notes, treatment narratives, and referral report writing**—several note the growing need to document/justify treatment decisions for third-party payors.
- Fragmented EHR systems complicating documentation.

5. Financial/Overhead Pressures

- Rising costs of materials, staff, and overhead outpacing fee growth.
- Cash flow management and collections cited as burdensome.
- Student loan debt (of associates/new grads) mentioned as compounding the broader affordability/practice-transition problem.

6. Corporate/DSO Contrast

- A handful of respondents note that **joining a DSO removed much of this administrative burden** from their plate—a rare positive mention of corporate practice structures in an otherwise consolidation-skeptical dataset (consistent with B2).
- Others cite **competition from DSOs/traveling endodontist models** and pressure from DSO-affiliated GPs to keep endo "in-house" as compounding referral-related admin difficulty.

7. Scheduling & Patient-Facing Admin

- Managing cancellations, no-shows, and emergency call-ins from referring doctors.
- Patients "shopping around" for estimates, undermining traditional referral relationships.

Approximate theme frequency (264 responses) insurance claims, verification, reimbursement, denials (140), staffing/hiring/retention (101), overhead/financial pressure (25), regulatory/compliance HIPAA, OSHA, CE, etc.) (20), referral relationships/marketing (13), and documentation/charting/referral reports (9).

Key takeaways:

- **Insurance** is mentioned in over half of all responses—by far the single largest administrative burden, consistent with the qualitative read.
- **Staffing** is the clear second-place theme, present in over a third of responses.
- Together, insurance and staffing dominate—everything else is a distant third tier (under 10%).
- Interesting contrast with B2: **DSO/corporate/private equity** barely registers here (2.3%) as an *administrative burden*—it shows up far more as a *structural/competitive* concern in B2. A couple of B2a responses even frame DSO affiliation as reducing admin burden.
- **AI** is barely mentioned as a current burden (1.5%), though a few flag it as an emerging concern (e.g., insurers using AI to deny claims).

What do you see as the limits to what AAE can achieve on behalf of your practice and endodontic practice in general?

Overview

Where B2 and B2a focused on external market pressures (insurance, staffing, corporate dentistry), B3 turns the lens on **the AAE itself**—its scope, funding, advocacy effectiveness, and perceived conflicts of interest. There's a notable split between respondents who feel "no limits" exist if the AAE tries hard enough, and a larger, more vocal group who feel the AAE is structurally constrained or even compromised.

1. Insurance Industry Power (the most cited structural limit)

Many respondents see insurance companies as simply too large, wealthy, and politically connected for the AAE to meaningfully challenge:

- Insurers seen as having far greater lobbying power, legal resources, political influence than organized dentistry.
- Frustration that reimbursement structures vary state-by-state, making national reform difficult (e.g., one respondent notes Blue Cross Blue Shield of Alabama is constitutionally exempt from the state insurance code).
- Specific anger at **Delta Dental**—one respondent cites the CEO's ~$7M salary as emblematic of insurer profiteering "off the sweat of dentists."
- Several doubt insurers will ever willingly raise reimbursement regardless of AAE advocacy.

2. AAE's Relationship with DSOs/Private Equity: major credibility concern

- Many respondents believe the **AAE accepts funding/sponsorship from DSOs and private equity firms** at its conferences and events, creating a direct conflict of interest with its stated support for independent practice.
- Several feel the AAE actively "promotes" DSOs or is "afraid" to take a stand against corporate consolidation because it depends on that funding.
- One response argues the AAE has failed to prepare graduating residents to resist DSO recruitment, effectively "funneling" new endodontists into corporate employment despite high student debt making them vulnerable.
- Calls for the AAE to explicitly limit corporate ownership, stop promoting DSO-friendly narratives, or at least achieve a "happy medium" between funding needs and member interests.

3. Organizational Size & Resource Limits

- Frequent comparisons to the **ADA**, described as much larger and better funded, with the AAE seen as too small to independently drive legislative or insurance reform.
- Some argue the AAE should let the ADA handle broad advocacy and focus its own limited resources narrowly (e.g., specialty recognition, public education).
- Limited member engagement/involvement (especially from younger endodontists) cited as constraining what the organization can accomplish.

4. Public Awareness/Marketing as a Core Opportunity

- A recurring, mostly optimistic theme: the public simply doesn't know what an endodontist is or does (compared to, e.g., orthodontists or oral surgeons).
- Many call for a national public-education campaign (billboards, social media) so patients "self-refer" for root canal pain rather than relying on general dentist referrals.
- Some note a tension: local practices avoid public marketing themselves for fear of upsetting referring GPs, leaving this as something only the AAE can safely do at scale.

5. General Dentists Performing Endodontics

- Many want the AAE to more directly confront/educate general dentists (and the public) about the quality gap in GP-performed root canals—including calling for real "teeth" (enforcement) behind referral standards.
- Some feel the AAE is too deferential to the ADA/general dentist establishment, unwilling to "bite the hand that feeds" since GPs are the referral source.

6. Legislative/Political Limits

- Several note the AAE has limited lobbying relationships with Congress/state legislatures compared to insurance industry lobbyists.
- General distrust of "the government" and skepticism that expanded Medicaid/Medicare dental coverage would help without reimbursement reform first.
- A minority raise broader macroeconomic/political grievances (e.g., comparisons to the ACA's effect on medicine, immigration, labor markets) as root causes beyond AAE's control.

7. Internal Governance/Leadership Critique

- A pointed critique that AAE leadership is dominated by "academicians" or high-earning clinicians disconnected from the economic reality of average practicing endodontists.
- Concern about a lack of diverse representation in AAE leadership (e.g., younger members, women) due to time/travel demands of involvement.
- A few note that as a large membership organization, AAE decisions inevitably won't satisfy all members.

8. "No Limits"/Optimistic Minority

- A meaningful subset of responses simply say **"no limits"** or "none," expressing confidence that AAE can achieve anything with sufficient will/effort—a notable contrast to the more skeptical majority.
- A few explicitly praise the AAE's advocacy track record as strong.

9. Practical/Operational Limits (outside AAE's scope)

- Several say AAE simply cannot solve **local, practice-level issues**—staffing shortages, employee housing costs, individual patient/referral relationships—since these are inherently local and operational, not policy-level.

Approximate theme frequency (N=194)**:** insurance industry power/reimbursement reform (50), AAE size/ resources vs. ADA/insurance lobby (26), DSO/private equity/corporate dentistry (23), Public awareness/marketing campaign (22), legislation/government/politics (22), student debt/education/training (20), general dentists performing endo/referral issues (18), no limits/optimistic (15), AAE leadership/governance critique (6).

Key takeaways:

- **Insurance industry power** is the chosen by more than a quarter of respondents framing insurers (their money, lobbying, and structural entrenchment) as the fundamental limit on what AAE can accomplish.
- **AAE's own size/resources relative to the ADA and insurance lobby** is the second most-cited limit—a resignation that AAE simply doesn't have the scale to win fights insurers/ADA can.
- **DSO/private equity** appears notably lower here than the emotional weight of the qualitative read suggested—but this reflects that many of the most detailed, passionate responses on this topic are single long entries, not high volume. Word count/intensity isn't captured by frequency alone.
- **AAE leadership/governance critique** is rare in frequency but comments are long pointed responses—another case where raw counts understate salience.

What advice can you share that would help make AAE advocacy more accessible to endodontists?

More constructive/suggestion-oriented with some frustration coming through. The 97 responses are mostly **actionable, tactical suggestions** for how AAE can improve member engagement with advocacy—communication style, time burden, awareness, and culture come up most commonly.

1. Communication & Awareness Gaps

- Multiple respondents express genuine surprise that an "AAE Advocacy Action Center" exists at all.
- Calls for more direct, personal communication—"call us personally," "email us personally rather than mass emails."
- Requests for regular (quarterly/semi-annual) plain-language summaries of advocacy activity and impact.
- Suggestions to diversify channels: text messages in addition to (or instead of) email, since email is easy to miss/ignore.
- Desire for a **simple, centralized digital hub** listing specific ways to help.

2. Time Burden/Low-Effort Participation

Most respondents are busy clinicians who won't engage with anything that feels like a large commitment:

- Strong preference for **pre-written, easy-to-sign advocacy letters** that can be sent to legislators with one click.
- Requests for "easy things to do"—petitions, quick digital actions—rather than open-ended asks.
- Several explicitly state they're too consumed with keeping their practice financially afloat to devote meaningful time to advocacy, even though they value it in principle.

3. Making Advocacy Feel Relevant/Concrete

- Suggest explaining issues in plain, non-policy-wonk language, since most aren't versed in policy-making.
- Desire clearer explanation of *why* specific issues (e.g., dental loss ratio transparency) directly affect practice.
- One suggestion to reframe messaging from "advocate for endodontics" to **"advocate for endodontists"**—protect the professionals directly rather than abstract campaigns.
- Some skepticism about existing messaging (e.g., "we don't need a 'tooth worth saving' campaign"—asking instead for simple public messaging like "What is an endodontist? Ask your dentist").

4. In-Person/Local Engagement

- Suggestions for AAE representatives to physically show up—attend local/state dental meetings, host sessions with food/lunch to boost turnout.
- Requests for **more local/regional touchpoints**: satellite groups (e.g., a "Colorado Springs Endodontist" model), local study groups, university meetings, and stronger outreach from regional directors.
- A few contrast this favorably with the **ADA's tripartite structure** (national/state/local), which some feel builds stronger grassroots connection than the AAE currently does—AAE described as feeling "more distant."

5. Culture, Inclusion & Leadership Concerns

- One criticizes AAE's academic culture for undervaluing private-practice clinicians and diverse leaders (young dentists, women), citing multi-day meetings in Chicago as a barrier to parents/practice owners participating.
- Broader mentorship pathways, rethinking meeting format/length/location to encourage wider participation.

6. Tangible Value/Incentives

- Suggestions for concrete membership benefits tied to advocacy involvement such as free job board for retiring endodontists to post practices/positions, described as an earned "retirement benefit" after decades of dues.
- A few want advocacy contributions to be tax-deductible or otherwise incentivized.

7. Substantive Advocacy Content Requests

- Several use this question to restate the underlying B2/B3 concerns—insurance reimbursement, DSOs, "just say no to the DSO"—treating advocacy accessibility as inseparable from *what* AAE is advocating for.
- One asked to leverage insurance-company outcome data to show endodontists have higher success rates than general dentists, to argue against insurers reimbursing GP-performed (and later retreated) root canals twice.
- A couple push back on continuing-education content itself, wanting more practice-management/business programming instead of repetitive clinical/materials lectures.

8. Skeptical/Dismissive Minority

- A small number say responsibility lies with the individual, not the AAE ("It's not up to the AAE... it's up to the individual endodontist").
- A few flatly state you can't access advocacy without joining AAE, framing membership itself as the barrier.
- One cautions against advocating for *more government involvement* at all, calling it "a deal with the devil."

9. Positive/Satisfied Responses

- A meaningful minority explicitly praise AAE's current advocacy efforts ("doing a great job," "keep it up," "AAE is doing a nice job making the public aware").

Keyword-based theme counts (97 total responses)
In-person/local engagement (20), communication/awareness: emails, texts, updates (18), time burden/easy low-effort participation (14), membership/tangible benefits (10), plain-language/clarity of issues (8).

Key takeaways:

- **In-person/local engagement** edges out communication as the top theme—members want AAE to show up locally (meetings, lunches, regional outreach), not just message better.
- **Communication/awareness** is a close second—many simply don't know advocacy resources exist, reinforcing the "awareness gap" read from the qualitative summary.
- **Time burden** is key as members ask for low-effort, quick-action participation rather than deep involvement.
- Note: "local" and "state" keywords overlap somewhat with communication-related terms (e.g., "state legislators")—treat the split between them as directional rather than precise.
- Substantive policy content (**insurance/DSO**) is a distant theme here (6.2%)—confirming C5 is mostly about *process and accessibility*, not re-litigating the industry grievances from B2/B3.

What are the primary factors that have led your practice to grow or stay constant over time?

Forward-looking/practice-specific with responses in two key areas: internal factors that practices actively control (quality, marketing, relationships, staffing, technology) and external market forces (competition, insurance, demographics, corporate dentistry) that help or hurt growth regardless of effort.

1. Quality of Care & Reputation

- Repeated emphasis on simply "being great at what I do," delivering consistent, high-quality clinical outcomes.
- Strong connection drawn between quality care → patient trust → **word-of-mouth referrals/**returning patients.
- Reputation built over decades cited often (several practices note 50–70 years of community presence).
- Bedside manner, honesty (e.g., recommending extraction when appropriate rather than overtreating), and taking time with patients repeatedly linked to loyalty and repeat referrals.

2. Relationships with Referring Dentists

- Long-standing referral relationships (some cited at 15–20+ years) seen as core to stability.
- Active relationship maintenance: post-op reports, communication, follow-up calls to referring GPs.
- Some note these relationships are increasingly fragile due to corporate consolidation of referring GP offices redirecting referrals in-house or to affiliated specialists.

3. Marketing

- Dedicated marketing staff/consultants, SEO investment, Google review management, and "consistent" or "constant" marketing efforts.
- Marketing framed as necessary both to attract patients directly and to stay visible to referring dentists.
- A few specifically credit hiring practice-management/marketing coaches (e.g., **EndoMastery**) or consultants for streamlining growth.

4. Technology & Efficiency Investments

- CBCT, GentleWave, advanced tech cited as differentiators improving diagnostic accuracy/patient throughput.
- Efficiency gains (faster procedures with experience, delegating tasks like buildups/anesthesia to support staff) allow seeing more patients per day.
- Several mention shifting to a "one-visit" treatment model to improve efficiency and patient satisfaction.

5. Staffing & Team

- Hiring additional endodontists/associates cited often as direct growth driver (more providers = more capacity).
- Quality, well-trained, and stable staff linked to both patient experience and operational capacity.
- Conversely, **staff turnover and inability to retain qualified personnel** cited as a factor limiting growth for some.

6. Insurance Strategy *(bi-directional comments)*

- Some practices report growth/revenue increases specifically from **dropping insurance networks** (going non-par or fee-for-service), citing higher per-case revenue despite lower volume.
- Others credit **increased insurance participation** or successful fee renegotiation with driving volume.
- A few cite insurance interference/reimbursement pressure as a constraint on growth rather than a driver.

7. Corporate Dentistry/DSOs (mixed direction—a notable contrast to B2/B3)

- Several respondents credit **joining a DSO** with enabling growth—streamlined workflows, reduced administrative burden, supply-cost contracts, or provided doctor support.
- Others frame corporate dentistry/DSO competition as actively **suppressing** their growth (rising overhead from corporate competitors, GPs selling to corporate groups and redirecting referrals, new corporate-affiliated endodontists entering their market).
- One respondent explicitly describes building a viable **non-corporate ownership model** (buy-in without loans) specifically as a countermeasure to corporate consolidation.

8. Local Market & Demographic Factors

- Population/city growth cited often as a natural tailwind for patient volume.
- Conversely, **market saturation**—increased number of competing endodontists in the same area—cited repeatedly as suppressing growth or causing plateaus.
- A few note baby boomer retirements (both of patients' referring dentists and of competing endodontists) creating opportunity.
- Rural/underserved locations cited as providing natural competitive insulation ("being only endodontist in the area").

9. Personal/Practice Owner Choices

- Several practices report deliberately choosing **not** to grow further—citing personal capacity limits, work-life balance, or having "found their comfort level."
- Hours worked, personal effort ("hard work," "working harder") cited plainly and frequently as a factor, especially by solo owner-operators.
- A few describe major structural moves: opening additional locations, purchasing another practice, selling a satellite location to refocus, or absorbing endodontists from a closing/competing practice.

10. Macroeconomic Factors

- Inflation and rising costs of goods/overhead mentioned as a growth pressure requiring fee increases just to maintain real revenue.
- COVID-19 cited by a couple of respondents as an unusual growth catalyst (as older dentists retired during/after the pandemic, creating openings).

Overall tone: Notably mixed—quality, relationships, and marketing are the clear, broadly-agreed-upon internal growth levers, while insurance strategy and corporate/DSO involvement appear as genuine double-edged swords depending on the respondent's specific situation, rather than a near-universal villain framing seen earlier.
Keyword-based theme counts (215 total responses, 165 respondents): local market/population growth/saturation (41), quality of care/reputation (37), referral relationships (33), marketing (28), staffing/team/hiring (19), insurance strategy: participation or dropping (17), availability/accessibility/same-day care (15), corporate dentistry/DSO/private equity (14), technology/efficiency (11), personal effort/hours worked/owner choice (10), economic factors: inflation, economy (8), fees/pricing increases (5).

Key takeaways:

- **Local market dynamics** (population growth, saturation, competition) is the single largest theme—growth is often described as something that happens *to* a practice due to geography/timing, not something practices actively build.
- **Quality of care/reputation** and **referral relationships** are the two clear "controllable" growth levers, together cited in roughly a third of responses—consistent with the qualitative read that these are the most broadly agreed-upon internal drivers.
- Note some overlap: "competition" and "market" keywords appear in both the local-market and marketing categories in a few edge cases, so treat the top two lines as directionally close rather than perfectly separated.
- **Corporate/DSO** (6.5%) is much lower here than in B2/B3—and unlike those documents, this theme is genuinely bidirectional (helping some practices, hurting others), not uniformly negative.
- **Insurance strategy** here is fundamentally different in character from B2/B2a—it's framed as a *lever practices pull* (drop insurance to raise margins, or add insurance to gain volume) rather than a *burden imposed on them*.

What are the primary factors that have led your practice to decrease in size?

The same forces (competition, corporate dentistry, insurance, referral relationships, staffing) reappear, but here they're described as causes of *shrinkage* rather than growth. There's also a distinct, sizable cluster of **voluntary/lifestyle-driven** decline—practitioners intentionally scaling back—that has no real counterpart in the growth document.

1. Competition/Market Saturation (dominant theme)

The single most common explanation for decline:

- Simple one-word answers ("Competition") appear repeatedly.
- Several cite a sharp rise in the number of endodontists in their immediate area (one notes a **25% increase in endodontists within a 5-mile radius**) diluting patient volume.
- Framed as compounding with insurance dynamics: new competitors "all take insurance," pulling patients who might otherwise wait for an out-of-network specialist.

2. Corporate Dentistry/DSOs/Private Equity A major and specific driver of lost referrals and volume:

- General dentist offices increasingly **hiring in-house endodontists** or being acquired by corporate groups that refer only within their own network—directly cutting off independent endodontists from referrals they used to receive.
- Several describe referring dentists **retiring or selling to corporate/DSO groups**, severing long-standing referral relationships.
- One respondent notes corporate-owned offices reportedly receive **~20% higher insurance reimbursement** than independent practices can negotiate, compounding the competitive disadvantage.
- DSO decisions (e.g., low pay policies) cited directly by at least one respondent as shrinking their situation.

3. Insurance-Related Decline A recurring, double-edged theme

- Some practices **dropped insurance networks/went fee-for-service** deliberately and saw volume decline as an expected tradeoff (a few frame this as an acceptable/intentional cost).
- Others were pushed out involuntarily—e.g., **Delta Dental cutting fees**, prompting the practice to go out-of-network, which then hurt volume.
- Medicaid fee cuts led at least one practice to drop most Medicaid patients (keeping only those whose fees weren't cut).
- One respondent describes a reversal: went fully out-of-network in 2025, then rejoined Delta Dental ("Satan Delta Dental") in 2026—illustrating how financially painful the fee-for-service transition can be.

4. Loss of Referral Relationships

- Referring dentists **retiring** cited multiple times as directly shrinking the referral base.
- Loss of referrals connected to both natural retirement and corporate acquisition of referring practices (overlapping with the DSO theme above).
- One case notes a top referring dentist's retirement combined with an endodontist's departure (replaced only part-time) compounding volume loss.

5. Staffing Losses

- Specific, concrete staffing departures cited as shrinking capacity: an assistant leaving for a new career (cardiac scanning), a front-desk employee on maternity leave, an assistant relocating.
- General difficulty **finding replacement staff** (e.g., unable to find an RDA for 3+ months) directly cited as constraining how many patients can be seen.
- Loss of an associate/partner endodontist (death, relocation, family circumstances) reducing overall practice capacity, sometimes only partially absorbed by remaining doctors.

6. Voluntary/Lifestyle-Driven Scaling Back

- Approaching retirement, aging, or health issues cited as reasons for intentionally reducing hours/days worked.
- Life-stage changes: kids grown and out of the house, mortgage paid off, reduced financial need—explicitly cited as reasons to "be satisfied with less."
- Physical/disability-related limitations mentioned as a factor in slowing down.
- A few describe simply cutting back to part-time (e.g., 2 days/week) by personal choice, sometimes combined with maternity leave.

7. Macroeconomic & Cost Pressures

- Rising overhead and wage costs cited as squeezing margins even where patient volume holds steady, sometimes forcing large fee increases (one notes fees up 88% since 2020) that in turn reduce case volume.
- General economic softness suggested as a possible cause for reduced patient willingness to spend on treatment, though a couple of respondents note uncertainty ("we're not sure why volume is down").
- One outlier mentions government shutdown/pandemic mishandling as contributing factors.

Overall tone: Much more fatalistic—many respondents attribute decline to forces largely outside their control (competitor growth, corporate consolidation of referral sources, insurer fee cuts) rather than internal missteps. The clearest actionable/voluntary causes are lifestyle-related scale-back decisions and deliberate insurance-network exits.

Keyword theme counts (N=85): insurance-related decline (21), voluntary/lifestyle scale-back: age, retirement, health (19), competition/market saturation (16), loss of referral relationships/retiring referrers (13), corporate dentistry/DSO/private equity (11), staffing losses/inability to hire (11), economic/cost pressures: overhead, inflation (10), general dentists doing endo in-house (6).

Key takeaways:

- **Insurance** (network exits, fee cuts, reimbursement) is the top cited driver of decline—often self-inflicted (dropping networks deliberately) but frequently involuntary too (insurer-driven fee cuts pushing practices out).
- **Voluntary/lifestyle scale-back** is nearly as large—a striking finding, since roughly a fifth of all "decline" responses aren't about market pressure at all, but deliberate personal choices (retirement, health, family, working less). This is the theme with no real counterpart in C-incr.
- **Competition/saturation** and **loss of referrals** are closely related and together suggest referral-network erosion (whether from competitor growth or corporate consolidation) accounts for a large share of decline.
- **Corporate/DSO** (12.9%) is notably higher here than among those describing increases (6.5%)—consistent with the qualitative read that corporate dentistry shows up more as a *cause of decline* than a *driver of growth* in this practice-level data, even though a few increasing credited DSO affiliation with helping them.

Please describe the actual or planned change(s)

Follow-up to a question about ownership/structural transitions. A log of concrete practice transition events, split evenly between DSO/corporate-related moves, retirement/succession, and partnership restructuring. Essentially a snapshot of the endodontic practice-transition landscape—what's actually happening (or being considered) at the ownership level. Three major categories dominate: DSO/corporate transactions, retirement and practice sales, and partnership/associate structural changes.

1. DSO/Corporate/Private Equity Transactions

Completed sales/joins to DSOs or corporate/private equity:

- Multiple respondents report having already **sold to a DSO or corporate group** (some with specific years: 2019, 2022, 2023, "5 years ago," "two years ago").
- A few describe now working *as a partner or employee* within the DSO post-sale.
- One notes that they sold 2/3 value to a "small specialty DSO."
- A couple sold specifically to **private equity**.
- Turnover/instability: one reports **4 different managing directors** since being acquired by a DSO in 2022.

Considered but declined DSO/corporate offers:

- A substantial cluster explicitly **investigated and rejected** DSO or corporate buyout offers—citing reasons like: the deal wasn't beneficial for their smaller practice, concern the entity wasn't right for the local community, or simply "realized that was a bad idea."
- One respondent notes a DSO itself declined to buy *them*, saying they were "too generous" to staff and needed to grow more first—an interesting reversal of the usual framing.
- Several frame a potential future DSO sale not as a preference but a **financial necessity** ("not necessarily out of want to, but financially due to competition and the squeeze of what it takes to run a practice").

Formed their own DSO-like structure:

- At least one respondent reports having **formed a DSO** themselves, rather than being acquired by one—an interesting counter-trend.

2. Retirement & Practice Sale: non-corporate

- Many straightforward reports: "Retired," "Sold practice," "Retirement and sale of the practice."
- Several describe **partial/staged retirement**: selling but continuing to work part-time, as an associate, independent contractor, or teaching (a few now teach at dental schools).
- A meaningful subset explicitly chose to **sell to an individual/local group instead of corporate**, citing preference to keep the practice in the local community rather than sell to the highest corporate bidder.
- Forward-looking plans are common too: several respondents state intent to retire and sell within a specific window (5 years, 5–10 years, "in two years").

3. Partnership & Associate Structural Changes

- Very common: **adding a new partner** or **associate buy-in** (several describe associates purchasing a percentage stake, e.g., "35% of practice").
- Multiple respondents describe a **pipeline model**—bringing on an associate with the explicit intent that they eventually become a partner/owner.
- Some report the reverse: **dissolving a partnership**, a partner leaving (sometimes citing being "solo" for years afterward), or letting an associate go due to performance/leadership/communication issues.
- A few describe merging with **other specialty groups** or forming multi-specialty partnerships.
- Restructuring **buy-in/buy-out agreements** within existing partnerships (without bringing in outside entities).

4. Management & Operational Restructuring

- Hiring dedicated **office managers/practice managers** (incl. multi-location oversight roles) as practices grow.
- Delegating more responsibility to staff/managers rather than the owner-doctor.
- A couple of cases where a spouse took on an informal office-manager/streamlining role.
- One mentioned instituting a patient **screening process before scheduling**.

5. Working Less/Lifestyle Adjustments

- Overlapping with the retirement theme but distinct: several describe deliberately reducing days worked, transitioning to part-time, or hiring associates specifically to reduce their own hours—without necessarily selling or retiring outright.

Overall pattern: This dataset shows the ownership transition landscape is more nuanced than the "DSOs are taking over." While completed DSO/PE sales are common and real, there's also a substantial, vocal group who actively investigated and **rejected** corporate offers, and an equally large group pursuing traditional **individual partnership/ associate buy-in** models as a succession strategy.

Keyword theme counts (N=133): sale of practice to any buyer (50), Partnership formation/associate buy-in (40), DSO/corporate/private equity (38), Retirement (20), of which: sold or joined a DSO/corporate/PE (13), considered but declined (9), management/office manager restructuring (8), working less/part-time transition (7), dissolution/ departure: partner or associate leaving (5).

Key takeaways:

- **Selling the practice** (to anyone—individual, partner, or corporate) is the single most common type of change reported, present in over a third of responses.
- **Partnership/associate buy-in** is nearly as common—a strong signal that the traditional succession model (bringing in an associate who becomes an owner) remains very much alive alongside corporate consolidation.
- **DSO/corporate/PE** touches nearly 29% of all responses—but critically, that breaks down to roughly **60% actually sold/joined vs. 40% who considered and declined** (13 vs. 9 of the 22 that specify an outcome). This confirms the qualitative read: rejection of DSO offers is a real, non-trivial pattern, not just a few outliers.
- **Retirement** alone (without corporate sale) is a substantial standalone driver of the reported changes.

Categories overlap heavily by design here (e.g., "sold to a DSO" counts in both "Sale" and "DSO" themes), so these percentages describe *co-occurring* attributes of the same transition events rather than mutually exclusive buckets.

What clinical technologies has your practice adopted, or plans to adopt

Four categories cover nearly all responses: **CBCT (cone-beam CT)**, **lasers**, **GentleWave** (advanced irrigation), and **AI**. A few respondents added detail on rationale, timeline, or skepticism.

1. CBCT (Cone-Beam CT Imaging)—near-universal

By far the single most frequently named technology, appearing dozens of times, often standing alone as the entire answer. Patterns include:

- Many practices already have it and are just listing it as part of their standard toolkit alongside microscopes and digital X-rays.
- Several are actively **upgrading to newer CBCT machines** or planning to purchase one in the next 2–3 years.
- Framed by multiple respondents as central to diagnosis and treatment efficiency (working length estimation, prep sizing, root fracture/resorption detection).

2. Lasers

- Frequently paired with CBCT and GentleWave as part of an "advanced irrigation/technology" bundle.
- Specific brands named: **Fotona**, **EdgePro/Edge Endo Laser**.
- A few describe *adding* laser therapy to all treatments; others are still "considering" or "possibly buying" one.
- One notable exception: a respondent reports **eliminating GentleWave in favor of laser**—suggesting some practices are actively comparing/replacing these technologies rather than just adding them.

3. GentleWave/Advanced Irrigation Systems Often mentioned, with mixed sentiment:

- Many list it as an implemented technology, sometimes for every case ("Gentlewave every case").
- Notable ambivalence: at least one practice **"implemented GentleWave then backed off,"** and another explicitly says they **considered GentleWave or laser but decided against it after attending an AAE meeting**—a rare direct signal that AAE conference content influenced a purchasing decision negatively.

- A few respondents in the "commercial products" skeptic camp explicitly say they're **not interested in expensive commercial products like GentleWave/lasers** because they don't believe these change prognosis/outcomes—directly pushing back against the trend.

4. Artificial Intelligence (AI)—clearly an emerging, high-interest category
- **Already using**: AI for radiograph interpretation, dictation/transcription of clinical notes, referral letter generation, and as a "second opinion" tool when reviewing CBCT scans or searching literature.
- **Trialing/testing**: several explicitly say they're piloting AI note-generation or transcription tools.
- **Considering/planning**: a large group uses hedging language—"maybe AI," "possibly AI," "starting to look at AI," "too early to know."
- **Use case concentration**: nearly all AI mentions relate to **documentation/administrative tasks** (notes, referral letters, charting) rather than direct clinical diagnosis or treatment—AI is being adopted as a scribe/admin tool first, not a diagnostic tool.

5. Imaging & Diagnostic Equipment (beyond CBCT)
- Digital X-ray/radiography, intraoral scanners (e.g., Trios), and updated apex locators mentioned as standard or recently upgraded equipment.
- Microscopes cited very frequently as baseline standard equipment (often "in all rooms").

6. Practice Infrastructure/Software
- A smaller but distinct cluster around **non-clinical tech**: cloud-based practice management software (to reduce reliance on onsite servers), updated computer systems, paperless/electronic documentation, and website updates.
- One respondent mentions increasing the number of operatories via broader equipment purchases (CBCT, GentleWave, scanner, microscopes) to expand capacity.

7. Skepticism/Minimal Change
- Minority explicitly report **little to no change** in recent years ("I have everything I need").
- Some are intentionally conservative about costly new tech unless it demonstrably improves outcomes.

8. Miscellaneous/Notable One-offs
- Mentions of **dynamic navigation** and **guided surgery** systems.
- A respondent notes their practice's tech adoption is now driven by a **younger endodontist** who took over ownership—suggesting a generational shift in tech enthusiasm.
- One playful/exaggerated mention of "robots."

Overall pattern: This dataset shows a clinical technology landscape where CBCT and microscopes are essentially baseline/mature standards, lasers and GentleWave are common but contested "advanced irrigation" additions (with real skepticism about cost-benefit), and AI is the frontier technology—widely discussed but still mostly in "considering" or early-pilot stages, concentrated almost entirely on documentation rather than diagnosis.
Want the keyword theme-count run for Cf_clin_tech?

Keyword theme counts (N=150 individual responses, 189 total responses)
CBCT/cone beam imaging (77), Laser (54), GentleWave/advanced irrigation (43), AI (31), Microscope (24), Software/IT/practice management systems (11), Digital imaging/X-ray/radiography (10), Skepticism about new tech/cost-benefit doubt (4).

Key takeaways:
- **CBCT** confirms that it's essentially the baseline "standard of care" technology at this point.
- **Laser** and **GentleWave** combined account for a large share of "advanced irrigation" adoption, though as noted there is real crossover, even substitution between the two (some explicitly chose one over the other).
- **AI** is a meaningful adoption signal for new technology, but it's still well behind the established clinical tools—consistent with it being mostly in "considering/piloting" stages for admin tasks rather than mature clinical use.
- Explicit **skepticism/rejection** of new tech is rare but tends to appear in more detailed, articulate responses, so its influence may be understated by frequency alone.

Administrative/operational technology adopted or planned

Where the clinical-tech document showed a maturing, diversified toolkit (CBCT, laser, GentleWave, with AI as an emerging minority interest), this document shows the opposite pattern: **AI is the dominant, almost singular focus** of administrative technology adoption—appearing far more often than any other tool, frequently as a one-word answer. The rest of the responses cluster around practice management software, patient communication automation, and insurance-processing tools—many of which are themselves AI-adjacent or AI-enabled.

1. AI—the dominant theme by a wide margin

Dozens of responses are simply "AI" with no elaboration, and many more specify a use case:

- **Insurance-related AI**: the single most common specific application—AI for insurance verification, claims processing, and billing, with several respondents explicitly framing this as a way to reduce the administrative burden of insurance (directly linking this document's theme back to B2a's top complaint).
- **Documentation**: AI for clinical note-taking, transcription, and generating reports/letters (referral letters, letters of recommendation).
- **Phones/scheduling**: AI for answering phones, managing scheduling, and even a "front desk" AI concept.
- **Marketing**: AI incorporated into marketing efforts and social media, sometimes paired with hiring a marketing-savvy office manager.
- **Mixed adoption stages**: similar to the clinical-tech document, responses span the full spectrum—already using it, "hope to," "possibly," "not there yet," "keeping an eye on."
- **Notable reversal**: at least one respondent explicitly **attempted AI for phone/insurance and reverted back**—an early signal that not all AI administrative tools are meeting expectations yet.
- **Explicit skepticism**: one clear pushback—"We need people, AI will not replace people"—representing a minority but pointed dissenting view.
- One unusual/lighthearted mention of "AI photo headshots for staff."

2. Practice Management Software (PMS)

- Frequent mentions of upgrading to new or more sophisticated practice management software, several naming specific platforms (**TDO**, **PBS/PBS Enterprise**, **Weave**, **QuickBooks/Practiceworks**, **Dental Intelligence**).
- Strong trend toward **cloud-based** systems, explicitly framed by some as reducing reliance on onsite servers/hardware maintenance.
- General movement toward **paperless/digital charting and documentation**.

3. Patient Communication & Scheduling Automation

- Automated **text/email appointment reminders and confirmations** cited very frequently—one of the more mature, already-widely-adopted technologies in this set (distinct from AI, more basic automation).
- Automated after-hours/weekend phone answering services (replacing live call services).
- Patient texting for both appointment confirmation and **bill payment**.
- Online/website-based booking.

4. Insurance & Billing Technology

- Electronic claims submission and electronic insurance filing cited as established or recent upgrades.
- Several mention **outsourcing** insurance processing/billing to third parties as alternative/complements to AI.
- One mentions "Cherry financing" (a patient financing platform) as an administrative tool.

5. Cybersecurity & IT Infrastructure

- Smaller cluster: improved cybersecurity practices (password managers, staff security training), new computer hardware, updated phone systems, and general "new software/hardware" upgrades without further detail.

6. Staffing & Outsourcing as an Alternative to Tech

- A few respondents frame their administrative "technology" change as adding staff or a dedicated role (e.g., hiring a PR person, an office manager with marketing/AI experience) rather than software—suggesting some practices see people, not tools, as the actual bottleneck.
- Some consider **outsourcing** admin duties (insurance processing, billing) as parallel strategy to automation.

Overall pattern: Much higher concentration on a single technology (AI) with it perceived as the primary lever for solving the #1 administrative pain point identified in B2a (insurance-related burden), rather than a broad, diversified toolkit like the clinical side. Adoption stage is still mostly aspirational/early (a lot of "possibly," "hope to," "considering"), with a handful of early adopters and at least one visible case of reversion after a failed attempt. Keyword-based theme counts (140 individual, 169 total responses):

Keyword theme counts AI (any mention) (79), practice management software (platforms/upgrades) (38), cybersecurity/IT infrastructure (11), patient texting/automated reminders (8), staffing (hiring people, not tech) (8), AI for insurance (7), electronic claims/insurance filing: non-AI (7), AI for notes/documentation/letters (6), AI for phones/scheduling (6), paperless/digital charting (6), cloud-based systems (4).

Key takeaways:

- **AI is half of responses**—a striking contrast to clinical-tech, where AI was a distant fourth behind CBCT, laser, and GentleWave. Administratively, AI is perceived as *the* frontier technology.
- **AI sub-use-cases** (insurance, notes/documentation, phones/scheduling) are about 4% each—no single application dominates; respondents are exploring AI across a full range of admin pain points simultaneously.
- **Practice management software** is a distant second theme—much overlapping with AI (many named platforms market for "AI capabilities"), so the true AI footprint may be somewhat larger than the raw 46.7% suggests.
- Explicit **skepticism/reversion** is rare in raw counts, but as with other documents, these tend to be the more detailed, telling responses rather than reflecting overall sentiment volume.

Other Technology 21 entries

1. AI (multiple specific use cases)

- AI-driven marketing, AI for strategic/growth planning, AI for letter writing, AI transcription for charting, and possible AI to assist with insurance research.
- Reinforces that AI adoption spans marketing, admin, and documentation — not a single narrow use case.

2. Marketing & Website Investment

- Hiring a dedicated marketing person/company, redoing or upgrading the website multiple times, general "better marketing."
- Suggests marketing investment is often bundled with broader technology upgrades rather than treated separately.

3. Software & Practice Management Systems

- New/upgraded practice management software (specifically naming **TDO**), new PMS software, general "upgraded software."
- One specifically named **Pearl**, a chart-dictation/AI service — bridging the AI and documentation themes.

4. Clinical Technology Consistency

- One respondent affirms staying current with the "big three" clinical technologies already seen dominating Cf_clin_tech: **CBCT** (imaging), **GentleWave** (irrigation), and **bioceramic materials**.

5. Operational/Quality Control

- Added an **auditing company** for monitoring and staff training — a notably unique operational investment not seen elsewhere in the dataset.
- Mention of improving **supply chain/management flow**.

6. Outlier: Pointed AAE/DSO Comment

- One response stands apart from the "technology" framing entirely, redirecting into advocacy territory: a call for the **AAE to prioritize dues-paying members over corporate/DSO event sponsors** — directly echoing the funding-conflict-of-interest concern raised repeatedly in B3.

Which best describes your practice? (N=13)

Write-ins mostly represent endodontists **outside traditional private clinical practice**:

- **Academic/education roles**: Clinical/didactic instructor, Full time teaching, Part time teaching, School affiliated Specialty Practice
- **Institutional/employed settings**: Hospital, Military, Navajo Nation direct hire, endodontist employed by a health system (specialty dental practice)
- **Corporate/administrative roles**: Admin position – Chief Dental Officer, Corporation – Specialty1 Partners (a known DSO brand)
- **Non-clinical/industry**: Works for a private dental manufacturing company
- **Transitional/retired**: Independent contractor (no longer a practice owner), No longer in practice

This small "Other" bucket captures the tail end not covered by standard practice categories—mix of academics, employed/institutional endodontists (hospital, military, tribal health, health-system), corporate/DSO admins, industry-side roles, and those who left clinical ownership. It's a useful reminder that respondents to the broader survey aren't all traditional private-practice owners, which is worth keeping in mind when interpreting the B/C-series theme counts.

Which best describes your private practice?

1. Group practice (most common category) The largest cluster — many simply answer "Group practice" or a variant, with several specifying scale:

- Ranges from small (2 partners) to large (8 equal partners, 5-doctor groups, multi-location groups).
- Several describe multi-location structures ("one location of a multi-location group practice," "single owner but multiple locations and multiple associate doctors").
- Few describe multi-specialty groups (practicing alongside periodontists, general dentists, or an OMFS spouse).

2. Partnership (2+ owners, roughly equal stakes) A very common structure, typically 2–3 doctors:

- Many describe simple two-doctor partnerships ("Joint partnership. Two endodontists," "each owning 50%").
- A few larger partnerships of 3 doctors.
- Some use S-Corp structures for tax purposes while operating as one unified practice.

3. Sole owner (with or without associates) Common baseline structure:

- Pure solo practitioners ("Solo individual Endodontist," "Practice alone and sole owner").
- Sole owner + one or more associate endodontists (a common stepping-stone structure, sometimes explicitly framed as a path toward eventual partnership).

4. Associate/Independent Contractor (non-owner) A meaningful subset describing non-ownership roles:

- Independent contractors working limited days/% -of-collection arrangements in someone else's practice.
- Associates in group practices with one or more owners.

5. DSO-Affiliated (private practice ownership within corporate structure) Several notable structural variants:

- Sole owner who **sold 100% to a DSO** and now works as a **W2 employee**.
- A more nuanced case: sold to a DSO but **retained the practice name/identity**, operating as a stand-alone entity within a DSO structure whose other practices are mostly general dentistry.
- A "small DSO specialty office" with one doctor as **part-owner** plus two associates — illustrating partial/hybrid ownership models under corporate umbrellas. One explicitly "Partnered with SDP" (a known DSO brand).

6. Other Notable Arrangements

- **Traveling endodontist** (no fixed single-location practice).
- **Admin position**–CDO
- One respondent shares practice space/ownership with a spouse who is an OMFS.

"Private practice" is structurally diverse—solo owners, equal partnerships, larger multi-doctor groups, associates ICs, a non-trivial number of **DSO-affiliated arrangements** that still identify as private practice (retained naming/identity post-sale, or partial ownership within a DSO).

Which best describes your priorities over the next five years? (N=26)

1. Academic/Teaching Priorities reflecting the academically-employed subset:

- Continuing or increasing time in academia/teaching, improving GPR (General Practice Residency) education, increasing full-time endodontic faculty, better academic recruitment practices.
- One notes their core focus remains research and teaching missions specifically.
- One mentions ongoing military service transitioning into private practice.

2. Succession/Retirement Planning Several actively navigate leadership transitions:

- Actively searching for a partner's replacement due to retirement.
- A senior partner potentially moving to part-time or retiring.
- Personal plan to phase out/sell within 3 years.
- Considering bringing on associate **to work less** (lifestyle-driven, echoing the "voluntary scale-back" theme).

3. Practice Growth/Staffing

- Growing the practice and hiring associates/partners.
- Finding an associate to join.
- Improving staff stability and scheduling.

4. Insurance Strategy

- Two mention **dropping Delta Dental** specifically — consistent with negative Delta Dental sentiment.

5. Clinical Quality/Advocacy

- Improving patient care and endodontic knowledge/education generally.
- One notably direct ask: wants **AAE to protect patients from GP-performed endodontic therapy** by publishing insurance-company outcome data — closely echoing similar asks in B3 and C5.

6. Efficiency & Technology

- Increasing efficiency generally, with one respondent specifically noting this is **"not necessarily via AI"** — a small but notable pushback against assuming AI is the default efficiency solution.

7. Financial/Personal

- "Make more money." Student loan concerns mentioned as a five-year priority. Increase personal skill set.

8. Military/Public Service

Why do you plan to make this change? (N=37)

The dominant theme is a strong, specific **anti-DSO sentiment driving people back toward independent ownership** — the clearest and most direct "why" behind the DSO skepticism seen in other questions.

1. Escaping/Avoiding DSOs (the dominant theme)

By far the most common and most pointed motivation — many responses read almost like testimonials:

- Explicit language: "escape the evil of DSO," "did not enjoy DSO," "I do not agree with the DSO model," "not a fan of DSOs."
- Specific critiques: DSOs/GD -owned offices seen as **not conducive to endodontists prospering**; DSOs described as having **absentee owners/managers**; DSO model seen as **not in the best interest of patient treatment**.
- One detailed account: took a DSO job out of residency **out of necessity** (to live in a desired location) despite "great compensation," but is now actively working to leave and buy an independent practice.
- One surprised **ADA/AAE haven't restricted DSO expansion**.
- One frames it bluntly: "Working for DSO is not a good retirement plan!"

2. Autonomy & Control

- Wanting to "be my own boss," make independent practice decisions, control staffing and "inner workings."
- Wanting to apply personal training/philosophy and "run things the way I like."
- Desire for control over pace, philosophy, and general situation of the practice.
- "Want a space to call my own."

3. Retirement/Life-Stage Transitions

- Several describe **gracefully transitioning into retirement** or semi-retirement, with practice sale as the first step toward downsizing.
- Distinct from DSO-related departures — these are simply age/career-stage driven.

4. Military Transition

- Multiple respondents specifically cite leaving the military as the driver, with related logistical concerns: insufficient patient volume to support multiple endodontists in a small (3-chair) practice, or wanting to preserve the collegial/team environment they're used to in the military after leaving.
- One mentions a potential military separation combined with a geographic relocation.

5. Financial/Insurance Pressure (PPO-driven burnout)

- One detailed, emotionally charged response cites the **unsustainable economics of a PPO-insurance-driven office**: rising staff costs post-COVID, fixed/stagnant reimbursement, and only modest insurance fee increases — concluding it's simply "not worth it" compared to a lower-overhead alternative.

6. Health/Personal Circumstances

- Musculoskeletal (lower back) issues affecting ability to continue current practice patterns.
- A partner's **embezzlement** cited as a direct precipitating cause for change —notably serious, specific incident.
- General "life circumstances," desire for schedule control, and being "sick of commuting."

7. Partnership/Ownership Path

- Several frame change as pursuing an associate-to-partner track; one notes they'd only consider DSO/associate route "if I don't have an option of partnership" — DSO explicitly framed as the fallback, not the goal.

Clear, direct evidence for *why* the anti-DSO sentiment is so strong elsewhere—it's not abstract; it comes from lived experience of former or current DSO-affiliated endodontists actively planning to leave for independence, citing loss of autonomy, absentee management, and misaligned incentives with patient care. Alongside this, retirement, military transitions, unsustainable PPO-insurance economics round out other major "why" categories.

With which insurers is your practice currently in network? (N=55)

1. Fee-for-Service/Out-of-Network not in any traditional network at all:

- Explicit "Fee for service"/"FFS" (multiple mentions).
- "Out of network"/"OON" (multiple mentions).
- Several flat "None" responses.
- One notes a **split model**: one practice location takes everything; the other is FFS — showing intentional segmentation strategy.
- Aligns directly with other findings, many are deliberately exiting insurance networks ("dropping Delta").

2. Smaller/Niche Third-Party & Discount Networks

- **Careington** appears repeatedly, suggesting it's a common baseline network.
- **Sun Life**, **GEHA**, **Connection Dental**, **Health Partners/HealthPartners**, **Principal**, **Delta Health Alliance**, **Zelis**, **DHA**, **HRI/Paramount HRI**, **Unitas**, **BAI**, **CSEA**, **Mcs**, **UPMC**, **Premera/Regence**.
- Notably, **major national carriers (Delta Dental, MetLife, Cigna, Aetna) are largely absent** from this "currently in-network" list — despite being the most frequently *criticized* insurers in B2/B2a/B3. A couple of exceptions specifically qualify their Delta relationship narrowly: "Delta Premier only – no regular Delta," suggesting selective/partial participation rather than full network membership.

3. Government/Military/VA-Affiliated Coverage

- **Tricare**, **VA**, **VA Community Care**, **VACCN**, **Veterans Hospital**, **Medicare**, **federal government** employment (no insurance relationship needed as a government employee).
- One in **Kuwait** and one in **Puerto Rico** citing local/regional insurance arrangements specific to their location.

4. Institutional/Structural Answers (not insurer names)

Several respondents answered structurally rather than naming carriers:

- "Every doctor has their own network with insurances" (independent contractor/associate model).
- "School determines which insurances to take" (academic setting).
- "I have no idea, work at a dental school."
- "Risk management Loma Linda Health" (institutional/hospital-affiliated).

There is a meaningful number who are **entirely out-of-network/FFS**, confirming a trend of practices deliberately opting out of insurance. Despite being the most-criticized insurer by name throughout the qualitative documents. **Delta Dental barely appears** in the actual in-network list — suggesting the criticism may stem disproportionately from practices that already dropped Delta, or from the burden of dealing with Delta even when not fully in-network with them.

With which insurance types or providers are you no longer in network? (N=21)

1. Delta Dental By far the most frequently named insurer dropped:

- Appears repeatedly and in multiple forms (Delta, Delta Dental, "Delta Dental, United Concordia, Medicaid").
- One respondent notes they currently **only take Delta and that relationship is about to end too** — suggesting a full exit from traditional insurance is underway.
- Another says they're "not in network with any [other] than Delta" implying Delta may be the *last* network they're still willing to keep, even as others cite it as the *first* one, they dropped. This nuance suggests Delta is polarizing even within this subset — some see it as the worst offender to cut, others as the only one still worth keeping.

2. Other Named Carriers Dropped

- **Anthem, United Concordia, Medicaid, Principal, Liberty, Southland, SunLife, Western Dental**, and generic **HMO/DHMO** plans.
- **Tricare, UHC (UnitedHealthcare), VA, and Workman's Comp** all named together by one respondent — likely a military/VA-affiliated practitioner exiting several government-adjacent networks at once.
- **VA Community Care** specifically named as dropped by another respondent.

3. Institutional/Non-Applicable Responses

- Government employees reiterating they have no insurance relationship.
- Academic responses noting the school determines insurance participation, so this doesn't apply to them individually.
- A few "I don't know"/"Not sure" responses — likely from associates/employees who don't handle billing decisions.
- One simply refers back to the previous question ("See previous question").

While Delta Dental is commonly mentioned, intense negative sentiment toward Delta supports a genuine split: while many actively exit Delta, several practices indicate keeping *only* Delta, having already dropped everything else. This suggests it may be seen as the "least bad" or highest-volume option even by its critics.

AAE Professional Issues & Advocacy Survey Form

This survey being administered by the American Association of Endodontists, using a third-party consultant to protect the privacy of your response. The purpose of this survey is:
1) to document your clinical practice and share general characteristics with the membership; and
2) to help us better understand what advocacy issues should be for endodontic practice.

A. Your Profile

1. **Which best describes your practice?** *(check all that apply; response required)*
- ❑ Private practice
- ❑ Public practice, such as government
- ❑ Academic practice
- ❑ DSO
- ❑ Fully or semi-retired
- ❑ Inactive or in transition
- ❑ Other *(please describe)* _____ *[if A1.5-6 go to Section C]*

1a. **Which best describes your employment status?** *(check all that apply; response required)* *[if not A1.5-6]*
- ❑ Sole owner
- ❑ Partner/partial owner
- ❑ Associate/employee
- ❑ Independent contractor
- ❑ Faculty/teacher

1b. **Which best describes your private practice?** *(check all that apply)* *[if A1.1]*
- ❑ Practice with multiple dentists who own/operate individual practices with shared space/costs
- ❑ Practice with a single-dentist owning and operating
- ❑ Other *(please describe)* _____

2. **Which best describes your priorities over the next five years?** *(check all that apply)* *[rotate]*
- ❑ Maintaining a steady practice with a consistent territory, referral patterns, and staffing level *[stick]*
- ❑ Increasing patient volume through referrals, digital marketing, and other techniques
- ❑ Adding one or more new offices
- ❑ Starting a practice of my own *[if A1a.3-4]*
- ❑ Changing jobs or moving to a different practice
- ❑ Selling all or part of my practice *[if A1a.1-2]*
- ❑ Buying into/partnering in a practice
- ❑ Increasing our total endodontists
- ❑ Increasing our other staff: hygienists, assistants, and/or administrative *[if A1a.1-2]*
- ❑ Broadening our territory of operation (new communities or metro areas) *[if A1a.1-2]*
- ❑ Reducing the size of our practice: fewer staff, cutting back on hours, etc. *[if A1a.1-2]*
- ❑ Increasing our efficiency with better use of technology and AI
- ❑ Considering academia *[if not [A1.3]*
- ❑ Retirement or semi-retirement
- ❑ Other *(please describe)* _____

2a. **What kind of practice do you plan to enter after leaving your current practice?** *(check all that apply)* *[if A2.4-5]*
- ❑ Solo private practice
- ❑ Group private practice
- ❑ Academic practice
- ❑ DSO
- ❑ Specialized endodontic practice
- ❑ Practice working with some general dentists

2b. **Why do you plan to make this change?** *[if A2.4-5]*

_____

B. Your Most Important Issues

1. **How important do you regard each of these challenges or opportunities to affecting your patient volume over the next several years?** *[rotate]*

Extremely Important / Very Important / Somewhat Important / Somewhat Unimportant / Not at all Important / No opinion

Insurers limiting treatment options	❑	❑	❑	❑	❑	❑
Overall levels of insurance reimbursement	❑	❑	❑	❑	❑	❑
Insurance down-coding or not covering specific codes	❑	❑	❑	❑	❑	❑
Regulatory compliance/changes	❑	❑	❑	❑	❑	❑
Increasing administrative burden	❑	❑	❑	❑	❑	❑
Telehealth treatment options	❑	❑	❑	❑	❑	❑
Ability to leverage AI for clinical treatment	❑	❑	❑	❑	❑	❑
Ability to leverage AI for practice operations	❑	❑	❑	❑	❑	❑
Workforce issues: ability to recruit/retain qualified employees	❑	❑	❑	❑	❑	❑
Level of competition in my area of patients	❑	❑	❑	❑	❑	❑
Ability to use mid-level providers for some of our work	❑	❑	❑	❑	❑	❑
Lack of access to endodontic care for underserved individuals	❑	❑	❑	❑	❑	❑
Growth and influence of corporate dental practices	❑	❑	❑	❑	❑	❑
The increasing influence of private equity	❑	❑	❑	❑	❑	❑
Choosing and spending for necessary technology	❑	❑	❑	❑	❑	❑
Managing overhead costs and profitability	❑	❑	❑	❑	❑	❑

2. **What other challenges and opportunities do you see as important?**

_____

2a. **What do you see as the top administrative burdens to endodontic practices today?** *[if B1.5.1-3]*

_____

3. **Please tell us about your practice's relationship with insurers:**

a. **With which insurers is your practice currently in network?** *(check all that apply)*

- ❑ Aetna
- ❑ Ameritas
- ❑ BlueCross Blue Shield
- ❑ Cigna
- ❑ Delta Dental
- ❑ DentaQuest
- ❑ Guardian
- ❑ Humana
- ❑ MetLife
- ❑ Physicians Mutual
- ❑ Spirit Dental
- ❑ United Concordia
- ❑ UnitedHealthcare
- ❑ Medicaid
- ❑ Other *(please describe)* _____

b. **With which insurance types or providers are you no longer in network?** *(check all that apply)* *[list not A3a]*

- ❑ None
- ❑ Aetna
- ❑ Ameritas
- ❑ BlueCross Blue Shield
- ❑ Cigna
- ❑ Delta Dental
- ❑ DentaQuest
- ❑ Guardian
- ❑ Humana
- ❑ MetLife
- ❑ Physicians Mutual
- ❑ Spirit Dental
- ❑ United Concordia
- ❑ UnitedHealthcare
- ❑ Medicaid
- ❑ Other *(please describe)* _____

c. **How would you rate each of your insurers for the ease of submitting claims and receiving payment now or in the past?**

Scale: Excellent / Good / Average / Fair / Poor / No opinion

Aetna *[if A4a-b.1]*	❑	❑	❑	❑	❑	❑
Ameritas *[if A4a-b.2]*	❑	❑	❑	❑	❑	❑
BlueCross Blue Shield *[if A4a-b.3]*	❑	❑	❑	❑	❑	❑
Cigna *[if A4a-b.4]*	❑	❑	❑	❑	❑	❑
Delta Dental *[if A4a-b.5]*	❑	❑	❑	❑	❑	❑
DentaQuest *[if A4a-b.6]*	❑	❑	❑	❑	❑	❑
Guardian *[if A4a-b.7]*	❑	❑	❑	❑	❑	❑

Humana *[if A4a-b.8]*	❑	❑	❑	❑	❑	❑
MetLife *[if A4a-b.9]*	❑	❑	❑	❑	❑	❑
Physicians Mutual *[if A4a-b.10]*	❑	❑	❑	❑	❑	❑
Spirit Dental *[if A4a-b.11]*	❑	❑	❑	❑	❑	❑
United Concordia *[if A4a-b.12]*	❑	❑	❑	❑	❑	❑
UnitedHealthcare *[if A4a-b.13]*	❑	❑	❑	❑	❑	❑
Medicaid *[if A4a-b.14]*	❑	❑	❑	❑	❑	❑

d. **Are you currently tracking any quality measures and if so, which insurers are tracking them?**

❑ Yes ❑ No

e. **Which insurers require your practice to submit quality measures?** *(check all that apply) [if A4d.1 & A4a items]*

❑ Aetna *[if A4a.1]*
❑ Ameritas *[if A4a.2]*
❑ BlueCross Blue Shield *[if A4a.3]*
❑ Cigna *[if A4a.4]*
❑ Delta Dental *[if A4a.5]*
❑ DentaQuest *[if A4a.6]*
❑ Guardian *[if A4a.7]*
❑ Humana *[if A4a.8]*
❑ MetLife *[if A4a.9]*
❑ Physicians Mutual *[if A4a.10]*
❑ Spirit Dental *[if A4a.11]*
❑ United Concordia *[if A4a.12]*
❑ UnitedHealthcare *[if A4a.13]*
❑ Medicaid *[if A4a.14]*
❑ Other *(please describe)* _____ *[if A4a.15]*

C. AAE Advocacy Priorities

1. **How important do you regard each of the current priorities of AAE's advocacy agenda?** ***[rotate within categories]***

Extremely Important / Very Important / Somewhat Important / Somewhat Unimportant / Not at all Important / No opinion

Dental plan advocacy: virtual credit card reform, non-covered and disallowed services and Silent PPOs	❑	❑	❑	❑	❑	❑
Pushing for transparency in dental loss ratio	❑	❑	❑	❑	❑	❑
Combating misinformation to address false narratives about root canals and reinforcing importance of saving natural teeth	❑	❑	❑	❑	❑	❑
Reducing administrative and regulatory burdens	❑	❑	❑	❑	❑	❑
Teledentistry	❑	❑	❑	❑	❑	❑
Promoting specialty recognition so that endodontists are recognized for their advanced training	❑	❑	❑	❑	❑	❑
Promoting scope of practice protections from non-dentists	❑	❑	❑	❑	❑	❑
Addressing workforce shortages	❑	❑	❑	❑	❑	❑
Supporting interstate compact legislation to allow easier practice mobility	❑	❑	❑	❑	❑	❑
Promoting tax/small business reform (tax deductions for small businesses to allow endodontists to reinvest in their practices	❑	❑	❑	❑	❑	❑
Implementing liability and tort reform	❑	❑	❑	❑	❑	❑
Promoting dentist mental health & wellness	❑	❑	❑	❑	❑	❑
Promoting use of quality measurements	❑	❑	❑	❑	❑	❑
Increasing oral health funding	❑	❑	❑	❑	❑	❑
Promoting water fluoridation	❑	❑	❑	❑	❑	❑
Expanding Medicare and Medicaid coverage	❑	❑	❑	❑	❑	❑
Advocating for reductions in the debt burden of dental students/recent graduates	❑	❑	❑	❑	❑	❑

2. **What do you see as the single highest advocacy priority for AAE?** *(use drop-down menu)*
[display items in C1 rated 1-2 and "other"-open-ended]

3. **What do you see as the limits to what AAE can achieve on behalf of your practice and endodontic practice in general?**

_____

4. **In what ways have you been involved in dental advocacy in the past?** *(check all that apply)*

AAE

- ❑ Visited AAE Advocacy Action Center online for grassroots organizing resources
- ❑ Supported AAE Dental Plan & Government outreach
- ❑ Supported AAE Save Your Tooth Month in May
- ❑ Supported other aspects of Worth Saving public awareness campaign
- ❑ Serve on or participate in state dental boards
- ❑ Accessed and shared patient outreach materials (e.g., patient education videos, graphics, digital communications)
- ❑ None, but I have considered it
- ❑ No AAE activity

Other associations

- ❑ Advocacy activities of the ADA
- ❑ Advocacy with my ADA state affiliate and/or local dental society
- ❑ Advocacy with other specialty or general dental organizations

5. **What advice can you share that would help make AAE advocacy more accessible to endodontists?**

_____

D. Your Practice Profile

1. **Please tell us about your current primary practice setting:** *(response required; feel free to estimate)*

a. **History**

How many years have you been a practicing endodontist? ..... _____
How many years have you been an owner of your current practice? ..... _____ *[if A1a.1-2]*
How many years have you been in your current practice? ..... _____ *[if A1a.3 or A1.3-4]*
What is your age? ..... _____

b. **Location**

What is the approximate population of the area that your practice is primarily located?

❑ Rural area (under 20k people) ❑ Small city (20-100k) ❑ Larger city (100-500k) ❑ Larger metro area (>500k)
[If Q1a.3-4 go to end ; if Q1.a5 go to D.d]

c. **Patient Volume & Profile** *[if A1a.1-3]*

Approximately how many patients do you and your practice (if different) work with in an average week?
You personally..... _____
Your practice (including other dentists) ..... _____

What proportion of your patients are pediatric vs. adult patients?
(please answer so the total adds to 100%) *[if A1a.1-3]*
Pediatric ..... _____ %
Adult..... _____ %
All patients: 100% *[autosum]*

What proportion of your patients would you estimate fall into the following payment categories?
(please answer so the total adds to 100%) *[if A1a.1-2]*
Fee for service/cash .... _____ %
Private insurance ..... _____ %
Medicare advantage.... _____ %
VA coverage ..... _____ %
Medicaid ..... _____ %
All patients: 100% *[autosum]*

What would you estimate to be your practice's total patients seen and total procedures per week performed in 2025?
[if A1a.1-2]
Total patients seen per week *(counting each person seen as 1 rather than total visits)* ..... _____
Total procedures performed per week..... _____

d. **Staffing**

How many full-time equivalent (FTE) staff do you have in your primary practice?
(Use a decimal if appropriate) *[if A1.1-3]*

Total endodontists (including yourself) ..... _____
Total general dentists or other specialists..... _____
Total dental hygienists..... _____
Total dental assistants ..... _____
Total administrative staff, excluding above ..... _____
Total FTE staff in your practice ..... *[Autosum]*

Has your practice had any open positions within the past 12 months (including current vacancies)? *[if A1.1-3]*

Dental assistant: ❑ Yes ❑ No
Dental hygienist: ❑ Yes ❑ No
Administrative staff: ❑ Yes ❑ No

How difficult was it to fill the position(s)?
Scale: Extremely difficult / Very difficult / Somewhat difficult / Somewhat easy / Very easy / Unsure

Dental assistant..... ❑ ❑ ❑ ❑ ❑ ❑ *[if A3d2.1.1]*
Dental hygienist..... ❑ ❑ ❑ ❑ ❑ ❑ *[if A3d2.2.1]*
Administrative staff ..... ❑ ❑ ❑ ❑ ❑ ❑ *[if A3d2.3.1]*

e. **Changes over time**

In what ways has your practice changed over the past five years (or since you began there) and if possible, can you estimate the number or percentage increase or decrease? *(check all that apply)*
Scale: Increased / Stayed the Same / Decreased / Unknown / How much did it change *(number or percent)*

Total FTE staff: ..... ❑ ❑ ❑ ❑ _____ *[if A1.1-3]*
Patient volume:..... ❑ ❑ ❑ ❑ _____ *[if A1.1-2]*
Total locations: ..... ❑ ❑ ❑ ❑ _____ *[if A1.1-3]*
Gross revenue: ..... ❑ ❑ ❑ ❑ _____ *[if A1.1-2]*
Total expenses: ..... ❑ ❑ ❑ ❑ _____ *[if A1.1-2]*

What are the primary factors that have led your practice to grow or stay constant over time? *[if A3e.1-5.1-2]*

_____

What are the primary factors that have led your practice to decrease in size? *[if A3e.1-5.3]*

_____

Have you experienced or considered a change in management structure/ownership within the past several years?
❑ Yes, changed ❑ Only considered, didn't change ❑ Planning a change ❑ No

Please describe the change(s): _____ *[if A3e4.1-3]*

f. **Technology**

In what ways have you implemented or are planning to use technology in your practice to improve operations?
Clinical ..... _____
Administrative... _____
Other ..... _____

Thank you for participating in the AAE Professional Issues and Advocacy Survey