Journal
CALIFORNIA DENTAL ASSOCIATION
February 2014

Dentistry at the Crossroads

The Perfect Storm

Who Will Tend the Dental Safety Net?

Controversies in Dentistry

Richard T. Kao, DDS, PhD

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CDA JOURNAL, VOL 42, N°2

It's Time to Say Goodbye

Jack Conley, DDS

Editor's Note: We have reached the last of our inventory of contributions from Dr. Horseman. Serving as your editor-in-chief has provided me with the supreme privilege and pure pleasure of working with Bob for the last five years. Bob is the person for whom the abbreviation "lol" was meant. His writing and humor are timely and timeless.

I hereby bestow on Dr. Horseman the title of "humorist emeritus." (As I am sure you understand, Bob, this title holds no monetary value and no complimentary parking space.) This honorary title is conveyed with my sincerest respect and an open invitation to continue to submit pieces whenever the notion strikes. On this occasion, there is no one better suited to deliver a tribute than our own editor emeritus, Dr. Jack Conley. (Jack did not get a parking space either, Bob.)
— Kerry K. Carney, DDS, CDE

I could see him staring directly at me as he emphatically continued, "Don't ever ... I repeat, don't ever let this writer get away from writing for your publication."

The above phrase has been utilized by this writer on two previous occasions on the pages of this publication in years past. It is time for me to bring it forth once again to salute an icon whose work has been immensely important to the *Journal*.

Dr. Bob Horseman's column first appeared in the *Journal* in 1979, meaning that this is the 35th year, spanning part or all of five decades that we have had the opportunity to read the work of a man who will undoubtedly forever hold the title of dentistry's finest humor writer.

I recall receiving inquiries from other dental editors back in the 80s commenting that they had unsuccessfully tried to run humor columns in their publications and expressed the hope that we could supply the formula that made Bob Horseman's writing so successful with the *Journal* readership. I was never able to supply a good answer, except to comment that the colorful word pictures he creates with unusual names and storylines provide a brand of humor that doesn't offend. Publication staff members have always said that he has his own special language.

To those who know him, Bob always has downplayed the achievement of his work. For example, in 1994 he was quoted as saying, "There has not been a single recorded instance of dental humor since 1917." We have also been asked, "How did you find Bob?" I certainly can't take credit, as Bob started his run four years before I came on the scene as editor. It is fair to say Bob found the *Journal*. He served as a rotating contributing writer in a column entitled "Your Turn," authoring three to four columns a year. When I became editor in 1983, I was faced with somewhat of a dilemma several months after I was appointed. Current readers who were active in CDA at the time will recall that CDA, then located in Los Angeles, by vote of its Board of Trustees, was about to relocate to Sacramento. I met with Cissie Cooper, who was then director of communications and sessions for CDA. She explained that the managing editor and assistant managing editor had decided not to move to Sacramento. Compounding that, the previous editor had departed five months prior, and the staff had been running the publication by utilizing everything in inventory. The only remaining item in inventory at that time was one Horseman column! Obviously, I would have my work cut out to solicit material. Cissie suggested that Dr. Horseman, whose columns had been very popular, might be recruited to contribute a column every month.

Soon after that meeting, I went to the journalism school at the University of Missouri in Columbia, Mo., to attend an ADA New Editor's Workshop. The first afternoon after lunch, our group of neophyte editors was stationed in a warm seminar room, with lights out and a carousel projector humming. Our instructor was a respected journalism professor. Every editor had previously been requested to send in sample copies of their publications for him to review. He would then evaluate everything from the layout of the journals, to the cover graphics and the editorial material. Then he would show the group a slide of one of these publication features and provide a critique of each.

About 30 minutes into the session, I was startled by a very directive question … "Who does this belong to?" As I recovered from a reduced level of consciousness induced by my lunch, I stared forward at the image projected on the screen. In the upper left corner of the screen there was a column heading that read, "Your Turn." At that moment, I realized that it was a page from the

Journal. Somewhat timidly, I raised my hand in response to the question. Even in the relative darkness of the room, I could see him staring directly at me as he emphatically continued, "Don't ever … I repeat, don't ever let this writer get away from writing for your publication."

Superlative descriptions on Bob Horseman's column started to flow. "Is he a dentist?" the professor asked. "Dentists typically can't write with this skill!" He appeared even more in awe when I responded that yes, Bob Horseman was indeed a practicing general dentist. He then went on to describe the skill, styles and techniques that made this column a meritorious piece of journalism. I already knew that readers had recognized that Bob's columns were special and in an outpouring of unreserved praise, a respected journalism professor had confirmed it. The *Journal* had a treasure who has continued to have no peer in the world of dental publications.

Bob's writing has been special because his columns have often taken the everyday challenges of being a dentist, including the stresses, the requirements and regulations that govern our practices, and has infused them with wit and colorful characters. Where else can you find a cast of characters such as Dudley Krautzmeyer, Dr. Bobby Jo Fallopian, Verdegris Gruenstik, Raja Gigi or King Tooth, Waldo Braunsweiger, Derek Cudlipp, Dr. Sal Ammoniac or Wilfred Fish, to name a few? I am certain that characters like these have given many a dental colleague an emotional lift after a particularly difficult patient or a tempestuous day in the dental office.

It is important to note that there have been a few people who have helped Bob Horseman make "Dr. Bob" the institution that he is. I refer first and foremost specifically to the late Charlie O. Hayward who gave "Dr. Bob" and his band of characters a unique and colorful artistic presence for many years. Also, six outstanding managing editors during Bob's tenure who have applied the finishing touches each month to his columns should be recognized.

I am certain that characters like these have given many a dental colleague an emotional lift after a particularly difficult patient or a tempestuous day in the dental office.

Bob Horseman has achieved respect in our profession, not by numbers of meetings attended, by a list of positions held or by clinical techniques developed, but by impact of the written word. In person, he comes across as quiet and unassuming and is highly respected by those of us who know him. Despite the quiet demeanor that I have observed whereby he doesn't particularly like to be in the public spotlight, he has demonstrated that he can rise to an occasion. Such was the case in 1990, when the San Francisco CDA meeting was dedicated to Bob in recognition of his prior contributions. While I was not present at the luncheon when he was honored, I heard from many individuals that Bob's comments and humor at the podium that day outshone NBC TV personality Willard Scott, who was the keynoter at that event.

Bob Horseman has made a unique and unselfish contribution to his profession through his long-term commitment to provide us with humor, particularly about things and themes that are either dental related or of interest to dentists. No one has done it better, and no one has probably ever done what he has done for so long. It has been a substantial time commitment to write his columns, particularly during the years when he had an active general dental practice. Over the years, his column has brought countless requests to the staff for reprint approval, and testimonials from readers have attested to the esteem in which his contributions are held.

He's entered his ninth decade according to my imperfect calculations, and he has decided that it is time to retire. Those of us who have been responsible for developing a professional journal that provides a unique balance of material every month that has appeal to all of the readership, are particularly grateful to Bob.

It is often said that no matter how valuable a person is to his or her organization or cause, he or she can be replaced. However, in this case, Bob Horseman's contribution has been unique and so longstanding that we doubt that a replacement will ever wield a "pen" with the same unique skill.

Robert E. Horseman, we will all miss you. You are a "dentist journalist extraordinaire!" Thank you for your unique and dedicated service to the *Journal* and to your profession.

We extend our best wishes for a fulfilling retirement. ■

The Shift in Dentistry

The December 2013 issue of the *Journal* is a great issue.

In my advocacy for the ADA Library and Archives, future historians should be able to research and find that this particular issue — in the big picture — described the universe that dentistry inhabits, and marked the shift.

It's not a matter of liking or disliking the message. History will be the judge. We should understand the place and significance the ADA Library has as a guardian of our profession's history. The December issue is sure to be one of those "a ha!" publications in those archives.

Steven D. Chan, DDS
Fremont, Calif.

I just finished my December *Journal* . . . thanks to Dr. Carney and Dr. Weber for crafting one of the best issues I can remember. The authors made dental benefit marketplace dynamics and evidence-based forecasts clear and compelling. I especially appreciated the focus on CDA leaders and members becoming fully engaged in the continuing evolution of the business of dentistry. This issue should be mandatory reading for anyone (which should be everyone) interested in helping to shape the environment in which we practice and provide care. Many thanks for an outstanding read.

Cindy Lyon, DDS
Chair, Department of Dental Practice
Arthur A. Dugoni School of Dentistry
San Francisco

I enjoyed reading the December 2013 editorial Stages and Stageism, which resonated with what I have been hearing from both younger and established members — that they do not appreciate being categorized nor are the categories applicable to their experience.

Deborah Elam, MS, CAE
Executive Director, San Francisco Dental Society

The *Journal* welcomes letters

We reserve the right to edit all communications. Letters should discuss an item published in the Journal *within the past two months or matters of general interest to our readership. Letters must be no more than 500 words and cite no more than five references. No illustrations will be accepted. Letters should be submitted at editorialmanager.com/jcaldentassoc. By sending the letter, the author certifies that neither the letter nor one with substantially similar content under the writer's authorship has been published or is being considered for publication elsewhere, and the author acknowledges and agrees that the letter and all rights with regard to the letter become the property of CDA.*

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CDA JOURNAL, VOL 42, N°2

License to Practice

David W. Chambers, PhD

The following document is on display in the Baldwin Home in Lahaina, Maui, dated 15 July 1865.

It is decided to be proper that _____ should act as a medical doctor, for under me, he having exhibited to my satisfaction his qualification as such doctor. Therefore, I hereby give my sanction to his practicing medicine from Hawaii to Kauai, so long as he obeys my directions and observes the laws of the King of this government, and conducts himself properly and honestly.

The following is the scale of fees to which I consent, if a cure is affected:

1.	Very great sickness	$50
2.	Less than that	$40
3.	A good deal less	$30
4.	Small sickness	$20
5.	Very small	$10
6.	Attending a friend	$ 5
7.	Incantation to find out disease	$ 3
8.	Taking case from another doctor	$10
9.	Certificate of a doctor	$ 3
10.	Refusal by the patient to pay	$10

Notice that there are no ICD-9 codes. Disease is defined generically and subjectively. But observe the introductory clause. These fees are valid only "if a cure is affected." We have changed from an older philosophy of paying for health outcomes to paying for technical services rendered, regardless of their impact. It is also noteworthy that the old Hawaiian fee schedule allowed a charge for diagnostic services, though it is unlikely these days that insurance companies would pay for incantations.

Whom one treats matters. Attending a friend is a social obligation that can reduce the fee charged from $50 to $5. Tough practice, since "ohana" in Hawaiian means that almost everyone is your friend. On the other hand, taking a case from a colleague deserves a $10 bump. That would certainly be an anticompetitive incentive. The currently fashionable practice of patients "shopping on price" would certainly be dampened if a fee equal to treating a small case were added. This would never fly in today's courts, but it could encourage comprehensive treatment.

The opportunity to increase a patient's bill by $10 if he or she refuses to pay is a boggler. Somehow my suspicious mind sees the shadow of a lawyer friend of the physician in the background. "If I collect," says the lawyer, "I would not want to take the entire award from your share, my colleague, so let's add a little something so you can have some and so can I."

Finally, note whose authority a physician in 1865 Hawaii was allowed to practice under. The state only handled the legal and ethical part of the practice and the established members of the profession controlled who came in and how they were to be compensated. We still retain some of those features after 150 years. ■

The nub:

1. It is worth reflecting on whether there should be a CDT code for oral health value.
2. The fee schedule influences good oral health outcomes.
3. It is possible that there are practice code features that protect professionals rather than patients.

David W. Chambers, PhD, is professor of dental education, Arthur A. Dugoni School of Dentistry, San Francisco, and editor of the *Journal of the American College of Dentists*.

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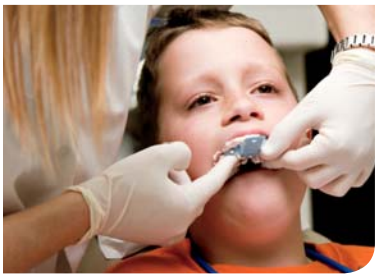
Millions More Now Benefit From Fluoridated Water

The U.S. Centers for Disease Control and Prevention recently released new data stating that about 6 million more U.S. residents are now receiving the benefits of fluoridated water than in 2010.

"We are very pleased to report this positive news about the continued increase in fluoridation coverage in our nation," said Katherine Weno, DDS, JD, director of CDC's Division of Oral Health, in a news story on ADA.org. "These new statistics show that a substantial number of additional people in the United States are now receiving the decay-prevention benefits of fluoridated water."

According to the CDC statistics as of December 2012, nearly 210.7 million people, or 74.6 percent of the U.S. population on community water systems, had access to optimally fluoridated water. CDC statistics from 2008 show that 72.4 percent of U.S. residents had access to fluoridated water and that since then, an additional 15 million people have received the benefit of fluoridated water.

For more information, see the data at cdc.gov/fluoridation/statistics/2012stats.htm or read the ADA news story at ada.org/news/9452.aspx.



Few Benefits in Two-stage Treatment for Class II Division I Malocclusion

A recent review has discovered that there are few benefits to a two-stage orthodontic correction for buck teeth in children versus treatment done in one stage during early adolescence, according to a news release from the Health Behavior News Service, part of the Center for Advancing Health.

Children with prominent front teeth, informally known as "buck teeth," often require orthodontic work to straighten their teeth. This can be done in one stage during early adolescence (age 10 to 16) or two stages with the first stage between age 7 and 11 and the second in early adolescence.

In the recent review, the goal of the authors was to "assess the effects of orthodontic treatment for prominent upper front teeth when this treatment is initiated when the child is 7 to 11 years old compared to when they are in early adolescence, or when treatment uses different types of orthodontic braces," the review noted.

The research team analyzed data from 17 randomized controlled trials of children treated for Class II malocclusion, which is one cause of prominent front teeth. They concluded that providing treatment early slightly reduced the risk of children damaging their front teeth if they had an accident while playing or participating in sports, but offered few other benefits.

"There was no other benefit for having treatment early, age 8, as opposed to having treatment during adolescent age," said Kevin O'Brien, professor of orthodontics at the University of Manchester in England, in the news release.

"The results of this review will provide information to allow the orthodontist to explain fully the potential risks of not having treatment when the child is 8 years old," O'Brien stated. "This can help orthodontists, parents and their children make an informed decision."

The authors also noted that a two-stage correction requires treatment over a longer period of time, which typically increases the cost.

For more, see the review published online November 2013, Cochrane Library, issue 11.

Improved Periodontal Health and Slowed Atherosclerosis

Taking care of your gums by brushing, flossing and visiting a dentist for regular checkups could help keep heart disease at bay, according to researchers at Columbia University's Mailman School of Public Health.

In the new study, published online in the *Journal of the American Heart Association*, researchers have shown for the first time that as gum health improves, progression of atherosclerosis — the narrowing of arteries through the build-up of plaque — slows to a clinically significant degree.

"When it comes to atherosclerosis, a tenth of a millimeter in the thickness of the carotid artery is a big deal. Based on prior research, it appears to meet the threshold of clinical significance," said Tatjana Rundek, MD, PhD, a co-author of the study, in the news release.

For this study, researchers followed 420 adults. Overall, 5,008 plaque samples were taken from several teeth, beneath the gum, and analyzed for 11 bacterial strains linked to periodontal disease and seven control bacteria. Fluid around the gums was sampled to assess levels of Interleukin-1β, a marker of inflammation.

Over a median follow-up period of three years, the researchers found that improvement in periodontal health — health of the gums — and a reduction in the proportion of specific bacteria linked to periodontal disease correlated to a slower intima-medial thickness (IMT) progression, and worsening periodontal infections paralleled the progression of IMT. Results were adjusted for potential confounders such as body mass index, cholesterol levels, diabetes and smoking status.

"These results are important because atherosclerosis progressed in parallel with both clinical periodontal disease and the bacterial profiles in the gums. This is the most direct evidence yet that modifying the periodontal bacterial profile could play a role in preventing or slowing both diseases," said Moïse Desvarieux, MD, PhD, lead author of the paper, in a news release from the university.

There was a 0.1 mm difference in IMT change over three years among study participants whose periodontal health was deteriorating compared with those whose periodontal health was improving.

For more information, see the study in the *Journal of the American Heart Association*, 2013; 2: e000254.

Autologous Platelet-rich Plasma and Periodontal Ligament Regeneration

In a recent study, authors set out to examine the biologic effects of the technology of platelet-rich plasma in growth factors on primary human periodontal ligament fibroblasts. To evaluate this, researchers "studied the response of periodontal ligament cells to this pool of growth factors on cell proliferation, cell migration, secretion of several biomolecules, cell adhesion and expression of α2 integrin," the study noted.

The authors concluded that "plasma rich in growth factors exerts positive effects on periodontal ligament fibroblasts, which could be positive for periodontal regeneration." The authors reported using a fluorescence-based method to evaluate cell proliferation and adhesion. Cell migration was performed on culture inserts.

According to the study, published in the *Journal of Periodontology*, "autologous technology significantly stimulated cell proliferation, migration, adhesion and synthesis of many growth factors from cells including vascular endothelial growth factor, thrombospondin 1, connective tissue growth factor, hepatocyte growth factor, and procollagen type I."

The researchers also reported finding that although no statistically significant differences were observed, the α2 integrin expression was lower in plasma that was rich in growth-factor treated cells compared to nonstimulated cells.

For more information, see the study in the *Journal of Periodontology*, November 2013, vol. 84, no. 11, pp. 1556-1566.

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Glycemic Control Does Not Improve With Nonsurgical Treatment of Periodontitis

A recent study in the *Journal of the American Medical Association* has found that for persons with type 2 diabetes and chronic periodontitis, nonsurgical periodontal treatment did not improve glycemic control.

In the study, led by Steven P. Engebretson, DMD, MS, MS, of New York University, the authors examined whether nonsurgical periodontal treatment reduces levels of glycated hemoglobin (HbA1c) levels in persons with type 2 diabetes and moderate to advanced chronic periodontitis.

The study utilized participants who had type 2 diabetes, were taking stable doses of medications, had HbA1c levels between 7 percent and less than 9 percent and untreated chronic periodontitis. The treatment group (257 participants) received scaling and root-planing plus chlorhexidine oral rinse at baseline and supportive periodontal therapy at three and six months, according to the study. The control group (257 participants) received no treatment for six months.

The researchers found that levels of HbA1c did not change between baseline and the three-month or six-month visits in either the treatment or the control group, and the target six-month reduction of HbA1c level of 0.6 percent or greater was not achieved, according to a news release from the journal. Periodontal measures improved in the treatment group compared with the control group at six months.

"Nonsurgical periodontal therapy did not improve glycemic control in patients with type 2 diabetes and moderate to advanced chronic periodontitis. These findings do not support the use of nonsurgical periodontal treatment in patients with diabetes for the purpose of lowering levels of HbA1c," the authors concluded.

For more, see the study in the *Journal of the American Medical Association,* 2013, vol. 310, no. 23, pp. 2523-2532.

U.S. Task Force Unable to Recommend for or Against Oral Cancer Screenings by Physicians

With the exception of dentists and otolaryngologists, the U.S. Preventive Services Task Force has concluded that current evidence is insufficient to recommend for or against routine oral cancer screenings by primary care providers.

Published online in the *Annals of Internal Medicine*, the USPSTF's "Screening for Oral Cancer: U.S. Preventive Services Task Force Statement" provides an update to its 2004 recommendation on screening for oral cancer.

In a news story from the American Dental Association, Edmond Truelove, DDS, MSD, chair of the ADA Council on Scientific Affairs, indicated that the exception of dentists in the latest recommendations highlights the importance of dentists in helping patients protect the oral cavity from diseases and other serious conditions.

"The statement places even greater importance on regular periodic evaluation by the patients' dentists to improve early detection of oral and dental conditions of the teeth and soft tissues of the mouth, including soft tissue changes that may represent lesions associated with cancer and premalignant change," Truelove said in the story.

"The evidence for screening for oral cancer remains insufficient; therefore, the USPSTF is unable to make a recommendation in favor of or against screening," the USPSTF statement concludes.

"The bottom line is clinicians, whether they're physicians or dentists, need to continue to fully examine the oral mucosa for signs of any disease, one of which might be oral cancer," said Mark Lingen, PhD, a professor of pathology at the University of Chicago Pritzker School of Medicine, in the ADA story.

For more, view the USPSTF recommendations published online Nov. 26, 2013, in the *Annals of Internal Medicine* or see the ADA news story at ada.org/news/9447.aspx.

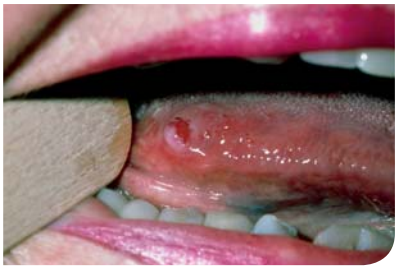
Study: Surgery First Shows Better Survival than Chemo for Tongue Cancer

Patients with tongue cancer who started their treatment with surgery fared significantly better than those who started with a course of chemotherapy first, according to a new study from researchers at the University of Michigan Comprehensive Cancer Center.

"Despite the proven success of this strategy in laryngeal cancer, induction chemotherapy should not be an option for oral cavity cancer, and in fact it results in worse treatment-related complications compared to surgery," said study author Douglas Chepeha, MD, MSPH, in the news release.

This is contrary to protocols for larynx cancer, in which a single dose of chemotherapy helps determine which patients fare better with chemotherapy and radiation and which patients should elect for surgery.

The study, published in *JAMA Otolaryngology Head and Neck Surgery*, enrolled 19 people with advanced oral cavity cancer. Patients received an initial dose of chemotherapy, called induction chemotherapy. Those whose cancer shrunk by half went on to receive additional chemotherapy combined with radiation treatment. Those whose cancer did not respond well had surgery followed by radiation, according to a news release from the U-M Comprehensive Cancer Center.



Enrollment in the trial was stopped early because results were so poor, the news release stated, noting that of the nine patients who had surgery after the induction chemotherapy, only two were alive and cancer-free after five years. Ten of the patients had a response to the chemotherapy, and of that group, only three had a complete response from the treatment and were cancer-free five years later.

The researchers then looked at a comparable group of patients who had surgery and sophisticated reconstruction followed by radiation therapy and found significantly better survival rates and functional outcomes.

For more information, see the study published online first Dec. 26, 2013, in *JAMA Otolaryngology Head and Neck Surgery*.

Gene Identified in Cleft Lip and Palate Syndrome

An international team of researchers has identified a new gene related to the Van der Woude syndrome (VWS), the most common syndrome with cleft lip and palate, according to a study in the scientific periodical *American Journal of Human Genetics*.

"Taken together, our data demonstrated that mutations in two genes, IRF6 and GRHL3, can lead to nearly identical phenotypes of orofacial cleft. They supported the hypotheses that both genes are essential for the presence of a functional oral periderm and that failure of this process contributes to VWS," the authors concluded.

Mutations in a gene called interferon regulatory factor 6 (IRF6) account for roughly 70 percent of cases of VWS, the authors wrote. In eight of 45 VWS-affected families lacking a mutation in IRF6, the authors reported finding coding mutations in grainyhead-like 3 (GRHL3).

"The discovery of a new gene, GRHL3, responsible for the most common of the syndromic forms of cleft lip and palate means that researcher or clinicians with collections of families or isolated cases with cleft lip and palate, syndromic or nonsyndromic, now will be able to look for mutations in this gene," said Myriam Peyrard-Janvid, the lead researcher of the study, in a news release. "As it has been shown for IRF6, one or several polymorphisms in GRHL3 might be found to be associated with increased risk of clefts in nonsyndromic cases."

For more, see the study in the *American Journal of Human Genetics*, published online ahead of print Dec. 19, 2013.

CDA JOURNAL, VOL 42, N°2

Controversies in Dentistry

Richard T. Kao, DDS, PhD

GUEST EDITOR

Richard T. Kao, DDS, PhD, maintains a full-time private practice in Cupertino, Calif. He also teaches at the University of California, San Francisco, School of Dentistry and the Arthur A. Dugoni School of Dentistry. Dr. Kao has extensive volunteer experience in organized dentistry and served as a trustee for the California Dental Association and is serving as a trustee for the American Academy of Periodontology.
Conflict of Interest Disclosure: None reported.

This issue has been a work in progress for the past year and a half. Like the title for this issue, the path has been bumpy and with many operational controversies. With the initial assignment, the original thought was to focus on dental technical/practice controversies. Instead, it was decided to focus on how our professional environment is changing. These changes are forcing us to make choices. Complacency, or the "ostrich" phenomenon, is not an option. In this issue, we provide controversial views as to possible responses to these changes. Consider how these changes will influence your practice.

In the first article, "Dentistry at the Crossroads," the increasing shift from small dental practice to corporate dentistry is discussed. The shift to this practice type may change the pattern of competition, practice management, multidisciplinary care and possibly the quality of dental care. The advantages and concerns about this practice modality are analyzed. Lastly, the challenges dental associations and specialties face in this changing practice style are reviewed.

In the second article, Marc Cooper, DDS, PhD, reviews advantages associated with corporate dentistry. Advantages include efficiency of scale and the competitive/financial strength. Over time, this can create survival pressure for classical solo private practices. This article outlines options practitioners should consider in this changing environment.

In a review of our current dental education, Charles Cobb, DDS, MS, PhD, questions if our educational philosophy is changing. Arguments are made that societal and financial issues are driving forces for expansion of dental institutions. This expansion has resulted in some "unintended consequences." Dr. Cobb questions whether dental schools will continue to focus on research and multidisciplinary care, which has been the hallmark for best practice management approach to patient care.

Natasha Lee, DDS, examines in-depth the decision dilemmas, challenges and opportunities that exist for new graduate dentists. In addition to analyzing these issues, stories relayed by new dentists give voice to these concerns. The profession must appreciate the dilemmas our young colleagues face and take a proactive stance to aid them in their professional development.

While the profession focuses on practice efficiency, what will happen to the dental access issue? A group of community dental health care providers headed by Pamela Arbuckle Alston, DDS, MPP, asks who will be minding the dental health care safety net and the potential difficulties these programs could face.

In the last article, Paul Rhodes, DDS, identifies a concern for quality patient care in this changing environment. In a world where patient care may be supervised by multiple dental providers because of practice efficiency systems and increased employment transitions, a risk to quality patient care may be presented. The importance of digital records in providing practice continuity is discussed. Additionally, practices can use these records to develop improved outcome regimens.

This issue is made up of speculative commentaries. As such, they may spark debate about the future of dentistry. We are in a changing time. Complacency is not acceptable. The rapid pace of change demands your attention. ■

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CDA JOURNAL, VOL 42, N°2

Dentistry at the Crossroads

Richard T. Kao, DDS, PhD

ABSTRACT The dental practice pattern is shifting from small dental offices to large corporate dental groups. This article analyzes the powers behind this change, and discusses the choices dental practitioners are facing and the reasons why many may choose to work in a corporate practice setting. Dental associations and specialty groups need to reaffirm their mission to provide quality oral health care. Dental treatment should not be viewed as a commodity used to measure corporate profitability.

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Dentistry has reached a crossroads. Small independent solo practices are increasingly being converted to corporate models. The ADA's Health Policy Resources Center recently reported that in 2006, 76 percent of dentists practiced as solo practitioners; however, by 2010 this figure had dramatically dropped to 69 percent.[1-3] This trend is expected to continue at a similarly rapid pace. Although corporate dentistry may still be considered somewhat controversial, the reality is that there is a rise in large dental group practices, dental management organizations (DMOs) and dental service organizations (DSOs).[3]

What are the reasons? How are the quality of patient care and the cost of delivery being affected? What is the role of organized dentistry in this evolution?

Why Corporate Dentistry?

Eric Curtis, DDS, recently provided an excellent analysis of corporate dentistry.[4,5] He points out that corporations generally can help maximize efficiency by offering valuable resources for staff management, marketing, laboratory and dental supply purchasing power and practice administration. Private equity groups and investors involved with these corporate entities are able to provide the deep-pocket capital necessary to support these services. Investors see the dental care industry as a $106-plus billion cottage industry that is ripe for consolidation, filled with a potential labor force and appealing to consumers when appropriately marketed.

Effective practice management has become progressively more difficult for solo practice owners. Increased government regulations, rising supply costs

and competitive labor markets have made practice overhead difficult to contain. Fierce competition requiring savvy marketing plans, limited insurance benefits and decreased payments, and rising PPO practices have further complicated matters. Soaring laboratory costs and technological advances present the clinician with a dilemma of whether to seek less expensive options or abandon the incorporation of new technologies. These stresses have made practicing dentistry all the more difficult for solo practitioners.

Many dentists make their business decisions based on participation in dental benefit plans; however, this may be unwise in the near future. With the Patient Protection and Affordable Care Act (ACA), the cost of medical care could increase for employers, adversely affecting dental benefits.[6,7] The ACA will expand mandatory dental benefits for approximately 8.7 million children at a cost of $4 billion and approximately 17.7 million adults may gain some level of dental benefits as the result of Medicaid, which varies significantly from state to state.[8,9] This added cost can increase business expenses, challenging employers' operational budgets. According to the Society for Human Resource Management, employers are looking to pare down benefits during these times of economic hardship, and dental insurance tops the list. With the ACA, dental benefits may be marginalized because the priority will be to sell medical insurance packages. Companies like Blue Cross, Aetna and MetLife, which can offer both medical and dental plans, may decide it is advantageous to package benefits for employers. Long-standing providers like Delta Dental of California may face a disadvantage because they do not have a medical package partner. To remain competitive, they might need to morph into competitive dental benefit providers.

The indirect effects of the ACA could increase the economic pressure for solo practitioners, resulting in a greater need for business efficiency. Toward that end, corporatization of American dentistry may appear to be one possible solution. Another alternative is to operate a boutique practice where patients are willing to pay a higher premium for services.

Dentists in various age categories will be affected by a movement toward corporate dentistry. Practitioners with 10 years or less to retirement might manage to complete their careers in the practice fashion they have selected. However, as this shift occurs, it could prove increasingly difficult to sell their practices. These soon-to-be retirees may need to sell their practices earlier than they originally planned, resulting in decreased cash flow. Alternatively, older practitioners could work one to two years longer to make the extra cash that would be equivalent to practice sale and close the practice. This would compensate the potential income loss from the difficulty of practice sale. Those with more than 10 years to retirement may be faced with the difficult decision to either join a corporate dental group or transform their business into a boutique practice that can garner patient loyalty. Young and new dentists will encounter a changing business landscape that is totally different from the practice style that was prevalent when they first entered the profession.

With the ACA, it is likely that dental benefits will be marginalized because the priority will be to sell medical insurance packages.

All specialists, regardless of age, could see their practice styles change as referral and practice patterns are altered with the increasing prevalence of corporate dentistry. It is important for dental organizations and specialty groups to understand these forces and modify their services so they can remain relevant to their members.

Workforces for Corporate Dentistry

No business can survive without a solid consumer base. According to the Robert Wood Johnson Foundation, more than 50 percent of uninsured and 30 percent of insured Americans skipped necessary dental care visits.[8] The recent CDC oral health survey reported that the prevalence of periodontal disease in the U.S. has been shockingly underestimated.[10] Disease is ever-present and consumer demand will be there if the public is made aware of the need to seek proper treatment. The challenge for corporate dental centers is to find an adequate workforce to meet these demonstrated needs and they are looking toward the new, young dentists — the "millennials."

New graduates think and work differently than previous generations. Most recent graduates are millennials, born between 1982 and 2001.[11,12] This group is often divided into Generation Y (born in the 1980s) and Generation Z (born in 1990s), the group that is currently entering, attending or completing dental school. Millennials are more ethnically and racially diverse with a confident and optimistic worldview. They prize lifestyle and friendships above work. Unlike their predecessors, millennials do not view their chosen profession as a life passion, a defining mark of self-worth or a source of income and security.

Instead, they see their jobs as a means to maintain their personal lives. They do not want to be the boss. They prefer a work environment that emphasizes teamwork, values structure over authority, utilizes the latest technology and provides time for personal interests outside the workplace. These traits make millennials a perfect fit for corporate dentistry.

During their dental school training, millennials have had the "new math" approach to dental education. Traditional dental education prior to the 1990s focused on mastering various skills in different disciplines like prosthodontics, restorative dentistry and periodontics, and applying the knowledge gained in managing patients. Students were exposed to various specialty areas and they learned to assess their strengths and weaknesses. Previous generations of dentists sought out continuing education opportunities and learned to work with dental specialists to provide multidisciplinary care. Millennials, on the other hand, have been exposed to "super generalist" concepts. As Dr. Curtis pointed out in a recent commentary, it is critical for this group to receive adequate training and build their knowledge through some type of residency (GPR/AEGD) or postgraduate continuing education.[5]

Financial challenges can also be debilitating for new dentists. Many recent graduates have student loans ranging from $200,000 to $350,000.[13] As the U.S. climbs out of its economic downturn, few practices have the luxury of supporting new associates. Positions in government agencies (Veteran Administration, prisons and county health clinics) and public health clinics, once difficult to fill, are becoming more scarce. The cost to start a new practice or purchase an existing one can be astronomical. Financing such a venture is particularly problematic when coupled with the burden of student loan debt. Plus, most new dentists possess fledgling business skills that make handling practice management issues difficult. The appeal of corporate dentistry is that it can offer dentists potentially impressive financial advantages, as well as relief from staff recruitment, practice management, marketing and business management chores.

Criticisms of Dental Corporations

There are various forms of corporate dentistry ranging from discount centers in shopping malls to quality-oriented group practices. All successful businesses seek a return on investment (ROI), and processing patients as efficiently as possible is a means for increasing ROI. However, the potential use of lower-quality materials and dental laboratories, along with abbreviated preventive periodontal care and up-selling alternative revenue-rich procedures to increase the ROI can pose ethical dilemmas. In addition to dental teams, dental corporations need to support executives and other corporate employees. Production quotas, whether implied or stated, could act as a perverse incentive to some dental providers. Providing the best possible oral health care for the patient might be jeopardized.

In addition to dental teams, dental corporations need to support executives and other corporate employees.

Corporate practices can seldom keep specialists busy full time, so satellite specialists may split their time between two or three of these practices. This may result in a fragmented practice focusing on script surgical or uniprocedural treatment. Difficult and complex cases may not be appropriately addressed in this model.

In a recent article in *The New Yorker* entitled "Big Med," Atul Gawande, MD, MPH, MA, discusses whether the Cheesecake Factory and other successful chain restaurants could serve as models for improving health care.[14] Approximately 20 years ago, in order to secure efficiency, reliability, consistency and cost control, medicine shifted to a corporate model. Rather than decry this change, Dr. Gawande argues that medicine could learn from the Cheesecake Factory model, where everyone is happy with reasonably priced food and good dining.

To test his theory, he met with managers, cooks and other workers at a Boston-based Cheesecake Factory to see how the company delivers consistent quality and service. He noted that kitchen operations follow procedure and are highly organized. He determined that the quality control exercised by the kitchen manager is critical to the restaurant's success. This person oversees the various line and broiler chefs. Dr. Gawande argues that successful medical teams have similar overseers. For instance, the head of a knee replacement team or the coordinator of an intensive care unit have established protocols in order to guarantee a consistent level of care. Dr. Gawande argues that "every clinician has his or her own way of doing things, and the rates of failure and complication for a given service routinely vary by a factor of two or three, even within the same hospital." He believes that standardization in medicine would provide better, more consistent patient care and improved cost control. Dr. Gawande concludes that "we're moving from a Jeffersonian ideal of small guilds and

independent craftsmen to a Hamiltonian recognition of the advantages that size and centralized control can bring."

So can the same argument apply to corporate dentistry? Can standardization of dental protocols based on evidence-based research along with good "kitchen manager" supervision provide quality patient care? To do this, corporate dentistry must commit time, expense and staff. Corporate decision-makers must put patient care ahead of profit. The Cheesecake Factory model may work for the masses, but how will patients with complications that require multidisciplinary care be managed? Will cost-effectiveness trump proper care? Ultimately, this is an ethical question for corporate dental groups.

Challenges to Specialties and Dental Associations

Here is a possible future: Within the next 10 years or so, there will be a shift to corporatization of American dentistry. "Big Dentistry" will dominate — promising efficiency, reliability, consistency and cost control — and the business environment will demand this. A group of small, independent operations will survive and compete as boutique practices.

With millennials being trained as super generalists, more dentists will be providing patient services that were previously performed by specialists such as advanced endodontic procedures, complex extractions and implant procedures involving sinus grafts or advanced site preparation. This trend is compounded by the fact that scope-of-practice rivalries already exist among various specialties over dental implants, extractions and implant restorative procedures. These competitive forces compromise the specialists' work volume and promote a satellite style, which could result in discontinuity in patient care. Consequently, specialty organizations should be concerned not only about work volume, but also about risks for work-related errors, inadequate post-operative care and malpractice that can be associated with these disjointed work environments. Specialty organizations should provide guidelines on how to minimize risks with this satellite pattern of care. Additionally, they need to promote to both general dentists and specialists the importance of comprehensive and multidisciplinary collaborative dental care.

The goal must be to nurture and channel members toward providing the very best care for their patients.

The mission of a dental association is to ensure the development of the profession and to enhance members' ability to deliver quality dental care.

Associations must instill in their members an appreciation for continuing education and provide it in a manner conducive to their learning style. The goal must be to nurture and channel members toward providing the very best care for their patients.

Associations must carefully consider the manner in which dental education is delivered to this demographic group. Millennials have been raised with technology like iPods, tablets and smartphones. They text, tweet and post on social media sites. If associations don't acknowledge this learning style and adapt programs to these new behaviors, their educational messages will be lost. Certifying boards should also assess in-house education courses offered by corporate dental groups to ensure they promote sound treatment and ethical behavior.

Associations must continue to advocate for good patient care. Dental professionals are always on a tightrope as they juggle between patients' desires, clinical resolutions and profitability. There are concerns that DMOs manage dental care like a commodity. A recent article cited examples of abuse and argued for more regulation of unnecessary procedures and quotas for dentists.[15] Legislators in various states are considering more stringent rules to guard against abusive practice. Similar concerns were reported by Sydney Freedberg of Bloomberg and Josh Kosman of the *New York Post*.[16,17]

Conversely, Thomas Climo, a dental practice management consultant, argues that the evidence is anecdotal and the abuse rate is similar to solo practitioner dentists.[18] According to Climo, these dental businesses would not ignore patients' basic oral health needs because of legal risks. DMOs can create a work environment with policies that either support ethical behavior or not; however, each individual dentist must ultimately bear responsibility for his or her own treatment practices. Associations can support ethical practice by both dentists and DMOs by providing risk management courses that emphasize evidence-based treatment. Additionally, dental boards can develop the necessary guidelines for defining good patient care.

Lastly, associations need to stay relevant. Many of their members may be in DMOs with a minority in boutique solo practices. Associations need to study and evaluate the changing needs and membership services required by these fragmented groups.

Conclusions

Corporate dentistry offers business efficiency, reliability, consistency and cost control, but there may be risks for dental abuse when profitability is the goal. Good dentistry is dependent on the dentists and DMOs who create the work environment. In this changing environment, there are concerns about the mindset and training of a new generation of dentists and questions about if patients with complex dental problems will have access to the best care. All of these variables lead us to ask whether this shift toward corporate dentistry will be in the best interest of patients.

For associations and specialties, this is a challenging era of changing practice demographics and member needs. Organizations must try to understand the reasons behind this shift and make the adjustments necessary to stay relevant. This is truly an interesting time that we are living in. ■

Editor's note: According to a 2011 ADEA Survey of Dental School Seniors, student loan debt ranges from $178,000 to nearly $246,000.

REFERENCES

1. American Dental Association, Health Policy Resources Center (2011). Distribution of Dentists in the United States by Region and State, 2009. [Research Brief] Chicago: American Dental Association.
2. Guay AH, Wall TP, Petersen BC, Lazar VF (2012). Evolving trends in size and structure of group dental practices in the United States. *J Dent Educ* 76:1036-44.
3. Fox K (2012). ADA explores growth of large group practices. *ADA News* (American Dental Association) April 9. www.ada.org/news/6947.aspx.
4. Curtis EK (2012). The business of oral health care: A look into the corporation of American dentistry. AGD Impact (Academy of General Dentistry) October:24-28.
5. Curtis EK (2012). The changing face of dentistry: Generations of dentists discuss the forces shaping our profession. *AGD Impact* (Academy of General Dentistry) September:22-26.
6. American Dental Association (2012). Breaking down barriers to oral health for all Americans. The role of finance [Internet]. Chicago; ADA; 2012. www.ada.org/sections/advocacy/pdfs/7170.
7. National Association of Dental Plans. NADP 2012 consumer survey: Dental health and health care reform. 2012. National Association of Dental Plans.
8. Robert Wood Johnson Foundation (2009). The costs of dental care and the impact of dental insurance coverage. www.rwjf.org/en/research-publications/find-rwjf-research/2009/04/the-costs-of-dental-care-and-the-impact-of-dental-insurance-cove.html.
9. American Dental Association, Health Policy Resources Center (2013). Affordable care act expands dental benefits for children but does not address critical access to dental care issues. [Research Brief] Chicago: American Dental Association.
10. Eke PI, Dye BA, Wei L, et al (2012). Prevalence of periodontitis in the adults in the United States: 2009-2010. *J Dent Res* 91:914-20.
11. Curtis EK (2013). The great dental divide: Bridging dentistry's multiple generation gaps. *AGD Impact* (Academy of General Dentistry) May 2013: 18-23.
12. Pew Research Social & Demographic Trends (2010). Millennials: Confident, connected, open to change. www.pewsocialtrends.org/files/2010/10/millennials-confident-connected-open-to-change.pdf.
13. Curtis EK (2013). The financial pinch. *AGD Impact* (Academy of General Dentistry) July:22-28.
14. Gawande A (2012). Big Med. www.newyorker.com/reporting/2012/08/13/120813fa_fact_gawande *The New Yorker*, Aug. 13, 2012.
15. Domino D. Private equity firms eye big profits in dentistry. www.drbicuspid.com/index.aspx?sec=prtf&sub=def&pag=dis&itemId=310662&pri.pdf, released May 30, 2012.
16. Freedberg SP (2012). Dental abuse seen driven by private equity investments. www.bloomberg.com/news/2012-05-17/dental-abuse-seen-driven-by-private-equity-investments.html. Bloomberg, released May17, 2012
17. Josh Kosman (2012). Private-equity firms $ink teeth into dentistry. *New York Post*, released Aug. 27, 2010.
18. Climo TA (2012). If pigs could fly and dental professionals could be turned bad by private equity investment. *Dent Econ* 62-636.

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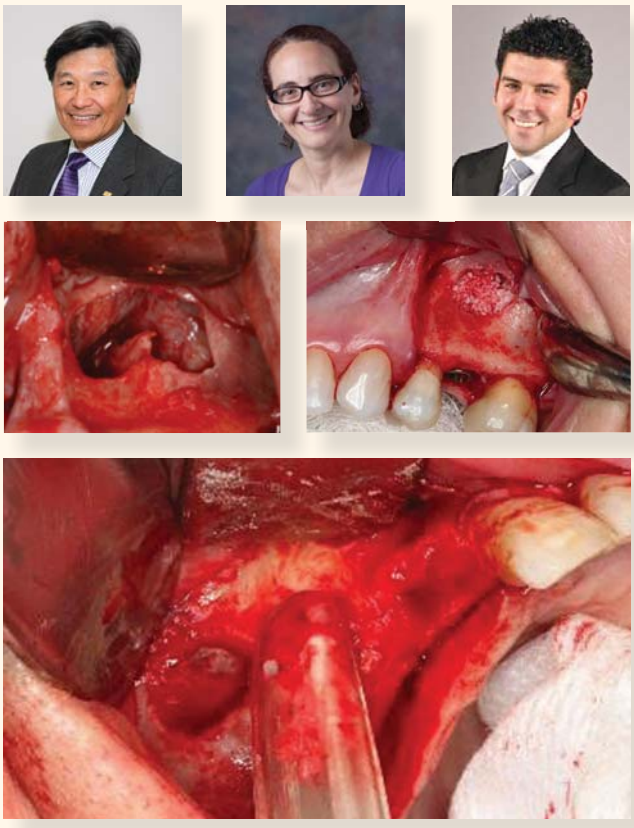

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The Perfect Storm

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In today's economy, solo private practice may not offer the future of stability and prosperity that was once the hallmark of dentistry. A perfect storm of circumstances has arrived, altering the previously calm seas of solo dental practice, completely upsetting the almost certain path to practice success.

The seas are rolling with waves caused by well-financed corporate entities, new government regulations and mandates, the ever-increasing cost of technology and doing business itself, numbers of for-profit dental schools, increasing third-party dominance as they rapidly shift to reduced fee PPOs and far fewer graduates seeking ownership because of their onerous debt burden, dramatically enhanced by the tremendous inflow of millions of dollars of capital from venture capitalists and equity partners to consolidate practices. In this storm, the engines of solo practice may become powerless as their boats get buffeted and tossed about, many overturning, others breaking apart.

Much larger vessels are riding the storm with little damage. In fact, these larger boats are experiencing smooth sailing. Their fleet is growing exponentially as the small crafts of solo practice are being destroyed. What is emerging as the dominant vessel in this perfect storm is "managed group practice."[1,2,4]

Managed Group Practice

There are many different kinds of managed group practices. There are small ones with four to 20 locations and large ones with as many as 350 to 400 offices. There are "big box" ones with 20,000 square feet and 200 staff and doctors. Some are internally managed with their own senior executives and managers. Others are externally managed and supplied with a variety of business services by managed service organizations (MSOs). But most of them have two things in common — managed group practices are attracting significant capital investment and they are experiencing strong growth and increasing market share.[1,3]

There are other forms of dental companies known as "retail corporate dental." These entities own and operate multiple locations, have strong corporate hierarchical structures and typically serve the underinsured, lower paying PPOs, HMOs and Medicaid markets. Dentists are generally contracted to work in clinics, and dentist turnover is usually high.[1] These particular retail dental entities are what most dentists think of when you mention "corporate dentistry."

Better for Everyone but Solo Practitioners

According to IBISWorld,[1] an industry research group, dentistry as a whole generated $109.6 billion in revenues with a profit of $18.7 billion in 2012, achieving an annualized growth of 5.1 percent. In fact, dentistry has averaged growth of 5 percent or greater (except in 2008) over the last 15 years. By the end of the decade, dentistry is forecasted to hit more than $180 billion in total revenue. The industry appears to be recession-resistant with a 17 percent profit margin and reliable sustained growth.

These numbers are greater than the majority of the gross national products of countries around the world. With numbers like this, capitalists are now being drawn to dentistry. Like moths to the light, they see tremendous financial opportunity in consolidating a fragmented delivery system. Capitalists believe that dentistry has shifted from a service business to a commodity, retail business over the last decade. They witness local ads for crowns at $890, exams at $89 and implants at $1,260. They see implants-in-a-day ads on television and dentists with 30-second spots on cable. They hear about the Ontario Teacher's Pension Plan buying a majority stake in Heartland Dental Care for $1.3 billion. Capital investors are champing at the bit to invest in the dental space, further stimulating the growth of managed group practices.

Currently, 72 percent of U.S. employers offer some form of dental benefits to their employees. In 2008, more than 176 million individuals, or roughly 57 percent of the U.S. population, were covered under dental benefits plans. The expected trend is that employers will continue to supply dental plans to their employees. The increased adoption of third-party payer plans benefits dental services and has led to increased utilization. More people will seek dental treatment as the plans extend their coverage. In addition, PPO coverage has increased to approximately 80 percent, while premium plans have shrunk to less than 20 percent of dental plans.[1,2,4,5] This trend isn't going unnoticed by capitalists and MSOs who are building their organizations to work within this environment.

Other factors are contributing to the increase in PPOs and employees' reliance on dental benefits. According to the U.S. Centers for Medicare and Medicaid Services (2011), dental expenses are now among the highest out-of-pocket health costs for consumers. In 2008, they accounted for $30.7 billion (22.2 percent) of such expenses, second only to prescription medications. In today's economy, patients are motivated to reduce out-of-pocket expenses, so if the employer only offers a PPO plan that will strongly influence their dental purchasing decisions.

Capital investors are champing at the bit to invest in the dental space, further stimulating the growth of managed group practices.

Capitalists realize that solo practice does not have the capacity for scalability and, therefore, is not able to generate dynamic growth or economies of scale to operate profitably in a PPO reduced-fee environment. Nor can solo practice meet the demand as the number of people utilizing dentistry continues to increase. Capitalists see managed group practice, particularly the MSO/DSO model, as the vehicle best able to take advantage of market conditions. They also realize that in this industry, where 70 percent of the practices are solo, consolidation and acquisition can be easily accomplished. It's like shooting fish in a barrel. Capitalists are pulling out their checkbooks and finding eager executives and managers to take their money to build or dramatically expand existing MSOs, enabling these organizations to aggressively pursue the purchase of existing practices as well as building de novo sites.

Many other factors are adding force to the winds of this storm:

- The Affordable Health Care Act mandates that dental and vision for children under 18 be covered.
- Sen. Bernard Sanders, I-Vt., Comprehensive Dental Reform Act now on the floor in Congress.
- Pressure from foundations to increase access.
- Seven new dental schools, three of them for profit.
- Continuing commoditization of dentistry.
- Decreasing access to many sectors of the population.
- Midlevel providers on the legislative docket in 22 states.

Solo practice is a dingy in this perfect storm, clearly not designed to withstand the increasing turbulence and uncertainty in the industry.

Choices to Consider for Young Practitioners

Today, young graduates of dental school or residency programs have very limited choices. Saddled with between $200,000 and $400,000 of educational debt and the cost of buying a solid practice between $800,000 and $1.4 million,

usually from a practice owner that has an aging patient population and a veteran staff reluctant to change, working for a "retail corporate entity" is often the most stress-free alternative.[1,2,4] Although the pay is not significant, averaging between $500 to $750 a day, or 25 percent to 30 percent of net production, where a day is a full eight hours, and the hours are dictated by management, other options are very limited. The queue for positions in the armed services and community health dental clinics are far too long to wait.[1]

Furthermore, the larger and mid-sized managed group practices (MSOs/DSOs) are now beginning to create strong packages for new graduates whereby they can reduce or pay off student loans and make decent dollars during their first five years of work. And at the end of this period of time, they may be sufficiently vested via stock or stock options in the company, binding them to the future of the company. Managed group practices are setting up recruitment booths at school functions and are spending time with the deans and department heads. Solo practitioners represented by brokers may not have the wherewithal to access students or faculty that managed groups are now accomplishing.

Many senior practitioners are holding onto their practices longer given the state of the economy and their own poorly performing retirement investments. So fewer practices are available and fewer buyers are available than ever before. And given the reduction in revenues, offers for associateships, which can diminish the senior doctor's income, are harder to find. No wonder the ADA's recent report shows less than 20 percent of graduates are becoming owners.[1]

This is somewhat different for certain dental specialists, particularly pedodontists and orthodontists, where the opportunities for employment and eventual ownership are much greater. But those ranks are quickly filling up. On the other hand, specialties like periodontics, oral surgery and endodontics are falling into the same boat with newly graduated general dentists. The majority of periodontist graduates are working in some form of group practice. Existing specialty practices in periodontics, endodontics or oral surgery may not have enough patients to support an associate, are too expensive to purchase and establishing a solid book of referrals from the get-go is nearly impossible.

Solo practitioners represented by brokers don't have the wherewithal to access students or faculty that managed groups are now accomplishing.

Choices to Consider for Exiting Dentists

At the other end of the spectrum sits the solo practitioner in his or her late 50s or early 60s. The last five years have not been kind to them. Practice revenues, new patients and higher cost treatments have declined or gone flat. Staying current both in training and new equipment has become very expensive and, for many, prohibitive. The competition has also become more intense. They are not just competing with the dentist down the street anymore, but with numbers of corporate entities. This translates into working harder for less. Although their practice may provide a very comfortable income, planning an executable exit strategy is becoming more and more difficult.

Many of these practices have already sold to managed group practices. Dentists are paid in stock and cash, hoping the stock becomes valuable enough that they can cash out when they retire in three to five years. Others may have saved enough money that they are willing to walk away at the end of their practice career.

For those who are hanging on, practice brokers are pitching the same tune, but given their own income is based on a percentage of the sale, they're clearly swinging for the fences. With young dentists unwilling to carry more debt, banks now becoming more and more conservative in their lending for solo practice purchase and revenues and new patients stuck in neutral, the mature practice will become harder and harder to sell. An asset that is not transferable is called a liability.

Still, many will stay the course and be stuck with a declining asset, hoping that dentistry will return to the way it was before 2008. It is unlikely to return to the way it was. If dentists are depending on the sale of their practice for a major piece of their retirement, they may be extremely disappointed.

If the future is managed group practice, then these mature dentists may consider how to get into this lane, whether through acquisition by an existing managed group or by working with like-minded dentists to form one of their own. Choosing the right managed group practice needs to be based on a host of factors. But seeking a managed group to join must rely on matching core values, vision, mission, as well as governing policies, operating policies, financial policies and structures, culture and clinical philosophy fit.

Redefining Quality

I constantly hear dentists in solo practice decry "corporate dentistry." You know what I mean, they reply,

"Those big groups that just squeeze the patient for as much money as possible while doing poor-quality dentistry."

Every time I stand in front of a group of dentists I ask, "If you don't do quality dentistry, please raise your hand." In my entire career of speaking with dentists, not one has ever raised his or her hand — not one. So, after speaking to thousands of dentists, every one of them claims to deliver excellent quality. Then I ask, "How many of you measure your quality, have quality assurance programs, peer review and serious chart review?" And not one of these dentists has ever raised his or her hand — not one.

According to Deming[5] and Juran,[6] and everyone else in every industry including medicine, quality is measurable. Peer review and case review are common practices in many industries. Nearly every managed group entity is ardently working on quality assurance, peer review and chart review. They have the money, they are gaining the expertise and they have the ear of the employers, payers and soon, patients. What will solo practitioners say when asked to report their numbers on quality to employers, payers and patients? "Just believe me?"

One aspect of the Affordable Health Care Act is the accountable care organization, which will be looking very closely at quality and outcomes in medicine. But I know people who are charged with forming these ACO organizations and they are pressing me on dentistry. It won't be long now until their attention focuses on dentistry.

Conclusion

Over the last few decades, dentists have evolved from being highly trained professionals treating dental disease and improving esthetics to becoming formidable small-business owners, leaders and managers. They have become excellent sailors on a very calm sea. But now that managed group practices are emerging like a tidal swell, the question becomes, "Can dentists make the leap to become partners, corporate executives and directors on boards, able to consolidate and integrate dental practices into highly successful managed group practices?"

I say they can. But it will require operating beyond today's standard of preserving the past and protecting the status quo. "Protect and preserve" will not allow dentists to generate the context, leadership or relationships necessary to create highly successful managed group practices. We need entities built on solid and authentic core values, with a true core purpose that will make a difference in the health and well-being of patients. It requires an envisioned future about what a managed group practice can become, a genuine vision.[8,9,10] Without developing groups standing firmly on core values, with a true core purpose and a well-articulated envisioned future, solo practices will splinter and break apart as the storm continues to rage.

"Protect and preserve" will not allow dentists to generate the context, leadership or relationships necessary to create highly successful managed group practices.

Can dentists become primary partners and drivers in managed group practices? Yes they can. Will they? We're working on it. ■

Editor's note: According to a 2011 ADEA Survey of Dental School Seniors, student loan debt ranges from $178,000 to nearly $246,000.

REFERENCES

1. IBISWorld-IBIS World Industry Report 62121: Dentists in the U.S.; May 2012.
2. AGD Impact; *The Changing Face of Dentistry;* July 2012.
3. Slate; *The American Way of Dentistry*; www.slate.com; September 2009.
4. The Progressive Dentist; *Are We Missing the Point?* Ben Burris; TheProDentist.com; June 2012.
5. *Dental Economics; If Pigs Could Fly and Dental Professionals Could Be Turned Bad by Private Equity Investment*; www.dentaleconomics.com; September 2012.
6. Aquayo R. *Dr. Deming: The American Who Taught the Japanese About Quality.* Simon and Schuster; 1991.
7. Defeo J, Juran JM. *Juran's Quality Handbook: The Complete Guide to Performance Excellence.* 6th ed., 2001; McGraw-Hill.
8. Collins J, Porras J. *Built to Last.* Harper Business; 2004.
9. Collins J. *Good to Great.* Harper Business; 2001.
10. Collins J, Hansen M. *Great by Choice.* Harper Business; 2011.

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Academic Dentistry in the 21st Century: Professional Dental Education or Development of a Trade Guild

Charles M. Cobb, DDS, MS, PhD

ABSTRACT Over the last decade, 10 new dental schools have been established and several more are on the drawing board for the near future. The overlying philosophy for this new generation of dental school is driven by a combination of societal and financial issues. As with many profound changes in educational philosophy, sooner or later there are always the unintended consequences that must be confronted. This article addresses several of the potential consequences.

AUTHOR

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Conflict of Interest Disclosure: None reported.

The "new generation" school of dentistry has arrived. Ten new schools of dentistry have become reality over the last few years and several more are on the drawing board for the near future. A recent article by Smith et al.,[1] implies that the overlying philosophy for establishment of this new generation of dental school is driven by a combination of societal and financial issues. The authors note the uneven availability of dental care for underrepresented, underserved and multicultural patient populations. Part of the solution, according to the authors, is to increase the number of graduates with an expanded social awareness and willingness to serve such populations. Others have noted the lack of dental care resources in rural and urban poverty areas.[2,3] Also, noted by Smith et al.,[1] the cost of educating dental students has increased to such magnitude that a paradigm shift to the utilization of nontenured, part-time clinical dental faculty is now seen as one way to control institutional educational costs. Lastly, unstated but implied by the basic structure of dental schools that train only generalists is that the balance of dental specialist-to-generalist is out of line with the need for specialty care.

The basic tenets of this evolving philosophy of dental education are commendable and aligned with current societal and political thought. However, as with many profound changes in educational philosophy, there are always the unintended consequences that must be confronted. As an example, the increase in dental school class size during the 1970s was precipitated by a

perceived shortage of practicing dentists. Most schools of dentistry found federal capitation money difficult to resist. It was hypothesized that the increased number of graduates would increase access to care and increase competition, which, in turn, would lower cost of care to the consumer. It can now be argued that a major part of the current "access to care" problem is the affordability of care.

There might be the potential for unintended consequences of the "new" 21st-century dental school philosophy. One only needs to read the multitude of articles that focus on esthetic dentistry and practice management and then note the lack of articles addressing access to care in the widely read "slick-paper trade journals," e.g., *Inside Dentistry*, *Dentistry Today*, *Dental Economics*, etc., to understand that commercialism has become a driving force in modern dental care. One can argue that private-practice dentistry and the representative professional organizations have done very little to address oral health care delivery. Consequently, the new generation of dental schools has evolved to change attitudes and deliver dental treatment to those most in need.

Should academic dentistry undergo profound changes because part of our society, for whatever reason, lacks the personal financial wherewithal to participate in the traditional fee-for-service model of dental health care? Taking care of the underserved should be an issue confronted by community, state and federal health clinics, the specialty of public health dentistry and the overall profession. How is it that our dental schools have become so central in addressing the issue of access to care?

According to Dillenberg,[4] 36 percent of the graduates from the Arizona School of Dentistry and Oral Health in Mesa, Ariz., enter community-service health clinics, either federal or state sponsored. Assuming this to be one model for the future of dental schools, what percentage of the 36 percent of graduates will be active in such a health care delivery system after four to five years of service — after their student loan debt is paid down to a manageable level? Could it be that dental schools founded on the principle of increasing access to care are simply providing clinicians on a continuing basis and that most of these clinicians eventually enter traditional private practice following relief of the major portion of their school debt?

Taking care of the underserved should be an issue confronted by community, state and federal health clinics, the specialty of public health dentistry and the overall profession.

Teaching, Research and Service

These newer schools of dentistry certainly fulfill the teaching and service parts of the traditional university mission. But the research initiative may legitimately be questioned and brings into the conversation other questions: What is a university and do the "new generation" dental schools fall within that definition?

In its most basic form, a university is an institution of higher education and research that has been given the legal and societal privilege of conferring academic degrees at the baccalaureate, master and doctoral levels. Many universities also provide education for an assortment of professional schools, e.g., medicine, law and dentistry. According to Lewis,[5] the term university is derived from the Latin *universitas magistrorum et scholarium*, or "community of teachers and scholars." The *Carnegie Classification of Institutions of Higher Education*[6] describes the characteristics of three types of doctoral/research universities. Does any institution calling itself a university have an obligation, as part of its mission, to generate new knowledge, i.e., to engage in a diversified research program? Obviously, public and private universities come in a bewildering variety of institutional forms, embedded in political arrangements and governance structures of remarkable diversity. However, regardless of the "corporate" structure or the educational survey cited, research remains at the top of the list when discussing the characteristics that best define a university.[7]

What are the research missions of the 10 new dental schools? Outwardly, such schools appear to not be engaged in diversified research programs. The full-time faculty in most of the "new generation" schools consists primarily of administrators and department chairs.[8] For the most part, the teaching faculty consists of part-time adjunctive faculty. Part-time faculty may not engage in a formal research program and have little motivation to become involved. The basic science teaching and research in the "new generation" dental school is generally provided by full-time faculty from the associated schools of medicine[1] and may not involve faculty from the school of dentistry.

Research distinguishes dentistry as a profession and makes the schools of dentistry a legitimate member of the university community. Without a mission of scholarship and a diverse research effort, dental schools may become trade guilds. The generation of new knowledge should be of paramount concern to all involved in the educational process or practice of dentistry.[9] Four of the seven dental schools

that were closed between 1985 and 2001 were then classified as "very high-research activity" programs.[10] Very few, if any, of the "new generation" dental schools, or those projected for a future debut, are part of a high-research activity university.[11]

As noted by Fox,[10] "access to care" has dominated the thinking of the profession the last several years and is "cited as the rational for opening many of the new dental schools." However, research in dental institutions must be afforded equal attention from those administrators who are charged with overseeing implementation of the institutional philosophy. Dentistry must be producers of knowledge, "not just consumers of knowledge produced elsewhere."[10]

Is it in the best interest of the profession that only a few schools of dentistry be heavily invested in research and thereby carry that burden for all the new schools? Should the production of a generalist be the only goal of a university-based school of dentistry? This approach may be shortsighted.

The advances in knowledge impacting the practice of dentistry that have occurred over the last 20 years are the result of intensive research programs. Examples include an increased understanding of the interactions of the microbial and human genomes and their associations with specific systemic diseases, the role of specific anaerobic microbes in chronic and aggressive periodontal disease, the host immune response to specific periodontal pathogens and the genetics of host susceptibility, alveolar ridge and sinus bone-grafting augmentation techniques, guided bone and soft tissue regeneration techniques, biocompatible implant designs and implant surface modifications that accelerate healing, and more recently, the rather startling results of epidemiology studies indicating that approximately 50 percent of U.S. adults between the ages of 30 and 70 years exhibit some degree of periodontitis.[12] Dentistry cannot afford to lose sight of the fact that new knowledge benefits all patients. A diversified research program should be a critical characteristic in defining a high quality, university-based school of dentistry. Indeed, the president and CEO of the American Dental Education Association (ADEA) has stated the one thing he would like to see more of in dental education is research.[13]

Is it in the best interest of the profession that only a few schools of dentistry be heavily invested in research and thereby carry that burden for all the new schools?

Education of the Generalist

The "new generation" dental schools have not become involved to any appreciable extent in specialty training programs. There are patients with severely advanced oral disease or patients with complex oral-systemic issues who require consultation and/or treatment by a specialist. The generalist and the specialist must participate in collaborative patient management. The new schools should make a clear decision to promote collaboration between generalists and specialists when confronted with patients presenting with severe disease and/or complex treatment plans. Dental school administrations should reward such collaboration; they should facilitate strategic planning for collaboration among generalist and specialty programs, learning from previous collaborative successes and failures. Ultimately, such collaborations enhance patient care, and in the process, conserve resources and possibly promote research devoted to delivery of primary care.

Many times questionable decisions are made by good people with good intentions. Obviously, there is never a bad time to do good things, but likewise we should be careful of a social philosophy that might irreversibly harm an entire profession. ■

REFERENCES

1. Smith KP, Woldt JL, Cottam WW, Cederberg RA. The Arizona model: a new paradigm for dental schools. *J Dent Ed* 2011;75(1):3-12.
2. Edelstein BL. W.K. Kellogg Foundation. *Training New Dental Healthcare Providers in the U.S.* December 2009 and updated June 2010.
3. Pew Charitable Trusts. *Two Kinds of Dental Shortages Fuel One Major Access Problem*. www.pewtrusts.org/uploadedFiles/wwwpewtrustsorg/Reports/State_policy/children_dental_shortage_access_brief.pdf.
4. Dillenberg J. Education that makes a difference. *Compendium* 2011;32(4):92.
5. Lewis CT. *Elementary Latin Dictionary*. Oxford University Press, 1999.
6. The Carnegie Foundation for the Advancement of Teaching http://classifications.carnegiefoundation.org/lookup_listings/institution.php. Accessed Oct. 6, 2012.
7. Lombardi JV, Craig DD, Capaldi ED, Gater DS. The top American research universities. The *Lombardi Program on Measuring University Performance*. The Center at the University of Florida. July 2000. mup.asu.edu/research2000.pdf. Accessed Oct. 6, 2012.
8. Cobb CM. Personal communication with administrators and faculty at A.T. Still University School of Dentistry and Oral Health. February 12-15, 2008; August 4-7, 2008; August 18-21, 2009.
9. Jahangiri L, Mucciolo TW. Toward a model of institutional scholarship in health professions education. *J Dent Ed* 2011;75(12):1569-1576.
10. Fox CH. Education and training. Letter to the editor. *J Am Dent Assoc* 2010;141(6): 621-622.
11. Carnegie Foundation for the Advancement of Teaching. Carnegie Classifications FAQs. http://classifications.carnegiefoundation.org/resources/faqs.php. Accessed Nov. 27, 2013.
12. Eke PI, Dye BA, Wei L, Thornton-Evans GO, Genco RJ. Prevalence of Periodontitis in Adults in the United States: 2009 and 2010. *J Dent* Res 2012;August 30 (Online): doi:10.1177/0022034512457373.
13. Bramson JB. Interview of Richard W. Valachovic, DMD, MPH. *Inside Dent* 2011;7(6). www.dentalaegis.com/id/2011/06/. Accessed Oct. 6, 2012.

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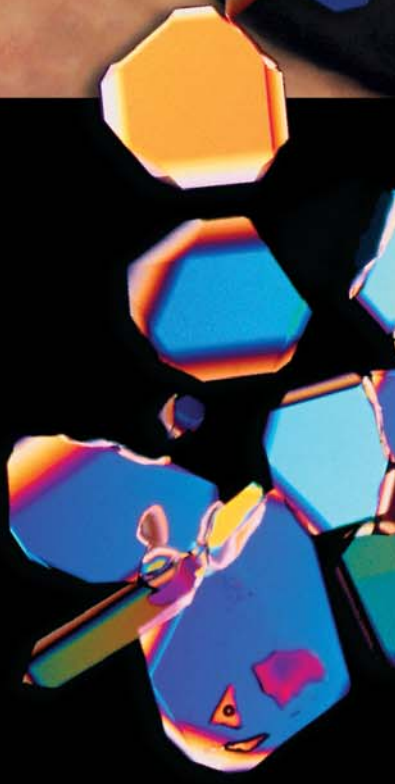

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Decision Dilemmas and Opportunities for the New Graduate Dentist

Natasha Anne Lee, DDS

ABSTRACT Career options for new graduate dentists are changing because of economic and management challenges in traditional practice, the growing trend toward group practice models, enormous educational debt load and lifestyle expectations of the millennial dentist. While new dentists learn to survive and adapt to an evolving profession with many pitfalls, they also have the opportunity to shape the future of our profession.

AUTHOR

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Many students on the verge of dental school graduation envision themselves following the traditional path — finding a job in a solo or small group traditional private practice where they can learn the ropes from a more seasoned dentist. They hope to be paid a guaranteed salary and have patients to treat. They expect to find a mentor and learn more about the clinical and nonclinical aspects of being a dentist. Most hope that such a job will lead to an opportunity to transition into ownership, or at least prepare them to purchase or start a practice when they feel that they have gained enough experience.[1]

The reality is that expecting such opportunities can be somewhat idealistic in today's economic environment. It is not uncommon to hear of a new dentist starting what promises to be a great job that turns out to be situation where there are not enough patients for the associate or the owner dentist. A number of dentists who had planned on retiring and transitioning their practice by hiring an associate have held on to their practices longer than they had hoped. With the economic downturn, many practitioners have seen a slow down in patient flow and treatment acceptance in their practices and they no longer need an employee dentist to handle additional patients. According to the American Dental Association, Americans are visiting the dentist less frequently and oral health expenditures have been on the decline.[2]

Many young dentists say they have had to become more open to the idea of relocating away from the often-

appealing metropolitan areas in favor of more rural communities and even out of California where there is a greater need and job opportunities. Fewer jobs being offered in the traditional private practice realm have led new graduates to venture into other job markets and have created opportunities for the business minded to create new business models that disrupt the traditional solo private practice of dentistry.

According to the American Dental Education Association's (ADEA) 2011 Survey of Graduating Seniors, the average amount of educational debt was $178,000 for those who had attended public dental schools and nearly $246,000 for those who were graduating from private dental schools.[1] It is not unheard of for some students to graduate with up to $400,000 in debt. These numbers do not even factor in the interest that a borrower will accrue on top of the principal owed. On debt of $246,000 consolidated over 30 years at 5.4 percent interest, the total amount paid in principal and interest over the lifetime of the loan would reach nearly half a million dollars for a private dental school graduate today.

So does the high level of student debt influence career decisions? The ADEA Presidential Task Force on the Cost of Higher Education and Student Borrowing says that it's not quite clear and that more research needs to be done, but that earnings over a lifetime still remain positive for dental professionals.[3] Corporate practice executives disagree. Some say that dental service organizations can attribute the growth of their practice model in part to increasing educational debt. They report that career options in large group practices have always existed but are particularly attractive to new dentists now because of record high educational debt. New graduates may worry about taking out practice loans on top of student loans and are concerned about their ability to ever get out of debt.[1]

Large corporate practice websites may be enticing to dentists seeking career opportunities. They advertise that their associate dentists earn wages that are significantly higher than their counterparts in traditional practices. Substantial benefits are also offered in large corporate practices when very few traditional associateships offer any benefits at all. In addition to the promises of big earnings, many large group practices offer formal mentorship programs, continuing education and training, leadership development programs, 401k and profit sharing plans, vacation and holiday pay, health insurance and professional liability insurance. In the case of international dentists graduating from U.S. schools, these large group practices offer to sponsor their work visas.

New grads worry about taking out practice loans on top of student loans. They are concerned about their ability to ever get out of debt.

Aspen Dental advertises on its website that the top 20 percent of its owner dentists can earn more than $1,250,000 after two years of ownership.[4] These big salaries may be particularly attractive to new grads with large educational debt.

Heartland Dental Care advertises "excellent income with guaranteed salary" and states that the average annual income for new doctors at Heartland is $225,000.[5] According to Pacific Dental Services, "the average full-time PDS-affiliated associate dentist earns $160,000 in his or her first year. By the fifth year, the average income increases to $220,000. The average income for a PDS-supported owner dentist, whose practice has been open at least two years, is $390,000."[6] These numbers are greater than typical reported incomes for owner and employee dentists in the U.S.

Besides the job market changing and educational debt increasing, the needs of the new graduate are evidently changing, as well, and that may very well be influencing the changes we are experiencing in dentistry. Those who were born between 1978 and 1996 are often referred to as the millennial generation,[7] and they are described as having very different opinions and characteristics than those generations who came before them. "Millennials are the most socially and diversely tolerant generation ever, the most educated and technologically savvy generation ever and also the most sheltered and structured generation in our country's history," according to authors of the book *Managing the Millennials*.[7]

Studies of high school seniors and college freshmen both indicate that the proportion of students who said that being wealthy was very important to them has increased dramatically from generations of the past. Research shows that millennials are expecting high material reward, great opportunity for growth, recognition for their accomplishments, rapid career promotion and more vacation and personal time.[8] A survey by a leading employment website reveals that the great majority of hiring managers and human resources executives report that they believe that a stronger sense of entitlement exists amongst millennials than amongst older workers.

Experts on generational differences warn though that the older generation must be cautious in judging the newer

generation. They must learn to adapt to the needs of the millennial because this generation is shaping the workplace in a very different way than past generations. While many new graduate dentists may initially entertain practice opportunities as nonowners because of financial constraints or a generational need for greater work/life balance, according to ADA research, most dental students and recent graduates who were surveyed expect that within 10 years they would own a practice.[1] Surveys also show that most new graduates plan on a career in "private practice."

According to the ADA's Health Policy Resource Center (HPRC), statistics show that dentists who choose the solo practitioner model of practice are declining, although the solo private practitioner still remains by far the greatest majority of dentists. In 2010, 69 percent of dentists were solo practitioners compared to 76 percent in 2006."[1] Practice consolidations into group practices is a growing trend. According to the ADA HPRC, in just two years the number of large dental group practices has risen by 25 percent.[1]

Dentists are not trained to be human resources managers, regulatory compliance officers, advertising and marketing specialists, efficiency experts or dental benefit plan administrators. Has it become too much work for one person to handle being the clinician as well serving as the CEO, COO, CFO and the IT department? Dental management service organizations say yes. They are offering to take these headaches away from the dentist by providing centralized practice support, administrative expertise, human resources oversight, marketing plans and dental benefit plan processing and fee negotiations. Dentists have often hired consultants and taken expensive practice management courses to try to learn these skills, but then fail to have the time or ability to integrate these protocols into their practices. Management organizations attempt to provide these services or offer dentists opportunities to walk into practices that already have systems and protocols in place.

In dentistry, we have counted ourselves lucky that we have believed ourselves fairly immune from the changes that have occurred in medicine over the past decades. The Physicians Foundation reports that doctors are dispirited. Besides just "professional grumbling" that surveys suggest that "physicians are at a tipping point at which they will seek ways to further disengage from today's medical practice environment, reducing their hours, decreasing the number of patients they see and accepting the status of salaried employees — trends that should be of urgent concern to both policymakers and the public."[9]

We may have something to learn from our physician counterparts that will help dentists shape the future of oral health care.

Will dentistry end up facing similar challenges? Have recent grumblings by new dentists entering the workforce begun to point to similar problems in dentistry? Will the millennial dentist be the generation to have to adapt or respond to these changes while older dentists sit back disgruntled like our medical colleagues? We may have something to learn from our physician counterparts that will help dentists shape the future of oral health care so that we do not end up with a new generation of dentists discouraged and disheartened because of their early experiences in our profession.

Jeremy A. Lazarus, MD, president of the American Medical Association, writes that consulting firms project that in only a few years that only one-third of U.S. doctors will be independent practitioners. Major employee search firms have projected that within a few years, 75 percent of all newly hired physicians will be hospital employees.[10] Frustrations in dealing with insurer demands have been reported as reasons why physicians have been increasing their efforts to consolidate or sell their practices to hospitals. In an Accenture survey of 204 physicians, 87 percent cited business expenses as a top concern influencing their decisions to seek employment. Dealing with health insurers was the second most influential concern, reported by 61 percent of those surveyed.[11] According to the Commonwealth Fund, in 2011, the average American medical practice spent $82,975 per doctor to deal with insurers.[10]

According to one survey of U.S. physicians, medical practice owners who deal with greater reimbursement challenges and higher levels of administrative paperwork were also found to be more likely dissatisfied with their profession than employee physicians. The Physicians Foundation suggests that this dissatisfaction may also be attributed to the fact that older physicians are less likely to view changes in the medical practice environment as positive, while younger physicians have only known and more easily accepted the new reality of medical practice.[9]

Of the physicians surveyed, 84 percent responded that they felt their profession was in decline and they reported that they attribute the decline to too much regulation and paperwork, loss of clinical autonomy, physicians not

being compensated for quality, erosion of the physician/patient relationship and money trumping patient care.[9]

Furthermore, more than 75 percent of physicians responded that they disagreed with the notion that hospital employment of physicians is a positive trend that is likely to enhance quality of care and decrease costs.[9]

Most states require dental practices to be owned by a licensed dentist, although there are some exceptions. In states requiring dental practices to be owned by a licensed dentist, there has been debate about what truly constitutes ownership of a dental practice and if the lines have been blurred when the intent of such laws is to assure that patient care is of utmost importance. Questions have been raised lately regarding the backing of many corporate practices by large equity firms who may be placing the interest of the investors over the well-being of the patient.

In July 2013, the U.S. Senate released the Joint Staff Report on the Corporate Practice of Dentistry in the Medicaid Program after completing a two-year investigation of dental chains owned by private equity firms and the findings are disturbing to a profession that generally prides itself on ethics and a reputation for being trusted by the public. "Across the country, there are companies that identify themselves as dental management companies. These organizations are typically organized as a corporation or limited liability company. They work with dentists in multiple states and purport to provide general administrative management services. In late 2011, whistleblowers and other concerned citizens came forward with information that some of these companies were doing more than providing management services."[12]

The report adds that "based on our review of several management services agreements, employment contracts and the payment structure, it appears that these arrangements are designed to give the appearance of complying with state laws requiring that dental clinics be owned by licensed dentists. However, in practice, dental clinics are not owned by dentists in any meaningful sense."[12] So while some may be quick to find appeal in new ownership configurations in dentistry, each must enter such opportunities with caution regarding ownership laws particular to each state as to not end up in legal trouble.

Dentists must still be responsible for the billing practices for their patients regardless of their ownership status because they can be held responsible for Medicaid and insurance fraud.

Additionally, dentists can be put at risk when billing practices are handled in an unethical and illegal manner when they are delegated to an entity other than the dentist and the dentist loses oversight. The U.S. Senate reports that in one large corporate practice the owner dentists were simply paid a salary and "despite the language in the management services agreement regarding the payment structure and management fees … it is clear that the 'owner dentists' have no idea where the money from the procedures for which they bill Medicaid actually ends up."[12] Dentists must still be responsible for the billing practices for their patients regardless of their ownership status because they can be held responsible for Medicaid and insurance fraud.

The Senate report also points to "flawed management services agreements, which remove traditional ownership authority from dentists. These agreements fundamentally limit the ability of dentists to exercise independent clinical judgment."[12] Many new dentists share negative stories of their early experiences where they had lost clinical autonomy and had no decision-making independence.

For instance, Dr. R has worked in many corporate chain practices in different states. He recounts stories of office managers, who were paid on commission, adding root canals to treatment plans when the dentist had only diagnosed and treatment planned crowns. He also has knowledge of practice policies requiring any tooth that needs a three or more surface filling to automatically be treatment planned for a crown instead.

Dr. T worked for a large corporate practice for several years before he decided he couldn't continue to practice the way he was expected. He tells stories of dentist employees being pressured to place posts in all endodontically treated teeth, whether they were clinically necessary or not, just because they were a billable service that could increase profitability for the company. He also felt like he was not able to do his best work given the number of patients he was expected to treat in short amounts of time.

Some dentists admit that even as owner dentists they do not have the authority to hire additional employees to handle unmanageable patient loads without approval from their management service organizations.[12] New graduate dentists are considered safe beginners in our profession and generally require more time to complete procedures with confidence and focus on patient safety. Placing new dentists into situations that are too fast paced for a beginner can be detrimental to patient care and

put the dentist at risk. For example, Dr. M, who just graduated six months ago, says she had to leave the DSO practice where she landed her first job when she was asked to perform a root canal, post and core buildup and a crown on tooth No. 15 while also completing four recall exams — all in one hour.

Earlier this year, a group of dentists in North Carolina, along with the state dental board, sued the large corporate practice where they worked, complaining of loss of clinical autonomy and pressures to over-diagnose and over-treat patients. The dentists then became defendants when the North Carolina Dental Board investigated these dentists because they participated in the alleged activities. Lessons like these are important for new graduates to understand when they enter into their first jobs, whether they are in small traditional practices or large group practices.

Not all accounts of insurance fraud, substandard care, upselling, overtreatment and excessive sales quotas and incentives occur in large group practices or practices managed by service organizations. Some new graduates report similar experiences in small, traditionally owned private practices that are struggling to stay in business with increasing pressures to control costs and maximize efficiency while accepting reimbursement levels from dental benefit plans and publicly funded plans that do not satisfy their cost of providing care.

Dr. S was working on the East Coast in a small, privately owned practice and began to question whether what she was taught in dental school was too idealistic. She was told not to use rubber dams in order to control overhead costs and was encouraged to deliver crowns to patients even though she thought the quality of the lab work was unacceptable. She was told that her patients' low reimbursing dental benefit plans did not allow her to use a higher-quality lab or allow her to waste a second nonproductive appointment to remake the crown.

Dr. J quit her first job because the traditionally owned practice where she was employed used color-coded charts for patients according to their dental benefits plans. Some patients with low reimbursement plans who had scheduled appointments were made to wait or were bumped out of the schedule altogether in favor of patients paying full fees for treatment. She reports that varying-quality labs were used for patients according to their insurance coverage and color-coding of charts. She knew she had to quit when staff changed a prescription form she had prepared to send to a lab and then billed the procedure for the higher-cost crown, even though it had been made of a less expensive material.

> Placing new dentists into situations that are too fast paced for a beginner can be detrimental to patient care and put the dentist at risk.

Participants in the Ethics Summit on Commercialism, a two-day conference held at the ADA in 2006, agreed that commercialism can have negative connotations when it consists of "attitudes or methods that excessively emphasize profit or business success."[13] On the other hand, some of the positive aspects of commercialism were said to include stimulation of innovation, improvement of support systems for dentists, receipt of fair compensation, as well as exchange of value and relationship building. But the participants warned against the "temptation of money over patient or the public good, working at the level of commodities (lowest common denominator for quality), large-scale operations that fail to respond to individual needs, advertising that is misleading and making profit a standard for colleagues."[13]

A Harvard School of Education project looked at the perspectives of young professionals entering various fields compared to the viewpoints of their successful veteran counterparts. They found that older professionals often underestimated the pressures and difficulties faced by the younger professionals. Writers on commercialism in dentistry suggest that because professional values taught in school were learned in an isolated and protected environment, that the first few years of practice outside of school could be dangerous, as some practitioners decide to temporarily suspend the professional ethics and values learned in dental school "just until they get established."[13] They also advise "because this generation of leadership in dentistry must inevitably pass the profession to its juniors, it is imperative to work with them rather than blame them. There is some evidence in both dentistry and other professions that the critical time for the creation of professional values is the first few years of practice."[13]

In response to concerns over the ethical dilemmas commonly being reported by employee dentists, the ADA House of Delegates in 2013 passed a resolution to create an ADA statement of fair practices in employing a dentist. The purpose was to create guidelines for dentists employed by another dentist or a management company in order to protect patients in their receipt of safe, high quality and cost-effective patient care. Included in that statement are provisions

that a dentist should not be disciplined or retaliated against for exercising his or her own independent professional judgment when it comes to patient diagnosis, treatment and comprehensive management or for reporting suspected illegal behavior by employers, including inappropriate billing practices.

The role of dental education, organized dentistry and experienced dentists should be to work to assure that our young professionals receive training and support in all aspects of dentistry, including business management and ethics so they are better prepared to understand the challenges facing dentistry. In addition, members of our profession must remain open minded to the fact that changes are occurring as pressures are placed upon health care providers. "We have entered a new economic era for dentistry. Those who recognize this fundamental fact and make the necessary adjustments will be the most successful … expectations may have to be adjusted accordingly, but under no circumstances should we ignore the changes that could threaten our patients, our professional reputations or the future appeal of dentistry as a choice of career for the next generation,"[14] writes practice management consultant Roger P. Levin, DDS.

We need to create more business-savvy dentists. For many years, dentists have complained that the biggest challenges to being a dentist have nothing to do with clinical aspects. Dental students learn to diagnose and treat dental disease, but relatively little time is spent preparing these students to own and operate a small business, even though the majority of dentists eventually do own and manage their own practices.

Levin adds, "It is notable that 67 percent of dentists report that inefficient practice systems are their biggest challenge right now. That number has doubled from just a year ago. More dentists realize that, in order to succeed in the new dental economy, practices must be operated as excellent businesses. This means implementing innovative systems that will increase production and profitability by addressing current economic challenges."[14]

Levin further reflects upon an annual survey that "more than a third of responding dentists (35.2 percent) said they are experiencing high or extremely high stress. This represents a marked increase in professional stress, even when compared to last year's high 28.5 percent response." He attributes the stress to minimal practice growth, working longer hours and dealing with increased financial pressures. He warns that until dentists implement effective business solutions, that their stress levels will likely remain high.[14]

Dental students learn to diagnose and treat dental disease, but relatively little time is spent preparing these students to own and operate a small business.

Surveys from the ADEA reveal that more than 40 percent of graduating senior dental students report that the amount of time dedicated to preparing them for practice administration and understanding the organization and financing of health services was inadequate to prepare them for a career in dentistry.[15] Results of California Dental Association surveys and focus groups frequently reveal that practicing dentists are most often frustrated with practice management and business administration. They report that they need the most help with gaining the knowledge and skills necessary to confidently and successfully own or manage a dental practice. In response to these needs, CDA developed its Practice Support Center in 2007 and the American Dental Association has just launched its online Center for Professional Success. Organized dentistry also has the opportunity to be at the forefront of offering quality educational courses on practice consolidation as some dentists attempt to move their practice in this direction and as those of the millennial generation seek to develop such group practices.

While CDA offers new programs such as the Dental Benefits Workshop and the New Dentist Boot Camp and many consultants are available to coach dentists on the business of running a practice, more practice management and health care economics need to be taught in dental school. However, dental school curriculums are already impacted. Perhaps courses in economics and finance should be required prerequisites to enter dental school.

Right now, we must not ignore the educational debt crisis and address what is being called a national educational debt bubble because it plays an important role in the economics and the future delivery of dental care. A bubble grows when consumers overpay for a product to the extreme that the price exceeds its value. Such growth becomes unsustainable and the bubble bursts, leaving behind an often shocking and detrimental reality.

The ratio of graduating dental student debt to the average annual income of a new graduate entering the profession can be used to measure the market economy. The current debt-to-income ratio for new graduate dentists should be cause for alarm and reflects the amount that students borrow.

According to a recent article published in *The New England Journal of Medicine*, the continued rising costs of health professional education can be justified "so long as it is believed that patients, or whoever purchases health care on their behalf, will keep paying more and more for physicians' services."[16] If students can be assured of a reasonable return on their educational investment in the form of reasonable future compensation, the economics make sense. But that may not be the case as we head into the future. "We just have to recognize that the high costs of medical education are sustainable only if we keep paying doctors a lot of money, and there are strong signs that we can't or won't."[16]

We must understand the access to care issue must be recognized for what it is, a health care affordability and financing issue. Pressures are placed upon all of health care to reduce the cost of care for the patient and for those who pay for their care, while at the same time reimbursement rates from government plans and dental benefit plans have not grown and are even on the decline. It's therefore no wonder that we are witnessing massive challenges and changes in dentistry.

Dentistry must not only maintain a position as the leading authority on the practice of dentistry but take a more active role as an authority on health care economics. In medicine, there are growing varieties of practice merger models that are evolving that still allow physicians to remain relatively independent. Independent practice associations, for example, allow physicians the advantage of being able to contract as a group clinically and financially while still maintaining their independent corporate status.[10] Many different configurations of private practice and ownership are at play today in dentistry as well and the environment is ripe for further innovation to challenge traditional solo private practice dentistry.

Over the decades the AMA has seen membership in its organization dwindle from 75 percent to only about 15 percent of practicing physicians.[17] The Physician's Foundation survey reports that now more than 82 percent of physicians agreed with the statement, "physicians have little influence on the direction of health care and have little ability to affect change."[9]

As dentists, we must be proactive and look to not only protect the positive attributes of current dental practice models, but also be willing to look with a critical eye at the problems oral health care is facing and be prepared to make recommendations and decisions based on a rapidly changing health care environment. The battles should be fought not in ways that isolate or polarize dentists who practice in new and innovative ways, but should be fought by dentists together to assure that within these emerging practice systems dentists maintain clinical autonomy and independence, that new graduates are aware of the ramifications of the decisions they make when exercising that clinical autonomy in any setting and that professional organizations have a role to continue to be a resource for all dentists so that they can navigate the current and future challenges being presented to us as a profession. ■

REFERENCES

1. Fox K. ADA Explores Growth of Large Group Practices. *ADA News*, April 09, 2012.
2. Soderlund K. ADA Poised to Help Dentists Adjust to Changing Landscape. *ADA News*, Nov. 4, 2013.
3. A Report of the ADEA Presidential Task Force on the Cost of Higher Education and Student Borrowing. March 2013.
4. www.aspendentaljobs.com/dentist-tremendous-earning-potential.htm.
5. ww2.heartlanddentalcare.com/jointheleadingdso/recruiting.cfm.
6. www.pacificdentalservices.com/careers/dentists/overview.
7. Espinoza C, Ukleja M, Rusch C. *Managing the Millennials: Discover the Core Competencies for Managing Today's Workforce*. 2010, John Wiley and Sons Inc.
8. Alsop R. *The Trophy Kids Grow Up: How the Millennial Generation Is Shaking up the Workplace*. 2008, Jossey-Bass.
9. A Survey of America's Physicians: Practice Patterns and Perspectives. A survey conducted on behalf of The Physicians Foundation. Merritt Hawkins, September 2012.
10. Lazarus, JA. Private Practice's Future in a Changing Time for Medicine. *AMNews*. April 29, 2013.
11. Cook, B. American Medical Association: Health Plan Market Dominance Causes "Competitive Harm." *AMNews*, Dec. 12, 2012.
12. U.S. Senate Joint Staff Report on the Corporate Practice of Dentistry in the Medicaid Program, July 2013.
13. Boyd MA, Roth K, Ralls SA, Chambers DW. Beginning the Discussion of Commercialism in Dentistry. *J Calif Dent Assoc*, vol. 36, No. 1, January 2008.
14. Blaes, J. The Dental Economics/Levin Group 2012 Annual Practice Survey. *Dent Econ*, October 2012.
15. Okwuji I, Anderson E, Valchovic R. Annual ADEA Survey of Dental School Seniors: 2009 Graduating Class. *J Dent Educ*, Sept. 1, 2010 vol. 74 no. 9 1024-1045.
16. Asch DA, Nicholson S, Vujicic M. Are We in a Medical Education Bubble Market? *N Engl J Med* 2013; 369:1973-1975 Nov. 21, 2013 doi: 10.1056/NEJMp1310778.
17. American Medical Association. Woes Continue, Roger Collier, *Can Med Assoc J* Aug. 9, 2011 vol. 183 no. 11; 183(11): E713–E714.

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Who Will Tend the Dental Safety Net?

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ABSTRACT The dental safety net relates to the sites, providers, programs and payer sources that are available to low-income people in households with incomes less than three times the federal poverty level. Thirty percent of the population of California depends upon the health care safety net. Proposed solutions to meeting the safety net's dental needs challenge conventional thinking about who is responsible for providing oral health care and what safety net groups gain improved access.

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Fishermen know that unattended fishing nets can pose a serious threat to marine life during a storm. Mammals may get caught in them and either drown or suffocate. The dental safety net is a lot like a fishing net. If the safety net is unattended and frayed, it becomes a threat to life. The dental safety net is frayed. Some parts of the dental safety net are shored up while other areas are weakened and continue to unravel.

The effectiveness of the dental safety net is being challenged by the growing burden of oral disease, persistent oral health disparities, barriers to access, workforce recruitment and integration and continuing threats to financial sustainability. This paper looks at the overall condition of the dental safety net and who will tend it in the days ahead.

Organization of the Health Care Safety Net

The health care safety net exists for those households whose earnings are less than 300 percent of the federal poverty level (FPL) and are either uninsured or publicly insured. It is cobbled together by a combination of legal mandates, organizational missions and by contracts to provide care to patients regardless of their ability to pay. In California, 30 percent of the population depends upon the health care safety net for health care services, including oral health.[1] The oral health care safety net programs for the noninstitutionalized population are provided by Federally Qualified Health Centers (FQHCs), Rural Health Centers, Indian Health Service and tribal clinics, hospital emergency departments, hospital outpatient dental clinics, Medicaid-oriented dental practices, school-based dental clinics, local health department clinics and a variety of other community-based, free and nonprofit organizations.

Threats to the Dental Safety Net

The dental safety net has expanded significantly over the past two decades. However, it does not yet have the capacity or resources to meet the needs created by persistent oral health disparities and a near epidemic of preventable oral disease in underserved populations. Inconsistent support for adult

dental services by many states, including California, creates another barrier to access. Recent national efforts to improve health care offer minimal, if any, support for adult oral health in the near term. Over the next five years, the Patient Protection and Affordable Care Act (ACA) proposes to overhaul the health care payment system, improve access to care and improve outcomes. The most significant change affecting the health safety net is the expansion of Medicaid. By 2018, when most of the changes have been implemented, the dental safety net can expect to see an additional 10.4 million dental visits.[2] Can a system that is struggling to address overwhelming oral health needs with its current resources handle the increased demand?

Oral Health Disparities

The ADA Dental Divide in America study conducted among adults in April 2013 by Harris Interactive found significant disparities in oral health and oral health visits among low-income and middle- and high-income adults.[3] The study noted that nearly half of lower-income adults hadn't seen a dentist in a year or more, while 70 percent of middle- and upper- income adults had. Twenty percent of lower-income adults said that they or a family member used an emergency room for a dental problem at some point in their lives, while only 7 percent of middle- and upper-income adults had that experience. Of the lower-income adults who used the emergency room, only 6 percent felt the problem was resolved. According to the National Center for Chronic Disease Prevention and Health Promotion, tooth decay affects more than one-fourth of U.S. children aged 2-5 and half of those aged 12-15.[4] Approximately 50 percent of all children and two-thirds of adolescents aged 12-19 from lower-income families have experienced dental decay.[5] The Centers for Medicare and Medicaid Services (CMS) reported that approximately 41.7 percent of Medicaid-eligible children received a dental service in 2011.[6] In California, only 33.8 percent of the almost 4.7 million eligible children received a dental service in that time period.[7]

The 2007 Harris Interactive Survey of California found that compared to all respondents, African-Americans, Latinos, the publicly insured and persons with incomes less than $25,000 most often reported fair to poor oral health.[8] The cost of oral health care was the most frequently cited barrier to accessing oral health care among the uninsured.

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Social Determinants of Health

The social determinants of health are the circumstances into which people are born and live that ultimately affect their health status. These circumstances are shaped by economics, social policies and politics. It is known that poor health outcomes, including poor oral health outcomes, are made worse in individuals by their physical and social environments.[9] According to the World Health Organization's Commission on Social Determinants of Health "in countries at all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health."[10] The dental safety net exists to support the health needs of those who find themselves in these difficult socioeconomic situations.

Payer Sources

The Health Care and Reconciliation Act of 2010 and the ACA expand Medicaid eligibility to include all individuals and families who are either citizens or have been legal permanent residents for at least five years and have incomes up to 133 percent of the poverty level. In addition, the ACA may provide federal subsidies on a sliding scale for low-income families with family incomes above 133 percent up to 400 percent of the FPL to purchase dental insurance for their children through a health exchange.

The ACA does not provide for a basic adult dental benefit. Adult dental services are an optional benefit under Medicaid. Access to adult dental services among Medicaid beneficiaries will continue to vary from state to state. In 2009, California eliminated most optional adult dental services. Recent legislation restores most of these services effective May 2014.

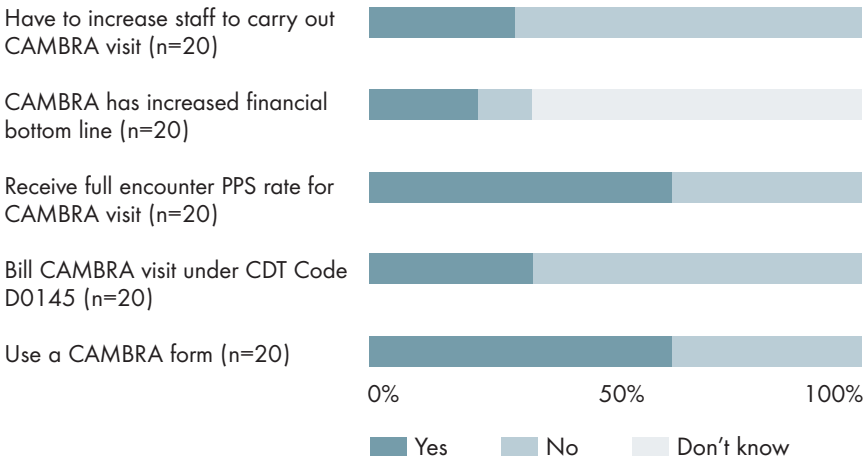
A large residual population that the ACA leaves out is undocumented residents or legal permanent residents who have lived in California less than five years. Section 17000 of the California Welfare and Institutions Code requires that counties provide comprehensive health care services to their medically indigent population. In rural areas of California, this population is funded through the County Medical Services Program.[11] The program currently includes 35 counties.

The ACA contains provisions that include dedicated, direct funding to health centers through a new trust fund and a permanent authorization. However, the Community Health Centers Trust Fund authorization levels are likely to remain well above the actual funding levels needed to sustain and grow the health center program.[12]

Chronic Caries Disease Management

Caries Management by Risk Assessment (CAMBRA) includes caries risk assessments and motivational interviewing, primary caregiver/parent education, modification of the oral flora, remineralization and minimal operative intervention.[13] CAMBRA and other risk assessment tools have not been adopted widely as the standard of care. However, an increasing number of dental safety net providers are incorporating

them into clinical practice. Potential increased costs in time and manpower to implement have not been determined for many programs. In a survey of 20 safety net dental directors conducted for the California Primary Care Association, the greatest impediments to implementation were questions of cost and reimbursement. While 60 percent were using a CAMBRA form in their encounters, it was unclear to many of the dental directors surveyed if CAMBRA visits were billable or if full payment would be received for the encounter under the Prospective Payment System (PPS) (**FIGURE 1**).



California Primary Care Association. Surveyed by Jack C. Luomanen, DMD, and Amanda Stangis (2010).

FIGURE 1. Safety net dental directors' CAMBRA experience.

Major Dental Safety Net Programs

FQHCs and Rural Health Centers

FQHCs and Rural Health Centers (RHC) are community health centers that meet the Community, Migrant and Public Housing Health Center grant requirements. They receive federal funding from the Bureau of Primary Health Care and are steadily building capacity. They provide access to primary care, especially through medical homes, which results in better health outcomes, reduced health disparities and lower health care expenditures.[14] According to the National Association of Community Health Centers, health centers saw an increase in dental patients, from 1.3 to 4 million between 2000-2011.[15] The number of dental visits at these health centers rose from 3 to 10 million during the same time period.[16] One of the goals of Healthy People 2020 is to increase the proportion of patients who receive oral health services at FQHCs. In 2010, 17.5 percent of patients at FQHCs received oral health-related services. If Healthy People 2020 (the nation's new 10-year goals and objectives for health promotion and disease prevention) meets its goal, one in three patients will receive oral health services at FQHC clinics by 2020.[17] In California, the 2013-14 legislative budget package included a partial restoration of Medi-Cal adult dental benefits due largely to the tremendous need evidenced by the CDA Cares clinics throughout the state that provided free dental services.[18] Basic preventive and restorative services, along with full dentures, will be brought back beginning May 1, 2014.[19] Adult medical patients at FQHCs where dental services are co-located will be able to access adult dental services. The CMS requires that FQHCs offer the Medicaid scope of services available to their uninsured patients.

Indian Health Service, Tribal Clinics and Consortia

According to the Indian Health Service (IHS), American Indian and Alaska Native (AI/AN) dental patients experience more tooth decay, periodontal disease and have less access to dental services than the general U.S. population.[20] Sixty-eight percent of adolescents had untreated tooth decay compared to 24 percent in the general population. Thirty-two percent of AI/AN adults aged 35-44 had advanced periodontal disease versus 12 percent in the general population. California has the largest Native American population (almost 650,000) in the United States.[21] All California Indian Health clinics are managed by the Native Americans. Most facilities are operated by individual tribes or consortia formed by groups of smaller tribes. Eight programs are urban health centers. Approximately 50 dental clinics are operated by tribal and urban Indian health programs.[22] Indian Health Service does not directly operate any hospitals or clinics in California. However, it does provide technical assistance on dental issues and sponsors continuing education for professional personnel.

Hospital Emergency Departments and Dental Clinics

According to the Health Care Cost and Utilization Project, more than 900,000 emergency department visits and nearly 13,000 hospital inpatient-stays in 2009 were related to dental conditions.[23] The study found that adults aged 18-44 accounted for more than 60 percent of the visits and the visit rates in rural areas were more than double those in large metropolitan areas. Emergency department dental visits were four times higher among patients from lower-income communities than those from higher-income communities. The American

Dental Association Health Policy Resource Center also looked at dental-related emergency department visits using national Medical Expenditure Panel Survey (MEPS) data.[24] Their analysis showed that there was not only an increase in dental visits from 2000 to 2010, but that there was an increase in percentage of dental emergency department visits relative to total dental visits. Between 2009 and 2013, when California limited the Medi-Cal scope of adult dental benefits to Federally Required Adult Dental Services, a significant portion of the increase was attributed to visits for oral conditions that could be managed more appropriately, definitively and cost-effectively in outpatient dental facilities.[25] Those using the emergency department were more likely to have Medicaid or no health insurance.

Some hospitals have dental departments with general practice residency (GPR) and advanced education in general dentistry (AEGD) programs. Graduate Medical Education (GME) funds support the program costs and the residents treat high volumes of the safety net population at public hospitals. It is unclear whether co-located dental departments at hospitals have any effect on reducing emergency department visits.

Local Health Departments

Some county and municipal health departments provide oral health prevention or oral health care visits. In 2008, 25.8 percent of local health departments offered oral health-related services.[26] The goal for Healthy People is for 28.4 percent of the local health departments to offer oral health-related services by 2020. Some health departments have found it beneficial to offer women enrolled in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) oral health information and initial infant oral care visits.

School-based Dental Programs

There are more than 7 million school-aged children in California. An estimated 504,000 miss at least one day of school each year because of a dental problem. According to the 2007 California Health Interview Survey, dental problems kept California students out of school an estimated 874,000 days a year, costing schools about $29.7 million in lost attendance-based funding.[27] In a study of Los Angeles elementary and high school students, researchers found that students with toothaches were almost four times more likely to have a low grade point average.[28] Students with limited access to dental care were more than twice as likely to miss school than those with access. Parents averaged 2.5 absent days from work or school each year because of their children's dental problems.

One solution is to bring oral health services to the schools in the form of mobile clinics or permanent facilities within the schools that are operated by community health centers, local health departments or dentist proprietors. According to the California School Health Centers Association, there are 226 school health centers.[29] Forty-five percent of the clinics are in high schools, 30 percent in elementary schools, 10 percent in middle schools and the remainder in mobile vans. The association also points out that school-based health centers tend to be located in schools with larger numbers of students from low-income families. Unfortunately, only 31 percent of the clinics offer dental prevention programs and even less (19 percent) offer treatment.

There is no single source of funding for school-based dental clinics. The sources used most often include reimbursement from public insurance programs and private health plans; local, state and federal grants; philanthropic foundations; and in-kind contributions from school districts and other partners.[30] Only with this complex funding are the clinics able to approach sustainability.

Dental Safety Net Workforce

In a 2010 review of available data, Burton Edelstein, DDS, MPH, estimated that less than 3 percent of U.S. dentists were employed in dental safety net organizations and less than a quarter of private practice dentists were accessible to this underserved population.[31] As the need for the dental safety net grows, where will we find the caregivers? (**FIGURE 2**.)

Dental Students and New Dentists

Will dental students help meet the oral health needs of the dental safety net population? Most clinics in California dental schools accept Medicaid patients and provide access to the safety net population. In addition, the Robert Wood Johnson Foundation's national program, Pipeline, Profession and Practice: Community-based Dental Education (more commonly known as the Dental Pipeline Program), has supported dental school efforts to prepare students to work in safety net institutions. The educational and training model developed by the Dental Pipeline Program included lectures, skills training and reflective learning to help students gain an appreciation for and value universal oral health access. Third and fourth-year students rotated through community health centers delivering oral health care to the safety net population. It has been shown that fourth-year dental students who rotate through well-run, patient-centered health centers are productive and make a significant impact on volume of patients receiving services.[32] Moreover, students report increased confidence and interest in treating the dental safety net population.[33]

FIGURE 2. This group of health care professionals conveys the interdisciplinary diversity of those caring for dental safety net patients.
First row, seated left to right: Parish Ford, RN; Hilda Romero Gomez, medical assistant; Candace Riley eligibility clerk; Lisa Pacheco; David Hoffman, MD, pediatrician; Debra Jackson, RN; Pamela Alston, DDS.
Second row, left to right: Rita Kelly, medical assistant; Tosan Boyo, MPH, Safety Net Clinic administrator; Elvia Chavez, eligibility clerk, Nicole Bartolome, fourth-year UCSF dental student; Sara Kent, fourth-year UCSF dental student; Gloria Harger, registered dental assistant, Beatriz Castillo, eligibility clerk; Jordan Coffey, predental student; Carmen Ayala, medical assistant; Lisa Rosequist, PhD, pediatric psychologist.
Third row, left to right: Erika Demonsant, registered dietician; Veronica Sood, MD, pediatrician; Danielle Nguyen, MD, pediatrician; Bob Savio, MD, pediatrician; Erin Tsuchimoto, MD, pediatrician; Jack Bayless, CAMBRA study clinical research assistant and predental student, Jeffrey Lazarus, PhD, pediatric/adolescent psychologist.

Dental education plays an important role in sensitizing students to access and accessibility issues as well as influencing graduates' long-term practice decisions. Survey results about dental graduates' long-term practice plans are not optimistic. A survey of graduating students in 2007 revealed that 1.7 percent planned a long-term plan to practice in a "community clinic." A follow-up study a year later revealed that 2.2 percent of the 2007 dental graduates were employed by dental safety net programs.[34] Health centers where the population is rurally dispersed experience regular clinical vacancies and challenges in recruiting clinical staff including dentists.[35] Nationally, more than 49 million residents live in Dental Health Professional Shortage Areas (DHPSA).[36] DHPSAs are primarily areas where the population-to-dentist ratio is at least 5,000:1 and have difficulty recruiting and retaining dentists even when the population has an adequate payer source.[37] Many of the FQHCs, RHCs and Indian Health clinics are located in DHPSAs. Dental graduates may be eligible for partial loan repayment programs through the National Health Service Corp if they serve in a safety net clinic and meet other criteria.

Registered Dental Hygienists in Alternative Practice

In California, registered dental hygienists in alternative practice (RDHAP) legally provide dental hygiene services to patients for up to 18 months without the involvement of a dentist in hospitals, residential care facilities and other public health settings in DHPSAs. Their numbers are still relatively small, but RDHAPs have been shown to increase access to dental hygiene services and to expand access to restorative care through referrals to dentists.[38]

Primary Care Providers

Some pediatricians are already incorporating oral health into their practices. The American Academy of Pediatrics website contains tools and resources to help physicians perform oral health risk assessments, provide oral hygiene counseling and apply fluoride varnish as needed.[39] Medicaid reimburses physicians and other medical personnel for oral health risk assessments and fluoride varnish applications in 44 states. Many pediatricians, despite their time demands, are willing to incorporate oral health into their pediatric visits until the child has a dental home.

Private-practice Dentists

Less than 25 percent of private-practice dentists are accessible to the dental safety net population.[31,40] Those who are accessible perform a critical role in providing access to the safety net population whether they are general dentists or specialists. Dentists who establish private practices in low-income communities can face significant challenges to their economic viability. Medicaid is a major public insurance among low-income patients. Dentists cite low payment rates as the primary reason for not treating more Medicaid patients.[40] In September 2013, the California Department of Health Care Services further reduced reimbursement to Medi-Cal providers when it began to implement a 10 percent payment reduction in Medi-Cal fee-for-service.

Since 2009, federal regulations have permitted FQHCs to contract with private dentists to provide oral health care to FQHC patients. The contracted dentists do not have to be Medicaid providers because the FQHCs bill Medicaid unless otherwise required by state regulations. Contracting between FQHCs and private dentists is a mutually beneficial arrangement. Private dentists are able

to negotiate a reasonable payment rate based on fair market value to provide oral health services to the dental safety net population. FQHCs can ensure that their patients receive oral health services without incurring the cost of building and maintaining dental facilities and staffing.

Expanding the Safety Net Workforce

Underrepresented minorities (URM) account for more than 30 percent of the U.S. population, but they are a much smaller proportion of the total workforce in health professions. Currently, the Institute of Medicine classifies African-Americans, Latinos, Native Americans, Alaskan Natives, some Asian-American subgroups and some Pacific Islander subgroups as URM. According to surveys, African-American and Latino dentists are almost twice as likely to accept Medicaid patients into their practices when compared to Caucasian dentists.[41,42] This suggests that a diverse workforce is critical to eliminating oral health disparities. Successfully recruiting low-income, underrepresented minority dental students *may* require a pipeline that starts in elementary school. The cost of dental education is a huge barrier to recruiting qualified URM students and any increases above the current percentage of URM in dentistry will likely depend upon financial aid packages and the effectiveness of a pipeline project that will motivate URMs to enter dentistry.

What if there continues to be a shortage of dentists and RDHAPs to service the needs of the safety net? Can telehealth technology and electronic dental health records extend the reach of dentists in DHPSAs? Do we need new categories of dental health care workers such as dental therapists who can provide elements of care in these underserved areas that are currently provided by dentists and RDHAPs?

A Health Workforce Pilot Project authorized by the California Office of Statewide Health Planning and Development allowed registered dental hygienists working in public health programs and registered dental assistants to place interim therapeutic restorations under the direction of licensed dentists at nine sites.[43] Preliminary data indicate that this model of care, which includes prevention, early intervention services and referrals to dentists for definitive treatment, can help patients achieve and maintain oral health. If regulatory, scope of practice, billing and financial hurdles are overcome to make this model of care legal, will dentists be willing to incorporate the model into their practices and make treatment decisions using telehealth technologies instead of an in-person oral examination?

Successfully recruiting low-income, underrepresented minority dental students *may* require a pipeline that starts in elementary school.

Summary

The latest health rankings place Americans' health below 16 other developed nations.[44] Yet, the U.S. devoted more of its gross domestic product (GDP) to health care than any other country in 2010.[45] There is a national health initiative, "Triple Aim," which has emerged as a galvanizing principle around better health, better health care and low per capita costs. Medicine, urged by coming changes in Medicare and Medicaid, is already moving away from traditional payment systems and to "pay-for-performance" or "value-based purchasing" schemes under which health care providers are rewarded for results and quality of care improvements.[46] It is likely that private insurers will follow Medicaid in devising financial schemes that emphasize payments for quality care delivered in the most cost-effective settings.[47] It is only a matter of time when dentistry will be tasked to do the same.

The "dental divide" that Robert Faiella, DMD, MMSC, past president of the ADA, calls the gulf between the population with the burden of untreated dental disease and those without active dental disease[3] is unconscionable. Moreover, there is a growing awareness that the fraying dental safety net impacts confidence in the dental profession as a whole. FQHCs, RHCs, Indian Health Centers and other providers are invested in increasing access to cost-effective care and gaining the best possible health outcomes for the safety net population. But they cannot shore up the safety net alone. The dental safety net is undersized and underfunded. Within dentistry's control is implementing effective prevention, working in teams within and across professional disciplines to improve oral health outcomes in coordinated fashion and developing public-private sector partnerships between safety net dental programs and dentists in private practice. Organized dentistry can lead the search for emerging workforce models that extend the reach of dentists in meeting the volume and complex needs of the dental safety net population without sacrificing safety, quality of care and cost-effectiveness.

In California, 30 percent of the population depends upon the health care safety net.

The dental profession cannot just hunker down and wait for its challenges

to pass. How the dental safety net grows and who gets involved may well determine options for serving patients on both sides of the dental divide in the future.

Among fishermen, there are radio code words that signal important information. Mayday is an emergency procedure word used intentionally as a distress signal in voice procedure radio communications. It derives from the French phrase, "venez m'aider," meaning "come help me." A mayday relay call is made by one boat on behalf of a different boat that is in distress. A mayday situation is in progress. "Mayday, mayday, mayday. Net is frayed, needs mending and tending. Who can help?" ■

REFERENCES

1. California HealthCare Foundation. California's Health Care Safety Net: A Complex Web, April 2012.
2. Nasseh K, Vujicic M, O'Dell A. Affordable Care Act expands dental benefits for children but does not address critical access to dental care issues. Health Policy Resources Center Research Brief. American Dental Association. April 2013.
3. Palmer C. Targeting the 'dental divide.' www.ada.org/news/8609.aspx. Accessed May 15, 2013.
4. Centers for Disease Control and Prevention. Preventing Cavities, Gum Disease, Tooth Loss, and Oral Cancers at a Glance 2011. www.cdc.gov/chronicdisease/resources/publications/aag/doh.htm.
5. National Center for Chronic Disease Prevention and health Promotion, Division of Oral Health, Oral Health at a Glance 2011, p1-4.
6. Centers for Medicare and Medicaid Services (CMS), Medicaid/CHIP Annual EPSDT Participation Report, Form CMS-416 (National) 2011. www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-Periodic-Screening-Diagnosis-and-Treatment.html.
7. Centers for Medicare and Medicaid Services (CMS), Medicaid/CHIP Annual EPSDT Participation Report, Form CMS-416 State: California 2011. www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-Periodic-Screening-Diagnosis-and-Treatment.html.
8. Pourat N. UCLA Center for Health Policy Research, "Drilling Down: Access, Affordability, and Consumer Perceptions in Adult Dental Health, November 2008. www.chcf.org/publications/2008/11/drilling-down-access-affordability-and-consumer-perceptions-in-adult-dental-health.
9. Healthy People 2020, section on Oral Health. www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=32.
10. World Health Organization. Backgrounder 3: Key concepts. www.who.int/social_determinants/final_report/key_concepts_en.pdf.
11. County Medical Services Program (CMSP). www.cmspcounties.org/benefits/medical_dental_vision.html. Accessed October 2013.
12. National Association of Community Health Centers. Health Centers and Healthcare Reform: Health Center Funding Growth. April 2010.
13. Young DA, Featherstone JD, Roth JR. Caries management by risk assessment: Implementation guidelines. *J Calif Dent Assoc* 35(11): 799-805, November 2007.
14. Health Resources and Services Administration. The Affordable Care Act and Health Centers. bphc.hrsa.gov/about/healthcenterfactsheet.pdf. Accessed August 2013.
15. National Association of Community Health Centers (2013). A Sketch of Community Health Centers Chartbook 2013. www.nachc.com/client//Chartbook2013.pdf.
16. National Association of Community Health Centers. Health Centers and Healthcare Reform: Health Center Funding Growth. April 2010.
17. Healthy People 2020 Summary of Objectives. OH-11 accessed at healthypeople.gov/2020/topicsobjectives2020.
18. American Dental Association News (2013). www.ada.org/news/8987.aspx. Accessed Dec. 5, 2013.
19. California Department of Health Care Services (November 6, 2013). www.dhcs.ca.gov/services/rural/Documents/SPA%2013-018%20(WEB%20COPY)%20Restoring%20Adult%20Dental%20Opt%20Bene.pdf. Accessed Dec. 6, 2013.
20. Indian Health Service (1999). An Oral Health Survey of American Indian and Alaska Native Dental Patients: Findings, Regional Differences and National Comparisons. p.9.
21. United States Census Bureau (2012) State and County Quick Facts. California. quickfacts.census.gov/qfd/states/06000.html.
22. Indian Health Service (2013) California Area. Dental. www.ihs.gov/california/index.cfm/clinical-management/dental.
23. Agency for Healthcare Research and Quality (2012). Healthcare Cost and Utilization Project. Emergency Department Visits for Dental-Related Conditions, 2009. www.hcup-us.ahrq.gov/reports/statbriefs/sb143.pdf.
24. Wall T, Nasseh K. Dental-related emergency department visits on the increase in the United States. Health Policy Resources Center Research Brief. American Dental Association. May 2013. www.ada.org/sections/professionalResources/pdfs/HPRCBrief_0513_1.pdf.
25. California HealthCare Foundation, Eliminating Adult Dental Benefits in Medi-Cal – An Analysis, December 2011. www.chcf.org/publications/2011/12/eliminating-adult-dental-medical.
26. Healthy People 2020 Summary of Objectives. OH-10.2 healthypeople.gov/2020/topicsobjectives2020.
27. Pourat N and Nicholson G. Unaffordable Dental Care Is Linked to Frequent School Absences. Los Angeles, CA: UCLA Center for Health Policy Research, 2009.
28. Seirawan H, Faust S et al. The Impact of Oral Health on the Academic Performance of Disadvantaged Children. *Am J Public Health* 2012 102(9): 1729-34.
29. California School Health Centers Association (2013). www.schoolhealthcenters.org/school-health-centers-in-ca.
30. California School Health Centers Association (2013). www.schoolhealthcenters.org/start-up-and-operations/funding.
31. Edelstein B. The dental safety net, its workforce, and policy recommendations for its enhancement. *J Public Health Dent* vol 70, Issue Supplement s1, p S32-39, June 2010.
32. Bailit H, Beazoglou T, Demby N, et al. Dental Safety net current capacity and potential for expansion. *J Am Dent Assoc* (137)6:807-815, June 2006.
33. Strauss RP, Stein MB, Edwards J, et al. The Impact of Community-Based Dental Education on Students, American Dental Education Association (Supplement), October, 2010.
34. American Dental Association (2009) The 2008 Survey of Dental Graduates. Chicago: American Dental Association.
35. National Association of Community Health Centers (2009). Primary Care Access: An Essential Building Block of Health Reform. www.nachc.com/research-data.cfm.
36. U.S. Department of Health and Human Services, Health Resources and Services Administration, Designated HPSA Statistics Report, Table 4, "Health Professional Shortage Areas by State, Detail for Dental Care Regardless of Metropolitan/Nonmetropolitan Status as of August 31, 2011," datawarehouse.hrsa.gov/quickaccessreports.aspx.
37. U.S. Department of Health and Human Services, Health Resources and Services Administration, Dental HPSA Designation Overview. bhpr.hrsa.gov/shortage/hpsas/designationcriteria/dentalhpsaoverview.html. Accessed October 2013.
38. Mertz E, Glassman P. Alternative Practice Dental Hygiene in California: Past, Present, Future. *J Calif Dent Assoc* vol 39(1), p 37-45, January 2011.
39. American Academy of Pediatrics(2013). Children's Oral Health. www2.aap.org/oralhealth/PracticeTools.html.
40. Government Accountability Office. Oral Health: Factors Contributing to Low Use of Dental Services by Low-Income Populations. Washington, D.C.: 2000.
41. Okunseri C, Bajorunaite R, et al. Racial/ethnic disparities in the acceptance of Medicaid patients in dental practices. *J Public Health Dent* 2008. 68(3):149-53.
42. Brown LJ, Wagner KS, Johns B. Racial/ethnic variations of practicing dentist. *J Am Dent Assoc* 2000;131:1750-4.
43. Glass P, Harrington M, Mertz E, et al. The Virtual Dental Home: Implications for Policy and Strategy, *J Calif Dent Assoc* 40(7): 605-611, July 2012.
44. Rubenstein G. New Health Rankings: Of 17 Nations, U.S. is dead last. The Atlantic. January 2013. www.theatlantic.com/health/archive/2013/01/new-health-rankings-of-17-nations-us-is-dead-last/267045.
45. Kane J. Health Costs: How the U.S. compares with other countries. PBS Newshour. October 22, 2012. www.pbs.org/newshour/rundown/2012/10/health-costs-how-the-us-compares-with-other-countries.html.
46. Center for Medicare and Medicaid Services. Affordable Care Act Update: Implementing Medicare Cost Savings. www.cms.gov/apps/docs/aca-update-implementing-medicare-costs-savings.pdf. Accessed August 2013.
47. National Association of Community Health Centers. Primary Care Access: An Essential Building Block of Health Reform. March 2009.

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Electronic Clinical Records: Having the Right Data to Navigate Through the Perfect Storm

Paul Rhodes, DDS

ABSTRACT U.S. health care is converting from paper to digital information management. This conversion has passed the tipping point and is showing evidence of the benefits. Yet effective clinical information systems for dentistry have barely begun to be adopted. Dentistry is changing and the new practice models will require digital information management, as there is increasing pressure for evidence-based practice, continuity of care and demonstration of the quality of care resulting from these models.

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Conflict of Interest Disclosure: Paul Rhodes, DDS, is the CEO and president of DecisionBase Inc., a company specializing in the development of electronic clinical records for dentistry.

Farzad Mostashari, MD, the recent national coordinator for health information technology, summed up the reason for converting to electronic health care information management by saying, "Data is power."[1] Digital information has the power to do things that were never even imagined with traditional paper patient records. This conclusion is supported by the general acceptance of the use of practice management software to administrate the business aspects of dental practices and imaging software to capture and organize radiographic images. The last area of dental information to convert to digital management is clinical documentation — not just the restorative or periodontal chart, but all of the progress notes (i.e., narratives, chart notes) and communications from other health care providers. Three trends in dentistry make it clear that this is the time: (1) the federal mandate for all health care providers to use digital records that can share information, (2) the growing trend away from solo practices to various types of dental group practices and (3) the increasing demand for analysis of clinical information to support the need for treatment and the determination of what treatment methods have the best outcomes for specific problem sets. Benefits administrators, patients and accountable care organizations (ACOs) are all expecting this from dentistry in the information age.

The Benefits of Electronic Clinical Records

The benefits of electronic clinical records have been well documented throughout health care from major medical centers to small primary care practices. The

TABLE

Benefits of an Electronic Clinical Patient Record

Feature	Benefit
Legibility of records	Eliminate errors related to poor handwriting
Accessibility to records	From anywhere, time savings – no need to move paper charts around an office
Portability of records	Patient assurance of continuity when going to another dentist; coordination of care; eliminate redundant requests for information, i.e., medical history
Privacy of records	Simplified by use of a unique user login name and password by authorized staff
Security of records	Ease of making multiple back ups to remote secure sites – automatic back-up with SaaS system
Space savings	Storing records on a local server or on the cloud instead of file cabinets
Simultaneous access to chart by multiple users	A patient's chart could simultaneously be used by multiple providers or administrative staff
Disaster recovery	Offsite back-up storage would have eliminated the need for 164 dentists in greater New Orleans to declare bankruptcy after hurricane Katrina because of loss of patient charts
Standardization of procedures and work flow	Organization assures proper work flow and greater detail in clinical documentation
Elimination of errors	By the use of procedure-specific checklists – first year after implementing a simple five-step checklist in an intensive care unit prevented 43 infections, saved eight lives and $2,000,000 for a Baltimore hospital
E-prescribing and drug interaction analysis	Eliminate errors when medications are dispensed; increased patient safety by knowledge of critical drug interactions between current medications and what might be prescribed by dentist
Organization	Can result in more complete documentation
Clarity of clinical records	By the use of a standard glossary of terminology, interpretation is avoided; graphical presentations can aid patient understanding and compliance
Sharing clinical information	With other health care or benefits providers and patients
Quality of care	With proper organization, design and features of the EDR
Patient confidence	Resulting from their impression that the practice is keeping up with modern technology
New doctor and staff recruitment	Most millennial-generation dentists, hygienists and other dental staff will be attracted to a practice where all information management is digital

TABLE shows a synopsis of benefits derived from the use of an electronic medical record (EMR), or electronic health record (EHR), or in dentistry, what has been referred to as an electronic dental record (EDR).[2] More than 55 percent of surveyed physicians[3] reported that using EHRs had improved care coordination, access to clinical data and working processes as well as reduced clinical errors.[3] Fifty-five percent of office-based physicians[4] using EHRs reported that the use of an EHR resulted in better care.

The use of a clinical EDR, along with digital imaging and practice administration software, would allow a practice to eliminate the paper chart. Challenges to the change have been the expense of setting up, learning and adapting to electronic systems of information management; and clinical record-keeping, aside from subjective, objective, assessment and plan (SOAP), has little standardization and differences in styles, vocabulary, abbreviations and work flow patterns have also made it difficult for the development of digital clinical records that will resonate with a majority of dentists and hygienists. This conversion will require an openness to change. But with half of the dental workforce (dentists, hygienists, assistants, staff) being part of the millennial generation, the rapid adoption of mobile computing devices and the migration to the cloud, one could conclude that we are about to see a rapidly growing interest in adopting digital clinical record keeping. Finally, a strategic reason for its adoption will be the perception of dental patients. As the majority of them see their medical care providers having migrated to digital records, are they not going to expect the same from their dentists? Access to their health care records and portability of their records are going to become significant factors in patient satisfaction with their dental practice.[5]

Why EDR Needs to Be Implemented in Dentistry

Federal mandate: coordination of medical and dental health records. Both the Bush administration in 2004 and the Obama administration in 2009 called for health care information management to convert to digital systems that can allow for better information sharing and portability by 2014. Federal legislation in the Health Information Technology for Economic

and Clinical Health (HITECH) Act of 2009 provided financial incentives for health care providers who comply with the meaningful use standards of EHR use (few dental practices are able to take advantage of these financial incentives because of the lack of Medicare or Medicaid benefits for adults). The rising interest in relationships between oral and general health is a strong reason for using electronic clinical records that will facilitate the sharing of information between medical and dental care providers facilitating the co-management of related oral-systemic conditions. The acceptance of relationships between oral and systemic conditions is resulting in more dentists setting a goal of treatment planning their patients to take into consideration their overall health and how dental treatment can improve their patients' general health.

The decline in development of new solo dental practices and the rise in development of group dental practices. It is not unusual for a new dental graduate to be burdened with $200,000 in educational debt.[6] Also, with the introduction of many new technologies to dentistry, setting up a new dental practice can cost $500,000.[6] Furthermore, the goals of many millennials are different from those of the baby boomers. They do not have the same desire for ownership, desiring to focus their energies on patient care and a balanced personal life.[6] For these reasons, many of them are drawn to working within a dental group.

Solo practitioners in the middle years of their practices are now faced with the challenges of a different economy, greater control by third-party payers and competition from dental groups. If they are to continue to be viable, their solo practice model is going to have to change. They are going to have to focus on providing higher quality of care and to demonstrate this to their patients. By using properly designed digital clinical records, they should be able to perform analyses that will provide evidence to patients in the level of service provided and to third-party payers of their superiority of service (outcomes of their care).

Another alternative for dentists in the mid-stage of their careers will be to join together in small to mid-sized groups of four to 40 dentists, hygienists and possibly future mid-level providers practicing in one large clinic or in several geographically distributed offices to appeal to a broader patient population. In either case, as it will be likely that a patient may be treated by several providers, for continuity of care, a structured digital clinical record using a rich standardized nomenclature will be a necessity. As with the "boutique" solo practice model described above, these groups may want to market and demonstrate their superior level of care backed up by evidence from analyses of data showing superior outcomes. This opens the door for this type of organization to fit into the ACO model now emerging in the group practice of medicine.

> Access to their health care records and portability of their records are going to become significant factors in patient satisfaction with their dental practice.

Then there is the emergence of "big-box"[6,7] corporate practices with multiple locations distributed over multiple states. (Note: the term big-box was used in the reference cited and is not meant to be derogatory, as Costco, for example, has developed a respected and successful business model.) The relationship in the small- to moderate-sized group above is patient-dentist while the relationship in these large corporate practices is patient-dentist-manager-investor. So these large groups are vulnerable to criticism as to whether they are best serving patients or investors. To respond to these criticisms, as well as the potential actions of state regulators, it will be essential that they be able to "defend" their standards and allegations of overtreatment that have already been made about them. To do this they will also need properly designed digital clinical records capable of providing outcomes analyses and evidence to support the indications for care provided. Also, due to the rapid turnover in dental staff and their many locations, a digital clinical record that can assure continuity of care between multiple providers and portability will also be a critical requirement of their business model.

The emergence of the evidence-based dentist practice model. Dental benefits underwriting plans continue to shrink the number of covered services or reimbursements for procedures. Their reason is to be competitive in the benefits marketplace. One of the emerging changes to underwriting is the request for more evidence to support the need for a procedure. This may naturally lead to providing evidence to support the efficacy of the procedure for treating the patient's specific problems. All of this will require more administrative time. To collect and provide such evidence within a practice with paper-based records is not practical. A properly designed clinical EDR should be capable of providing such pooled evidence, particularly in a group practice where the larger population pool would provide more evidence for proper statistical analysis. A similar process is

currently taking place in medical care. For example, hospitals in a region are being rated as to the outcomes of a particular surgical procedure as well as the relative charges for the procedure. This information has been made public by *U.S. News and World Report*, *Consumer Reports* and *AARP The Magazine* as well as others. This type of competition amongst provider groups could result in the elevation of the quality of care while reducing its cost. The use of a well-designed EDR is essential to meet the demands of underwriters and the press in this age of digital information.

A natural progression from this is to base reimbursement for care not on the procedures performed but on the relative effectiveness of the outcome for the specific presenting conditions. Such models must take in a multiplicity of factors and would be quite challenging to design. But this type of medical reimbursement model is active in certain communities in the U.S. It certainly motivates the care group to provide the least expensive care to treat any particular set of conditions to assure a good outcome. Again, it will take a properly designed dental EHR to collect and analyze the data needed to provide this type of outcomes analysis. Kushinka[8] concludes, "It is mission critical that an EDR capable of providing analysis for treatment effectiveness makes use of a standardized vocabulary with terminology organized in a structured format. This is essential if data is to be aggregated and evaluated for outcomes."

National Dental Practice-based Research Network

In 2012, the National Institute of Dental and Craniofacial Research (NIDCR)[9] awarded a $66.8 million, seven-year grant that consolidates its dental practice-based research network initiatives into a unified nationally coordinated effort. The National Dental Practice-based Research Network (NDPBRN) has been organized into six regional areas or nodes. The areas are divided into the Pacific, Southwest, Midwest, Northeast, South and Southeast. Each regional organization is made up of an investigative union of practicing dentists and academic scientists. The evidence provided from 1,718 voluntary private practices in 43 states may help expand a dental evidence base and further refine care by the analysis of data. Without the use of well-designed digital clinical records housing information in a database, using a standardized glossary of terminology and standardized formats for content of information collected for any given procedure, this type of activity would not be possible.[8] It certainly would be extremely labor intensive and costly to attempt to do this using paper-based information collection, which would then have to be fed into a computer database so that it could be analyzed.

> Health care is in the process of undergoing its greatest change in the U.S. in the past 100 years. Dentistry is a part of this change.

Conclusion

It is a foregone conclusion that the majority of health care providers in the U.S. will convert from paper records to an electronic clinical patient record system in the next two years. The driving force behind this is the federal mandate to create a national electronic health record. David Blumenthal, former national coordinator for health IT recently stated,[10] "It is inconceivable that the health system in the U.S. will indefinitely resist a force that is transforming modern civilization and that offers almost infinite promise for improved and more efficient care." A Medscape survey[11] of 21,204 practicing physicians in May 2012 reported that 74 percent had converted to EHR use and another 8 percent were in the process of implementation. One could project that today the percentage has increased significantly.

Schleyer[12] reported that 74-79 percent of dental practitioners used computers at chairside, and 15 percent managed patient information on a computer, representing "a high penetration of clinical computing" in dentistry. This lead author concluded that this study showed that "if you look at the computing adoption curve in the study, I think we will see a very rapid rise in adoption of EDRs (electronic *clinical* dental records) in the next few years." Any dental practice not thinking about converting to digital clinical records may be left behind.

The information age has brought about revolutionary changes to our society, economy and commerce. Health care is in the process of undergoing its greatest change in the U.S. in the past 100 years. Dentistry is a part of this change. The U.S. has the highest health care costs per capita of any nation worldwide and ranks 38th in quality of care received by its populace compared against 190 other nations.[13] The federal government has mandated that all health care providers convert to digital information management in an effort to reduce the cost of health care and to improve its quality.

Dentistry in the U.S. has been labeled a cottage industry for the last 100 years. Today, societal and economic conditions are pressuring dentistry to change its

business model. Health care is being held accountable for its performance and for the value received. The implementation of digital information systems can streamline the operation of a dental business, provide the evidence to support the quality of care and reduce the costs of care or support the value received. It is the necessary compass that dentistry needs to navigate the perfect storm to a safe port – for dentistry to regain its vitality and health as a business. ■

Editor's note: According to a 2011 ADEA Survey of Dental School Seniors, student loan debt ranges from $178,000 to nearly $246,000.

REFERENCES

1. Mostashari F. Quoted in *The Washington Post*, Health & Science section, Aug. 6, 2013.
2. Emmott L. Electronic Dental Records in Dentistry. *J Am Coll Dent*, 77:10,210.
3. Accenture, What do surveyed physicians report as being benefits of using health IT systems? iHealthBeat, www.ihealthbeat.org/data-points/2012/what-do-surveyed-us-physicians-report-as-being-benefits-of-using-health-it systems.aspx?utm_source=feedburner&utm_medium=feed&utm_campaign=Feed%3A+Ihealthbeat%2FEhrsAndPhrs+%28iHB+-+EHRs+and+PHRs%29&utm_content=Google+Reader#ixzz1mEoGD5fo
4. Physicians Practices, Most doctors with EHR systems satisfied with the technology; *iHealthBeat* July 18, 2012.
5. Frampton S, Horowitz S, Stumpo B. Open medical records allowing patients access to their records increases their satisfaction. *Am J Nurs* Aug 2009 109(8).
6. IBISWorld-IBIS World Industry Report 62121: Dentists in the U.S.; May 2012.
7. Matta A. A story not told: How dental service organization can improve your practice. Dentistry IQ Dec. 5, 2012.
8. Kushinka SA. Clinical Documentation: EHR Deployment Techniques. California Healthcare Foundation. www.chcf.org/resources/download.aspx?id=%7b41C279C4-19A9-4F50-969E-F34ED99529ED%7d.
9. Kuska B. NIDCR Establishes National Dental Practice-Base Research Network. Announcement from NIDCR 4-12-12.
10. Blumenthal D, Blumenthal discusses short-term, long-term success of HITECH Act. *iHealthBeat*, Jan. 4, 2012.
11. Results of Medscape survey of 21,200 physicians on EHR use. Information Week.com, Aug. 29, 2012. www.informationweek.com/health care /electronic-medical-records/ehr-adoption-grows-as-docs-bid-for-incen/240006440.
12. Schleyer T, et al. Electronic dental record use and clinical information management patterns among practitioner-investigators in The Dental Practice-Based Research Network. *J Am Dent Assoc* 2013;144(1):49-58.
13. Tandon A, et al. Measuring overall health system performance for 191 countries; GPE discussion paper series, (30), WHO.

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Transitioning in or out of an Insurance Contract

Michael Perry, DDS

A previous Practice Support column discussed the four different business models of private practice. The purpose of this article is to present strategies that are available for transitioning from one model to another.

Considering a Model Transition

Historical data is not available, but it is likely that the percentage of model 2 and model 3 practices in the marketplace is increasing, while the percentage of model 1 practices is decreasing. In light of changes in the dental benefits market, it is likely that a number of doctors are considering a transition to model 4.

Significant financial problems can occur when a practice operating in one model, knowingly or not, utilizes business systems best suited for a different model. Prior to considering a model transition, it is critical that the doctor understand which model he or she is currently operating in and whether or not the appropriate systems for that model are being utilized.

Previously, the four models were shown as a continuum. An analysis of practice statistics is recommended in order to identify the current model for each practice. Because it is possible that a practice could be midway between two different models, some confusion concerning category assignment could occur. If the models are viewed as a continuum rather than as separate categories, all private practices would fit somewhere on that spectrum (FIGURE).

Once a doctor has determined his or her current position on the spectrum, he or she should then assess the probable risks and benefits commensurate with a transition. Some of the critical areas to assess would be:

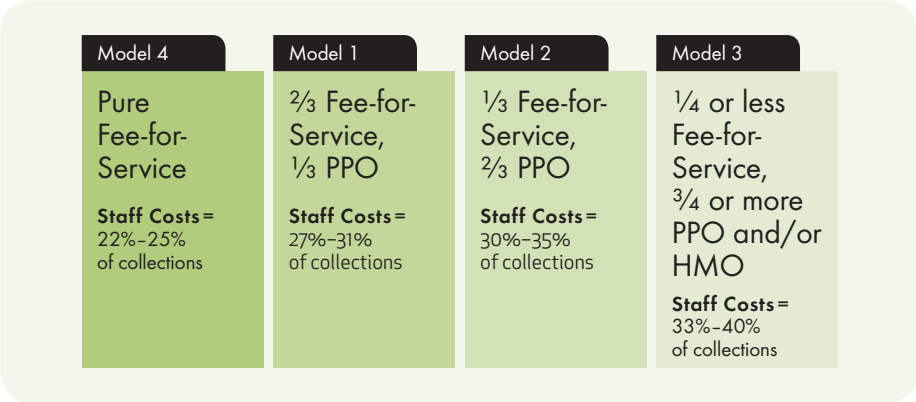

FIGURE. Models of practice support are defined by a dentist's relationship with third-party insurance. A model is determined by the percentage of treatment a doctor is providing under contracted insurance.

- Strength of the practice brand (reputation and community awareness).
- Ability to tolerate a short-term cash flow shortage.
- Ability to tolerate a loss of patients.
- Technical (clinical) ability of the doctor and team.
- Communication skills of the doctor and team.
- Ability to institute strategic plans.
- Level of team loyalty and commitment to change.

With sufficient time, communication training, working capital and practice leadership, it is theoretically possible to transition a practice operating within one model to any other model. That stated, the level of difficulty in implementing a successful transition from a model more than one position away on the continuum is significantly greater than moving to an adjacent model. It is therefore advisable to transition a practice one position at a time.

Making a Transition

It is beyond the scope of this article to provide the strategies necessary for every transition scenario. It is likely, however, that most doctors currently considering a transition are wanting to move from right to left on the models spectrum. This means that the doctor would be eliminating insurance contracts rather than adding them. The strategies that follow are with this in mind.

Inform patients of the pending change.

Prior to the cancellation of a dental benefits contract, be sure that:

- Communication is one-on-one with each patient, verbal and truthful (do not send patients a letter).
- Communications to patients convey how they will benefit and instill confidence that the practice is prepared to minimize the negative impact on them.

Sample script one — existing patient: *"We have become concerned that your insurance company's changing policies may have a negative effect upon the quality of care that we provide. We can no longer in good conscience remain contracted with them. We will, however, continue to bill all insurance claims and help you obtain the maximum benefit allowed. Best of all, you*

can continue to count on us for the same high level of service you have come to expect."

Send a contract cancellation letter to the PPO or HMO in question.

Send a certified, return receipt requested letter.

Your contract will likely remain in effect for 30 days or more after the company receives your letter.

You will be obligated to abide by the terms of the contract for the entire waiting period.

After contract termination, the doctor and business office employees must be adept at dealing with patient questions concerning the dental benefits plan that's been cancelled.

Sample script two — existing patient:

Patient:

"Are you a contracted provider for my insurance company?"

Front office employee:

"We don't contract with your dental insurance company, but many of our patients have your plan. We are very experienced at dealing with your company and I'm sure we can make a financial arrangement that's comfortable for you."

Consider Professional Help

Professional consulting services are available from a number of private companies to help doctors with dental benefit contract transitions. It is not known how many doctors have successfully made such transitions with and without professional guidance. It is clear, however, that a model transition can't be done without risk. The prudent doctor will want to minimize risks while maximizing benefits.

Analysts are available to answer questions in the CDA Practice Support Center. ■

Michael Perry, DDS, is a former member of the California Dental Association Council on Membership and the Dental Benefits Research Task Force. He is also the chair of the CDA Practice Support Center Task Force. Dr. Perry is a practicing general dentist in Santa Rosa,Calif., and a dental business consultant.

Use of Botox in Dentistry Is a Fine Line

TDIC Risk Management Staff

As questions increase about the use of Botox in dentistry, The Dentists Insurance Company advises California dentists that the use of preparations such as Botox and Dysport must be within the scope of dental practice.

"If doctors are practicing legally within the scope of their dental license, there is coverage under TDIC's professional liability policy," said TDIC Underwriting Director Dora Earls. However, Earls noted that if the Dental Board of California determines that use of Botox or similar drugs is not within the scope of dental practice, there is no TDIC coverage.

In California, dentistry is defined by the California Business and Professions Code section 1625. The Dental Board lists the pertinent language of the Code as, "diagnosis or treatment, by surgery or other method, of diseases and lesions and the correction of malpositions of the human teeth, alveolar process, gums, jaws or associated structures; and such diagnosis or treatment may include all necessary related procedures as well as the use of drugs, anesthetic agents and physical evaluation. …" The Dental Board states that a dentist may use any legally prescribed drugs to treat patients as long as the treatment is within this specified scope of practice.

Additionally, in California, dentists may not use Botox cosmetically without an Elective Facial Cosmetic Surgery permit issued by the Dental Board. Licensed dentists who have completed residencies in oral and maxillofacial surgery and additional criteria outlined by the Dental Board can apply for an Elective Facial Cosmetic Surgery permit. There are two categories for these permits. Category I relates to cosmetic facial surgery, such as contouring of the osteocartilaginous facial structure, and Category II relates to cosmetic soft-tissue contouring or rejuvenation. The details of this system can be found in the California Business and Professions Code section 1638.1.

Additionally, in California, dentists may not use Botox cosmetically without an Elective Facial Cosmetic Surgery permit issued by the Dental Board.

Currently, there are 26 dentists in California with these permits, according to the Dental Board, which also states, "Some permit holders may not be authorized to perform all cosmetic surgery procedures within the scope of the Elective Facial Cosmetic Surgery permit." Additionally, the Dental Board

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PRACTICE SALES • PARTNERSHIPS • MERGERS • VALUATIONS/APPRAISALS • ASSOCIATESHIPS • CONTINUING EDUCATION

ANAHEIM: General Dentistry Practice. 3 Ops, Nicely appointed, modern. Gross $423K with Adj. Net of $140K. Seller refers out specialty procedures. Retiring. Growth potential! #CA101

BAKERSFIELD: General Dentistry Practice. 8 Ops, 7 equipped. 3650 sq. ft. Digital X-rays and intraoral camera. Gross $1.2MM with Adj. Net of $453K. Growing area. #CAM554

BAKERSFIELD/SMALL FARM COMMUNITY: Two practices 30 mins. apart. Strong patient bases. Staff and doctor work both practices. Underserved communities with room for growth. Gross $588K with Adj. Net of $278K. #CAM557

BISHOP: General Dentistry Practice & Building. 5 Ops, 1800 sq. ft. 2011 Gross $1MM with Adj. Net of $387K. #14390

CENTRAL COAST: *Prosthodontic Practice* with 4 Ops. Full in-house lab. Gross Over $1.1MM. Near shopping. #CAM535

CERRITOS: General Dentistry Practice. 7 Ops, 6 equipped, 1 plumbed. 1500 sq. ft. Digital X-rays, SoftDent. Near shopping, residential and freeway. Gross $408K with Adj. Net of $140K. Room to grow. #CA100 — In Escrow

CHULA VISTA: General Dentistry Practice. 4 Ops. 3½ days of hygiene. Dentrix software. Gross $528K. #CA109

CLAREMONT: General Dentistry Practice. 6 Ops. 8 days of hygiene/week. Gross $581K with Adj. Net of $147K. #CA114

COALINGA: General Dentistry Practice. 3 Ops, remodeled in 2011. 1100 sq. ft. 1000 active patients. Excellent opportunity for new dentist or established dentist looking for satellite office. #CA564

COASTAL ORANGE COUNTY: General Dentistry/Implant Practice. 4 Ops. Implant system in all Ops. 1800 sq. ft. Gross $1.1MM. #CA520 — In Escrow

COASTAL ORANGE COUNTY: General Dentistry Practice. Retiring doctor spent $500K on 4 new Ops-High-end chairs, cabinetry and tenant improvements. Dentrix, Dexis, Digital Pan. Close to the ocean–dream location! Gross $600+K in '11, $500+K in '12. #CAM566

COASTAL ORANGE COUNTY: *Periodontal Practice.* 5 Ops, retiring doctor works 3 days/wk with 4 days of hygiene. Gross $450K in '12. Great location near freeway/hospital. #CAM533

DANVILLE: *Facility Only.* 5 Fully equipped Ops, digital x-ray, digital pano, and central nitrous oxide/oxygen. Seller relocating. #CA548 SOLD

FOLSOM/EL DORADO HILLS: General Dentistry Practice. 4 Ops. 1200 sq. ft. 2½ days hygiene/wk. Dentrix, Laser, Digital X-rays, and intraoral cameras. Gross $405K. #CA103

FREMONT: 10 Ops. 3000+ sq. ft. Digital X-rays and Pan. 4000 active patients. PPO/HMO with Gross $1.2MM in '12 with Adj. Net of $300K. #CA553— In Escrow

GRASS VALLEY: General Dentistry Practice. 5 Ops, 3 chair. 1500+ sq. ft. Gross $491K in '12. Adj. Net of $130K. #14379 SOLD

GRASS VALLEY: General Dentistry Practice. 6 Ops, 2000 sq. ft. condo. Gross $442K in '12. #14372 SOLD

GREATER CHICO/REDDING: General Dentistry Practice. 3 Ops with intraoral, Pan, Imaging system. Well-established. Gross $252K+ in '12. Owner retiring. #CA104 SOLD

GREATER SACRAMENTO: General Dentistry Practice. 3 Ops, 1200 sq. ft. Gross $879K in '12. Adj. Net of $446K. #CA525 SOLD

GREATER SACRAMENTO: *Orthodontic Practice.* Like-new 2300 sq. ft. office with extensive leasehold improvements and 6 chairs. 220 active patients. #CA551

HAWAII (MAUI): General Dentistry Practice. 4 Equipped Ops. 1200 sq. ft. Gross $636K. #20101

HENDERSON, NV: DECEASED DENTIST. *Pediatric Practice.* 6 Ops. Dentrix, Pan. Gross $[illegible]K in '11, $766K in '12, $668K in first 9 months in '13. Available for immediate sale. #NV100 SOLD

HOLLISTER: *Facility Only.* 3 Ops with 2 additional plumbed with cabinets. 1800 sq. ft. Adec chairs, units, and lights, Dexis, Easy Dental, Pano X-ray. Owner relocating to own building. #CA563

HUNTINGTON PARK: Retiring General Dentist. Large group practice started in 1984. 15 Ops. Dentrix/Dexis with 25 computer workstations. E4D CAD/CAM machine. Gross $1.1M+ in '12. Seller owns the building. #CA113

INDIAN WELLS: General Dentistry/TMJ Practice. 6 Ops. 4000 sq. ft. Gross $350K+ in '11 on 1 doctor-day/wk. #CAM530

LANCASTER: General Dentistry. 4 Ops. 2300 sq. ft. Gross $676K with Adj. Net in $174K. #14376

MILPITAS: General Dentistry. 4 Ops. 1440 sq. ft. Prof. designed office in major business district. Intraoral cameras, computers in each Op. Pano X-ray. Owner retiring. #CA562

MURRIETA: General Dentistry. 4 Ops. 1300 sq. ft. Gross $530K in '12 with Adj. Net of $213K. #CAM544

MURRIETA: General Dentistry. 5 Ops. 8 Days of hygiene/week. Gross $1.5MM in '12 with Adj. Net of $875K. #CA107 — In Escrow

NEWPORT BEACH: General Dentistry. 4 Ops near Fashion Island. Dentrix, Gross $256K. Seller refers out most specialty work. Room to grow. #CAM559 SOLD

NEWPORT BEACH: General Dentistry. 3 Ops. Newer high-end equipment, Gross $350K in '12 on 3½ days/week. #CAM534

NORTH EAST BAY: General Dentistry Practice. 7 Ops. 2324 sq. ft. Dental Mate software, intraoral camera, Pano X-ray, Digital x-ray. Gross $885K in '12 with overhead of under 70%. Building to be sold with practice. #CA108

NORTH OF SACRAMENTO: General Dentistry. Newly remodeled office w/4 equipped Ops, 5 available. Approx. 1500 active patients. Gross $515K in '12 on 32 hr/week and 37 weeks/yr. EZ Dental, Pan, fiber optics. 20 hrs. hygiene/week. Bldg available for purchase. # CA558

NORTH OF SACRAMENTO: General Dentistry. 4 Ops. 1650 sq. ft. Gross $521K in '12. Low overhead of 52%. #CA528

NORTH OF SACRAMENTO: General Dentistry. 5 Ops. 2050 sq. ft. Dentrix, Intra-oral cameras, digital X-ray, imaging system, and Pano. Gross $1.2M+ in '12 with overhead of only 54%. #CA106

NORTH ORANGE COUNTY: *Endodontic Practice.* 5 Ops, fully equipped. 3 Zeiss wall-mounted microscopes. Established 30 yrs. Gross $370K with Adj. Net of $172K on 3-day week. #CAM561

NORTH SAN DIEGO COUNTY: Large Legacy Practice. 12 Ops equipped. HMO practice with large CAP check. Desirable area in North County. #CAM543 — In Escrow

ORANGE: General Dentistry. 3 Ops in retail location. Gross $[illegible] in '12. #CA110 SOLD

RIDGECREST: General Dentistry Practice and Dental Building. 4 Ops. 1500 sq. ft. Small practice. Grossed $175K in '12. #CA523

RIVERSIDE: General Dentistry Practice. 5 Ops. Emphasis on Implants and Building. Established over 50 years. Gross $500K in '12. #CA120

SOUTH ORANGE COUNTY: General Dentistry. 8 Ops, 7 equipped. 2400 sq. ft. office/building with 54% overhead. Gross $642K in '12. #CA119— In Escrow

SAN JOSE: *Facility Only.* 6 Ops. 3700 sq. ft. Digital X-ray, sterilization, computer workstations in every room. Reception w/flat screen TV, equipped business office and conference room. #CA565

SAN JUAN CAPISTRANO: General Dentistry. 4 Ops fully equipped. Gross $650K in '12 SOLD

SAN RAMON: *Facility Only.* 4 Ops, equipped, 2 additional plumbed. 1400 SF. Pano, computer server, workstations w/Dentrix, intraoral camera. Priced to sell. #CA511

SANTA CRUZ: *Endodontic Practice.* 2 Ops. 850 sq. ft. Schick digital x-rays. Ideal for a satellite practice. Owner will work for new buyer 1–[illegible] days/week. Gross $350–$400K. 55% overhead. #CA102 SOLD

SANTA CRUZ COUNTY: ILLNESS FORCES IMMEDIATE SALE of General Dentistry Practice. 5 Ops. 1500 sq. ft. 3 days of hygiene/week. [illegible] NP/mo. CAD/CAM, intraoral cameras, Pano, Datacon software. In same location for 32 years. Will help buyer during the transition. Gross $465K in '12 on 4 day week. #CA105 SOLD

SANTA CRUZ COUNTY: General Dentistry. 3 Ops in prof. bldg. near Hwy 1. 1100 sq. ft. 2200 active patients. 10 new patients/month. Schick digital X-ray and Dentrix software. Equipment 5 yrs. old. Gross $338K on 2 day/week. Moving. #CA550

THOUSAND OAKS: Retiring General Dentist practicing for 37 years. 6 Ops. 8 days of hygiene/week. Dentrix /Dexis. Office collected $616K in '10, $621K in '11, $589K in '12. #CA118

TURLOCK: General Dentistry. Gross $950K in '12 with Adj. Net of $443K. #CA506

WALNUT CREEK: *Prosthodontic Practice.* 3 Ops fully equipped. Full lab. Gross $530K in '12. #CAM540

WEST LOS ANGELES: General Dentistry Practice. 4 Ops equipped, 1 plumbed, not equipped. Great LA location on the west side. Gross $342K on just 2 doctor days/week. Room to grow! #CA117

YORBA LINDA: General Dentistry Practice. 5 Ops in great location. Laser, intraoral camera, digital X-rays. 3 hygiene, 3 doctor days/week. #CAM531

CONTINUED FROM 127

notes that all procedures authorized under the Elective Facial Cosmetic Surgery permit must be performed in an acute care hospital or a certified surgical center as defined in California Business and Professions Code section 1638.1(f).

Botox and Dysport are commercial preparations of botulinum toxin derived from the bacterium Clostridium botulinum, a nerve "blocker" that binds to the nerves and prevents the release of acetylcholine, a neurotransmitter. The result is muscle paralysis, according to the National Center for Biotechnology Information. Botulinum toxin is approved by the FDA, and its most common use is in applications to minimize fine facial wrinkles.

Concerning professional liability coverage and training or certification for dentists to use Botox or similar drugs, TDIC's endorsement states, "Before performing the alleged injection(s), you must have obtained any license, permit, certification or training required by the state dental licensing authority where you practice."

For more information or if you have questions regarding this topic, contact the TDIC Risk Management Advice Line at 800.733.0634. ■

The Dentists Insurance Company offers policyholders a free advice line at 800.733.0634 for assistance with questions or concerns about potential liability. TDIC risk management analysts will work with policyholders to develop a solution.

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BAY AREA

BC-175 EAST CONTRA COSTA: Vast employment, shopping & activities! 1,995 sf w/5ops **$300k**

BC-221 EAST CONTRA COSTA: Well Respected w/ loyal patients, Seller is retiring! 1900 sf w/ 4 ops **$325k**

BN-183 HAYWARD: ***Kick it up a notch by increasing the current very relaxed work schedule!*** 1,300 sf w/ 3 ops **$150k**

BG-226 ANTIOCH (Real Estate): OWN your dental facility! Priced to move quickly at less than $100/ft. ~ 1,500 sf w/ up to 5 ops **$137k**

BN-233 ALAMEDA: If real estate and space are what you've been looking for, here's your practice! ~ 3,139 sf w/ 8 ops. **$275k, RE: $825k**

CC-151 SANTA ROSA: Stable patient base, well-respected, close to Memorial Hospital. 2,262 sf w/ 6 ops **$875k** *Real Estate avail.*

CC-170 SOLANO COUNTY: Near Wine Country! 950 sf w/3 ops **$225k**

CC-220 MILL VALLEY: In attractive Dental Professional Condo w/in block of Hwy 1. 1,200 sf w/ 3 ops **$499k & take over Cerec pmts**

CN-189 RIO VISTA: In the heart of the beautiful California Delta! 3 ops **$275k**

DG-116 SALINAS AREA: Large, loyal & stable patient base! Popular Retail Center. 1,400 sf w/5 ops. State-of-the-art Equipment **$195k**

DG-124 MILPITAS: Highly visible. Desirable area. 960 sf w/ 2 ops + 1 add'l **$130k**

DG-156 SAN JOSE: Hardwood Floors & plenty of windows! 1,160 sf w/ 3 ops (+2 add'l) **REDUCED! $125k**

DG-161 FREMONT: Beautiful office generating 40+ new pts/mo. 1,440 sf w/ 4 ops **$215k**

DG-222 SAN JOSE: High traffic Retail Shopping Center with unbeatable signage. 2,847 sf w/ 7 ops **$925k**

DG-223 SUNNYVALE: **Seller Relocating!** Popular Retail Shopping Plaza with major anchor tenants. 2,000 sf w/ 6 ops +1 **$475k**

BAY AREA CONTINUED

DG-212 FREMONT: One of the most beautiful practices we've listed! Courtyard Garden welcomes patients. Your talent and skill keeps them! 2,181 sf w/ 3 ops **REDUCED! Now Only $175k**

DG-232 SANTA CRUZ: Large, well-established Medical/Dental Prof complex! 1,063 sf w/ 3 ops **$345k**

DG-224 SANTA CRUZ: Fully computerized & digital upgraded. Exudes serenity w/ relaxed beach theme, enclosed courtyard. 904 sf w/3 ops **$375k**

NORTHERN CALIFORNIA

EG-198 SACRAMENTO: Tucked in well established "Pocket Area" in highly desirable corridor. 1,112 sf w/3 ops **REDUCED! $125k**

EG-237 ROCKLIN: Seller Moving out of the Country! Would cost over $300k to duplicate! Spacious & spectacular. State-of-the-art, top-of-the-line equipment. 1,000 sf w/ 2 ops. Plumbed for 2 add'l **$245k**

FN-181 NORTH COAST: Well respected FFS GP. Stable patient base. 1,000 sf w/3 ops **SELLER MOTIVATED! $150k (25% int. in bldg. avail.)**

FN-185 UKIAH: 900 sf w/ 3 ops. Seller Willing to Negotiate! **$250k**

GN-196 CHICO: Appealing location! ~2,510 sf w/4 ops **$150k**

GN-149 YREKA: Quality FFS, Warm & Caring. 900 sf w/ 3 ops. Now Only:**$180k/Real Estate $110k**

GN-201 CHICO: Beautiful practice located on major thoroughfare with stellar reputation! 1,400 sf w/ 4 ops & room for another **$425k**

GN-228 CHICO/PARADISE AREA: A reputation built on quality care and personalized service in a warm and caring atmosphere. Office ~ 898 sf w/ 3 ops. **$250k**

HN-213 NORTH EAST CA: Close to the Oregon Border, this FFS practice is ~2,200 sf w/ 3op +1 **add'l $145k**

HN-197 EAST LODI FOOTHILLS: Two practices for one great price! Call today for details! **$595k**

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SALES

CENTRAL VALLEY

IG-067 STOCKTON: Fully computerized, paperless, digitalized. 5,000 sf w/10 ops **Now $425k**

IG-165 TURLOCK: Well established Shared/Solo Group Practice. 10 ops (shared) **$428k**

IN-193 Modesto Facility: Recently remodeled! High foot traffic! Can be purchased with or without new equipment. 2,300 sf w/6 ops (4 fully equipped) **$169k**

IN-205 STOCKTON Facility: Desirable professional corridor. Newly remodeled. 1,565 sf w/ 4 ops **$169k**

JG-188 FRESNO: Loved, respected, Established! Net Profit over $350k! 1,452 sf w/4 ops **$390k**

JN-219 TULARE: Imagine working here in this highly esteemed **fee-for-service** practice! Office is ~ 1,500 sf w/ 4 ops. **$425k**

IN-211 MODESTO: Located in a single story, multi-unit Professional building, 1,500 sf w/ 4 ops. **$300k**

SPECIALTY PRACTICES

EG-131 ROSEVILLE Ortho: Reputation, loyal patient base, seasoned staff & beautiful, spacious facilities. 1,100 sf w/ 4 chairs **$95k**

I-7861 CENTRAL VALLEY Ortho: 2,000 sf, open bay w/ 8 chairs. Fee-for-Service. **$370k**

I-9461 CENTRAL VALLEY Ortho: 1,650 sf w/5 chairs/bays & plumbed for 2 add'l **$180k**

EN-203 SACRAMENTO Oral Surgery: This highly efficient office occupies ~ 3,000 sf w/ 4 fully equipped ops **$325k**

GN-209 SACRAMENTO VALLEY Endo: Be the one to carry on the stellar reputation and tradition! 1,400 sf w/ 3 ops **$350k**

BC-230 CENTRAL CONTRA COSTA Perio: Loyal patients @ 2 locations! **$650k**

EG-225 SACRAMENTO Ortho: Well-maintained, single-story Medical/Dental professional complex. 1,200 sf w/ 4 chairs **$95k**

DN-229 EAST BAY Endo: Strong referral & patient base. Attractive tree-lined street, mature landscaping and curb appeal. High foot traffic. 975 sf w/ 2 ops **$250k**

ASK THE BROKER

Do different types of practices require different types of negotiations?

Yes! This is an interesting question, especially in California. We are a melting pot of diverse cultures. The licensed dentists and enrollment in our dental schools reflect this fact. Both buyers and sellers would be wise to understand the different culturally-based negotiating tactics they might encounter. For instance, it is common in some cultures to automatically and immediately offer approximately 50% of the asking price to start the negotiations. Some sellers may be so offended that they might not even respond to that type of an offer. Other cultures start with a full price offer, even sign all the paperwork and get close to the finish line, and then reduce their offer for a perceived reason that something was not to their expectations. Another culture may be extremely polite and excited about the practice, repeatedly spending time with the seller reviewing all the details, but never make a formal offer until after a great deal of work and time has been invested, only to make an offer well below the asking price.

My advice to the sellers is to be cognizant of the differing cultural norms. That is easy for me to say but hard for me to do, even after completing hundreds of negotiations. While I understand that hot markets with a desirable practice demand quick decisions, I still believe that a written agreement carries weight and expectations, unless something ***very significant*** is discovered that was not represented accurately in the beginning. Once time, effort and money have been spent trying to finalize the details of the transaction, there is a reasonable expectation that the purchase price will not be changed.

My advice to the buyers is to understand that in most cases, ***goodwill*** is the greatest part of the asset you are purchasing. It is then best if your offer matches the cultural expectation of the seller, as to not damage the eventual goodwill by engaging in a 'tough' negotiation. Every seller expects some negotiation, but eventually, *how* it is done ***will*** affect the tone of the transaction. Creating ill-will during the negotiations may reflect negatively in the transition with the patients and staff. Of course, there are some practices where this relationship with the owner may not matter, but those are usually the exception, even in a PPO driven practice.

A good "back-and-forth" negotiation can solidify value for both the buyer and the seller in the process. However, the buyer must beware of harming the transfer of the goodwill if the negotiations are not handled properly. This includes properly managing the consultants and attorneys the buyer chooses to help in the transition.

Timothy G. Giroux, DDS is currently the Owner & Broker at **Western Practice Sales** and a member of the nationally recognized dental organization, ADS Transitions.
You may contact ***Dr Giroux at*: wps@succeed.net or 800.641.4179**

Access to Patient Records

CDA Practice Support Center

Patients have rights under both federal HIPAA law and state law to access their health records. "Access" means having a copy of or viewing the original records. A dental practice may not deny a patient access to his or her records if the patient has a balance due. Patients are not limited in the number of requests for access to, or copies of, records.

If access to records is denied, a patient may complain to the federal Office of Civil Rights and to the Dental Board. Where federal and state law conflict, the more stringent requirement applies. For example, HIPAA allows a covered entity 30 days to provide a copy of a record, but California law only allows 15 days.

What is included in a patient record?

A patient record includes X-rays, photographs and models, and can include any written document in the chart or recorded note, even if it is nonclinical. For the purpose of accessing records, billing records are considered by the state courts to be part of the patient record. In situations involving minor patients with divorced or separated parents, do not share the details of the other parent's financial information except for what each parent has paid.

What are the rules if a patient wants to inspect the records?

You must allow the records to be viewed within five working days of receiving a written request. You may ask the patient to specify dates of records to be inspected. The inspection of the records should take place during business hours and it is advisable to have an employee present in the room while the records are reviewed.

The patient or patient representative

is allowed to have one other individual present during the record review. If, during or after the review, the patient requests a copy of the records, you do not have to produce the copy right away. You have up to 15 days to provide the requested copy.

What are the rules if a patient wants a copy of his or her records?

You must provide the copy within 15 days of receiving the request. You may require the request be in writing and you may ask the patient to specify dates of records to be copied. If you maintain electronic patient records and the patient requests an electronic copy, you must provide it on a mutually agreeable electronic format.

What am I allowed to charge a patient for providing copies?

Be sure to provide patients with a document that lists your practice fees for copies. A HIPAA-covered entity may not ask payment for costs for retrieving or handling the information or for processing the request.

Paper copy: The dental office may collect from the patient no more than 25 cents per page, or 50 cents per page for copies made from microfilm, plus any additional reasonable clerical costs incurred in copying the records. Allowable charges include the cost of copying X-rays and postage if the patient requests receipt by mail.

Electronic copy: The fee charged for an electronic copy may include the cost of the electronic media (for example, CD or flash drive) on which to copy the information and the cost of labor to make the copy or transmit the information. The electronic copy also may be transmitted via unencrypted email to the patient only if the patient consents to receiving the information

in this manner after being informed of the risks of unsecure communications.

Public benefit program appeal: If a patient requires a copy of a portion of his or her record to support an appeal regarding eligibility for a public benefit program, such as Denti-Cal, the copy shall be provided by the dental office at no charge.

Allowable charges: The patient is entitled to no more than one copy free of charge, but may not be limited in the number of requests for copies.

What do I tell a patient who thinks his records (or X-rays) belong to him?

The information and images in a patient record are the work product of the dental practice. State law allows a patient to have access to the information in the record and requires patient authorization prior to disclosing information to other entities for nonpayment and nontreatment purposes. However, the law does not recognize patient ownership of the information.

Information on who else may access patient records is provided in the article "Patient Records: Requirements and Best Practices." The article and a sample form, "Access to Patient Records Request Form," are available on cda.org/practicesupport. ■

Regulatory Compliance appears monthly in the Journal, *featuring resources about laws and regulations that impact dental practices. Visit cda.org/practicesupport for more than 600 practice support resources, including practice management, employment practices, dental benefit plans and regulatory compliance.*

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6057 TRI-VALLEY AREA Great starter in very desirable area. 3-ops with 4th available. Small patient foundation.

6056 CENTRAL CONTRA COSTA COUNTY Annual revenues of $800,000+. Busy Hygiene schedule. Great location.

6054 TRACY Great starter practice. 2013 should collect $165,000+ on part-time schedule. 4-ops in shopping center location.

6053 SAN FRANCISCO'S SOUTH BAY – PEDO PRACTICE Long established. 2013 tracking $660,000 in production, $650,000 in collections and $255,000 in Available Profits. Great staff.

6052 BERKELEY Trendy north side shopping area. Very strong foundation. 2,000 active patients. 4-days of Hygiene. Beautiful hitech office with great curb appeal. 2012 collected $590,000. Lots of work referred out. SOLD

6051 FRESNO'S FIG GARDEN VILLAGE AREA Not a Delta Premiere practice. Collected $430,000 in 2013 on 3.5 day week.

6050 MERCED 2013 trending $360,000. Very profitable. Refers Endo, OS & Perio. Not a Delta Premiere Practice. Great foundation to build upon. Full Price $125,000.

6048 SALINAS Great opportunity for the ambitious, Ideal for two Dentists. 10 days of Hygiene per week. 2012 collected $1.1 Million. 2013 tracking $1.2 Million. Practice did well during Great Recession. SOLD

6047 STOCKTON Best location outside Brookside Community on West March Lane. Annualized revenues of $540,000. Attractive 3-Op office. Package sale includes condo.

6046 PINOLE Collected $500,000+ in 2012. 4-days of Hygiene produced $178,600. Beautiful office. Refers Endo. Lots of Goodwill here. SOLD

6045 MANTECA / MODESTO AREA'S RIPON Great location. 3 Ops, 2 wired & plumbed. $180,000 invested here. Practice did more when Owner worked harder. 2012 collected $327,000 on 3- day week with 5-weeks off.

6044 MODESTO Best location. New development occurring nearby. Collects $380,000. Digital with computers in Ops. Very attractive office. SOLD

6043 EL SOBRANTE 3-day practice collected $170,000 in 2012. 3-Ops. Building optional purchase.

6041 PLEASANT HILL Collected $365,000 with Profits of $142,000 in 2012. Owner slowing down. Previous 3-years averaged collections of $415,000 and Profits of $180,000. SOLD

6039 CALIFORNIA'S SOUTH LAKE TAHOE Long established. 2012collected $515,000 with 4 months off. Realized Profits of $230,000+. Attractive 3-Op office SOLD

SAN DIEGO Absentee Owner. Grosses $4 Million. 4 locations. Buy one or all.

HEMET Established 30 years. Grosses $650,000 part-time. Modern 10-op office. Cheap rent. Full Price $700,000. Seller will work-back for Absentee Buyer.

RIVERSIDE High identity dental building "For Sale" with practice. Part time Owner grosses $550,000. Elegant 5 ops includes CT & digital Panorex. Full time Buyer will do 1 Million in 5 years.

ALISO VIEJO Best shopping center location. Gross almost $1 Million. Gorgeous 5 ops, all digital, paperless. 70 New Patients per month. Part-time Owner. Full Price $945,000.

CUCAMONGA High identity shopping center on freeway exit. 5 ops. Grossed $850,000 in 2012. 2013 tracking $1.2 Million. Full Price $850,000 SOLD

RIVERSIDE Grosses $1.3 Million. Digital GP & Ortho. 10 Ops in 3,000 sq.ft. Low rent. High identity shopping center near Wal-Mart. Young GP will do $1.5 Million first year & net $500K. Full Price $800,000.

BEST HISPANIC CORNER IN SAN FERNANDO VALLEY Dental building & practice. 7 Ops with room to grow. 70 New Patients/month. Practice $1 Million, Building $1.75 Million. $2 Million location.

TORRANCE/GARDENA Conservative Chinese DDS. Established 31 years. Seller refers lots of work. Young Chinese/American Successor will do $600,000 first year. Bargain at $185,000.

SAN FERNANDO VALLEY Absentee Owner. Grosses $1.6 Million. $6,000-to-7,000/month in HMO checks. Full Price $1.4 Million. Seller to assist with financing.

REDLANDS Bank Repo! 4 ops. High identity location. Practice is operating. Bargain at $285,000. Make Offer.

ANAHEIM Established 50 years. Grossing $30,000/month part time. Rent $2,700/month for 2,000 sq.ft. 6 Ops. Full Price $185,000.

PASADENA AREA Grossing $750,000 part time. HMO $6,000-to-7,000/month. Did over Million when Owner had more time. Full Price $850,000.

LANCASTER Proven shopping center location. Equipped & ready to go. Seller needed more space. Many walk-ins daily. Seller grossed $900,000, collects $600,000+. Full Price $125,000. Stay 18 months and resell at $350,000 or more. Low overhead.

VICTOR VALLEY Divorce Sale. Classic/Quality GP with high Gross. Owner would rather sell and split value than fight and give to attorneys. This is simple and lets him go on with his life.

BAKERSFIELD High identity dental building. Grosses $750,000. Established 50 years. 5 ops. Successor will do $1 Million first year. Low overhead. Full Price $500,000.

SMALL TOWN NEAR BAKERSFIELD Practice and real estate. $400,000 with full time DDS. Practice and building $350,000.

ORANGE Part time Lady DDS. Does $30,000-to-40,000/month. 5 ops. Seller can work back for smooth transition. Full Price $295,000.

VICTOR VALLEY High identity shopping center. Grosses $650K. 8 Ops low overhead. Full Price $550,000.

REDLANDS Unique Location. Low overhead digital office. 5 ops, Gross $30,000+/month. Full Price $350,000.

NEVADA Small Resort City near Las Vegas. "State of art" 5-ops. Seller will stay for smooth transition. Grosses $600,000 on 3-days. Will do $300,000 more with 3 more days. Full Price $600,000.

DENTURE CENTER Over 30 denture patients per day. Grosses $1.3 Million. Patients not given option for implants as practice just does dentures. Full Price $1 Million. Specialist can take to $2 Million first year.

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3088 SAN JOSE GP & BUILDING

San Jose GP & Building Seller relocating out-of-country. Offering well-est. practice and 20 year old, 3,500 sq. ft. professional building. Office space is 1,755 sq. feet with 4 fully-equipped ops. New laser, and Dexis digital x-ray, digital camera, intra oral camera, and panorex. Approx. 1,200 active pts. and 3.5 doctor days/week. Call for details.

3092 SF FACILITY

1,600 sq. ft. street-level dental facility in Marina/ Cow Hollow neighborhood across from Presidio with excellent visibility and signage for foot traffic plus easy diagonal parking in front of building. Move in ready with 4 ops., 2 labs, kitchenette, reception and 2 desk areas plus 2 pvt. offices, 2 bathrooms, 1/2 basement & backyard with deck. Asking Rent $3.50/ sq. ft.

SOLD

4015 LOS ANGELES COUNTY GP

Quality East San Gabriel Valley, Foothill Community practice. Retiring seller working 4 doctor-days, approx. 1,600 active pts., seasoned & loyal staff. 1,103 sq. ft. modern office w/4 fully-equipped ops. Prominent, well-travelled street corner in desirable neighborhood surrounded by healthcare professionals with large daytime population draw. Recent equipment upgrades. New computers and new cabinets. 2012 GR $877K+ Asking $722K.

3096 NORTH BAY PERIO

Step into quality practice with established referral base. 2,200 sq. ft. office w/6 fully-equipped ops. Modern facility kept updated with recently purchased chairs, lights, Pano & lasers. Seller will grant a fair market lease and would consider selling the office space. 5 year avg. GR $1.2M+ Asking $825K.

4013 STANISLAUS COUNTY GP

Well-managed GP with regularly increasing revenue. State-of-the-art 1,600 sq. ft. well-equipped office w/4 ops. Digital x-ray, Dexis, 3 x-ray machines, laser and recent leasehold improvements. 2012 GR $883K+, 2013 on schedule for $968K+ as of Oct. Located near hospital in well-travelled area. Asking $604K+.

4007 FREMONT PERIO

Seller retiring from 30 year est. Periodontal practice in 3 op facility located in medical/dental building on well-traveled avenue in commercial neighborhood. Strictly Perio - no implants. Great starter practice opportunity, turnkey operation with equipment and no construction hassles. 2012 GR $133K+ w/just 1 Dr. day/week. Avg. 8 new pts. per month, 6 pts. per Dr. day & 7-8 pts. per hygiene Asking $75K.

4011 SANTA ROSA GP

Seller is changing careers and offering a well-established and successful practice. No insurance contracts, 4 doctor day/week & attractive 1,700 sq. ft. office in desirable neighborhood close to downtown. 2012 $576K+, 2013 on schedule for $612K+ as of June. Asking $450K.

SOLD

4014 SAN FRANCISCO GP

Seller has a sterling reputation throughout the community, and is ready to retire. Facility has 3 fully-equipped ops., reception area, business office, private office, lab + sterilization area, x-ray room, dark room + storage and bathroom. Asking $125K.

SOLD

4012 SAN RAFAEL GP

Ready to start your own practice? Check out this turnkey ready practice opportunity with brand new state-of-the-art equipment: Panorex, inter-oral camera, digital x-ray in well-deigned 800 sq. ft. facility w/3 fully-equipped ops. Located on well traveled street close to hospital in strategically located professional building. Averaging 5 new pts. per month. Asking $275K.

4018 NAPA COUNTY GP

Seller retiring from a profitable, well-established Napa County practice w/large & loyal patient base. Located in 2,750 sq. ft. office w/6 modern fully-equipped & upgraded ops. including digital x-ray in each op. 2012 GR 1.7M+ & 2013 GR on schedule for 1.8M+ as of October. Seller is willing to work-back for a smooth transition and will negotiate a fair market lease. Asking $1.4M.

3094 NORTH BAY PERIO

North Bay Perio now available. Seller retiring from well-est. practice with seasoned staff and active referral base. 1,300 sq. ft. very nice office with 4 fully- equipped operatories. 2012 GR $450K+ with just 3 1/2 doctor days and 5 days of hygiene per week. Great upside potential since owner does few implants. Asking $271K.

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IMPLANTS

Prevalence of peri-mucositis, peri-implantitis and implant success

Swierkot K, Lottholz P, Flores-de-Jacoby L, Mengel R. Mucositis, Peri-implantitis, Implant Success and Survival of Implants in Patients With Treated Generalized Aggressive Periodontitis: 3- to 16-year Results of a Prospective Long-term Cohort Study. *J Periodontol* 2012; 83: 1213-1225.

Purpose: Determine the prevalence of peri-mucositis, peri-implantitis and implant success and survival in a group of generalized aggressive periodontal (GAP) patients compared to healthy patients.

Method: 35 GAP patients were compared with 18 healthy patients all rehabilitated with dental implants. Exams were performed two to four weeks before extraction, three weeks after the final abutment and during routine three-month recall visits. Exams were gingival index, probing depth, bleeding on probing recession and clinical attachment level. At one, three, five, 10 and 15 years after prosthesis placement, microbiological and standardized radiographic exams were performed. The average age in situ of the implants was 8.25 years.

Results: Implant survival rates were 100 percent in the healthy group and 96 percent in the GAP group; but success rates were 50 percent and 33 percent in the two groups respectively. Mucositis was present in 40 percent compared with 56 percent and peri-implantitis was present in 10 percent versus 26 percent, in healthy versus GAP patients. GAP patients had a five times greater risk of implant failure, threefold greater risk of mucositis and 14 times greater risk of peri-implantitis. Implants in regenerated bone showed no significant differences with regard to any of the parameters studied. Implants that supported fixed bridges or removable superstructures displayed a higher risk, as did those in current and former smokers.

Conclusion: The data indicate that patients treated for GAP are more susceptible to mucositis and peri-implantitis, with lower implant survival and success rates.

Clinical Relevance: GAP patients lose more teeth and have more opportunity to receive dental implants. Clinicians need to recognize that these patients may not enjoy the same level of success as periodontally healthy patients. This paper differentiates between success or health of the implant and retention or survival. In many cases, a diseased implant cannot be considered a success even if it is retained.

—David W. Richards, DDS, PhD

ORAL AND MAXILLOFACIAL SURGERY

Functional sensory recovery (FSR) after the repair of lingual nerve injuries

Fagin AP, Susarla SM, Donoff RB, Kaban LB, Dodson TB. What Factors Are Associated With Functional Sensory Recovery Following Lingual Nerve Repair? Harvard School of Dental Medicine, Boston. *J Oral and Maxillofac Surg* 2012; 70 (December): 2907-2915.

Objective: The objective of the article was to identify factors that are associated with the improved likelihood of functional sensory recovery (FSR) after the repair of lingual nerve injuries. The article was based on a retrospective cohort study of 55 patients who underwent lingual nerve repair from 2004-2010. Patients who presented with lingual nerve injuries who had surgical management with primary repair and at least one postoperative evaluation were included in the study.

Materials and Methods: Patients were evaluated based on light touch, two-point discrimination, proprioception, pain and temperature to determine the British Medical Research Council (BMRC) level of sensation as well as the Zuniga and Essick level of sensation. Demographic data were collected including age, gender, presenting complaint and the duration since the injury. A total of 55 patients were included in the study, of those 55 who met the inclusion criteria, 42 were female. The average age of the patients was 30.7 years.

Results: The mean duration from injury to repair was 151.6 days and 74.5 percent of all of the patients achieved functional sensory recovery with an average 263 days. Eighty-six percent of the patients had an increase in sensation of at least two levels of the BMRC scale. None of the patients in the study became worse.

Conclusions: Younger patients had a higher likelihood of achieving FSR. FSR decreased at a rate of 9 percent for every additional year of age. Patients with higher sensory function preoperatively had shorter times to FSR.

Clinical Significance: Most patients who undergo lingual nerve repair achieve FSR; however, lingual nerve repair should be performed within the first six months of initial injury in younger patients.

— Dennis Yamashita, DDS

ENDODONTICS

Prognosis of apical microsurgery – a five-year longitudinal assessment

von Arx T, Jensen SS, Hanni S, and Friedman S. Five-Year Longitudinal Assessment of the Prognosis of Apical Microsurgery. *J Endod*; 38(5): 570-579, 2012.

Aim: This prospective longitudinal study examines the five-year prognosis for apical surgery as a treatment modality for teeth exhibiting signs of endodontic failure. Predictive factors for success were also evaluated in terms of patient-, tooth- and treatment-related variables.

Methods: Subjects were recruited from 251 patients undergoing apical surgery; 194 patients met the inclusion criteria and were examined at one year post-op. Three patients were lost to follow-up, so 191 patients were asked to return for a five-year evaluation. Evaluation criteria included clinical and radiographic exams, with two examiners interpreting. Healing was classified as complete, incomplete or unsatisfactory based on clinical and radiographic findings. Teeth were also classified as "functional" based on the absence of clinical signs and symptoms regardless of the radiographic appearance.

Conclusions: At the five-year evaluation, 76 percent of the treated teeth were classified as healed. This represented an 8 percent decrease from the one-year evaluation. At the same five-year interval, 85 percent of teeth were classified as "functional," meaning the radiographic appearance might not be that of complete healing, but there was an absence of clinical signs or symptoms. The predictors of outcome that were considered meaningful were: patient-related: smoking status; tooth-related: the crestal bone height within 3 mm of the cemento-enamel junction (CEJ); and treatment-related: the type of root-end filling material. In this study, two types of filling material were used, super ethoxy–benzoic acid (Super EBA) and mineral trioxide aggregate (MTA). The authors found that the use of MTA was a significant predictor of successful treatment with a healed rate of 86 percent compared to 67 percent for Super EBA.

Clinical Relevance: As with most studies on surgical procedures, case selection has a high level of influence on prognosis. In this instance, the level of bone relative to the CEJ was found to be a significant predictor of success, so periodontal evaluation prior to planning endodontic surgery is vital. This study predates the advent of newer bioceramic materials used for root-end fillings. These materials have shown even greater promise in preliminary studies as to their influence on healing and osteoinductive potential. Apical surgery remains a viable treatment option for those teeth exhibiting signs of endodontic failure and enjoys a relatively high success rate; a rate that can be enhanced by careful case selection and identification of those factors under the practitioner's control that are predictive of success.

–Craig Noblett, DDS, MS, FACD, FICD

IMPLANTS

A multicenter comparison of titanium-zirconium versus titanium implants

Al Nawas B, Bragger U, Meijer H, et al. A double-blind, randomized controlled trial (RCT) of titanium-13zirconium versus titanium grade IV small-diameter bone level implants in edentulous mandibles – results from a one-year observation period. *Clin Imp Dent and Rel Res* 2012; 14: 896-904.

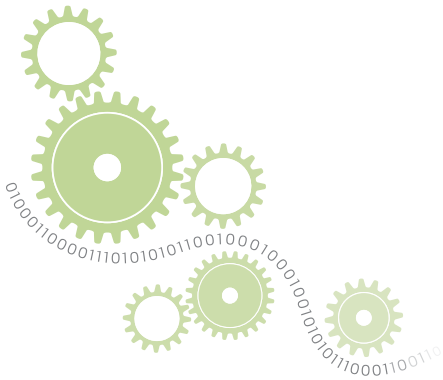
Purpose: The aim of this double-blind, randomized controlled trial was to determine if titanium-13zirconium implants performed as well as traditional-grade IV titanium implants in terms of peri-implant bone level changes, physical stability and safety after six and 12 month follow-ups.

Methods: In this prospective, randomized, controlled, double-blind, split-mouth and multicenter clinical trial, 89 patients were analyzed. Each patient received two Straumann Bone Level implants of 3.3 mm diameter with SLActive surface (one TiZr alloy implant and one grade IV titanium implant) between the interforaminal region of the edentulous mandible. Peri-implant bone level changes were assessed by comparing standardized panoramic radiographs taken at baseline and 12 months. Implant survival was defined as the implant still being in place at the 12-month mark and success was defined by the possibility for restoration and the criteria set forth by Buser, et al., 1990. The modified plaque index (PI) and modified sulcus bleeding index (SBI) were used to assess soft tissue status. Safety was evaluated by reporting all complications including adverse events (AE) and serious adverse events (SAE).

Results: Mean peri-implant bone level changes at 12 months post surgery was not significantly different between the TiZr alloy implant group (-0.34 +/-0.54mm) and the Ti Grade IV group (-0.31 +/-0.56mm). The survival rate of the TiZr group was 98.9 percent while the survival rate of the Ti Grade IV group was 97.8 percent. The success rates of the TiZr group and the Ti Grade IV group were 96.6 percent and 94.4 percent. There were no statistically significant differences in PI and SBI between the groups at either six or 12 months. Out of the 91 patients initially enrolled, two were not included in analyses because the treatment allocation was unknown in one and the other did not have efficacy data. Twenty-six patients had 37 adverse events with 19 of them being related to the implant. Most of these events were inflammation at the implant site, tactile implant mobility, loosening of a prosthetic component and minor discomfort due to the procedure. Three implants were lost during this study: one in the TiZr group and two in the Ti Grade IV group. All implants were lost before locator abutment connection.

Conclusion: This study suggests that titanium-13zironium implants perform as well as titanium grade IV implants in terms of peri-implant bone changes, survival and success rates and safety after one year of follow-up.

–Erik C. Low, DMD, and Richard T. Kao, DDS, PhD



A look into the latest dental and general technology on the market

Dentsio

(Sergio Tinoco, $999)

Dentsio is the first-ever attempt to enter the touch interface realm of electronic health records exclusively for the iPad, providing a touch interface for the entire patient chart. The main screen contains a scrollable list to select or add new patients from. Each patient chart has a set of tabs that allows a user to enter biographical data, oral examinations and clinical findings, periodontal charting, diagnoses and treatment plans. When performing periodontal charting or recording clinical findings, each tooth has its own window to navigate through and select choices along with buttons to jump to adjacent teeth. Pictures using the iPad camera or existing photos can be attached to each patient chart. While the Dentsio interface is clean and innovative, users may find it difficult to adapt this app to their own individual practices. Users cannot edit or customize fields of data entry and therefore are limited to what the app provides as the patient chart. The Dentsio app is a proof-of-concept that touch interfaces have the potential for increasing productivity by decreasing the amount of time needed for chart entries.

–Hubert Chan, DDS

hopTo

(hopTo Inc., Free)

Users waiting for Microsoft to release a version of Office for the iPad need not wait any longer. hopTo is an app designed to fill this void in the mobile workspace arena by making the productivity suite optimized for the iPad with an innovative touchscreen interface and cloud file sharing. Once users create a hopTo account, a file browser becomes the main screen where users can edit Microsoft Word and Excel documents directly from the app utilizing an easy-to-use interface. To share documents, users can link hopTo to their Google Drive, Box or Dropbox accounts. Users can also share documents with a Windows PC. Users can also view PowerPoint, Acrobat PDF and most popular graphics, audio and video files. Editing documents is extremely intuitive with hopTo. Users can also insert images into Word documents from the iPad or from Google image searches. For Excel, hopTo supports entering common functions within cells of a document. Although documents are displayed accurately, fonts appear pixelated in order to maintain performance while connected to the hopTo service.

–Hubert Chan, DDS

DoorBot

(BOT Home Automation, $199)

DoorBot is a Wi-Fi enabled video doorbell that allows users to see and talk with visitors through their smartphone from anywhere in the world. Installation is incredibly simple, involving only four screws and a mounting bracket. Once users download the free DoorBot app for their iOS or Android device and sync it to their DoorBot, they will be notified whenever someone presses the button on the device, letting them see, and talk to, whoever is at their door, all through a smartphone. Obviously, the device is weatherproof and can be moved around during installation to the proper angle for optimal viewing of whoever is at the door. There is also integration with Lockitron's remote door locking system, which allows users to remotely unlock the door. Set-up is easy and DoorBot can connect to multiple devices at once (iPhone, iPad, etc.). With a fast Internet connection at home, the quality of both the video and audio transmitted through the DoorBot is more than adequate. The company plans to add functionality such as recording video from the camera this year.

–Blaine Wasylkiw, director of online services, CDA

DDS Anywhere

(Dental Anywhere Inc., Free)

DDS Anywhere creates customized mobile apps for dentists. The app has enabled a new platform for dentists to market themselves, brand themselves, expand their business and enhance the overall patient experience. The creation of a customized mobile app has many benefits for the solo dentist. Ease of use is front and center with a mobile app because the user doesn't need a browser for access. The app icon remains present on the phone, eliminating the need to search for it. Appointments can be made, bills can be paid, seasonal office specials can be promoted and hygiene reminders can alert patients, among many other advantages. Patients who've had a great experience can easily tap into the social media sites the office participates in within the app. The layout and design are customized with original logos to create familiarity. Having a mobile app specific to your practice is part of the next wave in dental marketing, enhancing the patients' overall experience by providing tools and resources for them to stay connected to the practice.

–Darien Hakimian, DDS

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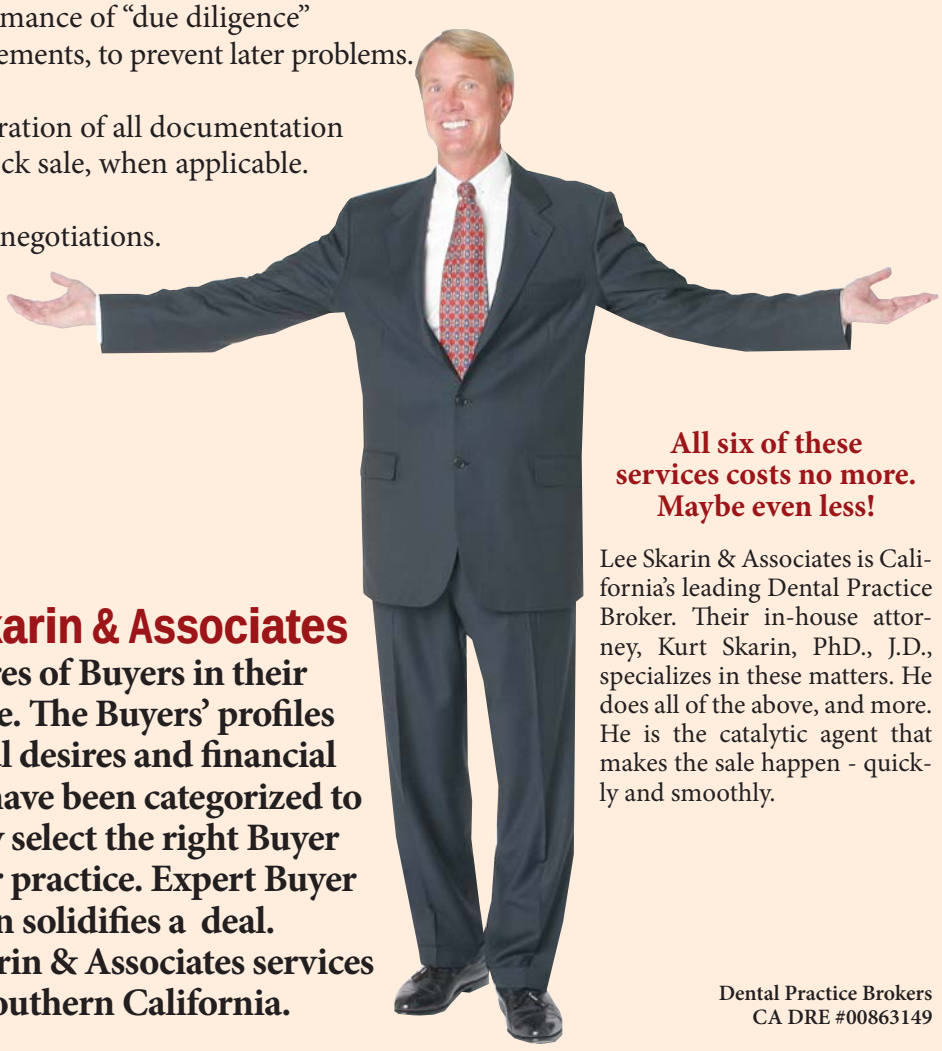

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CDA JOURNAL, VOL 42, N°2

Retirement: It's Not for Sissies

It is my contention that dental students, once granted their degrees and handed off to their debt-ridden parents, should immediately start implementing plans for retirement.

Robert E. Horseman, DDS

ILLUSTRATION BY VAL B. MINA

If you should be in my neighborhood and peer over the parapets surrounding a semidetached 12-by-20 piazza carpeted in Home Depot's lush green AstroTurf knock-off, you might espy the recumbent figure of a recently retired dentist, an open book spread upon his ample girth. Assessing his wrinkled visage evoking that of the late Margo expiring in the arms of a distraught John Howard as they paused at that fateful Tibetan pass after abandoning Shangri-La, the temptation would be to dial 9-1-1. Only the periodic explosive snorts characteristic of sleep apnea and the realization that the inert figure, inflated like a blowfish, resulted from an excess of lunchtime carbohydrates, might give pause to the summons.

I began my career as an ex-dentist with such high hopes. No more ridgeless full dentures — open margins and fractured cusps were history. With no thought for the morrow, the supposition went, la dolce vita would be the modus operandi.

And so it was during the unnerving quiet of the first couple of weeks of random inactivity, languidly poking about the premises in full possession of the TV remote in one hand, a bag of orange-shedding Cheetos in the other. Now, however, it has become abundantly clear that to a nonagenarian, leisure choices are going to be necessarily limited.

The amount of decrepitude one should expect after 66 years of practice, during which physical

activity was dictated by millimeter-based exercises, precludes pretty much everything but checkers, dominos and perhaps mixed-doubles lawn bowling enhanced by orthopedic knee socks.

It is my contention that dental students, once granted their degrees and handed off to their debt-ridden parents, should immediately start implementing plans for retirement. Furthermore, this planning should be imbedded in the freshman curriculum based on extensive courses taught, if possible, by a certain entrepreneurial USC graduate, who, after 17 years of practice and some shrewd diversification, recently donated $35 million to the school. The grateful school promptly renamed the institution after him when the check cleared.

Had I known a proper quid pro quo of this nature would be forthcoming, I might have done likewise, because the School of Dentistry at USC in 1939 was a sorry structure, haphazardly stabilized by sticky wax and miles of floss. State historians postulated the school's foundations were the work of early Chumash Indian tribes.

Neighborhood dogs, instinctively aware of the imminent collapse of the buildings, refused to relieve themselves on it. Archeologists with sable brushes dusting the Pleistocene cuspidors were as likely to be encountered in its ancient clinics as members of the dental community. Hard hats were as much a part of our armamentarium as our Doriot handpieces and nonfunctional saliva ejectors. To have had my name emblazoned on a dental school rivaling Dubai's Burj al-Arab Hotel would have been a dream realized. Unfortunately, it was summarily dashed after a gloomy discourse with a tight-fisted banker at Fiduciary & Usury Trust.

To cavil endlessly about the school's neglect to position me for retirement at age 55 would be considered graceless; after all, I did absorb enough technical knowledge to sustain me somewhat above the national poverty level for six decades. For that, I am appreciative.

I am about to have reversed my belief that I can help most with housekeeping when I stay away from home.

Life in retirement, other than offering extended periods of unrelieved tedium, is not divided neatly into the familiar repetitive 45-minute workday segments with 30 Tums-intensive minutes for lunch and Wednesday afternoons off. It has precipitously expanded into an all day, every day and every month off. Despite allowing me to indulge a preoccupation with my innards, I'll be hunky-dory, or at least as close as I can get considering my beneficiaries tend to openly refer to me in the past tense.

For $125 an hour, a grief counselor will explain how one should regard all this as not retiring from something, but retiring to something. This idea is not necessarily an option. I am about to have reversed my belief that I can help most with housekeeping when I stay away from home.

The first thing that I, a person with an antsyness factor of 10, discovered is that concerns over going crackers from ennui resulting after shucking the yoke of my recent profession are unfounded. Just as traffic quickly expands to overflow new freeways built to solve a traffic glut, I learn there are not enough hours in the day for my newly acquired responsibilities.

The second thing quickly realized is to forego kvetching audibly to my spouse about the endless conglomeration of housework chores formerly understood to be entirely within her purview. Whether these are now my tasks by volunteering or assignment, it is best to remain mute lest I am subjected to an endless loop of how she did all this and more for the last 50 years, raising three children simultaneously. ■

We're Still Taking Your Requests

Although Dr. Bob has retired from his regular column, he will contribute intermittently as his schedule allows. If you would like to see a favorite Dr. Bob column again, send an email to Publications Specialist Andrea LaMattina at andrea.lamattina@cda.org. We will oblige by reprinting requested favorites interspersed with any new Dr. Bob submissions. To enjoy past Dr. Bob columns, visit cda.org/journal and type "Horseman" in the search window.

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