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Journal

DECEMBER 2013

Health Care Reform

Future of Dental Care Financing

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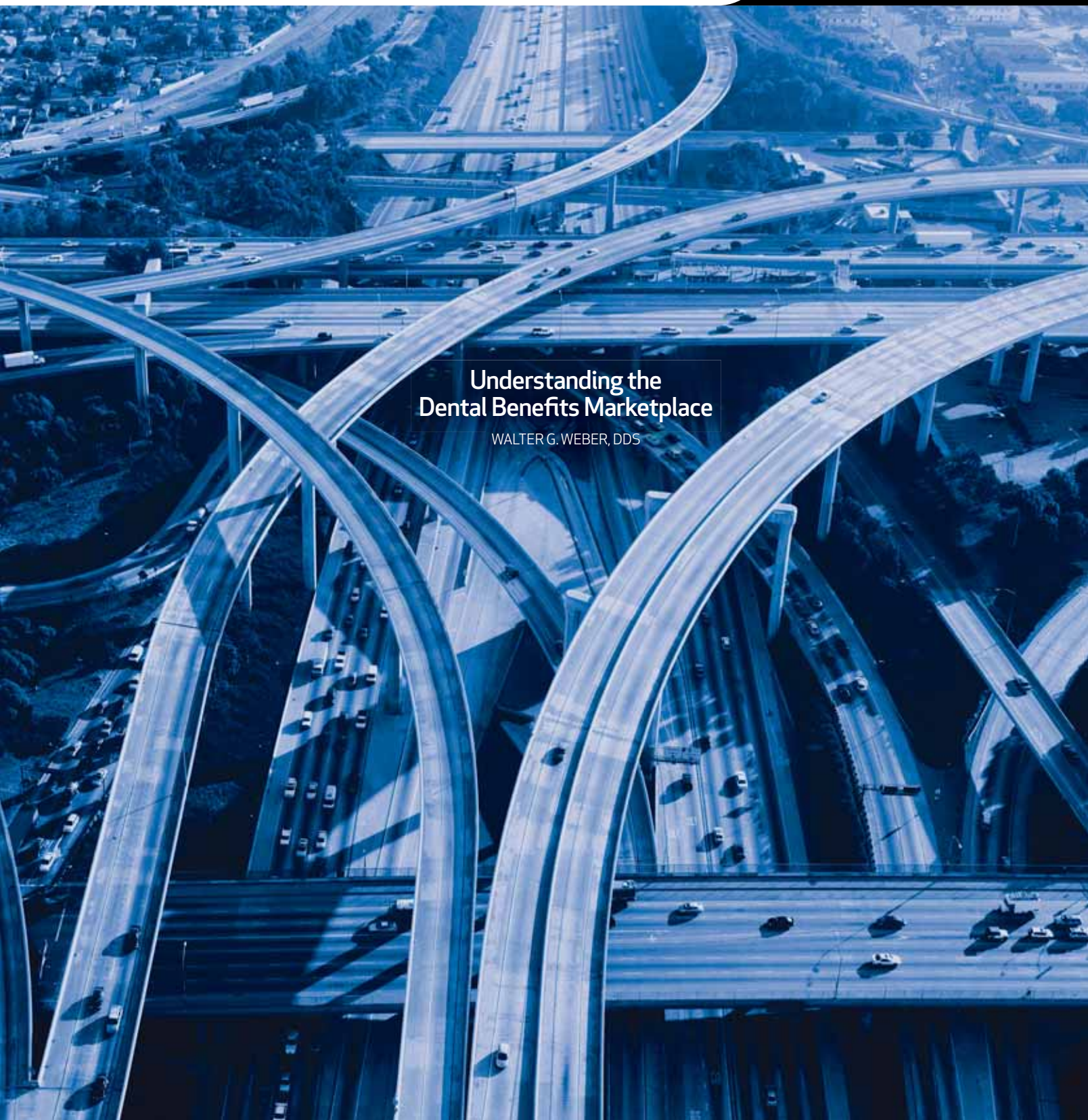
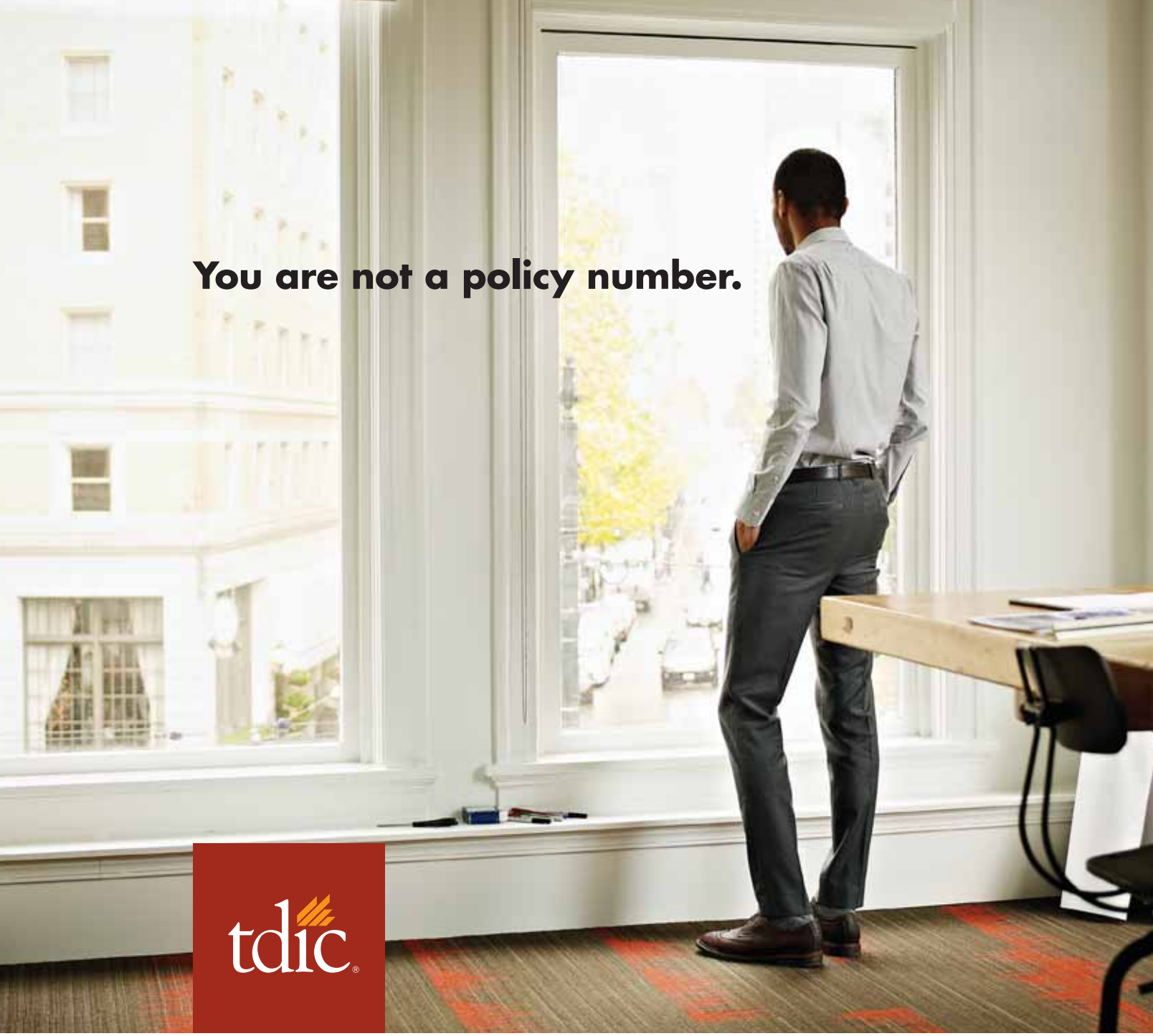


Understanding the Dental Benefits Marketplace

WALTER G. WEBER, DDS



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CDA JOURNAL, VOL 41, Nº12

Stages and Stageism

KERRY K. CARNEY, DDS, CDE

After an association member survey a number of years ago, it became clear that members' needs tended to sort out easily into four stages according to where they were in their career development. It was an easy concept to grasp. It provided a convenient framework upon which to design member services. These services could be tailored to coordinate with particular developmental periods in a classic career in dentistry. This demographic approach has been helpful. It has given us a reference point, a landscape upon which to base decisions.

The four career divisions were identified as Stage I: Beginning Your Career (those dentists practicing for zero to five years); Stage II: Starting a Practice (those practicing six to 10 years); Stage III: Enriching Your Career (those practicing 11 to 25 years) and Stage IV: Preparing for Retirement (those practicing 20-plus years). These stages have allowed us to focus on the needs of groups of dentists.

The CDA Practice Support Center has numerous resources available to help Stage I dentists make informed decisions about how to begin their careers in dentistry by joining an established practice as an associate.

Dentists in Stage II and Stage III are establishing and growing their practices. They can make use of resources aimed at helping minimize the friction of government regulation and improve the marketing and managing of growing or established practices.

Stage IV dentists have access to tools to help them sell the practice and plan for the transition into retirement. (Some of us discovered Stage V after the economic recession hit and retirement seemed to recede out of sight. But that is a different subject.)

The classic career path that was the basis of the Stages model grows less relevant with each passing year.

The demographic model has served us well. It has been a useful, easily grasped concept and tool. But I am tired of stages and the stageism that seems to have crept into the concept. Technology and changes in the business climate make these demographic categories seem increasingly less defined or separate. The classic career path that was the basis of the Stages model grows less relevant with each passing year.

New dentists have an array of possibilities before them and a load of debt to work through. Steady income from employment with large group practices seems to be tipping the scales for some recent graduates. How relevant is Stage I to them?

Increasingly burdensome government regulation and the constant downward pressure on reimbursement by third-party payers have made alternative forms of the dental enterprise more compelling. Dental service organizations (DSOs) are growing around the nation. Why spend one's time researching and implementing tools when one can easily off-load those chores to a DSO?

The Affordable Care Act innovations and requirements may prove a fertile environment for the further growth of large group practices and professional service networks. How do we wrap our minds around all these changes and figure out how best to serve our members' needs?

This is why I am tired of stages. Why should one's needs be confined to boxes labeled Stage I through IV? I am tired of a stageism that prejudges needs or behavior based on a career lifecycle. There are better measures for one's needs than the number of years one has been out of dental school.

It is time to break out of constricting, demographic boxes. The new Membership Development Plan is based on the following goals.

- It is time to respond to internal and external pressures and trends.
- Efforts need to be aligned with other organizational business plans.
- Membership will need to target efforts toward the most significant growth opportunities.
- And finally, we must continue to build meaningful relationships with our members.

This is not your grandfather's world or your grandfather's dental association. There are changes in consumer and member expectations. Advancing

technology gives us an improved capacity to collect and use data about emerging membership segments.

Preliminary analysis of some data is already available. One of the findings is a positive correlation of benefit usage with renewal and engagement. Members who take advantage of the benefits their CDA membership afford are more likely to renew their membership. They are also more likely to use additional benefits.

New emerging segments of the dental enterprise include newly licensed dentists, owners of corporate or large group practices and associates in those corporate or large group practices. New tools to assess and address the needs of these new segments will need to be developed.

The measure of success of a new strategy must rest, in part, on an increase in new-member totals and a reduction in member attrition over the same period. Successful reorganization of the member experience will be the result of tripartite collaborations and component support, enhanced dental school programs, data acquisition and new benefits designed for targeted segments of the dentist population.

It will be necessary to improve the acquisition and use of membership data to enhance operations, benefits and member experiences. Improving the customer experience is what has lead to the tremendous success of Internet giants like Amazon and eBay. There is no reason to think some of the lessons they learned enhancing customer experience could not translate well into the association member experience.

There will be a shift from "Stage" identifications to "needs-based" segmentation. This new strategy will be the basis for member outreach, communications and predictive behaviors. The success of this approach will lie in great part in its invisibility.

The machinery behind the customer experience at Amazon is of little interest to the customer. What matters is the simplicity and ease of use. The accomplishment is not in the recognition of the how it is done but in the amazingly customized or personalized interaction. It is important that the customers feel valued and cared for. The goal is to make the system fit and serve the customer rather than vice versa.

It will be exciting to see the member experience at CDA move from an assortment of demographic boxes to a data stream model. Maybe when every member finds our organization meets his/her needs in the most opportune manner, membership will be deemed as essential as an email address or an Amazon account.

The next time I make a dental equipment purchasing decision or attend a C.E. course, it may be incorporated into my engagement profile and help refine the prediction of my behavior and my needs. It is time to climb out of the box of Stage whatever and appreciate the needs of individuals. I can hardly wait. ■■■■

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Forensic Dentistry Expert Dies at 87

Dentistry lost a noted member of the profession with the passing of Gerald Lee Vale, DDS, on July 19, 2013. It is with great fondness I remember him as a mentor and instructor when I was a dental student at the Ostrow School of Dentistry of USC in the late 80s. I had the privilege of taking his forensics class in dental school and having him as an attending during my oral surgery rotation at Los Angeles County+USC Medical Center. Most of all, I remember his fairness and positive approach to teaching dental students. He will be greatly missed.

As a dentist for 65 years and CDA member for 60 years, Dr. Vale offered the complete package, overflowing. His breadth of accomplishments is remarkable. A lifelong learner, after graduating from New York University School of Dentistry, he went on to earn a master's of dental surgery degree in orthodontics from Ostrow, a master's in public health from the University of California, Los Angeles and a juris doctorate degree from Southwestern School of Law and was a diplomate in the American Board of Forensic Odontology.

Dr. Vale served as senior forensic dental consultant with the Los Angeles County Department of the Coroner from 1968 to 2008 and had conducted or supervised more than 3,000 forensic dental identification cases and 450 bite mark investigations. He left private practice in 1970 and became the director of dentistry for the Los Angeles County Health Department. In 1976, Governor Jerry Brown appointed him to the California State Board of Dental Examiners and he served as vice president his fourth and final year. From 1979 to 1992, he was the director of dentistry for the Los Angeles County/University of Southern California Medical Center. From 1991 to 1998, Dr. Vale served as the associate dean of hospital affairs at the Ostrow School of Dentistry of USC and during the 1999-2000 scholastic year, as interim dean of Ostrow. Dr Vale also lectured extensively throughout the United States. He was a founding member and diplomate emeritus of the American Board of Forensic Odontology and in 2004 was named a distinguished fellow of the American Academy of Forensic Sciences. He is survived by his wife of 61 years, Sydelle and his son, Donald Vale.

LINDSEY A. ROBINSON, DDS
Immediate Past President, California Dental Association

The *Journal of the California Dental Association* welcomes letters

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Low-cost Ethics

BY DAVID W. CHAMBERS, PHD

Most people favor ethics, lots of it. But they do not want to pay more for it than is necessary.

Charles Graeber's book *The Good Nurse : A True Story of Medicine, Madness and Murder*, tells the story of Charles Cullen, an effective nurse who worked at nine hospitals in New Jersey and Pennsylvania, and received sound employee ratings and letters of reference. He also murdered at least 40 patients.

Cullen was eventually brought to justice, and is now in prison, by the detective work of a police officer investigating a predatory assault incident outside the hospital, by a curious pharmacist and by a floor nurse. Authorities at some of the hospitals where Cullen worked had recognized the pattern and assembled the evidence —

CONTINUES ON 873

Study: Fat Grafting Shows Promise for Scarring Problems

A recent study has discovered that a new technique using injection of a patient's own fat cells is an effective treatment for hard, contracted scars, according to *The Journal of Craniofacial Surgery*.

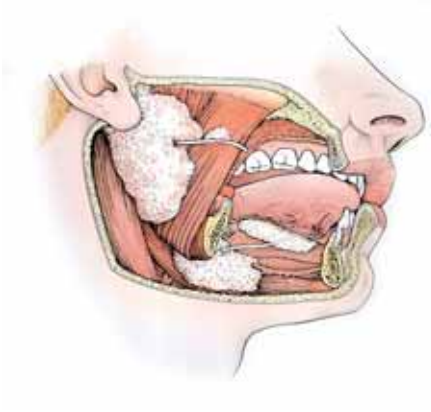
In the study, researchers used autologous fat grafting to treat persistent scarring problems in nearly 700 patients over six years. According to the authors, "all patients recruited had retractile and painful scars compromising the normal daily activity/mobility of the joint involved."

In all treated scars, a qualitative improvement was shown both from an esthetic and functional point of view, the authors wrote, adding that, "most importantly, reduction or complete resolution of pain and increases in scar elasticity were objectively assessable in all cases." Improvement began within two weeks, continued through three months and persisted through one year and beyond.

In this study, treatment was also associated with improved motion in areas where movement was limited because of tightness and stiffness of contracted scars, according to a news release.

"Injection of processed autologous fat seems to be a promising and effective therapeutic approach for scars with different origin such as burns and other trauma scars, and post surgery and radiotherapy outcomes," the researchers concluded.

For more, see the study in the *Journal of Craniofacial Surgery*, Sept. 2013, vol. 24, no. 5, pp. 1610–1615.



Fully Functional Bioengineered Salivary Gland Regenerated

Led by scientists in Japan, researchers recently regenerated a fully functioning salivary gland, according to the study published in the journal *Nature Communications*.

The study demonstrates "novel evidence of successful replacement of a fully functional salivary gland through the transplantation of a bioengineered germ," the authors wrote.

According to the study, the bioengineered gland germs were reconstituted with epithelial and mesenchymal single cells isolated from each gland germ at ED13.5–14.5. The researchers reported that after one day in organ culture, the bioengineered salivary gland germs exhibited epithelial–mesenchymal interactions and had developed to an initial bud stage. After three days in organ culture, the bioengineered salivary gland germs, including the parotid, submandibular and sublingual gland germs, underwent branching morphogenesis followed by stalk elongation and cleft formation. From three days of organ culture on, the accumulation of saliva could be observed in the ducts of the bioengineered gland germs.

The bioengineered submandibular gland, which was transplanted using an inter-epithelial tissue-connecting plastic method, produced saliva in response to the administration of gustatory stimulation by citrate, protected against oral bacterial infection and restored swallowing in a mouse model of a salivary gland defect.

Given that salivary gland hypofunction occurs as a result of radiation therapy for head cancer, Sjögren's syndrome or aging, and can cause a variety of critical oral health issues, including dental decay, bacterial infection, mastication dysfunction, swallowing dysfunction and reduced quality of life, the authors concluded that this study provides "a proof-of-concept for bioengineered salivary gland regeneration as a potential treatment of xerostomia."

For more, see the study in the journal *Nature Communications*, 2013, 4, article number 2498.

Novel Urease Technique Shows 'Great Potential' in Dental Implants

New research suggests a novel urease fabrication process for coating titanium implants with bioactive CaP/gelatin composites provide great potential in clinical joint replacement or dental implants. Because of its excellent biocompatibility and low allergenicity, titanium has been widely used for bone replacement and tissue engineering, the study noted.

"To produce a desirable composite with enhanced bone response and mechanical strength, in this study bioactive calcium phosphate (CaP) and gelatin composites were coated onto titanium (Ti) via a novel urease technique," the authors wrote.

Researchers implanted tiny 2 mm by 10 mm CaP/gel/Ti and CaP/Ti rods into the thigh bone of rabbits, while pure Ti rods served as controls. Four and eight weeks following the operation, the authors observed much more new bone on the surface of the composite CaP/gel/Ti rods than in the other two groups at each time point.

Published in *Science and Technology of Advanced Materials*, the study also found that the CaP/gel/Ti rods bonded to the surrounding bone directly, with no intervening soft tissue layer.

The authors concluded that the CaP/gel/Ti implants fabricated using their urease process not only enhanced the proliferation of stem cells and differentiation of bone cells, but also the bone bonding ability of the implants. This research suggests that titanium implants coated with CaP and gelatin "might have a great potential in clinical joint replacement or dental implants," authors wrote.

For more, see the study in *Science and Technology of Advanced Materials*, 2013; vol. 14, no. 5:055001.

Cellular Signals Discovered Between Pancreatic Cancer Tumors and Saliva

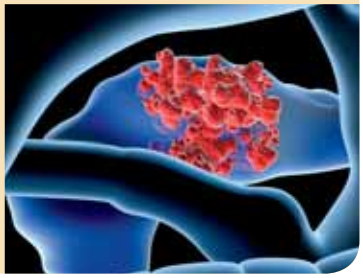
In a recent study in the *Journal of Biological Chemistry*, researchers at the University of California, Los Angeles, School of Dentistry set out to "examine the hypothesis that pancreatic tumor-derived exosomes are mechanistically involved in the development of pancreatic cancer-discriminatory salivary transcriptomic biomarkers." In the study on a tumor-ridden mouse model, the researchers were able to definitively validate that pancreatic cancer biomarkers reside in saliva.

To date, salivary biomarker panels have been successfully developed for systemic diseases such as pancreatic cancer, breast cancer, lung cancer and ovarian cancer. However, according to a news release from the university, researchers in the field of salivary diagnostics are still attempting to understand how biomarkers produced by other parts of the body ultimately appear in the mouth. Scientists have surmised that RNA molecules — which translate genetic code from DNA to make protein — are secreted into extracellular spaces and act as an information signal system, representing an innovative model in intercellular signaling.

The researchers examined mice models with pancreatic cancer whose saliva showed evidence of biomarkers for pancreatic cancer. When they inhibited the production of exosomes at the source of the tumor, the researchers found that the pancreatic cancer biomarkers no longer appeared in the mouse's saliva.

"This study supports that tumor-derived exosomes provide a mechanism in the development of discriminatory biomarkers in saliva and distal systemic diseases," authors concluded.

For more, see the study in the *Journal of Biological Chemistry*, vol. 288, no. 7, pp. 26888 26897.



LOW-COST ETHICS, CONTINUED FROM 871

but none acted. He was forced to resign from five, but given neutral references. In his final position, the hospital was confronted by state authorities with the proof, but they deliberated for three months over concerns about the reputation to the hospital, financial implications and the possibility of lawsuits. During that time, Cullen killed five patients. When the authorities notified the hospital that they intended to arrest Cullen, the hospital fired him — because of irregularities on his employment application. The hospital obstructed the investigation, even lying about what evidence it had.

The hospitals certainly knew right from wrong. They just did not feel they could afford to be very ethical.

A story closer to home. In the 1980s, the University of the Pacific, Arthur A. Dugoni School of Dentistry adopted a standard for academic status based on contracts. Students who were not on track to become good dentists could be dismissed for either of two reasons: they participated in the contract, but it did not correct the deficiencies, or they declined to participate.

One morning I found myself facing a student in my office as academic dean and I heard these words: "You may think you are pretty clever demanding that I get psychiatric help. But you are wrong. You wait right here because I am going to housing to get a gun and when I come back, you'll see."

The student was brilliant — 4.0+ GPA from a top school — and his technical skills were fine. But the faculty had signaled that his relations with others were unstable and that he likely could not function as an independent professional. His family did phone and ask that I have him arrested (before the gun comment) "so he could get help." When I said that was their responsibility, they hung up on me. Other schools use an "objective" standard based on grades in order to protect their reputations and are often in court defending these actions. Pacific has not had a single lawsuit over dismissals since the system was put in place.

The nub:

1. You get what you pay for in ethics.
2. Sometimes others pick up the tab for the ethics we fancy — sometimes the cost to others can be extreme.
3. There must be evidence that one cares for the ethics one espouses.

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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Study: Drinking Fluoridated Water Brings No Additional Risks for Hip Fractures

A new study has found that "chronic fluoride exposure from drinking water does not seem to have any important effects on the risk of hip fracture, in the investigated exposure range," according to the *Journal of Dental Research*.

The team of researchers, led by Peggy Näsman, Karolinska Institute, Department of Dental Medicine, Stockholm, investigated possible adverse health effects on bone tissue from drinking fluoridated water. The study included a large cohort of Swedish residents chronically exposed to various fluoride levels, with the hypothesis of a possible association between fluoride level in the drinking water and the risk of hip fracture.

"The cariostatic benefit from water fluoridation is indisputable, but the knowledge of possible adverse effects on bone and fracture risk due to fluoride exposure is ambiguous," the authors wrote.

Estimated individual drinking water fluoride exposure was stratified into four categories: very low <0.3mg/L; low 0.3-0.69mg/L; medium 0.7-1.49mg/L; and high ≥1.5mg/L. With 473,277 individuals participating in this study, it is believed to be one of the largest studies of its kind.

The researchers found no association between chronic fluoride exposure and the risk of hip fracture and risk estimates did not change in analyses restricted to only low trauma osteoporotic hip fractures.

"Research continues to prove the health benefits associated with drinking fluoridated water," said International Association of Dental Research President Helen Whelton, in a news release. "It is promising to know that this cohort study, performed in Sweden, doesn't find an association between drinking fluoridated water and hip fractures."

For more, see the study in the *Journal of Dental Research*, November 2013, vol. 92, no. 11, pp. 1029-1034.

High-dose Statins Reduce Gum Inflammation in Heart Disease Patients

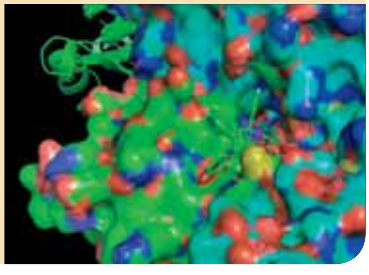
In a new study, researchers have found that statins, medications commonly prescribed for lowering cholesterol, also reduced inflammation associated with gum disease. The study, published in the *Journal of the American College of Cardiology*, suggests that steps taken to reduce gum disease may also reduce inflammation in the arteries and vice versa.

In the double-blind, randomized study, patients with heart disease or a high heart disease risk were assigned to take either an 80 mg statin or a 10 mg statin daily for 12 weeks. PET/CT scans were collected after four and 12 weeks and compared to scans taken before treatment began. The 59 patients included in the final analysis showed a significant reduction in inflammation in the index vessel from baseline after as few as four weeks of treatment with the 80 mg statin. Interestingly, the improvement in gum inflammation tracked closely with improvement in atherosclerotic disease, the study noted.

"Statins have beneficial effects beyond their lipid lowering properties," said Ahmed Tawkol, MD, co-author of the study, in a news release. "Physicians should take this into consideration when discussing antihyperlipidemic treatment options with their patients."

In this study, the authors concluded that statin therapy produced significant rapid dose-dependent reductions in FDG uptake that may represent changes in atherosclerotic plaque inflammation."

For more, see the study "Intensification of Statin Therapy Results in a Rapid Reduction in Atherosclerotic Inflammation," in the *Journal of the American College of Cardiology*, 2013, vol. 62, no. 10, p. 909.



Olympic Athletes Say Poor Oral Health Is Impairing Performance

Many of the elite athletes who competed at the London 2012 Olympic Games had poor levels of oral health similar to those experienced by the most disadvantaged populations, according to a study in the *British Journal of Sports Medicine*.

The 302 athletes who participated in the study were given a systematic oral health checkup before being asked to give a personal assessment of the impact of oral health on their quality of life and athletic training/performance.

Eighteen percent of the athletes surveyed said their oral health was having a negative impact on their training or performance levels while 42 percent said that they were "bothered by oral health" issues and 28 percent said that it affected their quality of life.

Overall, the research team found high levels of poor oral health with 55 percent of athletes suffering from dental caries, of which 41 percent was into the dentine. More than 75 percent of the participants had gingivitis.

Oral health is important for well-being and successful elite sporting performance. It is amazing that many professional athletes — people who dedicate a huge amount of time and energy to honing their physical abilities — do not have sufficient support for their oral health needs, even though this negatively impacts on their training and performance," said lead author Ian Needleman, in a news release.

For more, see the study in the *British Journal of Sports Medicine* published online ahead of print, Sept. 24, 2013.

New Material for Bone Regeneration and Dental Implant Stability

According to a study in the *Journal of Oral Implantology*, a new, more advanced method has been introduced for bone and tissue regeneration that prevents infection and maximizes bone regeneration to allow for a more stable placement of implants.

The most commonly used treatment for post extraction regeneration has been a combination of acellular dermis matrix (ADM), a type of bone regenerating material that uses cadaveric tissue with all of the cells removed, and different grafting procedures. However, there has been no solid histologic data or microscopic tissue samples to prove that this regeneration is working properly.

This case series examined a new ADM replacement material called decellularized dermis matrix (DDM) that, combined with mineralized bone grafts called mineralized cancellous bone allograft (MCAB), guides the regeneration of bone to allow for a more stable placement of the implant. This method has a higher regeneration percentage and supports a more stable future implant site than previous therapies.

Tissue samples were examined both microscopically and using 3-D imaging and valuable surgery preparation time was saved using DDM, which can be stored fully hydrated, and the material was easy to handle and adapted well to the shape of extraction-site defects.

"Within the limits of this case series, decellularized dermis used as a barrier over extraction sites grafted with freeze-dried mineralized cancellous particulate allograft bone can produce a significant percentage of new bone regeneration after 12 weeks in molar extraction sites and support stable implant placement," authors concluded.

For more, see this study in the *Journal of Oral Implantology, August 2013, vol. 39, no. 4, pp. 503-509.*

"Nanodiamonds have the potential to impact several other facets of oral, maxillofacial and orthopedic surgery, as well as regenerative medicine."

DEAN HO, PHD

Nanodiamonds Deliver Proteins to Promote Bone Growth

According to researchers from the University of California, Los Angeles, School of Dentistry, nanodiamonds, which are created as byproducts of conventional mining and refining operations, could be used to promote bone growth and the durability of dental implants.

Approximately four to five nanometers in diameter and shaped like tiny soccer balls, these nanodiamonds may provide a new way to improve bone growth and combat osteonecrosis, a potentially debilitating disease in which bones break down due to reduced blood flow.

During bone repair operations, which are typically costly and time-consuming, doctors insert a sponge through invasive surgery to locally administer proteins that promote bone growth, such as bone morphogenic protein, according to a news release from the school.

Authors of the new study discovered that using nanodiamonds to deliver these proteins has the potential to be more effective than the conventional approaches. They found that nanodiamonds, which are invisible to the human eye, bind rapidly to both bone morphogenetic protein and fibroblast growth factor, demonstrating that the proteins can be simultaneously delivered using one vehicle, according to the news release. The unique surface of the diamonds allows the proteins to be delivered more slowly, which may allow the affected area to be treated for a longer period of time. Furthermore, the nanodiamonds can be administered noninvasively, such as by an injection or an oral rinse.

"Nanodiamonds are versatile platforms," said Dean Ho, PhD, who led the study. "Because they are useful for delivering such a broad range of therapies, nanodiamonds have the potential to impact several other facets of oral, maxillofacial and orthopedic surgery, as well as regenerative medicine."

For more, see the study in the *Journal of Dental Research*, November 2013, vol. 92, no. 11, pp. 976-981.

UPCOMING MEETINGS

2014

Feb. 27–March 1	21st Annual Conference and Exhibition, Academy of Laser Dentistry, Scottsdale, Ariz., laserdentistry.org
April 6–12	Dental Tennis Association 47th Annual Spring Meeting, Innisbrook, Fla., dentaltennis.org
May 15–17	*CDA Presents The Art and Science of Dentistry*, Anaheim, 800.CDA.SMILE (232.7645) or cdapresents.com
Sept. 4–6	*CDA Presents The Art and Science of Dentistry*, San Francisco, 800.CDA.SMILE (232.7645) or cdapresents.com
Sept. 11–14	6th Annual CDA Motorcycle, Bicycle and Dual Sport Ride, Sequoia National Park, dentistrides@gmail.com
Oct. 9–12	155th ADA Annual Session, San Antonio, ada.org/session

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Understanding the Dental Benefits Marketplace

WALTER G. WEBER, DDS

GUEST EDITOR

Walter G. Weber, DDS, is the president-elect of the California Dental Association, past chair of the CDA Policy Development Council and chair of the CDA Dental Benefits Research Task Force. He also sits on the TDIC Board and previously held the chair position. He received his dental degree from the University of the Pacific School of Dentistry and an MBA in finance from Golden Gate University in San Francisco. Dr. Weber practices general dentistry in Campbell, Calif.
Conflict of Interest Disclosure: None reported.

There is no mistaking that the dental benefits industry has undergone a major transformation in the last decade that most likely is just the prelude for much more change to come. The articles in this issue are drawn from presentations in the first phase of CDA's Dental Benefits Research Task Force work. The task force was charged with researching the dental benefits industry. At the time of publication, our task force was using the research from more than 25 expert presentations to instruct us in developing strategies to help our patients in this fast-changing marketplace and offer paths for our member dentists to manage the changes we experience now and those we anticipate in the future.

It would seem too easy to say that all the recent changes to dental benefits are caused by larger market forces related to the challenging economy and the high cost of health care, but it is almost entirely true. Whether the source of payment is the government, company-sponsored insurance or our patients, all payers are looking increasingly at price and value.

In our first article, Michael Sparer, PhD, JD, makes it clear that the health care trends he sees are ones that would have occurred even without the Affordable Care Act, and believes those trends may have far-reaching effects for dentistry.

The second article, on the future of dental care financing, looks at it from the perspective of the dental benefits company. Paul Manos, DDS, and James Bramson, DDS, make the point that dental benefits exist in a marketplace,

and that it is increasingly a price-driven marketplace. Payers want value, and for payers that means driving patients into networks where both cost and quality are more easily controlled. Accountability and quality measurement will be the future that payers will demand.

We call dental benefit companies "third-party payers," but in fact, there are many more stakeholders in the dental benefits matrix than just three. Besides patient, provider and insurance company, we need to make room for the government, corporations, labor unions, consultants and brokers, to name just a few. Vincent Catalano, MBA, will offer insight into how the broker advises the payer on which insurance product to place for a company's employees. As the task force has learned, this is an important part of the story.

Finally, Albert Guay, DMD, makes the case that the economic pressures of the general economy and the dental plan marketplace have led to one notable response: the rise of group practice. While he makes the point that there will always be room for all types of practices, to the extent that group practice can lower overhead and create efficiencies, that form of practice will have an advantage moving forward.

After I graduated from dental school in 1976, there was no shortage of predictions about the demise of private practice, spotlighted by a famous cover article from *Forbes* magazine circa 1982. As I remember, the title was something like "Why dentists aren't smiling." Predicting the future with certainty is a fool's game. However, in 2013 there are forces that would lead one to believe that this time it is different. We have seen major changes in dental benefits already and we know there will be dislocations from the Affordable Care Act, along with the megatrends mentioned by Dr. Sparer. The rise of private insurance exchanges referenced by Drs. Manos and Bramson and Mr. Catalano could be a game changer. If the corporations who pay insurance premiums move to a defined contribution model as a predictable way of controlling costs, while promoting the move as consumer choice, what insurance purchases will consumers make? Will this new approach to providing employee benefits lead to a change in the number of people covered or the type of insurance coverage? Time will tell.

Understanding the environment is essential to making the sound business decisions each dentist needs to make. There will always be multiple paths and choices for dentists to take. Solo practice will survive even as group practice continues to increase. The goal of this *Journal* issue is to provide readers with a deeper understanding of the forces in the dental benefits marketplace today to provide some clarity as to what may happen in the future. Equally important to remember is that the one true constant for a profession remains the doctor-patient relationship. Dentists who embrace serving our patients will survive in any future. ■■■■

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Health Care Reform and Dentistry

MICHAEL S. SPARER, PHD, JD

AUTHOR

Michael S. Sparer, PhD, JD, is a professor of Health Policy at the Joseph L. Mailman School of Public Health at Columbia University in New York. Dr. Sparer is the editor of the *Journal of Health Politics, Policy and Law,* and the author of *Medicaid and the Limits of State Health Reform,* as well as numerous articles and book chapters. In his writings, Dr. Sparer examines the politics of the American health care system, with a particular emphasis on the health insurance and health delivery programs for low-income populations. *Conflict of Interest Disclosure: None reported.*

In my role as department chair of Health Policy and Management at the Mailman School of Public Health at Columbia University, I have had the privilege, and the challenge, to be deeply engaged in perhaps the most important and most controversial health care debate in our nation's history. That the health care system is changing is undeniable, driven by a combination of high costs, inadequate access and a host of other factors (including an astounding rise in chronic disease, an explosion of diagnostic and treatment technologies and unhealthy lifestyle choices that have become endemic to the American way of life). Combined, these have made the health care delivery system as we know it in America unsustainable.

In this context, we find ourselves today in the midst of bitter and partisan debate over the future of our health care system. What role should government play in regulating and subsidizing coverage and quality? Which level of government should do what? What issues and decisions should be left to the private market? What will be the impact of the Affordable Care Act (ACA), enacted in March 2010, upheld by the U.S. Supreme Court as constitutional and now slowly being implemented?

The debate over the ACA, and the debate over the future of the health care system more generally, is a debate that will involve each and every one of us in some way.

To be sure, some in the oral health community feel relatively immune from the gathering storm. After all, doesn't the ACA mostly affect the uninsured, the Medicare beneficiary and the medical care system? Hasn't there always been a bit of a wall between the medical and dental systems anyway? The answer to these questions, in a word, is no — perceived immunity from change is an illusion. Indeed, if I have any single message to deliver, it is that the times they are a-changing for all of us, dentists included.

Why? For starters, the ACA contains provisions that seek to change the way the entire U.S. health care delivery system is organized and financed. More importantly though, the trends that the ACA seeks to push were — and are — changes that are occurring in health care *regardless of the ACA*. They would continue even if the ACA were repealed tomorrow. While the ACA is important to that discussion, it is not nearly the most important thing, because the health care

marketplace is changing in fundamental ways that affect how the system works. This is often misunderstood, as ACA antagonists lay these changes at the feet of the Act. What are these trends? Here are my top 10:

Trend No. 1: Consolidation of the health care industry. Hospitals are merging with each other and going into the insurance business. Insurance companies are buying hospitals and becoming care providers. Both hospitals and insurers are buying physicians' practices. There is every reason to believe that dental practices eventually will be affiliated with these growing consortiums of care. How soon is difficult to tell, but the need to develop leverage in the system and consolidated service delivery will inevitably lead to impacts on the delivery of oral health care services.

Trend No. 2: A more integrated delivery system. Directly related to the consolidation trend is integration. The health care delivery system is slowly becoming more and more integrated. The day of the solo-practice physician is fading fast; though it is not entirely gone, it is certainly headed there. I think the day that the solo practice of dentistry will be gone is farther away, but it is coming as well. Listen to the news and you will hear about accountable care organizations (ACOs), health homes, medical homes, even medical villages. These are efforts to combine and integrate services so that individuals go to only one system for all their health care needs. The recognition that oral health is integral to overall health will contribute to pressures to integrate oral health care services into these comprehensive care settings.

Trend No. 3: Reliance on nonphysician providers and debates more generally over scope of practice. In a more consolidated and integrated health care industry, the question of "who does what" emerges. This issue, and the debates surrounding it, is as old as the health care workforce itself. Yet, as efforts to reduce the overall costs in the U.S. health care system lead to concerted efforts to expand coverage, *who* will provide that care must be addressed. One of the ways that the ACA explicitly seeks to address this with oral health care delivery is through endeavors to provide funding to test new dental workforce approaches. I think one question dentists should be thinking about is, "What is the role of the dentist in primary health care; in health homes; in an integrated delivery system?" I think dentists should be thinking about scoping up in this environment and expanding their role in overall care. Dentists should be planning how they can become an explicit part of a primary care health home. For many people, their first entry into the health care system is through their dentist. This could be an opportunity that was not fully available prior to now.

THE DAY OF THE solo-practice physician is fading fast; though it is not entirely gone, it is certainly headed there.

Trend No. 4: The rise of the retail clinic. The drugstore chains CVS and Walgreens have moved aggressively to create retail health clinics, and there are now more than 650 such CVS clinics and 370 at Walgreens. Other pharmacy chains are following, as are superstores such as Walmart. These retail clinics provide low-cost primary care, typically in collaboration with a hospital, insurer or large primary care physician network. As the ACA is more fully implemented, more and more of the newly insured will seek their basic health care through the retail clinic model. While these clinics do not currently offer oral health services, the guess here is that they may well move in that direction. The main obstacle at this point is state-based limits on the ability of dental hygienists to practice independently, but as noted earlier, those limits may soon be eased.

Trend No. 5: Value-based purchasing. The payment relationship between payers and providers is changing. Some of this is the result of the integration of care and some is from a growing desire of payers to move away from fee-for-service (FFS) reimbursement — a system that rewards the number of services rendered, rather than the outcome of the care provided. As payers think about new delivery systems, they see other ways to pay for care and incentivize providers to focus on outcomes. There is a lot at stake here and likely major battles coming as to how the available pot of money is divided. Key questions arise: who is the captain of the health home; who has autonomy; who makes decision; who divides up the fiscal pot? Especially concerning to providers are payment systems that reward health when all evidence suggests that health care services are responsible for just a small fraction of the "health" equation. Bottom line message here: you can be sure that the funding allocated for care will not be divided in the same way it has been. This trend is fast and furious in the medical world, and while it is not happening to a significant degree in the oral health community yet, it is coming.

Trend No. 6: A focus on care management. I come from a school of public health so I have to acknowledge that as my bias, but health systems are generally looking toward more primary prevention activities and classic public health approaches. And in a population-based health system, oral health should be (and will be) part of any successful approach to population health. The trend we're seeing is to carve more and more services *in* with this approach so that vision, mental health and oral health are all addressed in a single system. Along with this trend is a focus on care management. Few consumers or providers like "managed care," but they all know "care management" is critical to controlling the costs associated with high-risk, chronically ill populations. Everyone in charge of health care programs knows that to be successful we must better manage the most expensive care; we must create delivery systems that are responsive to these populations and provide care in more cost-effective and high-quality ways. Oral health cannot remain a separate island when trying to manage the high cost of care for the chronically ill, as we know that these populations have dental care needs that impact their nondental health needs. This means over time there will be an increasing emphasis on population health, on care management and on how to have a population-based health system.

Trend No. 7: A more engaged employer community. These trends mean we will see — and are already seeing — more focus on employee wellness programs. Many Fortune 500, 1000 and even Fortune 2000 companies are developing internal wellness programs. They are devoting more resources to ensuring the wellness of their workforce, not only because they want to keep their health care costs down as employers, but also to keep their workforce healthier and more productive.

Trend No. 8: Focus on comparative effectiveness. Right now, there are a lot of experts evaluating the costs and benefits of different health services, beginning with equipment and technology, surgical approaches and diagnostic tests, but oral health is soon to be added to the equation. These analyses are not easy to conduct and they create conflicts between the autonomy of the provider to provide the care he/she believes is best for the patient and other forces trying to regulate those choices, such that money in the system is well spent. It's fair to say we have been down this road before, in the 90s with the expansion of the managed care industry. There was a tremendous backlash then, so I'm not saying this won't be a major battle. But the need to control costs and get value for our health care purchases puts tremendous pressure on this aspect of health care delivery and feeds this trend.

ORAL HEALTH
cannot remain a separate island when trying to manage the high cost of care for the chronically ill.

Trend No. 9: Advances in personalized medicine. Not only are we moving toward a population-based health care future, but perhaps ironically there also is a trend toward individualized or personalized treatment. Advances in genomics opens up possibilities in targeted prevention and personalized medicine. The move in the system toward both delivering population-based health care and personalized medicine will be a balancing act for payers and providers.

Trend No. 10: Increased use of data and health information technology. To make integration and comparative care work, sophisticated and integrated information systems are essential. In fact, information system implementation is an area where the U.S. lags behind other industrialized nations. The ACA recognizes the value of collecting, processing and *using* data and creates several incentives to increase the capacity in the health care system for that purpose. At the same time, super computers are increasingly able to process "big data" sets, and these quantitative analyses will be at the heart of care delivery and care payment systems. Yet another venue in which we will see tension between payers and providers over treatment decisions. It is a trend we are already familiar with and will continue to see more of.

Sans a crystal ball, my predictions must be based on years of observing and studying discrepancies in health treatments, rising health disparities and skyrocketing health care costs. Can I tell you exactly what will happen and when? No. But what I can tell you is:

- Health care systems are changing.
- They are changing in ways that will profoundly affect the dental community.
- The oral health community should not (indeed cannot) live in denial.
- Now is the time for individual dentists and organized dentistry to think about what the future could be.

- No one knows exactly how this will play out, but CDA and other oral health leaders know it is essential to see the trends and to work with and influence them.

Indeed, the old cliché applies: if you don't manage change, change will manage you. Some individual dentists, those who are in mature, stable practices, may decide to ride this out. No doubt, there will be different paths for different dentists. But there is no question of the leadership required by the organized dental community. Consolidation of services and provider settings, scoping down and up, new payment methodologies and changing relationships with other provider types and payers are all on the horizon for dentistry.

Leaders facilitate the work of others to reach mission driven goals. I believe that is the leadership CDA is showing as it investigates and influences the changing health care delivery environment. ■■■■

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Potential Future Elements of Dental Care Financing — A Third-party Payer's Perspective

PAUL A. MANOS, DDS, AND JAMES B. BRAMSON, DDS

ABSTRACT The future of dental care financing may take on many changes in the future. These changes will likely have a dramatic affect on how dental care is delivered, reported and paid. Consumers and purchasers are keenly focused on price. In addition, areas of key focus in the dental benefits industry will be compensation, metrics and wellness initiatives, which will likely lead to high levels of transparency, accountability and development of the capability to report measurable outcomes.

AUTHORS

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There is little doubt that to most consumers, dental care is perceived as expensive. In fact, the cost of dental care is the No. 1 reason people delay going to the dentist.[1] Dental insurance provides a source of funding for dental care, but is limited in the extent of that funding. Because insurance is the pooling of funds from the many to pay for the needs of the few, the higher the usage of insurance benefits, the higher the cost to all insured consumers in the form of increasing insurance premiums. Couple this principle with the concept that the current structure of a dental insurance benefit is more of a "limited, defined, contractual funding assistance mechanism," or more of a fund set aside for what will be known, and highly predictable expenses, and it does not take much utilization of elective services to send the insurance premium skyward. Certainly, elective or preventive services provide a benefit to the patient, but the more services that are rendered and covered on an insurance plan, the higher the cost of that plan. And, with so much of the health care dollar being consumed by medical expenses, and the relatively high out-of-pocket cost for dental care, fewer and fewer dollars are available for that dental care.[2]

With rising costs all around, what can be done with dental benefits to address the patients' need for dental care, the dentists' need to be appropriately compensated for providing that care and the desire by purchasers to hold down premiums? There are some key initiatives taking place in the dental benefits industry to address these issues. Dental benefits have changed

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somewhat in the last few years, but still are structured in much the same way as in the past. This lack of change is due to a variety of reasons, but not the least of which is, yet again, cost, because the majority of dental benefits are provided through employers[3] and paid for directly or indirectly by the patient. In addition, multiple stakeholders are involved in the dental benefits decision-making process, each having their own desires and needs. Some of these stakeholders include consumers and patients; employers; trusts and unions; brokers and insurance benefit consultants; insurance carriers; dentists and dental staff; organized dentistry groups; research and teaching institutions; and federal, state and local regulators. Clearly, the dental benefit of today is not as simple as the dental benefit of the past.

The concept that the insurance benefit should simply pay for whatever the dentist renders on the patient cannot be sustained in today's economy. Obviously, this concept creates much friction between the dental profession and the dental insurance industry. Therefore, innovation must take place to find a way to best meet the needs, values and goals of all of the stakeholders involved in dental benefits. The following discussion centers on some of that innovation and change, from a third-party payer's perspective.

Future Conditions of Dental Benefits

The dental benefits marketplace is just that: a marketplace. The benefits stakeholders enter the marketplace to buy, to sell and/or to influence the benefits and services available to the ultimate end-user: the consumer. While the marketplace is a dynamic entity, changing with the economy, technologic developments, and consumer needs and desires, the current pressure on benefits is a simple one: price-driven. That is, overriding all of the benefits and services available, the ultimate decision factor by a purchaser today is price. In fact, in a recent survey of employer group administrators, value is an important consideration, but getting the lowest possible premium was cited as "important or very important" by 71 percent of group purchasers of benefits.[4] How long this current trend will last is unknown, but it is highly likely the benefit design will change to attain and maintain affordable price points. New ways of structuring, measuring and reimbursing for dental services are also on the horizon. Some of those new ways are discussed below.

EVEN AS THE ANNUAL maximums on many plans have increased in recent years, those increases generally have been less than the increases in dental costs.

Fewer and Slimmer Benefits

Dental premiums are relatively low in comparison to many other insurance offerings. As such, there are very limited funds from those dental premiums with which to pay for services, which limits the benefits. Even so, if one considers that a basic dental premium may be about $30 per person per month (or $360 per year), with an annual maximum payable insurance benefit of $1,000 per year, dental insurance represents a good investment for the individual who utilizes the full extent of the benefit (i.e., invest $360 to receive $1,000). Even with such great returns, dental treatment costs continue to go up, leaving much less service per dollar available. Using a very simple example, when the fee for a crown was about $500 and the insurance benefit paid out 50 percent on crowns, then a patient could receive up to four crowns in a calendar year on a plan with a $1,000 annual maximum. However, if the fee for a crown today is $1,000, then the patient can only receive up to two crowns, or only half of the former benefit, with the same plan. Even as the annual maximums on many plans have increased in recent years, those increases generally have been less than the increases in dental costs.

Therefore, in a price-driven marketplace, consumers, or more exactly, employers and purchasers of care, will be looking for lower cost benefits and one way to achieve that goal may be to reduce the level of benefits available. Example: if a dental plan did not cover major services, such as crowns, fixed partial dentures or removable prosthetics, then the price point would be much lower. Another example may be in changing the level of co-insurance such that the insurance benefit covers a lower percentage of the cost of the services. Clearly, if the insurance benefit is lowered, then the patient will be required to pick up the cost on the other end with higher out-of-pocket payments.

While this method to lower the cost of a dental plan benefit may not be overly desirable for many of the stakeholders, it is an effective way to reach a lower price point. Ideally, the purchaser or consumer should be allowed to make an informed decision and choose between multiple benefit offerings, so if a more modest dental benefit is chosen, it is the choice of the purchaser or consumer based on what best meets the needs of that purchaser or consumer.

"Smarter" Benefits

One way to better allocate the available funds is to develop a dental benefits package that encourages utilization of more beneficial services. Clearly, if a patient needs root canal therapy and a crown, it would be nice to have funding available to pay for those services. However, would it not be nicer to prevent the need for the root canal therapy and crown in the first place? Currently, coverage for preventive care in a typical dental benefit is already allocated at a very high level, frequently at 100 percent coverage, subject to frequency limitations. However, this one-size-fits-all methodology will likely be revisited to determine if better ways exist to prevent dental disease when patients' needs differ. If the dental benefit allocates dollars and provides incentives to patients for preventive care and good home care habits, then costly dental services may be able to be avoided, particularly with patients who would otherwise be at high risk for dental disease. Theoretically, the idea is that if good home care helps prevent disease and frequent follow-up visits with the dentist for high-risk patients help prevent disease and find early disease for early treatment, then the cost of doing so should be less than the cost of rendering more expensive treatment. Therefore, smart benefits would encourage high-risk patients to visit the dentist more often and receive greater reward for utilizing preventive services. There are multiple ideas on how to accomplish this goal, among them being benefits that pay more for preventive care, cash or product rewards to the patient for utilizing preventive services, increasing benefits each year that the patient exhibits good preventive history, and so on.

Evidence-based Dentistry

The American Dental Association defines evidence-based dentistry (EBD) as "… an approach to oral health care that requires the judicious integration of systematic assessments of clinically relevant scientific evidence, relating to the patient's oral and medical condition and history, with the dentist's clinical expertise and the patient's treatment needs and preferences."[5] It is challenging for a dental insurance company to incorporate EBD into a dental benefit offering. Part of the reason for the difficulty is that even if an insurance company eliminates or reduces a benefit based on sound science, it will likely be viewed negatively by both the consuming public and the dental profession for a variety of reasons, even if that alteration of benefit is implemented with increases in other benefits. However, EBD may allow for the opportunity to rearrange benefits, reducing some and increasing others, as well as providing a higher level of benefit for patients at higher risk. Determining if a patient is at high, moderate or low risk requires some sort of risk assessment based on established parameters. The idea of accurate and usable risk assessment tools requires enhancement of the dental profession's current reporting logistics, and data that show these tools are specific enough to warrant a change in insurance coverage for that patient, as well as development of supportable metrics, which will be discussed later in this article. In short, these tools are not specific enough at this time to warrant a carrier to use as the sole means of determining a benefit. There will be a significant industry challenge in establishing acceptable protocols to determine who gets what benefits and at what frequencies, if these benefits are not standard for all insureds.

SMART BENEFITS would encourage high-risk patients to visit the dentist more often and receive greater reward for utilizing preventive services.

Disease Management

Disease management is somewhat of a foreign term in dentistry because the technology and techniques that we dentists use predominately have treated the affects of the disease and not the disease itself. Times are changing, because many more treatment modalities, particularly in the field of periodontology, are focused on management of the bacterial infection that is causing the disease. In addition, there has been an increase in the evidence to support a relationship between dental health and overall health. This relationship gives promise to the management of medical disease outcomes by managing dental disease. There have been identified links between oral health and diabetes, cardiovascular disease, cerebral artery disease and stroke, pregnancy complications and low birth weight babies, rheumatoid arthritis and respiratory infections.[6,7,8,9] Therefore, disease management in dentistry can have a beneficial effect on both dental disease and medical disease. Before disease can be managed, though, there must be a way of objectively measuring it so that progress of the disease or progress of health can be properly tracked. Again, metrics and outcomes reporting are necessities.

In addition, dental benefit offerings will need to include coverage for treatment

protocols that address the disease. Historically, dental benefits have been slow to move with technology. Part of the reason is that there are so many different ways to treat a dental condition. Dental benefit companies will need to be more nimble to adopt new technologies when it is shown that these new technologies produce more acceptable outcomes. Similarly, benefit offerings will need to provide coverage for dental treatment that can lead to better medical outcomes, such as enhancement of periodontal treatment coverage for those patients with specific chronic medical diseases.

Reimbursement Levels

OK. Please do not shoot the messenger! The bottom line, though, is that one way to make the dental dollar go farther and to provide more benefits is to reduce the amount of money that is paid to dentists who participate in the networks of insurance companies. While this method is not favorable to the dentist, it certainly is attractive to the purchasers of the dental benefits (i.e., patients, employers and unions/trusts). These purchasers are interested in what is called the "network discount," which is the average amount of money, usually by percentage, the consumer will save by receiving covered services in a participating dental office as opposed to receiving the dental services in a nonparticipating dental office.

Purchasers want discounts and they know that network discounts translate into lower premiums for fully insured employers or union groups and greater dental care cost savings for union groups or self-insured employers who are under an "administrative services only" arrangement. Most dental purchasers want to drive in-network utilization and require regular metrics and reporting of how much in-network utilization occurs. In other words, the purchasers use the dental insurance companies' networks to get the most care for the fewest dollars. In addition, network discounts also translate into greater out-of-pocket savings for the purchasers' members. Hence, network discounts are very attractive to purchasers and patients.

Closed Networks

Another way for purchasers to save money on dental care is to use a closed network, or an EPO. An EPO is an exclusive provider organization and is essentially the same as a PPO, except that the patient has no benefit or coverage outside of the participating network of dentists. Since there is no coverage out-of-network, the entire benefit is subject to the network discount, which often yields even greater savings in dental care costs and out-of-pocket costs as described immediately above. The patients in these arrangements offset the lack of broad accessibility with a larger potential for cost savings.

DENTAL BENEFIT COMPANIES will need to be more nimble to adopt new technologies when it is shown that these new technologies produce more acceptable outcomes.

Government Involvement and Public and Private Insurance Exchanges

While governmental entities (federal, state and local) have been involved with dental benefits for decades in the form of Medicaid and other public assistance programs, recent developments with health care reform have recharged the interest in government involvement in dental care. While at the time of this writing, there is still much to be discovered as to the full extent of government involvement with health care reform, some aspects of this involvement are clear. Some of those aspects include the level of government oversight, the type of coverage available for many people, the distribution channels of dental benefits (i.e., how the consumer purchases coverage) and compensation levels associated with those government initiatives, all of which are subject to change. One significant area of transformation is the development of state health insurance exchanges, also referred to as health insurance marketplaces, where many consumers will be able to shop and purchase dental benefits. California's state exchange is called Covered California and was the first exchange to be implemented since the passage of the Patient Protection and Affordable Care Act.

Of additional interest is the fact that *private* health care exchanges are being considered by some health benefits consulting firms and other consumer-centric entities, such that the dental benefits marketplace is transforming from being employer driven to one that is consumer driven.[10] The dynamics of the dental benefits marketplace will likely become more complex as consumers are now faced with the task of understanding and choosing their own dental benefit packages, as opposed to those packages being provided through their employers. To be sure, many consumers will still have benefits provided through their employers, but the number of individual purchase opportunities will increase, as will the complexity of the entire health

benefits marketplace. Some day in the near future, a Google search for dental benefits may yield hits for insurance companies, government exchanges, private exchanges, Walmart, Amazon and others, all who may be distribution channels for dental benefits.

Accountability and Transparency

It is obviously a new day for purchasers of dental care. They want it all — better benefits, increased customer service, lower costs and, few, if any, member complaints. And the information flow they desire is increasing. What services did you perform? How did members utilize the care? What improvement in health can you demonstrate? How do you measure quality? An example of these inquiries is contained in the Qualified Health Plan Solicitation questionnaire that the California Health Exchange, Covered California, issued for participation on the open insurance exchange market. Among those inquiries were multiple questions regarding quality measures used by the dental plan. The solicitation specifically asked dental "care management" questions that included:

- Risk assessment
- Disease management
- Activities to "ensure that all preventive and diagnostic services are provided … to all enrollees eligible for EHB [essential health benefits] … within the plan year."
- The dental plan's "approach to use of a health assessment to proactively identify Exchange enrollees who are actively in need of covered dental services beyond the preventive and diagnostic dental services covered by the EHB."[11]

In short, purchasers are asking deeper questions about the care for which they are paying and want to be assured that what they purchase is worth the money that they invest in it. That fact drives a need for greater transparency and accountability on the part of dental insurers to the purchasers and greater transparency and accountability on the part of providers to the dental insurers.

To mitigate rising health care costs, an increasing number of companies are considering adopting strategies that will improve the way they pay for health care services in the future, according to recent survey data by Aon Hewitt. According to the survey of nearly 800 large and mid-sized U.S. employers covering more than 7 million employees, 53 percent said that moving toward provider payment models that promote cost-effective, high-quality health care outcomes will be a part of their future health care strategy, and one in five identified it as one of their three highest priorities.

ACCOUNTABILITY IN purchased care or provided services means that we are quickly moving from simply "what" service was done to "why" it was done.

According to Aon, the ever-shifting health care landscape has created a broad array of tactics that employers are considering. These tactics include:

- Increasing focus on pay-for-performance models: 31 percent of employers said they decrease or increase health care vendor compensation based on specific performance targets.
- Growing interest in reference-based and value-based pricing models: 8 percent of companies today limit plan reimbursements to a set dollar amount for certain medical services, but 62 percent are considering adopting this type of reference-based pricing model in the future.
- Direct care models: 59 percent of employers plan to steer participants — either through plan design or through lower cost — to high-quality hospitals or physicians for specific procedures or conditions.[12]

Accountability in purchased care or provided services means that we are quickly moving from simply "what" service was done to "why" it was done. To answer those questions, it takes much better record systems, expanded audit trails and more sharing of information about a patient's dental conditions. Providers often see this inquiry as an intrusion into their doctor-patient relationship or a questioning of their treatment decisions. However, the purchasers of the care want to make sure that what is done meets practice standards, is based on evidence and best practices and that unnecessary treatment is not compensated.

Further, the federal government is very interested in driving better transparency. In fact, Health and Human Services (HHS) Secretary Sebelius' goal 4 is to "Increase efficiency, transparency and accountability of HHS programs."[13] This government emphasis for transparency is further evidenced, for example, by the recent Centers for Medicare and Medicaid Services website to post hospital charges, and the data show, not surprisingly, great variation across the country and within communities for those hospital charges for common inpatient services.[14]

Payment Reforms

United States expenditures on health care are nearly three trillion dollars a year — 18 percent of the gross domestic product or about $8,000 per person annually — and exceed that of any other developed country.[15,16] This huge investment is being questioned in light of data comparing the health of U.S. citizens to other countries. The World Health Organization ranked the U.S. 37th in health status behind, among others Oman, Morocco and Paraguay.[17,18]

The *Report of the National Commission on Physician Payment Reform,* published in March 2013, called for 12 specific recommendations to reform physician payments. Among those recommendations were elimination of the standalone fee-for-service payment system; transition to more value-based and quality-based reimbursement; development of more transparent physician payment reporting; removal of the disparity that exists in paying services based on the facility; and including quality and outcomes-based performance reimbursement. Certainly, dentistry is delivered in a different manner than medicine, but we cannot deny that medical models for quality, payment, outcomes assessment and other tenets of reform will be used as discussion outlines and formats to review and reform dentistry. These reforms may include pay for performance mechanisms in addition to, or instead of, the current fee-for-service method of compensation. Pay for performance likely will be based on measured improvements in outcomes, and may include other measures, all of which are not part of the current process of compensation today in dentistry.

Measuring Outcomes and Return on Investment

Operational and quality metrics are being discussed in dentistry for process improvement and outcomes evaluation. Work progresses on the CMS- and ADA-led initiative to develop quality measures for dentistry. The Dental Quality Alliance has recently published draft metrics[19] for quality measures in children with the intent of eventually forwarding these recommendations to the National Quality Forum for acceptance as validated quality measures in dentistry. These metrics are designed as HEDIS-like measures of large groups of individuals who might be covered in a dental plan.

THE WORLD HEALTH
Organization ranked the U.S. 37th in health status behind, among others Oman, Morocco and Paraguay.

For example, a measure might be the number of enrolled children who receive a dental service in a plan year, or the number of sealants placed on children ages 6 to 9 in any given year.

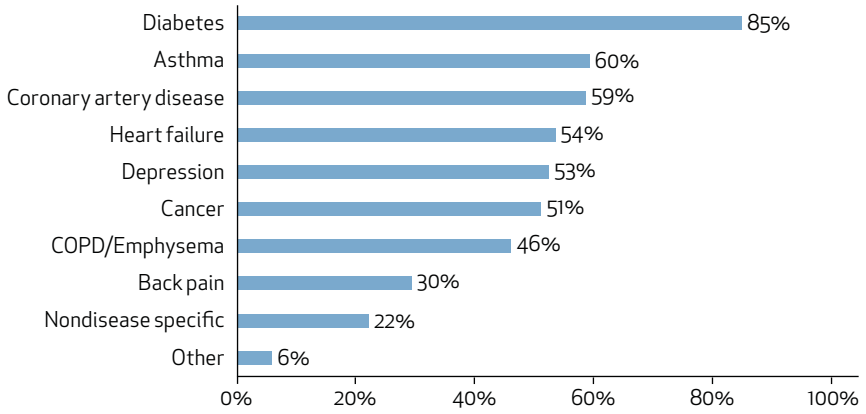
The purpose of these measures is to establish benchmarks for care that is thought to be indicative of services or measures that are beneficial to improved dental health. Eventually, these measures will take on greater meaning as they become applied to purchaser groups who will want to know how their members stack up against the benchmarks and what return they are receiving on their dental care dollar investment. And that information will drive the benefit plans or dental insurers, themselves being held accountable, to work with their participating network dentists in new and different ways to drive the improvements that benchmarking inherently reveals. If plans need to show improvement, they can only achieve that goal through improvement in the care that their network providers deliver.

Some examples of these changes will likely be seen in:

- Application of outcomes measures and use of large data sets to understand the effects of care delivery.
- New and innovative benefit plans that use evidence-based guidelines and research to determine coverage that is designed to foster care delivery consistent with that evidence.
- Financial incentive-based methods (pay for performance) to compensate providers for delivering care that improves measured health outcomes.
- Wellness programs that integrate medicine and dentistry. These programs would encourage the coordination of overall care, especially to those who have systemic chronic inflammatory conditions.
- Increased fraud and abuse detection efforts to ensure a responsible stewardship of resources and eliminate improper payments.

Wellness Programming

Over the last several years, employers have begun to embrace wellness programs designed to combat unhealthy lifestyles, such as inactivity, poor nutrition, tobacco use and frequent alcohol consumption. Altering these lifestyle issues with programs of education, outreach and intervention is thought to mitigate rising costs to



Source: RAND Employer survey, 2012.
Notes: The graph represents information from employers with at lease 50 employees that offer any disease management intervention as a component of a wellness program. 51 percent of employers offer a wellness program, and 56 percent of those have a disease management intervention.

FIGURE. Conditions targeted by employers with any disease management components in their wellness program.

treat such diseases and the social costs of illness-related loss of productivity due to absence from work (absenteeism) and reduced performance while at work (presenteeism). Thus, we see employers are adopting health promotion and disease prevention strategies, commonly referred to as workplace wellness programs. Disease prevention programs aim either to prevent the onset of diseases (primary prevention) or to diagnose and treat disease at an early stage before complications occur (secondary prevention).[20]

According to the RAND Employer Survey references in the study above, approximately half of U.S. employers offer wellness promotion initiatives, and larger employers are more likely to have more complex wellness programs. These programs often include wellness-screening activities to identify health risks and interventions to reduce risks and promote healthy lifestyles. Most employers (72 percent of those offering a wellness program) characterize their wellness programs as a combination of screening activities and interventions. Wellness benefits can be offered by employers or a vendor to all employees or through their group health plans to plan members.[21]

A wide variety of conditions is addressed through employer-sponsored disease management programs (**FIGURE**). Diabetes is the most commonly targeted condition at about 85 percent of employers.[22]

Obviously, there is a role in these disease education, prevention and outreach efforts to include awareness of dental disease, especially periodontal disease. Much has been written and researched regarding the physiology behind an oral-systemic connection. These studies typically have shown that the incidence and severity of periodontal disease can be associated with several chronic medical conditions, including diabetes, coronary heart disease, cerebrovascular disease and others.

However, now research has shown an economic affect between treating periodontal disease and the medical cost savings that can accrue. These data show that treating diabetics for their periodontal disease and following up on that treatment for a period of three years resulted in an average medical cost savings of $1,814 annually as compared to those diabetics who had incomplete periodontal treatment.[8]

Further studies by Marjorie Jeffcoat, DMD, and reported by UCCI, a large national dental insurer, have shown substantial savings through the intervention of periodontal disease treatments in associated pharmacy costs for diabetics and medical costs for patients with coronary heart disease and cerebrovascular disease.[9] Broader inclusion of periodontal disease management in benefit programs that target these chronically diseased patients is the next logical extension of wellness programming. These new findings regarding the impact of dental health on overall health and chronic disease outcomes, will have significant influence on the future of dental benefits, how dental care is measured and potentially on how dental services are compensated.

Conclusion

The dental profession, because of economic pressures, health care reform and marketplace changes involving purchaser expectations, is subject to experience much change currently and in the future. These changes will likely have dramatic affects on how dentistry is delivered, reported, measured and compensated. With the growing interest in how dental health affects overall health, dental care and medical care will probably become more closely associated, which will probably be a driver for dental care to be more closely measured and reported much like medical care is measured and reported. In addition, incorporation of dental wellness initiatives into employer wellness programs will continue to place pressure on the dental profession and

dental payers to develop meaningful and cost-effective ways of managing dental health and reporting outcomes.

The number of stakeholders in the delivery and purchasing of dental care has increased over the years. The level of demand by many of these stakeholders for oversight, reporting, metrics and outcomes measures has also increased, even to a degree that is taxing upon the current extent of ability or technology to provide that level of transparency and accountability to the purchasers of dental benefits. The demands by the purchasers are many and also include pressures to "receive it all" at the lowest price. Therefore, the dental profession and dental benefits industry must develop ways to accurately and fairly balance the needs and expectations of the purchasers of dental services in an efficient and cost-effective manner. Due to current health care reform initiatives, the new development of technologies for gathering and reporting metrics and outcomes measures must be placed on the fast track. Because so much of the dental purchasing power of the consumer comes through the available dental benefit packages and insurance company reimbursements, much of the technological developments and reforms will likely require concerted and cooperative efforts on the parts of many of the stakeholders, with significant government oversight due to health care reform initiatives. ■■■■

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How Employers Select Dental Plans in the New Era of Health Law Reform

VINCENT CATALANO, MBA

ABSTRACT How employers choose a dental insurance plan for their employees depends on several factors, including how their consultant/broker advises them, their budget and their view of the Patient Protection and Affordable Care Act (ACA). This paper describes the landscape of players and what dentists need to be aware of in this new environment.

AUTHOR

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Conflict of Interest Disclosure: None reported.

In the ever-evolving world of employee benefit plans, there are generally three key players: the employer, the insurance company and the insurance broker/consultant. It is the purpose of this article to give a perspective on how these three parties interact in order to deliver a quality employer-sponsored dental plan.

Employers can be divided into a variety of categories: government/union, large commercial group and small commercial group. Each of these groups generally approaches their decision making differently depending on their constituents and how they are guided by their consultant/broker.

The role that the consultant/broker plays is very important in the decision-making process. It is up to the consultant/broker to evaluate the needs of the client and suggest a sustainable employee benefits strategy. Insurance coverages considered beyond dental include medical, vision, life, disability, long-term care, critical illness, accident and others. They may also help define the employer's retirement plan. These days, the cost of a comprehensive employer-paid benefit plan can run between 18 and 30 percent of payroll — a significant amount of money.

The benefit planning process is a complex one at times, as several factors must be considered, including budget, level of medical plan increase, employee demographics, union contract, benchmarking against competitors and many times, in the case of a small business, what the owner's spouse might want.

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As a consultant/broker, I spend most of my time discussing medical plan renewal with my clients since this represents the bulk of their employee benefits spend. After our medical discussion, we discuss dental, vision and other coverages. Generally, this discussion revolves around their current renewal and whether the carrier gave a rate pass or tried to pass along an increase.

If an increase is warranted, we'll discuss things to do to mitigate the increase. This includes a discussion of carrier, network utilization and plan design. If the client asks, we'll do a comprehensive marketing to the available insurance companies to determine whether there's a more competitive option to offer employees with a similar plan design.

Plans generally cover 100 percent for preventive care, 90 percent for basic/class 2 services (fillings, etc.), 60 percent for major/class 3 services (crowns, etc.) for in-network providers and 100/80/50 respectively for out-of-network providers. These percentages are based on either a fee schedule or what is usual, customary and reasonable (UCR) at some percentage like 90 percent (UCR 90). UCR 90 means that within a region, 90 percent of dentists will charge no more than a certain contract reimbursement schedule if they are in-network.

Network is an important consideration for employers. If they can get their employees to go to in-network providers, they can help mitigate cost increases on renewal as well as keep employees from complaining about balance billing for services, especially preventive. The consultant/broker and employers are training their employees to ask their dentists the question, "Are you in such-and-such network?" versus "Do you take such-and-such insurance?" The answer to the first question is either yes or no. The answer to the second could be, "We take all insurances," and can be slightly misleading. Employers are training their employees to get pre-authorizations before receiving care so there is no confusion as to the employees' out-of-pocket costs.

Employers are also modifying plan designs to encourage in-network participation by reducing the annual maximum benefit. Typical plans offer the employee a $1,500 annual maximum for services in or out of network, but now employers are considering dropping the out-of-network benefit to $1,000 or even raising the deductible for class 2 and 3 procedures.

UNFORTUNATELY, WE ARE not seeing a rise in the annual level of benefit or an increase in the number of employers offering dental.

So, what happens when a consultant/broker goes to the insurance markets to get a competitive dental plan quote?

First, we get an employee "census" showing the names, ages and home ZIP codes of the employees and their dependents. We then send this census to as few as four but as many as 10 dental insurance carriers to bid on the business. We then take the proposals, review them, choose the best carriers on price, plan design and value and generally spreadsheet them from low to high. We take into account various differences in carrier plan design, such as the number of annual cleanings and other services. We also factor in things like benefit carryover, whereby a member can carry over some unused portion of this year's benefit to the following year.

Then we show this information to the incumbent carrier to see if it is willing to match price and plan design. If the incumbent agrees to match, we generally recommend that the client stay with the incumbent. If not, we then discuss the optimal choices with the client to determine to which new carrier to make the move.

There are numerous dental carriers to choose from. Some offer dental only while others offer dental along with life insurance, long and short-term disability and other coverages. We've also seen a rise in medical carriers offering dental products and providing a discount on the medical if the group chooses their ancillary lines like dental, life and disability.

Unfortunately, we are not seeing a rise in the annual level of benefit or an increase in the number of employers offering dental. One of the strategies we are seeing is employers focusing on reducing costs by either dropping sponsored dental coverage or making it employee-paid or voluntary. We are also seeing a possible long-term trend that employers are moving back toward a defined contribution model, giving employees a fixed amount of money and allowing them to purchase ancillary benefits that suit their needs.

Another cost-saving plan design is to offer employees a limited network (DHMO) product as a base plan and allow them to buy up to a PPO to get broader access. This allows the employer to offer a base dental plan with a limited network and provide an option for those employees who would like to buy a plan with wider

network access. The cost difference could be about $25 per single employee or more than $100 per family to buy up.

Larger companies generally self fund their dental plans. This means that they pay the cost of the claims based on some network discount. The employer "rents" the network from a major insurer and has a third-party administrator process the claims. The benefit to the employer is more control over plan design and the employer gets to hold on to whatever financial reserves it needs for claims. It offers larger employers more flexibility.

As of the writing of this article, employer groups are finally coming to grips with the enactment of the ACA. For small employers and individuals, we'll see a growth in the number of people covered, as pediatric dentistry is meant to be covered by the base health plan. Large groups will not have this obligation and could very well keep it out of their health plan structure.

The ACA is creating a new level of administration for employers to deal with and many of them are deciding whether to "pay or play," meaning pay an annual per-employee penalty ($2,000) for not offering benefits or "play" by offering an affordable health plan. We're seeing employers not offering medical coverage today reconsider because of the steep penalties levied by the law. After tax and employee contribution considerations, it is almost a wash whether to offer coverage or pay the penalty depending on employer size.

The next several years will change the landscape of how employers cover their employees. Many employers not currently offering medical may consider offering dental insurance as a voluntary benefit, meaning that the employee pays the entire premium. Employees would then decide on their own whether dental is a valuable benefit versus other coverages, such as life, long-term disability, critical illness, vision and other voluntary offerings.

For employers already offering dental coverage, the offerings will remain constant. Annual benefit maximums and in-network and out-of-network benefits will all remain constant, though there is a larger interest in groups of more than 100 employees to seriously consider self funding their coverages.

Those groups considering self funding will incent their employees to go to an in-network provider in order to keep claims costs lower.

In summary, the more things change, the more they stay the same. We will likely see a modest decrease in those groups offering employer-paid dental insurance and see a small move to voluntary offerings giving employees more choice. Employees will be better educated on being medical consumers and will ask more difficult questions of providers in order to get the most value for their money. ■■■■

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The Evolution of Dental Group Practices

ALBERT HENRY GUAY, DMD

ABSTRACT Dentists and the dental profession are changing. One significant change in the delivery of dental care is the evolution of group practices to include networks of dental practices with central management by various service organizations that are owned or financed by private equity firms. This article discusses their evolution and potential advantages and disadvantages for dentists who join them. The article concludes with a prediction about the future heterogeneity of the dental care system.

AUTHOR

Albert Henry Guay, DMD, was an orthodontist for 26 years before joining the American Dental Association as head of the Division of Dental Practice. He is now the chief policy advisor, emeritus.
Conflict of Interest Disclosure: None reported.

As with anything changing significantly, there are uncertainties about the future and anxiety on the part of some, especially when some long-held beliefs and customs are challenged. In order to better understand this evolution, it would be helpful to identify some of the changes that have occurred within the component parts of the dental care system — "why" some of the changes have happened.

The Dental Profession

The dental profession is charged with caring for the oral health care needs of the public. As these needs change, the profession must change accordingly. A comprehensive description of the evolution of the dental profession, including that which is still underway, is beyond the scope of this discussion. However, suffice it to say, the most striking change, because of the success of efforts to prevent oral disease, is the conversion of the profession from one that is centered on the treatment of disease to one that is concerned with the maintenance of wellness. Although that is generally the case, some segments of the population have not achieved good oral health as of yet and still require more treatment of disease, as well as wellness maintenance for any of several reasons.

There is an increasing number and percentage of female dentists in the dental workforce. Although their productivity in practice is comparable to male dentists when they practice full time, their practicing cycle may be different. Twice as many female dentists practice part time compared to male dentists, particularly early in their professional careers. After age 60, there is a significant increase in the percentage of male dentists practicing part time, approximately five times

greater. With female dentists, the number practicing part time levels off after age 40 and then decreases, with more female dentists practicing full time.[1]

Over time, there has been an increase in the procedures that can be delegated to ancillary personnel that were traditionally authorized to be performed only by dentists. That trend is still evident.

The Health Care Marketplace

There are three overriding concerns that are driving the many changes occurring currently in the health care marketplace: the costs for health care consume an unsustainable share of the gross domestic product (GDP); there must be an improvement in the quality of the care provided; and there must be adequate access to needed care for all. These concerns are addressed in the Department of Health and Human Services three aims for improving the U.S. health care system — improving the experience of care, improving the health of populations and reducing the per capita costs for health care.[2] Adequate value received for the money spent for health care is becoming a prime consideration in evaluating health plans.[3] Adjustments in the health care marketplace are being made to address these concerns. There is considerable uncertainty about what effects the implementation of the Patient Protection and Affordable Care Act (ACA) will have on the health care market. Undoubtedly, there will be direct and indirect effects on the dental marketplace, also.

In recent times, the general health care market has been through significant consolidations in all of its segments in attempts to preserve market share and increase market power and in an increasingly competitive health care market.

The Oral Health Care Marketplace

The oral health care marketplace is about evenly divided between those who are beneficiaries of dental benefit plans and those who pay for their care from their own resources. However, in today's market, even those who are covered by dental benefit plans pay a significant portion of their costs for care out of pocket, either through paying deductibles or a portion of the costs for treatment they receive and/or sharing the cost of the premiums for their plan.[4] There has been an increase in the number of individuals with dental benefits that almost compensates for the recent decrease experienced, but not quite to the maximum numbers recorded in 2008.

ADEQUATE VALUE
received for the money spent for health care is becoming a prime consideration in evaluating health plans.

There has been significant pressure within the market to reduce the costs of dental benefit plans. Benefits organizations have responded to these pressures in a variety of ways that have resulted in limiting benefits, reducing reimbursement levels for providers, increasing the costs to beneficiaries, narrowing beneficiaries' choices, managing the use of specialty care and other ways. Consolidations like those seen in the medical world have not occurred in dentistry, in either numbers or the scope of consolidation. Some consider the growth of large group practices as an attempt at consolidation in dentistry.

Historically, the system for delivering oral health care to the general public has been very homogenous. Although partnerships and small group practices existed, almost all care, 98 percent in 2007, was delivered by single-site practices owned and operated by a solo dentist practitioner. Most were "neighborhood" practices. At the same time, about 2,500 practices operated at more than one site, group practices operated at about 8,442 sites.[5]

Dental practices also responded to the pressures exerted by the marketplace. One response among many was a significant change in the nature and organization of group practices.

Dentists

Changes in the nature, goals and financial status of dentists were also changing as the dental marketplace was undergoing changes. In the past, the goals of the vast majority of dental students were to complete their dental education and to establish an independent private dental practice, which they owned and operated. Capital to establish a practice was not difficult to obtain and the debt incurred was not burdensome and could be repaid relatively easily and quickly. Some did become employees of established dentists or institutions to gain clinical experience and/or to enhance their financial status.

When new dentists opened their private practices, they were thrown into the "business world" as operators of a small business, most with no managerial training or experience. They and their families endured a period of relatively low income as their practices grew; and as their practices and income grew, they had less time to spend with their families and for leisure activities. At the end of their professional careers, they were burdened with disposing of their practices and assuring that their patients would be cared for.

Over time, an increasing number of dentists determined that they wanted to spend their professional lives practicing dentistry, for which they were well prepared, and not operating a small business, for which they were ill prepared. They resented the time that took them from clinical activities to manage the day-to-day business affairs needed to operate a business, often doing as much of that work as possible at night or on weekends, further impinging on family and leisure time.

As the costs of a dental education escalated, many dentists finished their dental education with very large debts accrued through borrowing to pay educational and other expenses.[6] This debt load often made the acquiring of capital to establish a practice very difficult. In addition, some new dentists were unwilling to add to their debt and the additional length of time they would be so burdened. They did not want to extend the time they had to "live like a student" and wanted to hasten the day when they could begin "living like a doctor."

Health care, including oral health care, had been evolving from being a "solo sport" to becoming a "team sport." Dentistry was becoming more closely related to medicine. Some dentists began to feel that being an isolated individual practitioner did not allow them to interact with their professional colleagues easily.

Changes in the dental marketplace, the profession and the aspirations of some dentists have lead to added interest in group practices and the development of new configurations of groups. One of the innovations that has attracted great attention and discussion within the dental community is corporately managed group dental practices.

Group Dental Practices

The traditional array of dental group practices, not-for-profit groups, government agencies and health maintenance organizations still exists. Some have made relatively minor adaptations to the dental marketplace while keeping their basic structure unchanged. Their adaptations might generally be characterized as "expansion." The ownership and operational features of these practice configurations are pretty well known and have not changed significantly in recent years.

CORPORATIONS THAT manage all of the business activities of a dental practice that do not involve the statutory practice of dentistry have evolved.

The percentage of dentists who are associated with a large company that delivers dental care at more than one site remains relatively small, 6.4 percent, but is growing, having increased by 1 percent between 2008 and 2010. The age of dentists who practice in groups ranging from less than five dentists to more than 20 dentists is pretty similar, except for a larger percentage of dentists younger than age 35 practice in groups with greater than 20 dentists than in smaller groups, 29.1 percent compared to 24.2 percent. Dentists who have held their dental degree for less than 10 years are three times more likely to join group practices than those who have been dentists for more than 10 years.[5]

There were about 2,600 multisite groups in 1992, but about 2,400 such groups in 2007. Despite the decrease in the number of groups, the number of treatment sites they controlled increased from about 5,600 in 1992 to about 8,400 in 2007. The amount of total revenue generated for dental care from these multisite groups increased from 8 percent to 11.3 percent between 1992 and 2007.[5]

The entry of corporately managed group practices into the dental practice arena is a significant development that actually introduces two new players onto the list of stakeholders inserted into the relationship between the patient and the doctor — management companies and private equity investors; more about them later.

Corporately Managed Group Practices

Corporations that manage all of the business activities of a dental practice that do not involve the statutory practice of dentistry have evolved. They contract with the professional organization that provides care to supply a variable menu of practice management services, which may even include ownership of the physical assets of the practice. The issue of the legality of the ownership of a dental practice by anyone other than a licensed dentist complicates the structure and the relationship between the professional and business management aspects of a practice that contracts with a management organization.

The individual states determine who is allowed to own and operate a dental practice, who can employ a dentist and what control nondentist owners and managers can have over a practice. So, the relationship between the management corporation and the professional organization of the group must be carefully crafted so that the practice is operating within the dental practice act of the individual state. Generally, states try to restrict the ownership of practices to a dentist and/

or restrict the interference nondentists can exert on professional judgments.

Twenty-five states, including California, define the ownership of a dental practice as engaging in the practice of dentistry, which only dentists can do. Twelve states, including California, allow a person or legal entity not licensed in his/her state to participate in the ownership of a private dental practice. Since 2003, California has allowed physicians, surgeons, hygienists and dental assistants to own up to 49 percent of a dental practice. Twenty states, including California and the District of Columbia, allow dentists to be employed by nonprofit health facilities not owned or operated by a dentist. Twenty-two states, including California, prohibit nondentists from interfering with the professional judgment of a dentist.[7]

At the time of this writing, there was some active legal action involving large group practices and the networks they have assembled. In North Carolina, an action regarding the definition of practice ownership and the illegal practice of dentistry was taken by the North Carolina State Board of Dental Examiners and 17 dentists against their corporate management organization with whom they have partnership interests. The Board suit claims that the management company is, in fact, engaged in the illegal practice of dentistry. The dentists claim that the management company had breached their contract by exceeding its legal authority through control of their practice operations and finances, and interfered with their clinical decisions concerning patients.[8] Several issues should be clarified by this action. Although the decisions rendered will only affect dentistry in North Carolina directly, it's probably safe to assume that it will have nationwide implications.

There are other specific regulations that some states adopt to manage this relationship. It is important to understand the laws and regulations of any state within which the group considers establishing a practice location.

Some of the functions that can be on the menu of management services that are offered by management organizations are:

- Recruitment of dentists.
- Recruitment and management of dental ancillary personnel.
- Recruitment and management of nondental staff.
- Management of the patient appointment schedule.
- Management of the office financial affairs, including patient finances.
- Selecting and purchasing capital equipment.
- Ordering dental supplies.
- Management of external laboratory services.
- Practice marketing.
- Monitoring office productivity.
- Monitoring the quality of care provided and patient satisfaction.
- Establishing practice standards.
- Continuing education and training.
- Reporting periodically on the state of the practice and making recommendations for improvements when appropriate.
- Gathering and utilizing detailed practice management data.
- Increased flexibility.

Even though these management organizations have contracted to provide management services as a categorical commonality, they vary in their structure and the functions they provide, and are referred to by different names. The American Dental Association is currently studying this group of organizations to better understand their various structures and the functions they perform. Some of the names commonly encountered are dental management service organization (DMSO), dental service organization (DSO), dental management organization (DMO), group practice organization (GPO), dental franchises and perhaps others. In states where nondentists are allowed to own and operate dental practices, they are usually organized simply as a group dental practice (GDP).

Although there is some variation in the organization and operation of management services organizations, they are generally organized in a specific pattern. They are networks of small practices aligned with a central management organization that provides a veritable array of business services for a professional group that provides clinical care. The owners and operators of the management organization need not be a dentist. This structure provides two advantages that may not be initially apparent — efficient centralized management and a number of small practices located "where the patients are." Some operate as franchises, some only provide services to practices that operate under the dentist's name and others allow practices to operate under the name of the management organization.

The number of dentists who participate in these networks is small, about 6.5 percent, but growing. They are located mostly in heavily populated areas, with the largest percent of participants from the South Atlantic, the Pacific Coast and the East North Central areas. The smallest percentage of participants is found in the East South Central and New England areas. California leads the nation in the percentage of participating dentists, 11.5 percent.[9]

Besides the entry of dental management organizations into the dental care system, private equity firms have taken a keen interest in dental

management organizations as financiers. They are allowed to own and control them, but not allowed to interfere with the professional judgment of doctors or the clinical aspects of patient care. According to *The McGill Advisory*, a 20-percent return on investment is not uncommon for the average equity fund owning a management organization.[10] The distinction between clinical judgment and business is not always a bright line. Some feel that avoiding the potential influence of business interests over clinical judgments is the philosophical basis for laws in the states that require that only a dentist can own and operate a dental practice. Some critics of private equity backed or owned management organizations believe they exert pressure on providers to do the most expensive and sometimes unnecessary care, especially for Medicaid beneficiaries.[11,12] Others do not share that opinion.[13,14]

Practice Efficiencies

Besides the economies of scale, large group practices claim to improve office efficiency through several means:

- Optimal, uniform centralized management of business operations.
- Ability to purchase durable equipment and supplies at a reduced price.
- Management of nonprofessional staff.
- Ability to build and/or lease office space economically.
- Negotiate better reimbursements from third parties.
- Reduce laboratory expenses.
- Maximize the utilization of the fixed assets of the practice.
- Most efficient use of professional and ancillary personnel.
- Practice marketing.
- Gathering and utilizing detailed practice management data.
- Increased flexibility.

Economies of Scale

Economic theory tells us that, when the average costs of producing goods or services in the long-term decline as more are produced, the enterprise is experiencing economies of scale. Larger firms will be more efficient than smaller firms. The cost-output relationship is not linear, however. A point is eventually reached when increased production comes at increased unit costs — diseconomies of scale.[15]

Production function studies of dental practices done in the past have yielded mixed results concerning economies of scale (Scheffler and Kushman-1979[16]) (Nash and Wilson-1079[17]) (Crakes-1984[18]) (Lipscomb and Douglas-1986[19]) (Brown-1989[20]). Some did see the potential for economies of scale, however. The problem with these studies is they observed, for the most part, solo and very small group practices only. They may not have reached the practice size where economies of scale appear.

THE DISTINCTION between clinical judgment and business is not always a bright line.

A recent study published by L. Chen and S.C. Ray[21] indicated that the vast number of private practices in the United States operate in the area of positive economies of scale, with a relatively few operating with diseconomies of scale. They did find, however, that dental practices in the U.S. on average operate at between 12 percent and 21 percent below their optimum efficiency. This means that they could maintain their current level of production with a reduction of between 12 percent to 21 percent in office operating expenses; or, put another way, they could increase office production and net office revenue by 12 percent to 21 percent without significantly increasing office expenses. Depending upon individual practice characteristics, office efficiency can be increased in a number of ways, for examyple, improved purchasing, use of labor, utilization of facilities, negotiations with payers, general management, etc. Practice resources should be allocated to where they add the greatest degree of efficiency to the practice.

Economies of scale and efficiencies are not unlimited, because the individual factors of production cannot be expanded infinitely — workers can only work efficiently so many hours per day, machines cannot operate at full speed 24 hours per day, facilities can only be used when patients are willing to come for care or dentists are willing to work, there is a limit to the reduction in the cost of supplies vendors can offer, etc. Beyond those limitations, additional production input units must be employed, increasing the costs of production. That is the point at which diseconomies of scale can appear.

Future studies of economies of scale should include all size organizations and practices, including the latest innovations in group practices. It may be that economies of scale do not appear until a practice reaches a critical size.

Why Do Dentists Join Large Group Practices?

There are many reasons an individual dentist may choose to associate with or become an employee of a large group dental practice. However, several reasons are seen most commonly. Sometimes the reasons for joining a large group practice change over time and no longer serve as

motivation to continue with the group. Some reasons are so basic that they do not change over time and continue to drive dentists to remain with the group.

The section above on the changing nature of dentists offers some background into what characteristics of large groups may appeal to some dentists:

- They can practice dentistry without the burden of operating a business.
- They can earn money and benefits immediately.
- They do not have to invest any money in building and equipping a dental facility.
- They can enjoy family time and lead a balanced private life.
- They can begin to pay off any educational debts, rather than add to their debt load.
- They can work on a part-time basis if they wish.
- They can become "9-to-5" employees.
- They can gain clinical experience and enhance their skills.
- They may be able to enjoy collegiality and tutoring of experienced dentists.
- They may be able to retire from practice without the stress of selling a practice.

There are other characteristics of joining a large group practice that may be viewed by some as a disadvantage:

- Becoming an "owner," with the equity consequences, may not be possible.
- There can be a loss of individual identity.
- There is some loss of control or autonomy in decision making.
- Use of outside vendors and suppliers may be dictated and/or restricted.
- Employment status of nonowners may be jeopardized in times of economic stress.
- Business pressures may be applied to clinical decisions.

The Future

Predicting the future of large group dental practices is, at best, a shaky undertaking. The most accurate description of this effort is "reasoned speculation."

Historically, management service companies blossomed in medicine for a while and ultimately failed. In dentistry, some specialty management organizations were introduced and thrived for a while, then also failed. The market environment today is different from that when failure was the fate of management organizations, however, such direct inferences cannot be made safely.

The homogenous nature of the dental care system all have experienced is changing. There is no reason to expect that the resultant structure of practices with these changes will not be heterogeneous. There will be room for different types of practices. There will not be only one solution to the challenges the public feels in receiving good oral health care.

If things work out rationally, systems that provide good oral health care at a fair price to all that demand care will survive and flourish. Outcomes and value are ultimately the characteristics that will determine the success or failure of systems of delivery of care. Don't expect any one system to overwhelm the dental marketplace — or one system to totally disappear. ■■■■

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

MyCAMBRA Mobile App Streamlines Caries Risk Assessment ($29.99, Developed at the UCSF School of Dentistry by Peter Rechmann, DDS, PhD, Richard Kinsel, DDS, John Featherstone, Msc, PhD and Firsthand Technology Inc. [$9.99 on iTunes until Dec. 31])

Caries Management By Risk Assessment (CAMBRA) is an alternative way of treating caries as opposed to the traditional "drill and fill method." CAMBRA is a research-based, systematic approach to integrate caries risk assessment as a centerpiece of the dental practice. CAMBRA aims to diagnose and prevent caries through the process of assessing a patient's risk for caries by examining various health and lifestyle factors as part of their regular dental checkup. And now, there's an app for that. MyCAMBRA lets dentists perform a risk assessment right on their iPhone or iPad (it's currently only available on iOS). The app makes the risk assessment simple and easy to integrate into the flow of care. When a dentist opens the app, it asks him or her to enter the office name and it offers a "caries 101" type of breakdown. The goal of the app is to promote "dialogue" and allow dental professionals "to share health literacy information emphasizing the bacterial causes of caries, promoting better self-care strategies and delivering a custom care plan targeted to the patient's caries risk level." The dentist can enter patient information and the app takes the dental provider to the caries risk assessment form and runs through a concise checklist of disease indicators, risk factors and protective factors. The app uses a proprietary analysis method based on the observations of expert dentists and patients at the UCSF School of Dentistry to rate the patient's caries risk on a scale of low, moderate, high and extremely high. If desired, the app gives in laymen terms for the patient information about the different risk levels: low risk (cariogenic bacteria are in check and the patient is healthy), moderate risk (elevated caries risk is present and requires preventive treatment to avoid a frustrating cycle of drill and fill), high risk (intense, focused preventive treatment is required to reduce cariogenic bacteria and lower the caries risk) and extremely high risk (caries is a serious health problem and aggressive preventive treatment is required to halt the disease and preserve existing teeth). Following the analysis phase, the risk of the patient is automatically determined and shown graphically, presented with a risk meter in a "traffic light" format with green being low risk, yellow being moderate risk and red being high or extremely high risk. This interactive graphical risk meter helps patients better understand caries risk and how their behavior directly relates to reducing their risks. Step-by-step treatment and self-care approaches to reduce caries risk are suggested as an "Action Plan." After discussing the results with the patient, the dentist can then send the "Action Plan" directly to the patient over encrypted email, and the dentist can send a copy of the exam to him or herself to be put in the patient's record. The app's developers have assured HIPAA compliance by using patient-specific encryption.

— Blake Ellington, Tech Trends Editor

Brush DJ (Benjamin Underwood, Free)

Brush DJ, developed by UK dentist Benjamin Underwood, was released earlier this year as a National Health Service-approved app, and is now available stateside. It's a great and fun tool to pass on to patients of all ages, helping ensure that they brush for the ADA-recommended two to three minutes. The app syncs with the users' smartphone music playlist and allows them to listen to two minutes of music while brushing their teeth. Just press "play" on the home screen and users are ready to brush. A circular timer lets them track how far along they are and their phone vibrates at each 30-second segment. The song chosen can be set to random, customized or to an existing playlist via the settings tab. While randomizing the selections, users can choose other songs by pressing the center button at the bottom of the screen and it will move on to another song. On the information page, suggested hygiene regiments are broken down into age groups. Also under the settings tab on the lower left, daily brushing reminders and dental visit reminders can be set to remind patients as needed.

— Darien Hakimian, DDS

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iOS 7 (Apple Inc.)

In advance of its slate of fall releases of new iPhones and iPads, Apple released the latest version of its mobile operating system, iOS 7, on Sept. 18. Touted as being the "most significant upgrade to iOS since the first iPhone was released," Apple has completely overhauled iOS from both a user interface perspective as well as under the hood. The visual changes to iOS are the most obvious, and the most striking, as it is at once both familiar and entirely re-envisioned. Gone is the "skeuomorphism" in which real-world elements (such as wood paneling and tape recorders) were incorporated to help users feel more comfortable with these portable devices. Instead, Apple has now embraced the modern, flat look favored by Android and Windows Mobile devices. Every design element serves a purpose, the interface is "purposely unobtrusive" and the focus is all about intuitive functionality. With hundreds of improvements and new features, the list is endless, but there are some definite highlights. The new Control Center provides one-swipe access to such oft-needed settings as Airplane mode, Wi-Fi, Bluetooth, Do Not Disturb, screen orientation, brightness, volume controls and even a new built-in flashlight. The revamped Notification Center is no longer simply a laundry list of app alerts, but features a "Today" summary that provides an overview of things such as appointments, birthdays, weather and even traffic information. The Camera functionality has also been improved, providing options such as still photo, video, panorama and Instagram-friendly square photos, all with new filters that users can easily apply before they shoot photos (not just after). AirDrop has moved from being exclusive to Mac desktops to the iOS ecosystem, allowing the sharing of photos or documents with someone who is standing nearby — no Internet or cellular connection required. Finally, automatic app updating is a welcomed feature that Apple users have had on their wish list for a long time. Overall, the new iOS is a significant improvement over the previous version and delivers more, and easier, functionality all wrapped up in a slick, modern interface. While it does take a few days to get used to the new colors, icons and interface tweaks, it quickly becomes effortless and intuitive to use, without having to give much thought to the interactions. Ultimately, that is exactly what Apple was striving to deliver with this new version: "… a pure representation of simplicity."

— Blaine Wasylkiw, director of online services, CDA

Dentaltown App (Dentaltown.com LLC, Free)

Dentaltown.com, a widely used online community for the dental industry, recently released its own app, downloadable on Apple iTunes or Google Play for Android. The message boards allow dentists, specialists, RDHs, management experts, lawyers and more to all take part. There is myriad information embedded within the message boards on Dentaltown on most, if not all, subjects. Overall, it's a unique experience being able to pose questions and read comments and opinions coming from clinicians and some of the most well-known names in dentistry. The app consists of a simple homepage design, with a similar feel and look to the full website, creating an immediate familiarity. The home screen has links to the message boards page, from which users can select from 46 categories. Within each category, more headings are available, which helps narrow what topic users might be looking for or what sections they want to peruse. Should users want to begin a new forum topic from the app, they just have to tap on the "new" icon at the bottom right of the screen, once in the category they want to post on. Also available from the home screen is the active topics and active cases category, which lumps the day's most commented-on threads and cases. Accessing and uploading photos from a phone into threads is also straightforward using the camera icon in the reply page. Finally, users can gain access to the monthly magazine from Dentaltown via the home screen and read up on the current issue's articles and other sections. Access to user profiles, private messages and recent activity is also available. The speed of the app makes it very convenient, using any Wi-Fi or cellular data package. Continuing education, blog postings and classified ads are not available on the app, which helps keep the feel of the app uncluttered. Having access to one of the more popular dental community websites while on the go is both convenient and helpful.

— Darien Hakimian, DDS

Would you like to write about new technology?

Dentists interested in contributing to this section should contact Tech Trends Editor Blake Ellington at blake.ellington@cda.org.

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Doing Business in the Current Dental Benefits Marketplace

MICHAEL PERRY, DDS

The current dental benefits market has fewer capitation plans and indemnity plans, and a lot more PPO plans. Government-subsidized dental benefit programs are subsidized less than in the past.

HMO and PPO dental benefit plans have traditionally been labeled as forms of "managed care." A health maintenance organization (HMO) plan is one in which the contracting doctor is paid a fixed amount per unit of time to provide all of the dental health care needed for a defined population. These are often called capitation plans.

A preferred provider organization (PPO) plan is a fee-for-service plan in which the doctor contracts directly with a benefit company, agreeing to a fee schedule lower than what he/she would charge in the open market.

An indemnity plan provides fee-for-service benefits regardless of which doctor a patient chooses. The doctor has no contract with the benefit company and can therefore charge what the market will bear. As with patients paying cash, these market-based fees are known as usual, customary and reasonable (UCR).

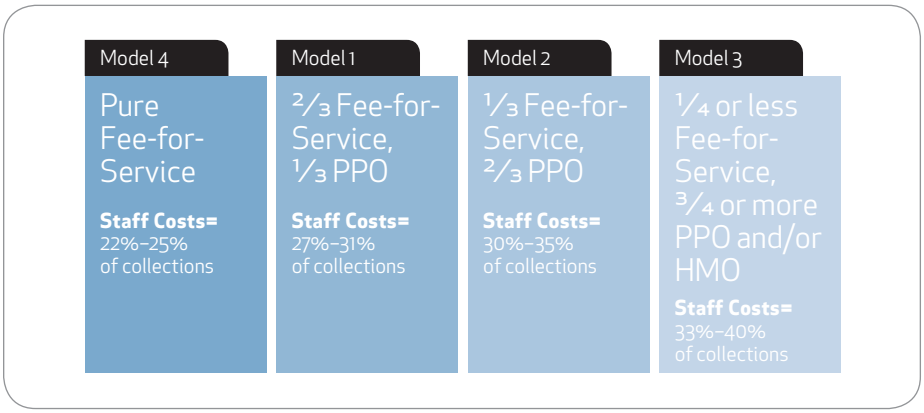

FIGURE. Models of practice support are defined by a dentist's relationship with third-party insurance. A model is determined by the percentage of treatment a doctor is providing under contracted insurance.

Then and Now

When I started practice in 1979, Delta Premier was the dominant PPO. Delta PPO, Delta's lower fee product, did not exist. Other than plans sold by Delta Dental, indemnity plans were the most common. The Delta Premier fee schedule was at or very near the UCR rates for most doctors. The majority of doctors in private practice only treated patients who were insured by an indemnity plan or Delta Premier, or who paid cash at UCR fees.

How things have changed! According to Delta Dental of California, it has not sold a new Delta Premier plan in more than three years. It asserts that the only Premier plans that exist are renewals, and those are largely for public employee unions. Delta Dental of California claims that the policies that it has been able to sell are Delta PPO plans, which now account for more than 73 percent of the existing Delta Dental of California plans. The remainder is 10 percent Delta Care HMO and 17 percent Delta Premier. Indemnity plans account for less than 7 percent of the total dental benefits market in California. However, Delta has chosen not to share enough actual data to enable CDA either to verify these claims or to determine what exactly accounts for this evolution.

What to Do

Most dentists see a practical reality: they must adapt to the marketplace that exists today, and not waste energy wishing for the one that existed in the past. That is a wise, if not inevitable, decision.

To survive and thrive in the existing marketplace, some dentists who own practices may choose to change their business models. The logical first steps toward determining the wisdom of such a change would be to learn what models currently exist and what model a practice is in.

There is a resource on cda.org called "Choosing a Model of Dental Practice." This article describes four current business models that differ primarily by relationship with contracted dental insurance (PPO and HMO). They are in numerical order based upon their prevalence in the marketplace.

Model 1 is a practice where approximately one-third of the services provided are to patients who have a PPO plan under which the doctor is contracted. Model 2 is one where approximately two-thirds of the services are provided to contracted PPO patients. In Model 3, three-fourths or more of the services are to contracted patients, including PPO and HMO patients. Model 4 practices have no contracted insurance.

An analysis of practice statistics will identify the model that each practice is currently in. It is possible that a practice could be midway between two different models, causing some confusion concerning category assignment. If, however, the models are viewed as a continuum rather than as separate categories, all private practices would fit somewhere on a spectrum from least percentage of patients covered by insurance contracts to most (FIGURE).

The remunerative levels among different managed care plans vary. Restrictions on treatment affecting reimbursement also differ. These factors create some differentiation among practices occupying the same place on the continuum, but in general, the similarities among practices in the same model are more important than the differences. Contrasting one model to another allows a doctor to gauge and plan what would be involved in changing to a different model.

Looking at the Model Continuum, practices further to the left tend to be slower paced, have lower variable costs (staff, supplies and lab) and are generally less constrained by issues related to time. Practices further to the right tend to see more patients per unit of time, use more supplies and have more expanded function auxiliaries.

Practices anywhere on the continuum can be profitable. Practices on the left generally achieve profitability via lower overhead, those on the right via higher production.

Changing Models

Some say that the percentage of Model 1 practices is diminishing and the percentages of Model 2 and Model 3 practices are increasing. Many doctors are considering transitions to Model 4, but relatively few have done so. Changes in the dental benefits marketplace may create further shifts.

An upcoming Practice Support column will focus on strategies for changing from one model to another. ■■■■

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 and a dental business consultant.

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Continuing Education Courses

Listed are C.E. courses offered by California's dental schools, local dental societies, ethnic dental societies and specialty organizations, from January through June 2014. For more information, please contact the course provider.

TOPIC	DATE	PRESENTER	LOCATION	COST	UNITS
ARTHUR A. DUGONI SCHOOL OF DENTISTRY dental.pacific.edu/ce1 CONTINUES ON NEXT PAGE					
Implant Treatment Planning Seminars	Jan. 6–March 31	Edmond Bedrossian, DDS	San Francisco	$995 dentists; $795 allied dental professionals	15
Stay Out of Jail: Avoid Coding Errors and Excel in Insurance Administration	Jan. 11	Charles Blair, DDS	San Francisco	$245 dentists; $185 allied dental professionals and office managers	6
Periodontics: Antimicrobials, Probiotics and Host Modulation Therapies	Jan. 23	William Lundergan, DDS, MA	San Francisco	$75	3
Infection Control and the California Dental Practice Act	Jan. 25	Eve Cuny, BA, MS; Bruce Peltier, PhD, MBA	San Francisco	$125	4
Turning Conflict into Opportunity: Conflict Resolution and Communication Skills for Dental Professionals	Feb. 1	Mary O'Neill, MA, MFT	San Francisco	$245 dentists; $185 allied dental professionals	6
Medical Emergencies in the Dental Office: Yes, They Actually Happen and Are You Prepared?	Feb. 8	Anders Nattestad, PhD, DDS	San Francisco	$245 dentists; $185 allied dental professionals	6
Smile Reconstruction Using Porcelain Veneers	Feb. 15–16	Dino Javaheri, DMD	San Francisco	$1,205 ($1,095 for registrations received by Jan. 15)	16
20th Annual Pacific/UCSF Island Dental Colloquium	Feb. 17–21	David C. Brown, BDS, MDS, MSD; Mark A. Dellinges, DDS	Kauai	$725 dentists; $495 allied dental professionals	20
Treating Trauma Without Drama	Feb. 20	Kenneth Tittle, DDS, MS	San Francisco	$75	3
Forensic Odontology: Is it CSI Dentistry?	March 1	Duane Spencer, DDS	San Francisco	$245 dentists; $185 allied dental professionals	6
Minimally Invasive Dentistry: Everyday Systems for Indirect All-ceramic Restorations	March 22	Brian LeSage, DDS	San Francisco	$245 dentists; $185 allied dental professionals	6
Dental Ergonomics: How to Minimize Pain and Extend Your Career	March 27	Tiffany Tang, OTD, MBA, OTR	San Francisco	$75	2
Multirooted Endodontics Two-day Workshop	March 28–29	Christine I. Peters, DMD; David C. Brown, BDS, MDS, MSD	San Francisco	$1,205 ($1,095 for registrations received by Feb. 28)	14
Infection Control and the California Dental Practice Act	April 5	Eve Cuny, BA, MS; Bruce Peltier, PhD, MBA	San Francisco	$125	4

TOPIC	DATE	PRESENTER	LOCATION	COST	UNITS
ARTHUR A. DUGONI SCHOOL OF DENTISTRY dental.pacific.edu/ce1 CONTINUED					
Certification in Radiation Safety for Allied Dental Professionals	April 5–26	Elena Francisco, BSDH, RDHAP, MS; Elham Mandavi, DDS	San Francisco	$645	32
Dentistry as Beautiful Art: How to Achieve Highly Esthetic and Predictable Restorations	April 12	Jose-Luis Ruiz, DDS	San Francisco	$245 dentists; $185 allied dental professionals	7
Live Patient Denture Treatment Study Club	April 12, 26, May 10	Eugene LaBarre, DMD, MS	San Francisco	$2,995	12
Live Patient Denture Treatment Study Club	April 14, 28, May 12	Eugene LaBarre, DMD, MS	San Francisco	$2,995	12
Practical Oral Health Promotion and Care for Seniors	April 24	Elisa Chavez, DDS; Christine Miller, RDH, MHS	San Francisco	$75	3
29th Annual Charles A. Sweet Sr. Pediatric Dentistry Memorial Lecture	April 26	Pamela Zarkowski, JD, MPH	San Francisco	$365 dentists; $285 allied dental professionals	6
Implant Dentistry: Restorative and Esthetic Fundamentals for the General Practitioner	May 3–4	Dino Javaheri, DMD; Ali Alijanian, DDS	San Francisco	$1,095 ($995 for registrations received by April 3)	16
Are You Numb Yet? The Anatomy of Local Anesthesia	May 10	Alan Budenz, MS, DDS, MBA	San Francisco	$245 dentists; $185 allied dental professionals	7
Minimally Invasive and Maximally Effective Dentistry: CAMBRA	May 17	Allen Wong, DDS, EdD	San Francisco	$245 dentists; $185 allied dental professionals	6
Oral Surgery for General Practitioners: Comprehensive Hands-on Training from A–Z	May 31	Len Tolstunov, DDS, DMD; Anders Nattestad, PhD, DDS	San Francisco	$495	7
Socket Preservation Bone Grafting for General Dentists: A Hands-on Workshop	June 7	David Ehsan, MD, DDS	San Francisco	$395	4
49th Annual Colonel Allyn D. Burke Memorial Dental Symposium	June 27–28	TBD	Monterey	$385 dentists; $195 allied dental professionals	14
CALIFORNIA ACADEMY OF GENERL DENTISTRY cagd.org					
California AGD 2015 Annual Meeting	Jan. 25–26	Jack Griffin Jr., DMD; Reid Pullen, DDS	Newport Beach	$149–$358	0
CALIFORNIA ASSOCIATION OF ORAL AND MAXILLOFACIAL SURGEONS calaoms.org					
CALAOMS 2014 January Anesthesia Meeting and SimWars Competition	Jan. 18–19	Michael Rollert, DDS	San Francisco	TBA	10
CALAOMS 14th Annual Meeting	May 3–4	Lee Walker, MD, DDS; Gary Morris, DDS; Ed Braly, DDS	Newport Beach	TBA	9
CALIFORNIA DENTAL SOCIETY OF ANESTHESIOLOGY cdsahome.org					
Perils/Pitfalls Treating Drug-resistant Patients with Sedation/General Anesthesia	March 5–6	Steven Ganzberg, DMD, MS; Christine Quinn, DDS, MS	Costa Mesa, San Jose	$349	8
CALIFORNIA SOCIETY OF PEDIATRIC DENTISTRY cspd.org					
PALS Recertification	March 26	John Bovia	Monterey	$275	7.5
Corporate Dentistry and Its Effect on Pediatric Dental Care	March 27	TBA	Monterey	included in annual meeting registration fee	3.5
Sedation	March 28	Steven Ganzberg, DMD, MS	Monterey	included in annual meeting registration fee	3
Pulp Therapy	March 28	N. Sue Seale, DDS, MSD	Monterey	included in annual meeting registration fee	3
Social Media and Your Practice	March 28	Jim Squires	Monterey	included in annual meeting registration fee	2.5
Challenging Cases in Dental Traumatology	March 29	Dennis McTigue, DDS, MS	Monterey	included in annual meeting registration fee	3
Infant Oral Health: Effects on Subsequent Use, Costs and Oral Health Status	March 29	Jessica Lee, DDS, MPH, PhD	Monterey	included in annual meeting registration fee	2.5
Lasers and the Future of Dentistry	March 30	John Featherstone, MSc, PhD	Monterey	included in annual meeting registration fee	2.5

TOPIC	DATE	PRESENTER	LOCATION	COST	UNITS
CONTRA COSTA DENTAL SOCIETY ccdds.org					
Immediate Loading of Dental Implants: 15 Years of Learning	Feb. 7	Lyndon Cooper, DDS, PhD	Walnut Creek	$195 ADA members, $98 retired	0
Evidence Based Dentistry: A Paradigm Shift	Feb. 18	Ronni Kimbrew-Brown, DDS	Concord	$40 ADA members	0
New Materials in Indirect Restorative Dentistry and Wellness — Better Health, Better Care	April 11	Marc Geissberger, DDS	Walnut Creek	$195 ADA members, $98 retired	0
FRESNO-MADERA DENTAL FOUNDATION fmdentalfoundation.org					
Implant Therapy for the Edentulous; Enhancing Successful Outcomes	Jan. 10	Michael Forde, DDS, MS	Fresno	$140 FMDF member dentists; $170 non-FMDF member dentists; $90 RDH, RDA, tech	7
Periodontics Update	Feb. 7	William Lundergan, DDS, MA	Fresno	$140 FMDF member dentists; $170 non-FMDF member dentists; $90 RDH, RDA, tech	7
OSHA, Infection Control and Dental Law	Feb. 28	William Carpenter, DDS; Bruce Peltier, PhD, MBA	Fresno	$140 FMDF member dentists; $170 non-FMDF member dentists; $90 RDH, RDA, tech	7
Treatment Planning, Design and Delivering Complex Cases	April 4	Marc Geissberger, DDS	Fresno	$140 FMDF member dentists; $170 non-FMDF member dentists; $90 RDH, RDA, tech	7
Update in Hormone Balance and Living a Physically Fit Life	May 2	Charles Carpenter, MD	Fresno	$140 FMDF member dentists; $170 non-FMDF member dentists; $90 RDH, RDA, tech	7
TBA	June 6	TBA	Fresno	$140 FMDF member dentists; $170 non-FMDF member dentists; $90 RDH, RDA, tech	7
HARBOR DENTAL SOCIETY harbordentalsociety.org					
Mastering Marketing in the Digital Age — Reputation Management/Patient Reviews, Social Media	Feb. 13	Fred Joyal	Lakewood	$155	5
Periodontal Therapy You Need to Know in 2014	March 13	Paolo M. Camargo, DDS, MS, MBA, FACD	Lakewood	$155	5
Systemic Perio — Where Is the link?	April 10	Joan Otomo-Corgel, DDS, MPH, FACD	Lakewood	$155	5
Smarten Up! Create Superior Restorations With Smart Materials	June 12	Edmond R. Hewlett, DDS	Lakewood	$155	5
KERN COUNTY DENTAL SOCIETY kerncountyds.org					
Infection Control, Dental Practice Act, OSHA Compliance	Jan. 24	Diane Morgan-Arns, BS	Bakersfield	$200 members; $300 nonmembers; $75 auxiliaries	6
The End — to Complications, Sensitivity, Discomfort and Open Contacts	Feb. 21	Todd C. Synder, DDS, AAACD	Bakersfield	$200 members; $300 nonmembers; $75 auxiliaries	6
The Role of the Leader: Communicating Vision & Setting Goals/Creating a Premium Patient Experience With Brand Awareness	March 21	Steve Swafford, BS, MDiv	Bakersfield	$200 members; $300 nonmembers; $75 auxiliaries	6
Implant Prosthetics in the Esthetic Zone: Science, Protocol and Technique	April 25	Todd R. Schoenbaum, DDS	Bakersfield	$200 members; $300 nonmembers; $75 auxiliaries	6

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LOMA LINDA UNIVERSITY SCHOOL OF DENTISTRY dentistry.llu.edu CONTINUES ON NEXT PAGE					
Interdisciplinary Evidence Approach to the Restoration of Endodontically Treated Teeth	Jan. 12	Leif K. Bakland, DDS; C. John Munce, DDS, MS	Loma Linda	$175 dentists; $125 auxiliaries	7
A Methodological Approach to Fabrication of CAD/CAM Framework in Implant Dentistry	Feb. 2	Fernando Munguia, DDS	Loma Linda	$20 dentists; $20 auxiliaries	1
Practice Transition	Feb. 6	Bette Robin, DDS, JD	Loma Linda	no cost	0
Dental Implants in Your Everyday Practice. Boney Incisions versus Osteotomies! Achieving Mandibular Bone Regrowth and a Stable, Long-lasting Prosthesis	Feb. 6	Ralph A. Roberts, DDS	Loma Linda	$40	2
Implant Selection in the Fully Edentulous Patient	Feb. 6	Michael Knutsen, DDS	Loma Linda	$10 dentists; $10 auxiliaries	0.5
Medical Management of the Unhealthy Patient	Feb. 6	Kirollos Zakary, DDS	Loma Linda	$10 dentists; $10 auxiliaries	0.5
Early Infection Management	Feb. 6	Ayleen Rojhani, DDS	Loma Linda	$10 dentists; $10 auxiliaries	0.5
Dental Rehabilitation in the Patient With Microvascular Reconstruction	Feb. 6	Andre Guerrero, DDS	Loma Linda	$10 dentists; $10 auxiliaries	0.5
Management of Medical Emergencies in the Office	Feb. 6	Ryan Falke, DDS	Loma Linda	$10 dentists; $10 auxiliaries	0.5
Obstructive Sleep Apnea	Feb. 6	Chad Allen, DDS	Loma Linda	$10 dentists; $10 auxiliaries	0.5
Contemporary Management of Third Molars	Feb. 6	Nicholas Breig, DDS, MD	Loma Linda	$10 dentists; $10 auxiliaries	0.5
Botox and Injectable Fillers	Feb. 6	Trevor Griffitts, DDS	Loma Linda	$10 dentists; $10 auxiliaries	0.5
Facilitating Communication Between the Restorative Dentist and Implant Surgeon During Treatment With Dental Implants	Feb. 6	MariaElena Rodriguez, DDS	Loma Linda	$20 dentists; $20 auxiliaries	1
From Simple to Complex Case Management With Dental Implants	Feb. 6	Jaime L. Lozada, DMD	Loma Linda	$20 dentists; $20 auxiliaries	1
Cone Beam CT in the Assessment of Implant Angulation Prior to Dental Implant Surgery	Feb. 6	Meisam Faeghinejad, DDS	Loma Linda	$20 dentists; $20 auxiliaries	1
Management of Single Implants in the Esthetic Zone	Feb. 6	Pakpoom Yuenyongorarn, DDS	Loma Linda	$10 dentists; $10 auxiliaries	1
Simplified Techniques for Guided Surgery	Feb. 6	Ana Mesquida, DDS	Loma Linda		1
Methods for Evaluation of Bone Loss Around Dental Implants	Feb. 6	Keerthi Senthil, DDS	Loma Linda	$20 dentists; $20 auxiliaries	1
Update on Endodontics for the Dental Hygienist	Feb. 6	Robert Handysides, DDS	Loma Linda	$30 dentist; $30 auxiliaries	1.5
Orthodontic Updates for Dental Hygienists	Feb. 6	V. Leroy Leggitt, DDS, MS, PhD	Loma Linda	$30 dentist; $30 auxiliaries	1.5
Iatrogenic Periodontal Concerns for Dental Hygienists	Feb. 6	Dennis Smith, DDS	Loma Linda	$40 dentist; $40 auxiliaries	2
Direct Posterior Restorations Revisited	Feb. 6	Carlos Chavez, DDS	Loma Linda	$20 dentists; $20 auxiliaries	1
Evidence-based Dentistry in Everyday Practice	Feb. 6	Madelyn Fletcher-Stark, DDS	Loma Linda	$20 dentists; $20 auxiliaries	1
Multidisciplinary Considerations in Restorative Dentistry	Feb. 6	Jose Torres, DDS	Loma Linda	$20 dentists; $20 auxiliaries	1

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LOMA LINDA UNIVERSITY SCHOOL OF DENTISTRY dentistry.llu.edu CONTINUES ON NEXT PAGE					
Cerec Implants Overview	Feb. 6	Paul M. Richardson, CDT	Loma Linda	$20 dentists; $20 auxiliaries	1
Predoctoral Issues in Implant Dentistry	Feb. 6	Ronald Young, DDS	Loma Linda	$20 dentists; $20 auxiliaries	1
Local Antimicrobial Therapy in the Treatment of Periodontitis	Feb. 6	Meera Maveli, DDS	Loma Linda	$30 dentists; $30 auxiliaries	1.5
Hormonal Effects on the Periodontium	Feb. 6	Christen Sather, DDS	Loma Linda	$30 dentists; $30 auxiliaries	1.5
Papilla Esthetics for Maxillary Anterior Implants	Feb. 6	Yi Yang, DDS	Loma Linda	$30 dentists; $30 auxiliaries	1.5
Ethics and Dentistry	Feb. 6	Martyn Green, DDS	Loma Linda	$20 dentists; $20 auxiliaries	1
Pediatric Dentistry Case Presentation #4	Feb. 6	Residents of the Advanced Specialty Education Program in Pediatric Dentistry	Loma Linda	$10 dentists; $10 auxiliaries	0.5
Pediatric Dentistry Case Presentation #3	Feb. 6	Residents of the Advanced Specialty Education Program in Pediatric Dentistry	Loma Linda	$10 dentists; $10 auxiliaries	0.5
Pediatric Dentistry Case Presentation #2	Feb. 6	Residents of the Advanced Specialty Education Program in Pediatric Dentistry	Loma Linda	$10 dentists; $10 auxiliaries	0.5
Pediatric Dentistry Case Presentation #1	Feb. 6	Residents of the Advanced Specialty Education Program in Pediatric Dentistry	Loma Linda	$10 dentists; $10 auxiliaries	0.5
Pediatric Antibiotics: A Review	Feb. 6	Afsaneh Matin, DDS	Loma Linda	$20 dentists; $20 auxiliaries	1
Pediatric Preventive Dentistry	Feb. 6	Bonnie Nelson, DDS	Loma Linda	$20 dentists; $20 auxiliaries	1
Esthetic Challenges in Young Patients	Feb. 6	Samah Omar, DDS, MSD	Loma Linda	$20 dentists; $20 auxiliaries	1
Use and Abuse of the Physical Restraint	Feb. 6	Wesley Okumura, DDS	Loma Linda	$20 dentists; $20 auxiliaries	1
Ortho-Perio New Horizons in Oral Tissue Engineering Theory and Practice (From PAOO to TMP)	Feb. 6	Neal C. Murphy, DDS, MS	Loma Linda	$175 dentists; $125 auxiliaries	7
SPEED TMJ: A Finite Protocol	Feb. 7	Harold Avila, DDS, MS	Loma Linda	$40 dentists; $40 auxiliaries	2
How to Maximize Your Practice by Utilizing Expanded Function Personnel	Feb. 7	Holli Riter, DDS	Loma Linda	$20 dentists; $20 auxiliaries	1
The Impact of Cone Beam CT on the Endodontic Practice	Feb. 7	Rod Tataryn, DDS, MS	Loma Linda	$30 dentist; $30 auxiliaries	1.5
What's Going on Inside That Tooth?	Feb. 7	Rolf Wuerch, DDS	Loma Linda	$30 dentist; $30 auxiliaries	1
Summary and Conclusion	Feb. 7	Yiming Li, DDS, MSD, PhD	Loma Linda	$20 dentists; $20 auxiliaries	1
The Key Aspects of Bad Breath	Feb. 7	Sean Lee, DDS	Loma Linda	$20 dentists; $20 auxiliaries	1
External Root Resorption During Orthodontic Treatment: What Should We All Know?	Feb. 7	Rodrigo Viecilli, DDS	Loma Linda	$20 dentists; $20 auxiliaries	1
Photon Induced Photoacoustic Streaming (PIPS) — A New Era in Root Canal Irrigation	Feb. 7	David Jaramillo, DDS	Loma Linda	$20 dentists; $20 auxiliaries	1

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LOMA LINDA UNIVERSITY SCHOOL OF DENTISTRY dentistry.llu.edu CONTINUED					
Immediate Implant and Provisionalization in the Esthetic Zone: Science, Art and Limitations	Feb. 7	Joseph Kan, DDS, MS	Loma Linda	$20 dentists; $20 auxiliaries	1
Dentistry Outside the Box	Feb. 7	Parnell Taylor, DDS	Loma Linda	$20 dentists; $20 auxiliaries	1
If Odontoblasts Could Talk ...	Feb. 7	Brian Novy, DDS	Loma Linda	$20 dentists; $20 auxiliaries	1
A Prosthodontic Approach to Diagnosis, Treatment Planning and Treatment: Case Reports	Feb. 7	Montry Suprono, DDS, MSD	Loma Linda	$20 dentists; $20 auxiliaries	1
Complete Dentures: An Evidence-based Approach to Fabrication	Feb. 7	Wendy Gregorius, DDS, MSD	Loma Linda	$20 dentists; $20 auxiliaries	1
Management of a Complex Implant Patient Situation	Feb. 7	Antoanela Garbacea, DDS	Loma Linda	$20 dentists; $20 auxiliaries	1
Current Concepts in Clinical Geriatrics for the Dental Team	Feb. 7	Stephen K. Shuman, DDS, MS	Loma Linda	$175 dentists; $125 auxiliaries	7
Restorative Materials: What, Where, When and How	Feb. 9	Charles W. Wakefield, DDS	Loma Linda	$175 dentists; $125 auxiliaries	7
Practice Management	Feb. 24	Jim Rhode, BME, CSP; Naomi Rhode, RDH, CSP, CPAE	Loma Linda	$175 dentists; $125 auxiliaries	7
Hot Topics in Infection Control and California Law	March 2	Bette Robin, DDS, JD; Nancy Andrews, RDH, BS	Loma Linda	$175 dentists; $125 auxiliaries	7
CAMBRA — It's a Verb	March 9	Brian Novy, DDS; Michelle Hurlbutt, RDH, MSDH	Loma Linda	$175 dentists; $125 auxiliaries	7
Fixed Prosthodontics	March 16	Steven M. Morgano, DMD	Loma Linda	$175 dentists; $125 auxiliaries	7
LLUSD and AAID Implant Dentistry MaxiCourse 2014	March 27–Dec. 5, semimonthly	Jaime Lozada, DMD; Mathew Kattadiyil, DDS, MDS, MS	Loma Linda	$13,500 dentists	300
Are You Numb Yet? Problem Solving the Delivery of Local Anesthesia	March 30	Alan W. Budenz, MS, DDS, MBA	Loma Linda	$175 dentists; $125 auxiliaries	7
Dental Management of the Medically Compromised and Special-needs Patient	April 6	Kevin N. Nakagaki, DDS	Loma Linda	$175 dentists; $125 auxiliaries	7
Esthetic Dentistry: Keys to Success	April 27	Gerard Kugel, DDS, MS, PhD	Loma Linda	$175 dentists; $125 auxiliaries	7
Current Concepts in Clinical Geriatrics for the Dental Team	June 1	Gregory K. Spackman, DDS, MBA	Loma Linda	$175 dentists; $125 auxiliaries	7
LOS ANGELES DENTAL SOCIETY ladentalsociety.com					
Infection Control and California Dental Practice Act	Jan. 14	Diane Morgan-Arns, BS	Los Angeles	$65	4
Medical Emergencies	Feb. 11	John P. Khalaf, DDS	Los Angeles	$65	2
Social Media	March 18	Lorne Lavine, DMD	Los Angeles	$65	3
Digital Impressions	April 29	TBA	Los Angeles	$65	3
Complications of Dentoalveolar Surgery	June 10	Alan Felsenfeld, DDS	Los Angeles	$65	3
MARIN COUNTY DENTAL SOCIETY mcdsweb.org					
TMD and Orofacial Pain in a Nutshell	Feb. 18	Andrew L. Young, DDS, MSD	San Rafael	$49	3
18 C.E.s and Ski Trip — Update on Adhesive Dentistry, New Matrix Systems, Ongoing Research in Endodontic Post Design and Erosive Tooth Wear	Feb. 22–March 1	Patrick Roetzer, DDS; Ward Noble, DDS	Telluride, Colo.	See registration	18
Dental Benefits	March 18	Michael Perry, DDS	San Rafael	$49	3
Current Trends in Geriatric Dentistry: In Sickness and in Health, til Death Do We Part?	May 20	Eric Shapira, DDS, MAGD, MA, MHA	San Rafael	$49	3

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MID-PENINSULA DENTAL SOCIETY mpds.org					
Dental Practice Act/Infection Control	Jan. 24	Eve Cuny; Stacy Pruitt	Palo Alto	$85	4
Making Successful Clinical Decisions in Anterior Esthetic and Implant Therapy	March 28	Henry Salama, DMD	Palo Alto	$275	7
MONTEREY BAY DENTAL SOCIETY mbdsdentist.com					
The Digital Waterfall	Feb. 7	Mark Hyman, DDS	Seaside	$250 members; $350 nonmembers; $115 auxiliaries (first), $95 (additional)	7
The Changing Concepts in Periodontics: What the General Dentist Should Know	March 21	William Lundergan, DDS	Seaside	$250 members; $350 nonmembers; $115 auxiliaries (first), $95 (additional)	7
OSHA, Infection Control and California Dental Practice Act	May 2	Leslie Canham, CDA, RDA	Seaside	$210 members; $300 nonmembers; $90 auxiliaries	6
NORTHERN CALIFORNIA DENTAL SOCIETY ncdsonline.org					
Easier, Faster, More Predictable Oral Surgery for the General Practice	Jan. 10	Karl R. Koerner, DDS, MS	Red Bluff	$125 CDA members; $225 nonmembers; $55 auxiliaries	7
Contemporary Complete Denture Fabrication	Feb. 7	Frederick C. Finzen, DDS	Red Bluff	$125 CDA members; $225 nonmembers; $55 auxiliaries	7
Technology in Your Practice: What Is Here and What Is Coming?	March 14	Paul Feuerstein, DMD	Red Bluff	$125 CDA members; $225 nonmembers; $55 auxiliaries	7
CDPA, OSHA Refresher and Infection Control	April 18	Leslie Canham, CDA, RDA	Red Bluff	$125 CDA members; $225 nonmembers; $55 auxiliaries	6
A New Standard for Caries Management	May 2	Douglas A Young, DDS, MS, MBA	Red Bluff	$125 CDA members; $225 nonmembers; $55 auxiliaries	7
ORANGE COUNTRY DENTAL SOCIETY ocds.org					
Infection Control/CDPA	Jan. 7	Leslie Canham, CDA, RDA	Irvine	$89	4
BLS for the Health Care Provider	Jan. 15	Helen McCracken, RDH, MS	Orange	$69	3
CBCT: Image Interpretation and Legal Obligation	Feb. 11	Burdick Ray, ESP; Bruno Azevedo, DDS	Irvine	$89	2.5
One-day Dental MBA	March 14	Howard Farran, DDS, MBA, MAGD	Costa Mesa	$225	6
Recent Discoveries in Craniofacial Morphogenesis and Tissue Regeneration	April 8	Yang Chai, DDS, PhD	Irvine	$89	2.5
OSTROW SCHOOL OF DENTISTRY OF USC uscdentalce.org CONTINUES ON NEXT PAGE					
USC Periodontal and Implant Symposium: Hands-on Cadaver Workshop I: Vista Soft Tissue and Bone Augmentation	Jan. 22	Homayoun Zadeh, DDS, PhD	Los Angeles	$1,895 dentists	8
USC Periodontal and Implant Symposium: Hands-on Cadaver Workshop II: Alveolar Ridge Augmentation	Jan. 23	Michael Pikos, DDS	Los Angeles	$1,895 dentists	8
The 39th Annual USC International Periodontal and Implant Symposium: General Sessions	Jan. 24–25	Homayoun Zadeh, DDS, PhD	Los Angeles	$545 dentists; $345 auxiliaries	14
The 39th Annual USC International Periodontal and Implant Symposium: Optional Dental Hygiene Hands-on Workshop	Jan. 25	TBA	Los Angeles	$105	2

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OSTROW SCHOOL OF DENTISTRY OF USC uscdentalce.org CONTINUES ON NEXT PAGE					
The 39th Annual USC International Periodontal and Implant Symposium: Dental Hygiene Forum	Jan. 25	Homayoun Zadeh, DDS, PhD	Los Angeles	$155	7
USC Periodontal and Implant Symposium: Hands-on Workshop IV: Extraction Socket Management	Jan. 25	Mauricio Araujo, DDS, MSc, PhD	Los Angeles	$495 dentists	4
USC Periodontal and Implant Symposium: Hands-on Workshop III: All-On-4 Restoration	Jan. 25	Fernando Rojas-Vizcaya, DDS, MS	Los Angeles	$495 dentists	4
USC Periodontal and Implant Symposium: Hands-on Cadaver Workshop V: Wilckodontics: Accelerated Osteogenic Orthodontics	Jan. 26	Thomas Wilcko, DMD	Los Angeles	$1,895 dentists	8
USC Periodontal and Implant Symposium: Hands-on Cadaver Workshop VI: Sinus Augmentation	Jan. 26	Alexandre-Amir Aalam, DDS	Los Angeles	$1,895 dentists	8
Chronic Orofacial, Orodental and Headache Pains for the Dentist	Jan. 31–Feb.1	Glenn Clark, DDS, MS; USC faculty	Los Angeles	$495 dentists; $385 auxiliaries	14
Oral Surgery for the General Practitioner	Feb. 1	Bach Le, DDS, MD, FICD; USC faculty	Los Angeles	$295 dentists; $225 auxiliaries	7
Implant CPR! Successful Management of Prosthetic Implant Complications (Module I: Lecture)	Feb. 7	Harel Simon, DMD	Los Angeles	$295 dentists; $225 auxiliaries	7
Implant CPR! Successful Management of Prosthetic Implant Complications (Modules I and II: Lecture and Hands-on)	Feb. 7–8	Harel Simon, DMD; USC faculty	Los Angeles	$1,595 dentists; $1,055 auxiliaries	14
Emerging Diseases, Infection Control and California Dental Practice Act	Feb. 8	Joyce Galligan, RN, DDS; Patricia Galligan, JD	Los Angeles	$195 dentists; $155 auxiliaries	6
Implant CPR! Successful Management of Prosthetic Implant Complications (Module II: Hands-On)	Feb. 8	Harel Simon, DMD; USC faculty	Los Angeles	$1,465 dentists; $945 auxiliaries	7
Mastering Molar Endodontics	Feb. 21–22	Ilan Rotstein, DDS; USC faculty	Los Angeles	$1,495 dentists	14
Implant Therapy in the Esthetic Zone	Feb. 28–March 2	Homayoun Zadeh, DDS, PhD	Los Angeles	$1,995 dentists; $1,195 auxiliaries	20
Porcelain Veneers: Optimizing Results Using Supragingival Principles, and Understanding Adhesion and Occlusion	Feb. 28	Jose-Luis Ruiz, DDS, FAGD	Los Angeles	$245 dentists; $175 dentists	7
Surgical and Periodontal Perspectives on Implant Treatment Planning	March 7	Alon Frydman, DDS, Krikor Simonian, DDS	Los Angeles	$245 dentists; $195 auxiliaries	7
USC Ruth Ragland 28th Dental Hygiene Symposium	March 8	Diane Melrose, RDH, BSDH, MA; Brian Nova, DDS	Los Angeles	$195 dentists and RDH	7
Fundamental Principles of Restorative Implant Dentistry for the Single Missing Tooth (Part I and II: Lecture and Hands-on)	March 14–15	Baldwin Marchack, DDS, MBA	Los Angeles	$1,295 dentists	16
Fundamental Principles of Restorative Implant Dentistry for the Single Missing Tooth (Part I: Lecture Only)	March 14	Baldwin Marchack, DDS, MBA	Los Angeles	$345 dentists	8
Esthetic Full-mouth Implant Reconstruction: From Treatment Planning to Fixed Restoration (Module I, II and III: Lecture and Hands-on)	March 21–23	Harel Simon, DMD; USC faculty	Los Angeles	$1,995 dentists; $1,695 auxiliaries	21
Esthetic Full-mouth Implant Reconstruction: From Treatment Planning to Fixed Restoration (Module I: Lecture)	March 21	Harel Simon, DMD	Los Angeles	$295 dentists; $225 auxiliaries	7

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OSTROW SCHOOL OF DENTISTRY OF USC uscdentalce.org CONTINUES ON NEXT PAGE					
Esthetic Full-mouth Implant Reconstruction: From Treatment Planning to Fixed Restoration (Module II: Lecture)	March 22	Harel Simon, DMD	Los Angeles	$295 dentists; $225 auxiliaries	7
Esthetic Full-mouth Implant Reconstruction: From Treatment Planning to Fixed Restoration (Module III: Hands-on)	March 23	Harel Simon, DMD; USC faculty	Los Angeles	$1,875 dentists	7
Obstructive Sleep Apnea, Snoring and Dental Advancement	March 28–29	Glenn Clark, DDS, MS; USC faculty	Los Angeles	$495 dentists; $385 auxiliaries	14
Mastering Bone Grafting for Esthetic Implant Site Development — Lecture and Hands-On Workshop (Module I)	March 29	Bach Le, DDS, MD, FICD; USC faculty	Los Angeles	$1,295 dentists; $695 auxiliaries	8
Mastering Bone Grafting for Esthetic Implant Site Development — Lecture and Hands-On Workshop (Module II)	March 30	Bach Le, DDS, MD, FICD; USC faculty	Los Angeles	$1,795 dentists; $1,095 auxiliaries	7
Basic Protocols in Bone and Soft Tissue Grafting in Implant Therapy	April 4–6	Homayoun Zadeh, DDS, PhD; Ira Sy, DDS, MS	Los Angeles	$1,995 dentists; $995 auxiliaries	20
Common Oral Lesions: Soft and Hard Tissue Diseases	April 11	Parish Sedghizadeh, DDS, MS; USC faculty	Los Angeles	$245 dentists; $195 auxiliaries	7
Intermediate Dental Implant Restorative Principles, Procedures and Protocols (Part I and II: Lecture and Hands-on)	April 25–26	Baldwin Marchack, DDS, MBA	Las Vegas	$1,295 dentists	16
Intermediate Dental Implant Restorative Principles, Procedures and Protocols (Part I: Lecture)	April 25	Baldwin Marchack, DDS, MBA	Las Vegas	$345 dentists	8
Applied Hypnosis: Treat Pain, TMD and Other Dental Conditions	April 26–27	Peter Stone, DDS; Ronald M. Kaminishi, DDS	Los Angeles	$595 dentists	14
Learning Implant Dentistry for the Restorative Dentist	May 3	George Cho, DDS, FACP	Los Angeles	$255 dentists; $195 auxiliaries	7
Extraction Site Management: From A–Z (Module IA: Lecture)	May 3	Bach Le, DDS, MD, FICD	Los Angeles	$345 dentists; $245 auxiliaries	5
Extraction Site Management: From A–Z (Modules IA and IB: Lecture and Hands-on Cadaver Workshop)	May 3	Bach Le, DDS, MD, FICD	Los Angeles	$995 dentists; $745 auxiliaries	8
Physical Evaluation	May 5	Stanley Malamed, DDS; Ken Reed, DMD	Los Angeles	$295 dentists; $225 auxiliaries	7
Emergency Medicine	May 6	Stanley Malamed, DDS; Ken Reed, DMD	Los Angeles	$295 dentists; $225 auxiliaries	7
Pharmacology	May 7	Stanley Malamed, DDS; Ken Reed, DMD	Los Angeles	$295 dentists; $225 auxiliaries	7
Monitoring and Sim-Man	May 8	Stanley Malamed, DDS; Ken Reed, DMD	Los Angeles	$455 dentists; $295 auxiliaries	7
Advanced Restorative Options With Dental Implants for Fully Edentulous Arches (Part I and II: Lecture and Hands-on)	May 9–10	Baldwin Marchack, DDS, MBA; Christopher Marchack, DDS	Los Angeles	$1,295 dentists	16
Advanced Restorative Options With Dental Implants for Fully Edentulous Arches (Part I: Lecture)	May 9	Baldwin Marchack, DDS, MBA; Christopher Marchack, DDS	Los Angeles	$345 dentists	8
Comprehensive Periodontal Surgery: Esthetic and Functional Procedures for the General Practitioner (Module I, II, III: Lecture and Hands-on)	May 29–June 1	Ziv Simon, DMD, MSc; USC faculty	Los Angeles	$1,995 dentists	25
Comprehensive Periodontal Surgery: Esthetic and Functional Procedures for the General Practitioner (Pre-course Lecture)	May 29	Ziv Simon, DMD, MSc	Los Angeles	$65 dentists	4

TOPIC	DATE	PRESENTER	LOCATION	COST	UNITS
OSTROW SCHOOL OF DENTISTRY OF USC uscdentalce.org CONTINUED					
Comprehensive Periodontal Surgery: Esthetic and Functional Procedures for the General Practitioner (Module I: Lecture and Workshop)	May 30	Ziv Simon, DMD, MSc; USC faculty	Los Angeles	$745 dentists	7
Comprehensive Periodontal Surgery: Esthetic and Functional Procedures for the General Practitioner (Module II: Lecture and Workshop)	May 31	Ziv Simon, DMD, MSc; USC faculty	Los Angeles	$745 dentists	7
Comprehensive Periodontal Surgery: Esthetic and Functional Procedures for the General Practitioner (Module III: Lecture and Workshop)	June 1	Ziv Simon, DMD, MSc; USC faculty	Los Angeles	$745 dentists	7
Endodontics from A to Z: Hands-On Workshop for the General Practitioner	June 6–8, 20–22	Ilan Rotstein, DDS; USC faculty	Los Angeles	$2,975 dentists	42
Temporomandibular Disorders, Arthrocentesis and Botox/Trigger Point Injections	June 13–14	Glenn Clark, DDS, MS; USC faculty	Los Angeles	$495 dentists; $385 auxiliaries	14
Advanced Soft Tissue and Bone Grafting with Cadaver Workshop	June 13–15	Homayoun Zadeh, DDS, PhD; Steve Wallace, DDS	Los Angeles	$2,995 dentists; $1,595 auxiliaries	24
Minimally Invasive Adhesive and Esthetic Direct Anterior Restorations	June 27	Abdi Sameni, DDS	Los Angeles	$495 dentists; $395 auxiliaries	7
PACIFIC COAST SOCIETY FOR PROSTHODONTICS pcsp.org					
79th Annual Scientific Session of the Pacific Coast Society for Prosthodontics	June 24–27	Markus Blatz, DMD, PhD; Baldwin Marchack, DDS	Laguna Beach	$750	16
SACRAMENTO DISTRICT DENTAL SOCIETY sdds.org					
Energy Drinks, Abfractions and GERD — What Do They Have in Common?	Jan. 14	Warden Noble, DDS	Sacramento	$60 SDDS/ADA members	3
HR Webinar — 2014 Labor Laws Update	Jan. 15	California Employers Association	Sacramento	$35 SDDS/ADA members	1
CPR Renewal — BLS for the Health Care Provider	Jan. 24, April 5	SDDS member instructors	Sacramento	$65 SDDS/ADA members	4
SDDS 34th Annual Midwinter Convention	Feb. 20–21	see sdds.org for speakers	Sacramento	see sdds.org for pricing	14
Build Your Own Employee Handbook Workshop	March 7	Mari Bradford	Sacramento	$149 SDDS/ADA members	4
Nutrition Prescription for the Dental Team and Your Patients	March 11	Charles Carpenter, MD	Sacramento	$60 SDDS/ADA members	3
What's New in Denture Implant Prosthetics	March 14	Joseph Massad, DDS, FACD, FICD	Sacramento	$175 SDDS/ADA members	5
What We Never Taught You in Dental School: Practical Pediatric Dentistry	April 4	David Rothman, DDS	Sacramento	$175 SDDS/ADA members	5
Oral/ Head and Neck Cancer: Is It True What They Say?	April 8	Darren Cox, DDS, MBA	Sacramento	$60 SDDS/ADA members	3
Is It Time to Brand — or Rebrand?	April 10	Gordon Fowler, CE	Sacramento	$59 SDDS/ADA members	0
HR Webinar — Pregnancy and Other Leaves for the Dental Office	April 17	California Employers Association	Sacramento	$35 SDDS/ADA members	1
Maximizing Social Media and Your Practice, While Minimizing Risks	May 8	Conor McNulty	Sacramento	$59 SDDS/ADA members	0
CAMBRA	May 13	John Featherstone, MSc, PhD	Sacramento	$60 SDDS/ADA members	3
California Dental Practice Act and Infection Control	May 30	LaDonna Drury-Klein, CDA, RDA, BS	Sacramento	$125 SDDS/ADA members	4

TOPIC	DATE	PRESENTER	LOCATION	COST	UNITS
SAN FERNANDO VALLEY DENTAL SOCIETY sfvds.org					
2014: Your Year for Extraordinary Professional and Personal Success	Jan. 29	Steven Rasner, DDS	Van Nuys	$150	7
How to Achieve Predictable Success in Cosmetic Dentistry	Feb. 26	Mike Malone, DDS	Van Nuys	$150	7
Dental Implants	March 26	Ziv Simon, DDS	Van Nuys	$150	7
California Dental Practice Act and Infection Control	April 23	Marcella Oster	Van Nuys	$150	7
Dental Materials	June 25	Todd Snyder, DDS	Van Nuys	$150	7
SAN FRANCISCO DENTAL SOCIETY sfds.org					
CPR Renewal	Jan. 29	Adrian Curry, EMT	San Francisco	$65 (plus $12 for required CPR book)	4
2014 Labor Law Update	Feb. 6	California Employers Association	San Francisco	$89	2
Infection Control/Blood-borne Pathogens/HazCom Refreshers	Feb. 14	Marcella Oster, RDA	San Francisco	$95	4
California Dental Practice Act	Feb. 14	Marcella Oster, RDA	San Francisco	$60	2
CPR Renewal	Feb. 26	Adrian Curry, EMT	San Francisco	$65 (plus $12 for required CPR book)	4
CPR Renewal	March 26	Adrian Curry, EMT	San Francisco	$65 (plus $12 for required CPR book)	4
Is Your Practice Disaster Ready?	April 9	Adrian Curry, EMT; panel: Frederic Warren, DDS, MSD; Deborah Elam, MS, CAE	San Francisco	$109	4
Review of Oral Precancerous and Malignant Lesions With HPV Update	May 1	Darren Cox, DDS	San Francisco	$74	2
California Dental Practice Act	May 9	Marcella Oster, RDA	San Francisco	$60	2
Infection Control/Blood-borne Pathogens/HazCom Refreshers	May 9	Marcella Oster, RDA	San Francisco	$95	4
CPR Renewal	May 28	Adrian Curry, EMT	San Francisco	$65 (plus $12 for required CPR book)	4
CPR Basic Life Saving	June 28	Adrian Curry, EMT	San Francisco	$65 (plus $12 for required CPR book)	4
SAN GABRIEL VALLEY DENTAL SOCIETY sgvds.org					
Infection Control and California Dental Practice Act	Jan. 21	Leslie Canham	Alhambra	$75 members; $110 nonmembers; $55 auxiliaries	4
Restorative Dentistry	Feb. 18	Ed Hewlett, DDS	Alhambra	$65 members; $100 nonmembers; $40 auxiliaries	3
Medicine for Dentistry	March 18	Steven Ganzberg, DDS	Alhambra	$65 members; $100 nonmembers; $40 auxiliaries	3
Orthodontic Considerations for the General Practitioner	April 15	Brian Bergh, DDS	Alhambra	$65 members; $100 nonmembers; $40 auxiliaries	3
SAN JOAQUIN DENTAL SOCIETY sjds.org					
Insurance Billing Tips/Codes	Feb. 20	Paul Manos, DDS	Stockton	TBA	2
Periodontal Forum	March 20	Periodontist panel	Stockton	TBA	7
Managing Social Media	April 17	Conor McNulty	Woodbridge	TBA	2
Implant Failures/Maintenance	May 29	Debra Finney, DDS	Sonora	TBA	2

TOPIC	DATE	PRESENTER	LOCATION	COST	UNITS
SAN MATEO COUNTY DENTAL SOCIETY smcds.com					
Implants in the Esthetic Zone	Jan. 23	Todd Schoenbaum, DDS	Foster City	$45 members; $70 nonmembers	3
BLS CPR Renewal Course	Jan. 28	Stephen R. John, DDS	Redwood City	$50 members; $65 nonmembers	4
3-D Dental Imaging	Feb. 21	Jerry Peck, DLXT	Foster City	$45 members; $70 nonmembers	3
BLS CPR Renewal Course	Feb. 24	Richard A. Fagin, DDS	Redwood City	$50 members; $65 nonmembers	4
BLS CPR Renewal Course	March 18	Stephen R. John, DDS	Redwood City	$50 members; $65 nonmembers	4
Adhesive Dental Materials	March 27	Adriana P. Manso, DDS, MSC, PhD	Foster City	$45 members; $70 nonmembers	3
Insurance Claims Submission Process	April 17	Rita M. Hart, DDS	Foster City	$45 members; $70 nonmembers	3
BLS CPR Renewal Course	April 21	Richard A. Fagin, DDS	Redwood City	$50 members; $65 nonmembers	4
BLS CPR Renewal Course Blended	April 29	Richard A. Fagin, DDS	Redwood City	$50 members; $65 nonmembers	4
BLS CPR Renewal Course Blended	May 19	Richard A. Fagin, DDS	Redwood City	$50 members; $65 nonmembers	4
Laser Dentistry	May 22	Donald J. Coluzzi, DDS	Foster City	$45 members; $70 nonmembers	3
BLS CPR Renewal Course	May 27	Stephen R. John, DDS	Redwood City	$50 members; $65 nonmembers	4
BLS CPR Renewal Course	June 9	Richard A. Fagin, DDS	Redwood City	$50 members; $65 nonmembers	4
SANTA BARBARA VENTURA COUNTY DENTAL SOCIETY sbvcds.org					
Day-to-Day Technology That Can Improve Your Practice	Feb. 7	John Flucke, DDS	Oxnard	$185	7
Practice Management	March 25	Michael Perry, DDS	Santa Barbara	$75	3
Changing Concepts in Periodontics	June 6	William Lundergan, DDS	Oxnard	$185	7
SANTA CLARA COUNTY DENTAL SOCIETY sccds.org					
The Christensen Bottom Line	Jan. 24	Gordon J. Christensen, DDS, MSD, PhD	Campbell	TBA	6
TBA/Pediatric	Feb. 13	Rinku Saini, DDS	Campbell	$35 non-SCCDS members; $90 non-CDA members	2
Take a Stand Against Periodontal Disease — The Full Team Approach	March 13	Rhonda Savage, DDS	Campbell	$35 non-SCCDS members; $90 non-CDA members	2
Your Fantastic Dental Team, What Makes it Work	March 14	Rhonda Savage, DDS	San Jose	TBA	5
TBA/Oral Surgery	April 10	Earl Freymiller, MD, DMD	Campbell	$35 non-SCCDS members; $90 non-CDA members	2
TBA/Internal Medicine	May 8	Bradley Sharpe, MD	Campbell	$35 non-SCCDS members; $90 non-CDA members	2
SOUTHERN CALIFORNIA OROFACIAL ACADEMY socalorofacial.org					
12th Annual Spring Scientific Meeting	April 16		Los Angeles	$390 hands-on course; $390 lecture course	12

TOPIC	DATE	PRESENTER	LOCATION	COST	UNITS
UCLA SCHOOL OF DENTISTRY	**dentistry.ucla.edu/continuing-education**				
Sleep Medicine Mini-residency	Feb. 7–8, March 7–8, April 4–5, May 9–10, June 6–7	Robert Merrill, DDS,MS; Dennis Bailey, DDS	Los Angeles	$6,000	60
TMJ — Orofacial Pain Mini-residency	Feb. 14–15, March 14–15, April 11–12, May 9–10, June 13–14	Robert Merrill, DDS,MS	Los Angeles	$4,450	68
RDA Infection Control	Feb. 22	Charlene Flowers, RDA; Cara Batson, RDA	Los Angeles	$250	8
Evidence-based Dentistry	Feb. 22	Francesco Chiappelli, PhD	Los Angeles	250	7
California Dental Practice Act	Feb. 22	Andy Wong, DDS	Los Angeles	$150	4
Esthetic Reconstruction Using Etched Ceramic Restorations: An A-to-Z Course	Feb. 27–March 2	Edward McLaren, DDS; Sandra McLaren, DDS	Los Angeles	$3,500	32
Pediatric Dentistry Update Lecture: Managing Carious Lesions and The Pulp Tissue	March 1	Daniela R. Silva, DDS, MS	Los Angeles	$300	7
Recertification in Pediatric Oral Sedation	March (TBA)	Steven Ganzberg, DDS, MS; Christine Quinn, DDS, MS	Los Angeles	$400	8
Advanced Anterior Esthetics	March 14–16, April 25–27	Jeff Morley, DDS; Todd Schoenbaum, DDS	Los Angeles	$6,000	46
Peri-implantitis and Osteonecrosis of the Jaw: Current Guidelines for Prevention and Treatment	March 1	Tara Aghaloo, DDS, MD, PhD	Los Angeles	$400	7
Pediatric Dentistry Update Workshop: Managing Carious Lesions and the Pulp Tissue	March 8	Daniela R. Silva, DDS, MS	Los Angeles	$500	7
The Efficacy of Hypnosis	March 22–23	Don M. Goodman, PhD, CCHt	Los Angeles	500	14
Sinus Augmentation: The Complete Course and Workshop	March 28–30	Peter K. Moy, DMD; Tara Aghaloo, DDS,MS	Los Angeles	$2,500	18
Endodontic Continuum	March–April (TBA)	Bernice Ko, DDS; Mo Kang, DDS, PhD	Los Angeles	TBA	0
Implants A to Z	April 4–6, May 2–4	George Perri, DDS; others	Los Angeles	$4,000	42
Update on Removable Partial Denture Therapy	April 5	Kumar Shah, BDS	Los Angeles	$250	7
Moderate Sedation with Multiple Oral and Parenteral Agents	April 11–13, May 14–18	Steven Ganzberg, DDS,MS; Roger Wendel, DMD; others	Los Angeles and Vancouver, Wash.	$12,500	80
Restorative Update 2014	April 26	Richard Stevenson, DDS; Todd Schoenbaum, DDS	Los Angeles	$400	7
RDA Pit and Fissure Sealants	May 3–4	Charlene Flowers, RDA; Cara Batson, RDA	Los Angeles	$600	16
Digital Dentistry	May 10	Richard Stevenson, DDS	Los Angeles	$400	7
Pediatric Dentistry Update Lecture: Esthetics in Pediatric Dentistry	June 7	Daniela R. Silva, DDS, MS	Los Angeles	$300	7
Pediatric Dentistry Update Workshop: Esthetics in Pediatric Dentistry	June 21	Daniela R. Silva, DDS, MS	Los Angeles	$500	7
California Dental Practice Act	June 28	Andy Wong, DDS	Los Angeles	$150	4
Pre-Conference Hawaii 2014 — The Fairmont Orchid	June 28	Richard Stevenson, DDS; Perry Klokkevold, DDS, MS	Kohala Coast, Hawaii	$250	4
Hawaii 2014 Main Conference — The Fairmont Orchid	June 30–July 4	Richard Stevenson, DDS; Paulo Camargo, DDS, MS	Kohala Coast, Hawaii	$800	24

TOPIC	DATE	PRESENTER	LOCATION	COST	UNITS
WESTERN LOS ANGELES DENTAL SOCIETY westernlads.org					
OSHA, Infection Control and California Dental Practice Act	Jan. 24	Marcella Oster, RDA	Los Angeles	$195 ADA members; $225 nonmembers; $95 nondentists	6
Anesthesia and Medical Emergencies	March 25	Christine Quinn, DDS	TBD	$75 ADA members; $120 nonmembers; $60 nondentists	3
Implant Restorations	May 6	Todd Schoenbaum, DDS	TBD	$75 ADA members; $120 nonmembers; $60 nondentists	3
The Christensen Bottom Line — 2014	June 13	Gordon J. Christensen, DDS, MSD, PhD	Los Angeles	TBD	6

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LOS ANGELES COUNTY

BEVERLY HILLS - GP/Perio Prosth emphasis on Perio Surgery & Implants in 4 story med bldg w/ 3ops. Grossed 1M in 2012. ID#4035
BOYLE HEIGHTS (GP) - Fifty yrs of gdwll w/ 6 ops in a one story bldg. Bldg for sale. Revenues of ~$31K/mo. Seller retiring. ID#4381.
COVINA - Leasehold & Equip Only! 3 eq op office located in 1 story med bldg. Reasonable rent with excellent terms. ID #4355. **SOLD**
CULVER CITY - Leasehold & Equip Only! 10 eq op office in a single story bld. In residential area. Heavy traffic flow. ID #4261.
HAWTHORNE - GP Turn-Key practice located on a busy blvd. Office consists of 5 eq ops w/ digital x-ray & Diamond softare. #4369.
HUNTINGTON PARK (GP) Price Reduced! Estab. in 2008. In a 2 story free stranding bldg near residential area. Has 4 eq ops. ID#4295.
LOS ANGELES (GP) - Well designed practice w/ 5 eq op in a strip shopping center. 20 years of goodwill. Some Denti-cal. ID#2771.
LOS ANGELES (GP) - Three operatory office located on a 13 story prof bldg. Fee for service. 14 yrs of goodwill. Net $209K. ID#2831.
MONTROSE - GP w/ 35 yrs of gdwll is located in a residential area w/ great street visibility. 4 ops. Fee for service. ID #4383. **SOLD**
PACOIMA - Leasehold &Equipment Only! Two eq op w/ 1 plmbd not eq office in small strip mall. Charts included. ID #4361.
TORRANCE (GP) - Modern designed office w/ 44 yrs of gdwll. Has 3 eq ops, 1 plmbd not eq w/ digital x-ray & Eaglesoft soft. ID#4375.
TORRANCE - GP w/ over 30 yrs of gdwll in 2 story prof med bldg. Consists of 8 eq ops, 1 plmbd not eq in 2,208 sq ft suite. **SOLD**
TORRANCE - Free for service turn-key practice in busy shopping center. Heavy foot traffic. Modern decor office w/ 3 eq ops. ID #4391.
WESTWOOD VILLAGE - With over 70 yrs of gdwll this practice consists of 4 eq ops in a 2 story prof bldg. Net $266K. ID #4401.

ORANGE COUNTY

DANA POINT - Leasehold & Equip Only! Located in a 2 story dent/med bldg. Consists of 5 eq ops in a 1,200 sq ft ste. ID #4397.
HUNTINGTON BEACH (GP) - Fee for service practice w/ 3 eq ops, 3plmbd not eq in a 2,100 sqft ste on a busy street. ID#4395.
MISSION VIEGO (GP) - Well designed turn-key practice w/ 3 eq op & 3 plmbd is located in a prestigious shopping center. ID #4303.
SAN CLEMENTE (GP) - Modern designed turn-key office in 2 story med bldg w/ 4 eq ops, 2 plmbd not eq for expansion. ID 4359.

RIVERSIDE / SAN BERNARDINO COUNTIES

APPLE VALLEY (GP) - Well established practice w/ 5 eq op, 3 plmbd not eq, Dentrix software and digital x-ray. Net $214K. ID #4349.
BANNING - Leasehold & Equip Only! Modern designed practice w/ 3 eq ops in 1 story prof bldg. Remodeled in 2011. ID #4117.
BARSTOW(GP) - Long established office w/ 4 eq ops in a single story bldg. Easy freeway access. Fee for service. ID #4241
FONTANA (PEDO) State of the Art practice located in 1 story multi use bldg with 2 eq ops / 3 chair in open bay. 85% Denti-calID #4301.
PALM DESERT (GP) - Well established practice w/ 5 eq ops in 1 story bldg w/ ample parking & excellent signage. Net $119K. ID#4331.
PALM SPRINGS - Leasehold & Equip Only! Practice located on a busy street w/ 4 eq ops in a 2,000 sq ft office. ID #4387.

SAN DIEGO COUNTY

CHULA VISTA (GP) - Located in downtown. Store front. Consists of 4 eq ops 1 plmbd not eq. Some Cap. Net $152K. # 4279.
OCEANSIDE - Leasehold & Some Equipment Only! Beautiful office in a single shopping center w/ 5 not eq ops in a 1,500 sqft ste. #4363
RAMONA (GP) - Established in 1979 and located in single strip mall. Busy area. Fee for service. Consists of 3 eq op. ID #4305. **SOLD**
SAN DIEGO (GP) - In free standing bldg w/ private prkng. Consists of 5 ops w/ Dentrix software. Monthly revenues of ~$40K. ID #4279.

VENTURA & SANTA BARBARA COUNTY

SANTA BARBARA (GP) - Well established practice w/ 3 eq ops in a 1,100 sqft ste. 100% Cash . Net $215K. Condo for sale. ID # 4393.

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For information on display advertising, please contact Corey Gerhard at 916.554.5304 or corey.gerhard@cda.org.

AVAILABLE POSITIONS

REGISTERED DENTAL ASSISTANT — We are two Pediatric Dentists opening up a brand new, state-of-the-art pediatric dental practice in Albany. We have two part-time opportunities for RDAs that will hopefully evolve into full-time positions as the office grows. Looking for a candidate who has an outgoing, bubbly personality to suit working with children from ages 0 to 18. Previous pediatric experience a plus but we are willing to train the right candidate. Ability to speak a second language and sealant certification preferred. Computer literate as office has digital radiographs and paperless charting. Qualifications: High school graduate or GED equivalent, certificate of RDA. Hourly wages to be determined by experience. Email resumes to powdental@gmail.com.

REGISTERED DENTAL ASSISTANT — Our dental team in Huntington Beach is looking for a positive, experienced Dental Assistant who would like to share several years of solid assisting experience in our wonderful modern office. We have some of the best patients in the world and need a professional who appreciates the TLC needed to work with patients to make them feel comfortable. We are happy to offer competitive compensation for top candidates. Proficiency in Vietnamese a plus. Please send your resume and cover letter to vpham@oceanicdental.com for consideration.

DA/RDA — We are looking for a Dental Assistant in Redwood City who has positive energy, good people skills and is motivated. Please call 408.644.0475 or 650.701.1122.

OFFICE MANAGER — Office Manager needed in West Covina. Must be bilingual, English/Spanish. Will do marketing, patient coordination, collection, computer, digital X-ray. Salary is base plus commission. Please email resumes to martinezj994@gmail.com or fax to 626.965.4203.

DENTAL ASSISTANT — Dental Assistant needed in West Covina. Must be bilingual, English/Spanish. Please email resumes to martinezj994@gmail.com.

CONTINUES ON 934

WESTERN PRACTICE

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WPS@SUCCEED.NET
WESTERNPRACTICESALES.COM

BAY AREA

AG-194 SAN FRANCISCO: Established ~ 25 years. State-of-the-art equipment. Modern, spacious and spectacular office. Richmond District off Land's End. 3,410 sf w/ 7 ops **$1.925m**

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

BC-221 EAST CONTRA COSTA: Well Respected Practice for providing quality dentistry to its loyal patients, Seller is retiring! 1900 sf w/ 4 ops **$325k**

BN-218 UNION CITY: Located in a modern and attractive office building. Large, efficiently designed office ~ 2,404 sf w/ 5 ops **$495k**

BG-217 DISCOVERY BAY: Remarkable, family-oriented practice in an affluent, planned waterfront community. 1 of only 2 dentists in town! Unlimited Potential! 1,250 sf w/2 ops **$385k**

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**

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: Minutes from nearby wine country! 950 sf w/3 ops **$225k**

CN-158 PETALUMA: Predominantly Capitation practice. 1,000 sf w/ 4 ops **Reduced! $395k**

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

DC-113 MILPITAS: Seller retiring! Great location 1,009 sf w/ 3 ops. Plumbed for 1 add'l **$110k**

DC-164 WATSONVILLE: Shopping complex/main thoroughfare. Modern & Attractive. 2,365 sf w/ 6 ops **$395k**

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

DN-204 SAN JOSE Facility: Located in a popular Dental Professional building! ~1,635 sf w/ 3 ops (+2 add'l) **$95k**

DC-191 MOUNTAIN VIEW: Rare opportunity! High quality, potentially large -scale practice. Heart of Silicon Valley. 2,000 sf w/7 ops (+1) **$950k**

BAY AREA CONTINUED

DG-202 SARATOGA Facility: Affluent, upscale area. Great Location & Excellent Visibility! Across from major shopping center/Starbucks. Call for Details! 1,568 sf w/ 4 ops **REDUCED! Now Only $145k**

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-214 CUPERTINO: **Seller highly motivated and will consider all reasonable offers! Opportunity to own property in the future. Highly desirable commercial corridor.** 1,200 sf w/ 3 ops +1 $100k obo

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. 1,900 sf w/ 6 ops +1 **$475k**

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! $140k**

EN-206 SACRAMENTO Facility: Affluent and desirable location! ~1,800 sf w/ 4 ops **$95k**

EG-215 WOODLAND: Look no further for your dream opportunity! Immaculate, free-standing office. ~ 1,000 sf w/ 3 ops. **$210k**

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-087 LAKE COUNTY: Quality practice, friendly staff & Cerec 2,400 sf w/3+ ops **$699k**

FN-148 MENDOCINO CO: "Gateway to the Redwoods!" Quality care in 4 ops **$325k**

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

GN-134 REDDING: Stellar reputation, quality care and location! 2,264 sf w/4 ops. **$500k**

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-177 CHICO/OROVILLE: Spacious 2,500 sf w/6 ops **$399k**

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

What separates *us* from other brokerage firms?

As dentists and business professionals, we understand the unique aspects of dental practice sales and offer more practical knowledge than any other brokerage firm. We bring a critical inside perspective to the table when dealing with buyers and sellers by understanding the different complexities, personalities, strengths and weaknesses of one practice over another.

Our extensive buyer database and unsurpassed exposure allows us to offer you…

A Better Candidate A Better Fit and A Better Price!

Sales

NORTHERN CALIFORNIA CONTINUED

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 Broader, this FFS practice is ~2,200 sf w/ 3op +1 add'l **$145k**

HN-059 LASSEN CO: Quality, well-established, family-oriented. 1,600 sf w/3 ops **$120k**

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

CENTRAL VALLEY

I-9721 STOCKTON: Prof. complex. 1,450 sf w/ 3 ops & plumbed for 1 add'l **$75k**

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 **$199k**

IN-205 STOCKTON Facility: Get ready to practice your best dentistry here! One of the most desirable professional corridors. 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**

IC-163 CENTRAL VALLEY Perio: Well-respected FFS. 2,300 sf w/5 ops **$175k (Bldg: $250k)**

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**

Ask The Broker

As the Year Comes to a Close

The end of last year was an interesting one as many sellers elected to close the sale of their practices before December 31 to avoid the additional tax increase on capital gains. Since this year is back to normal, I expect to see most of our sellers push the close of sale of their practices into January.

It is still a *"seller's market"* out there as we wind down this year. Having said that, practices in the smaller, rural areas still take more time to sell and the facility-only opportunities without patients are not moving as well as they have in the past, even in the larger urban markets. At some point in the next few years, we do expect a large increase of inventory as the baby boomers who graduated in the late 70's and early 80's will finally let go.

I believe that The Affordable Health Care Act, aka Obamacare, may also be an impetus for some tentative sellers make a decision to sell. The more we learn about how the health care premiums or deductibles will be increased two to fourfold for older, highly successful dentists, the more these dentists may consider retirement as they may qualify for the "free" or "subsidized" health care plan if they are no longer working.

Here is my year-end advice for Sellers : If your practice is currently on the market or you are contemplating selling your practice next year, ***finish the year strong***!! Lenders and Buyers value your practice almost exclusively on the most current year-end P&L. Try ***not*** to take too much time away from the office until January. Make all of your December bank deposits on time and try to have them posted ***before*** January, as opposed to some accountant's advice for you to wait until January so that the tax burden is delayed for a year. If you are currently in contract, most accountants will again advise their sellers to close in January. If you are thinking of selling next year, begin the process now so that you are ready for what is traditionally the busiest time of the year for buyers coming into the market, which is usually mid to late January.

Here is my year-end advice to Buyers: If you are frustrated searching for the right opportunity, I believe that the inventory and activity will start to pick up next year as compared to the past few years because many Sellers who have been holding on may decide that it is time to finally retire next year as they probably realize that taxes and expenses will only increase in the future. Their investment portfolios should have rebounded from the 2008 crisis and that will also be a factor.

To all of you, have a safe, happy holiday season and continued prosperity throughout the year!

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**

CLASSIFIEDS, CONTINUED FROM 931

PERIODONTIST — We are inviting a board-eligible or certified Periodontist to work in a friendly general practice in Martinez one to two times per month. Please send resume to my personal email at monamor38@sbcglobal.net. Thank you for your time and consideration.

ASSOCIATE DENTIST — Opportunity! Could this be yours? Are you energetic, personable and a highly skilled General Dentist? We are looking for a full-time Dentist to join our team in Santa Rosa. Our state-of-the-art office offers a wide variety of services for our patients. We keep up with the latest technology such as electronic records, digital X-rays, intraoral camera, diagnodent and more. We are looking for an Associate with two years of experience who is proficient in all aspects of general dentistry. Molar endodontic experience preferred. This position has the opportunity of ownership in the future. Please email resumes to nicole@santarosadentalcare.com.

GENERAL DENTIST — We are looking for a part-time General Dentist in San Pablo. Please email your available days to jleo1@yahoo.com.

ASSOCIATE DENTIST — Get out of the crowded city, make great money and get excellent additional training working with me in my rapidly growing office in Oroville. We do all areas of dentistry and pride ourselves on our outstanding gentle care. We are growing too fast to keep up. We are proving that taking excellent care of patients can bring great dividends. Come work with a great team, with great equipment in our state-of-the-art new office in a beautiful part of California. Experience is always helpful, however, as long as you are willing to learn, a lot of experience is not necessary. Please email CV to brent@parrottdds.com or fax to 530.533.3161.

ASSOCIATE DENTIST —Opportunity available in a growing, established practice in Lemoore with a comfortable, modern design. State-of-the-art equipment, digital

panoramic, CAD/CAM, laser and much more. Doctor must be ethical, have a positive, outgoing chairside demeanor and be a participating team player with our fantastic supportive staff. Ability to perform full dental services including extractions, molar endo and have an interest in cosmetic dentistry. This is a wonderful opportunity for the right candidate. Benefits include an assistant, medical, 401k, vacation and a stable patient base. Contact Dr. Denise Riemer via email at denise_riemer@yahoo.com to learn more or Tiffany (practice administrator) at tiffany@lemooredentalcare.com.

ASSOCIATE DENTIST — Long-established private dental practice located in Folsom is looking for an experienced Dentist as a part-time associate. Must have a minimum of four years of clinical experience and be comfortable performing all aspects of general dentistry including molar endo, extractions and quadrant dentistry. We are looking for an individual with excellent interpersonal and communication skills who can effectively treatment plan and present ideal treatment to patients. Experience with placement and restoration of implants a big plus. We will provide additional training for the right candidate. Position requires availability on weekends, early and evening appointments. Possible future buy-in opportunity for the successful candidate. Please email CV and three references to foothillsmiles@gmail.com.

ASSOCIATE DENTIST — Associate Dentist needed in Redwood City. Must be able to perform all phases of dentistry. Great team. Please email resume with two references and desired salary to sivasch@hotmail.com. Thank you very much.

PERIODONTIST — Looking for a Periodontist with a minimum of five years post-training clinical experience to be part of a multispecialty private practice in La Jolla. Long-term commitment of one to two days per week. Proficiency with soft tissue esthetics, Nobel and Straumann implant systems and current ridge augmentation techniques required. Excellent interpersonal and team skills a must. Please email cover letter, resume and photo to drnick@scrippsdentalcare.com or fax to 858.535.8309.

ASSOCIATE DENTIST — Part-time and full-time Associate Dentist position available in West Covina. Must be open to traveling to other offices. PPO/HMO multispecialty dental office. Must have experience working in a multispecialty environment. Two years work experience required. Proficient in molar endo. Please email your CV to sdpartners346@yahoo.com or contact our office at 909.985.1966.

ASSOCIATE DENTIST — Part-time and full-time Associate Dentist position available in Upland. PPO/HMO multispecialty dental office. Must have experience working in a multispecialty environment. Two years work experience required. Proficient in molar endo. Please email your CV to sdpartners346@yahoo.com or contact our office at 909.985.1966.

ORAL SURGEON — Growing group practice in Sacramento seeks Oral Surgeon for part-time work, one to two days a month. Flexible scheduling based upon your availability. Compensation will make it worth your while. Please email resumes to drsteele@sacramentodentistry.com.

ASSOCIATE DENTIST — An amazing opportunity has become available at Tulare Family Dentistry for an Associate Dentist position. This is a rare opportunity to work in a well-established private dental

CONTINUES ON 936

CLASSIFIEDS, CONTINUED FROM 935

office, alongside a motivated and terrific staff. Patient treatment will focus on both pediatric and adult patients. This is an opportunity to earn a great living and be in an environment that is progressive and positive. Full-time position is available, Mon-Thurs. from 12:00 p.m. to 8:00 p.m. Please contact Rebecca at 559.688.7529, or email resumes to rmarquez@233.comcastbiz.net.

DENTIST — Associate Dentist position available in Los Gatos/San Jose for two to four days per week. Please send email to dmengdds@gmail.com.

DENTIST — Dear Prospective General Dentist: We are a stable, growing private dental office in east San Jose with a loyal patient base. We are well staffed but are in need of a dentist who can help take us to the next level. This position may lead to potential part ownership for the right candidate. You must have the experience and efficiency in all phases of general dentistry to succeed. Implant placement and Invisalign treatment experience a plus but not required. Must be comfortable with simple extractions. Some knowledge of Spanish preferred but not required. We invite you to email your resume to bayareadentist2009@gmail.com if you have at least three years of experience post dental school.

DENTIST — General dental office in San Jose needs one Orthodontist to start treating for our patients. We have many patients in need of orthodontist's treatment. Please email your resume to tominh13@yahoo.com or contact us at 408.885.0106.

FRONT OFFICE RECEPTIONIST/ ADMINISTRATIVE ASSISTANT — We are two Pediatric Dentists opening up a brand new, state-of-the-art dental practice in the city of Albany (adjacent to Berkeley). We are looking to fill the role of Dental Receptionist/Administrative Assistant. This will be a full-time position for the right candidate. Candidate must promote and believe in Pediatric Oral Wellness' mission statement of "empowering kids with happy, healthy smiles!" Staff member must be a team player, take initiative with a bright, energetic personality as our ambassador to the public. Responsible for the day-to-day activities of the business office including scheduling of patients, maintaining records, ensuring a clean and orderly environment of the dental office, accounts receivable, presentation of the financial treatment options, marketing and public relations management. Qualifications: High school graduate or GED equivalent. Previous business experience preferred, computer literate

CONTINUES ON 938

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

ANAHEIM: General Dentistry Practice. Nicely appointed with 3 modern Ops. Gross Receipts $423K. Adj. Net Inc. $140K. Seller refers out specialty procedures and is retiring. Growth potential! #CA101

BAKERSFIELD: General Dentistry Practice. 3,650 sq. ft. suite. 8 Ops. (7 equipped). Digital x-rays and intra-oral camera. $1.2MM in collections. $453K Adj. Net Inc. Growing area. #CAM554

BAKERSFIELD and SMALL FARM COMMUNITY: Strong patient bases. Staff/doctor work both. Underserved communities. $588K Gross Receipts. $278K Adj. Net. Inc. #CAM557

BISHOP: General Dentistry Practice & Building. 1,800 sq. ft. 5 Ops. 2011 collections of $1MM. $387K Adj. Net Inc. #14390

CENTRAL COAST: *Prosthodontic Practice.* 4 Ops with full in-house lab. Over $1.1MM in Gross Receipts in '12. Near shopping. #CAM535

CERRITOS: General Dentistry Practice. 1,500 sq. ft. suite. 7 Ops, 6 fully equipped, 1 plumbed. Digital X-rays, SoftDent software. Near shopping and freeway. '12 Adj. Net Inc. $140K on $408K collections. Established with room to grow. #CA100

CHICO: General Dentistry Practice. 2,400 sq. ft. free-standing building. Option to purchase or lease. 2012 collections 1.4MM. SOLD

CHULA VISTA: General Dentistry Practice. 4 Ops. '12 Gross Collections $528K. 3 ½ days of hygiene, Dentrix software. #CA109.

COALINGA: General Dentistry Practice: 1,100 sq. ft., 3 ops, remodeled in 2011. 1,000 active patients. Excellent opportunity for new dentist or established dentist looking for satellite office. #CA564

COASTAL ORANGE COUNTY: General Dentistry/Implant Practice. 1,800 sq. ft., 4 Ops. Implant system in all Ops. Gross Receipts $1.2MM in '11. #CA520

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

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

DANVILLE: *Facility Only.* 5 Fully equipped & furnished Ops. Digital X-ray, Digital Panoramic X-ray, and central nitrous oxide/oxygen. Relocating. #CA548 – In Escrow

FOLSOM/EL DORADO HILLS: General Dentistry Practice. 1,200 sq. ft. with 4 Ops. '12 Gross Receipts of $405K., 2½ days hygiene/wk. Dentrix, laser, digital X-rays, and intra-oral cameras. #CA103

FREMONT: 3,000+ Sq. Ft. Suite. 10 Ops. Digital X-rays and Pan. 4,000 active patients. PPO/HMO with '12 Gross Receipts of $1.2MM w/ Adj. Net Inc. of $300K. #CA553

GRASS VALLEY: General Dentistry Practice. 1,500+ sq. ft. office. 5 Ops, 4 equipped. Collections of $491K with Adj. Net Inc. of $130K. #14379. – In Escrow

GRASS VALLEY: General Dentistry Practice. 2,000 sq. ft. condo. with 6 Ops. '12 Gross Receipts $442K. #14372. – In Escrow

GREATER CHICO/REDDING: General Dentistry Practice. Well-established, 3 Op. office with intra-oral, Pano, Imaging System, and patient education software. '12 Gross receipts of $252K+. #CA104

GREATER SACRAMENTO: General Dentistry Practice. 1,400 sq. ft. office with 5 Ops. 2012 Gross Receipts $879K+. Adj. Net Inc. $446K. #CA525 – In Escrow

GREATER SACRAMENTO: General Dentistry Practice & Building. 2,300 sq. ft. office with 6 Ops. EZ dental software, Pan, 8 days hygiene/wk. $900K aver. prod. last 3 yrs. Great location. #CA560 – In Escrow

GREATER SACRAMENTO: *Orthodontic Practice.* Like-new 2,300 sq. ft. office with extensive leasehold improvements. 6 chairs. 220 active patients phase 1. #CA551

HAWAII (MAUI): General Dentistry Practice. Approx. 1,200 sq. ft. w/ 4 equipped Ops. Gross Receipts $636K #20101

HENDERSON, NV: *Pediatric Practice.* Deceased Dentist – **Available for immediate sale.** 6 Ops. Dentrix and Pano. '13 collections (first 9 months) $688K. '12 — $766K. '11 — $875K. #NV100.

HOLLISTER: ***Facility Only.*** 1,800 sq. ft. 3 Ops w/ 2 add'l plumbed with cabinets. Adec chairs, units, and lights, Dexis, Easy Dental, and Pano X-ray. Owner relocating to own building. #CA563

INDIAN WELLS: General Dentistry/TMJ Practice. 4,000 sq. ft. suite. 6 Ops. '11 Gross Receipts $350K+ on 1 doctor-day/wk. #CAM530

LANCASTER: General Dentistry. 2,300+ sq. ft., 4 Op office. Gross Receipts $676K w/ $174K Adj. Net Inc. #14376

MILPITAS: General Dentistry. 1,440 sq. ft., prof. designed office in business district. 4 Ops w/ intra-oral cameras and computers in each Op., plus a Pano X-ray. Owner retiring. #CA562 – In Escrow

MURRIETA: General Dentistry. 1,300 sq. ft. office with 4 Ops. '12 Gross Receipts $530K+. $213K Adj. Net Inc. #CAM544

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

NEWPORT BEACH: General Dentistry. 4 Ops near Fashion Island. Dentrix. Collections of $256K. Refers out most specialty work. Room to grow. #CAM559.

NEWPORT BEACH: General Dentistry with 3 Ops. Newer high-end equipment, '12 Gross Receipts of $350K on 3½ days/wk. #CAM534 – In Escrow

NORTH EAST BAY: General Dentistry: 2,324 sq. ft. 7 Ops. Dental Mate software, intra-oral camera, Pano, digital X-Ray. '12 GR of $885K w/ OH under 70%. Estab. 35+ yrs. Bldg. being sold w/ practice by retiring dentist. #CA108

NORTH OF SACRAMENTO: General Dentistry. Remodeled office w/ 4 equipped Ops, 5 available. 1,500 active patients. '12 Gross Receipts of $515K on 32 hr/wk. and 37 wks/yr. EZ Dental, Pan., Fiber Optics. 20 hrs. hyg./wk. Bldg. for purchase. # CA558

NORTH OF SACRAMENTO: General Dentistry. 1,650 sq. ft. w/ 4 Ops. '12 Gross Receipts of $521K. Low overhead - 52%. #CA528.

NORTH OF SACRAMENTO: General Dentistry. 2,050 sq. ft., 5 Ops. Dentrix, intra-oral cameras, digital X-ray, imaging system and Pano. '12 GR of $1.2MM. OH of 5%. Current location for 15+ yrs. #CA106

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

NORTH SAN DIEGO COUNTY: Large legacy practice. 12 equipped Ops. HMO practice with large CAP check in a desirable area in North County. #CAM543.

ORANGE: General Dentistry. 5 Ops. '12 Gross Receipts of $830K+. #CAM543 – In Escrow

ORANGE COUNTY: *Periodontal Practice.* 6 Ops available, 5 fully equipped. '12 Gross Receipts of $450K on 4 day/wk. #CAM536

RIDGECREST: General Dentistry Practice and Dental Building. 1,500+ sq. ft. office building with 4 Ops. Small practice Grossed about $175K in '12. #CA523

RIVERSIDE: General Dentistry Practice. 4 Ops, Priced for immediate sale - deceased doctor. Contact our office for more information.

SACRAMENTO: General Dentistry. 2,400 sq. ft. office/building with low OH (54%). 8 Ops, 7 equipped. '12 Gross Receipts of $642K #CA549

SAN GABRIEL VALLEY: General Dentistry. 4 Ops. '11 Gross Receipts of $590K on 3½ day wk. #CAM541 – In Escrow

SAN JOSE: *Facility Only.* Blossom Valley Prof. Location near Oakridge Mall. 3 Ops, 1,200 sq. ft. Includes digital sensor, EagleSoft, and computer network. Move-in ready. #CA515

SAN JUAN CAPISTRANO: General Dentistry. 4 fully equipped Ops. Gross Receipts of $[illegible]K in '12. SOLD

SAN RAMON: *Facility Only.* 1,400 sq. ft. with 4 Ops. equipped, 2 add'l plumbed, Pano, computer server & workstations w/Dentrix, intra-oral camera. Priced to sell. #CA511

SANTA CRUZ: *Endodontic Practice.* 850 sq. ft. office, 2 Ops w/ Schick Digital X-ray. Ideal for a satellite practice. Owner will work for buyer 1-1½ days/wk. Gross Receipts $350-$400K. 55% OH. #CA102

SANTA CRUZ COUNTY: General Practice. Immediate sale. 1,500 sq. ft. with 5 Ops. CAD/CAM, intra-oral cameras, Pano, and Datacon software. '12 Gross receipts of $465K on 4 day/wk. 3 days hyg./wk and 12 NP/mo. Same location 32 yrs. Owner will help transition. #CA105

SANTA CRUZ COUNTY: General Dentistry in 1,100 sq. ft. office. 3 Ops in prof. bldg. near Hwy.1. Gross Receipts $338K on 2 day/wk. 2,200 active patients. 10 new patients/mo. Schick digital X-ray and Dentrix software. Equipment 5 yrs. old. Moving. #CA550

SOUTH ORANGE COUNTY: General Dentistry Practice with 5 Ops. 4 fully equipped. Most specialty work referred out. '12 Adj. Net Inc. $324K on $739K Collections. #CAM556

TURLOCK: General Dentistry. Gross Receipts in '12 over $950K w/ $443K Adj. Net Inc. #CA506 – In Escrow

WALNUT CREEK: *Prosthodontic Practice:* with 3 fully-equipped Ops and full lab. '12 Gross Receipts of $530K. #CAM540

YORBA LINDA: General Dentistry Practice with 5 Ops in great location. Laser, intra-oral camera, and digital X-rays. 3 hygiene and 3 doctor days/wk. #CAM531

CONFIDENTIAL: *Pedodontic Practice:* 4 Ops. Gross over $750K with a low overhead. Call for more information on this great opportunity. #CA111

CLASSIFIEDS, CONTINUED FROM 936

and Quicken proficient is a plus. Hourly wages to be determined by experience. All interested parties can email their resume and cover letter to pts218@nyu.edu.

FRONT DESK, SCHEDULER — Growing private family practice in Hercules is looking for a new team member who is experienced, professional, friendly and able to multitask. We are requiring a minimum of two years of experience with dental front-office work, excellent skills with Eaglesoft software and familiarity with PPO insurances and DeltaCare USA. Must be willing to help in back office as needed. Must be willing to work on Saturdays. The office manager will provide further training on the job. Must be hard working, trustworthy, efficient, dedicated and reliable. If you're interested in this position, please email a resume and a cover letter with three dental references to lovelymanlapazdds@yahoo.com to be considered for an interview. Onsite interviews will start immediately. Spanish speaking is a plus.

REGISTERED DENTAL ASSISTANT — Oral and maxillofacial surgery office is seeking a qualified RDA with three plus years experience assisting oral surgery for IV sedation (chinning, running emergency sequences, anesthesia charting), implants, grafting, dentoalveolar, etc. The practice is located centrally in Irvine in a professional building. Expectations: engaged in assisting in both front/back when required, marketing, running monthly meetings, building and executing marketing plans, quality patient interaction, cross training new RDA staff. Salary is dependent on experience and the position can range from part to full-time. Qualifications: BLS required, ACLS a plus, OS certified preferred. Only serious candidates please. Please contact socalomfsdds@gmail.com or call 949.514.8714.

OPPORTUNITIES WANTED

IN-HOUSE PERIODONTIST/IMPLANT SURGEON FOR YOUR OFFICE — In-house Periodontist/Implant Surgery/Oral Surgery available for your office in the greater San Francisco Bay Area. Implant surgery/bone grafting/perio surgery/third molar extractions/surgical extractions. Send email to bayareaperio@gmail.com or call 617.869.1442.

COMPREHENSIVE ORTHODONTICS, TMD, SLEEP DENTISTRY — Offering my services to do comprehensive, short-term orthodontics as well as TMD and sleep dentistry. Looking for a position one day per week or one day per month. I have my own private practice in Malibu but am looking to exclusively practice those three aspects of dentistry as an associate in another office. 50/50 split on all work. Refer to my website, www.smilesinmalibu.com, and to my YouTube link, www.youtube.com/watch?v=7daqPqiLLEQ, regarding my comprehensive orthodontic philosophy. Please email me at smilesinmalibu@gmail.com.

OFFICES FOR RENT/LEASE

OFFICE FOR RENT/LEASE — Located on the border of Campbell and Los Gatos in the area's medical/dental hub. This office is 1,090 sq. ft. and has three operatories, private doctor's office, private consultation room and a large reception area with granite counter tops The space is currently a dental office with a practice that will be vacating soon. Plumbing, fixtures, etc., are already in place for dental use. Rent is $3,585, not triple net. Please call 408.356.3146 or email tfollmar@follmaroms.com.

CONTINUES ON 940

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4009 WOODLAND GP

Woodland GP and building available w/4 fully-equipped ops in approx. 1,500 sq. ft. office in gorgeous garden setting. Well est. prevention oriented family practice w/ seasoned & loyal staff. 2012 GR $232K+ w/just 3 doctor days. Only those interested in both the building and practice need respond. Practice asking price $138K, building asking price $315K.

PENDING

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.

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+

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

4011 SANTA ROSA GP

Seller is changing careers and offering a well-established and successful practice. No insurance contracts, well-trained staff, 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. This is a terrific opportunity! Asking $450K.

4014 SAN FRANCISCO GP

Located in Cow Hollow neighborhood. 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.

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.

3098 SALINAS GP

Well-known GP specializing in restorative dentistry retiring from 28 year practice located in highly visible downtown office. 4 fully-equipped ops., Panorex, digital x-ray & recent equipment upgrades. 2 year avg. GR $331K+ w/approx. 152 doctor days/yr. Asking $150K.

4002 SANTA CRUZ AREA GP & BLDG

Well-est. practice in modern 1,250 sq. ft. office w/4 ops. 5 year avg. GR $630K+ w/ just 4 doctor days. Selling building & practice together. Practice asking price $430K, building to be determined.

PENDING

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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UPCOMING: OAKDALE GP & LARGE SONOMA COUNTY GP

CLASSIFIEDS, CONTINUED FROM 938

OFFICE FOR RENT/LEASE — Great opportunity in Chico to lease a fully equipped dental office. This standalone building is 1,966 sq. ft. and has three operatories, a large waiting room and reception area, full windows with ample natural light and a full basement for storage or staff lounge. Close proximity to Enloe Hospital. Available for lease on or near December 1, 2013. Please call Diane at 530.570.1007 for more information.

OFFICE FOR RENT/LEASE — Established 1,000 sq. ft. specialty dental office available in Bakersfield. The newly remodeled office has four plumbed operatories and a quiet room. Tremendous amount of under-serviced young families in the area. Perfect for pediatric dentist, endodontist or oral surgeon. Asking $1,250 a month. Please call 661.871.0780.

OFFICES FOR SALE

OFFICE FOR SALE — Dental office with three functional operatories in Carmichael, a suburb of Sacramento, for sale. Highly visible area. Take over lease and option to renew. All equipment is available for purchase. Asking $29,000 or best offer. Please call 916.233.8932 or send email to carmichaeldental@yahoo.com.

OFFICE FOR SALE — Poised on the corner of Fifth and Oak Streets in Colusa, this handsome professional building has two units and has been occupied by a history of successful dentists. Each unit has its own entry, meters, heating and A/C. Unit A is 1,275 sq. ft. and features a waiting/reception area, central clerical station with five desk spaces, a private office, four exam/operatory rooms, X-ray room, lab and more. Unit B is 694 sq. ft. and offers a waiting room, reception area, restroom, private office, storage room, storage closet, lab and more. Speaker system throughout the building. Roof replaced in 1990. A/C, plumbing and electrical updated and upgraded 2000-2010. Two parcels included: additional APN 001-094-008 and 001-094-009. Please call 530.790.7000 or send email to donnaphelan@interopride.com.

PRACTICES FOR SALE

PRACTICE FOR SALE — The practice is on pace to produce approximately $897,000 for the year 2013. Adjusted OH is currently at approximately 53 percent, and we are slightly overstaffed for current production levels, so as further growth occurs this will become even better. We are at mostly FFS/OON, and contracted only with Delta (approximately 35 percent of patient base). Doctor works an average of 3.2 days of patient care per week. Average 24 NP per month. Office is well appointed and modern with a diode laser, digital X-rays, computers in all opps, cerec and cone beam CT (sold separately or take over payments). The practice is in a semirural region of the Central California mountains. The population base we draw from is more than 40,000 people and we have all the amenities in town someone might want. Great restaurants, shopping and an active theater and art scene. We are in the mountains in a region near Yosemite. Our patient base is made up largely of middle to upper middle class retirees with a high demand for dental care. The area is beautiful with world-class hiking and other outdoor activities like skiing very close by. The procedure mix is varied with most molar endo, all ortho and most third molars being referred out. The doctor places and restores implants. We do not see many children or market to children. There is a high demand for pediatric and orthodontic dental care in

CONTINUES ON 942

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Performance realized by One Dentist. Surprisingly, this practice is not close to realizing its potential. Smart Successor who tweaks the practice where it needs to be tweaked shall then make this into something special. Paperless and digital. Ambitious SoCal Dentist who is not averse to commuting should consider this opportunity. Location shall be constant New Patient generator. Great Two Dentist purchase. Make this a "One Stop" Shop. Little competition with phenomenal upside.

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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

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.

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.

6045 MANTECA / MODESTO AREA'S RIPON Great location. 3 Ops, 2 more 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 x-ray 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.

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

6008 MENDOCINO COAST'S FORT BRAGG Cultural haven offers attractive lifestyle. 2012 collected $750,000. 2013 shall top $800,000. 4-days of Hygiene. Digital radiography. Computers in Ops. Full price $235,000.

TEMECULA - MURIETTA VALLEY Hi identity. Classic GP. Gorgeous 6-Op office. Grosses apprx $800K. Right Buyer can gross to $2 Million in 5-years. Valuable Dental/Professional Building also available.

PASADENA AREA $6K-to-$7K/mth in HMO. Grossing $750,000 part-time. Did $1+ Million when Owner spent more time here. Full Price $850,000.

FONTANA 100,000 autos pass daily. Hispanic. PT Owner grosses $250K. FT Successor should Gross $500K+. Remodeled. Firm price $275,000.

ALISO VIEJO Best Shopping Ctr location. Grosses almost $1 Million. 5 ops "state-of-the-art". PT Owner. Wants "hands-on" Owner. Work here, live at beach! Over 70 NPs/month. FP $900,000.

CUCAMONGA 50 NPs/mth. Located off freeway exit. 5-ops. Beautiful Grossed $850K in 2012. Should do $1.2 in 2013. FP $850,000.

RIVERSIDE Hi Identity building 4 Sale. Elegant 5-ops. CT digital Pan & x-rays. PT Conservative Female Owner Grossed $550K. One PPO. Full-time Successor shall do better.

RIVERSIDE Grosses $1.3 Million. $6-to-$7K/mth from HMO. Does ortho. 10-ops in 3,000 sq.ft. with low rent. Hi identity Shopping Ctr near Wal-Mart. FP $1 Million.

IRVINE Grossed $1.2 Million in 2012. 2013 should do $1.3+. 5-ops. Absentee Owner. Unique transition assistance available. FP $1 Million.

SAN FERNANDO VALLEY Best location. Grosses $1.2 Million. Lots of work referred. This is $2 Million location. 8-ops. 30 Hygiene pts/ day. Full price $1.2 Million.

SAN FERNANDO VALLEY – BEST HISPANIC LOCATION 7 state-of-art Ops, room to expand. 70 NP's/mth. Building part of sale. Another $2 Million location.

TORRANCE – GARDENA Very conservative Chinese DDS. Lots of work referred. Young Chinese/AM Successor will do $600K. FP $185,000.

LANCASTER Established location. Equipped. Seller needed more room. Many walk-ins each day. Seller did $900,000 here. FP $125,000.

BALDWIN PARK 80% Hispanic. High identity building. 3-ops. Grosses $250,000. FP $150,000.

BAKERSFIELD Grosses $750,000. Established 50-years. 5-ops. Successor should do $1 Million. FP $500,000.

SMALL TOWN NEAR BAKERSFIELD Practice & RE. Gross $400,000 with full time DDS. Practice & Building $350,000.

ORANGE Female DDS doing $30-to-$40K/mth part-time. Seller will work-back for smooth transfer. FP $295,000.

VICTOR VALLEY High Identity Shopping Center. Grosses $650,000. 8-ops, low overhead. FP $550,000.

REDLANDS Low overhead, 5-ops, digital. Gross $30,000+/mth. FP $350,000.

NEVADA Small resort city near Las Vegas. 5 state-of-art Ops. Grosses $600K 3-days. Will do $600K more with 3 more days. FP $600,000.

DENTURE CENTER 30+ denture patients/day. Grosses $1.3 Million. Patients ask "Will you do Implants?" Answer always "We just do dentures." Specialist will take to $2 Million. FP $1 Million.

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CLASSIFIEDS, CONTINUED FROM 940

the area, and if someone was to market for and focus on more family dental care, he or she could grow this part of the practice easily. A simple 65 percent of collections calculation puts the value of the practice at $580,000. With our overhead being low by industry standards, most more complicated valuations would put the practice valued at closer to $600,000. I would be happy to sell at $560,000. Please direct all inquiries via email to relocatingdentist34@gmail.com.

PRACTICE FOR SALE — Dental practice for sale in Simi Valley. Office is 1,100 sq. ft. with four ops, two equipped. Business has been in existence for 15 years. Fee for service, panorex, digital X-rays, growing community. Please call Bob S. Perkins, DDS, at 818.300.7711 or send email to smilesinmalibu@gmail.com.

MISCELLANEOUS

MS DEGREE IN OROFACIAL PAIN AND ORAL MEDICINE AND MS DEGREE IN GERIATRIC DENTISTRY — The University of Southern California Ostrow School of Dentistry has launched two innovative 37-month hybrid online and face-to-face graduate training programs in orofacial pain and oral medicine and in geriatric dentistry. The programs allow practicing dentists from across the world to gain expertise in treating complex orofacial pain and oral medicine or geriatric patients using an evidence-based medical model. The program is specifically designed for the full-time practicing dentist who wants to develop competency in treating patients with orofacial pain and oral medicine conditions or geriatric patients. For more information, please email us at ofpom@usc.edu or geriden@usc.edu, call 213.821.5831 or visit our websites at ofpom.usc.edu and geriden.usc.edu.

QUESTIONS MOST OFTEN ASKED BY SELLERS:

1. Can I get all cash for the sale of my practice?
2. If I decide to assist the Buyer with financing, how can I be guaranteed payment of the balance of the sales price?
3. Can I sell my practice and continue to work on a part time basis?
4. How can I most successfully transfer my patients to the new dentist?
5. What if I have some reservation about a prospective Buyer of my practice?
6. How can I be certain my Broker will demonstrate absolute discretion in handling the transaction in all aspects, including dealing with personnel and patients?
7. What are the tax and legal ramifications when a dental practice is sold?

QUESTIONS MOST OFTEN ASKED BY BUYERS:

1. Can I afford to buy a dental practice?
2. Can I afford not to buy a dental practice?
3. What are ALL of the benefits of owning a practice?
4. What kinds of assets will help me qualify for financing the purchase of a practice?
5. Is it possible to purchase a practice without a personal cash investment?
6. What kinds of things should a Buyer consider when evaluating a practice?
7. What are the tax consequences for the Buyer when purchasing a practice?

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ADVERTISER INDEX

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In the catalog of aging, that period is called *Geezer Plus*, and I reflect on it with mixed emotions. It was when I thought an old person was anybody 10 years older than I was. It was when I realized I was old enough to know my way around, but had to concede that I wasn't going anywhere. I gave up going to any movie that didn't have a matinee. Forced to choose between two evils, I always took the one that got me home earlier. On the plus side, I am given a discount at IHOP without asking for it. I can go conveniently deaf when I want, a feat that has stood me in good stead through the last two generations' "music."

Geezerhood is what used to be called the *Golden Years*. That term has largely fallen out of favor, particularly with those of us actually enrolled in this period. Ask any Medicare person in a doctor's waiting room how he or she is enjoying the Golden Years — if you want to get a cane whacked across your shins.

It is obviously not Kansas, but I am now blissfully bivouacked in that period that lies beyond *Geezer Plus*; I am a *Super Geezer*, formally called an "Old Timer" or frequently "Deceased." If there is any geriatric nomenclature above that, it falls into the field of paleontology and I don't want to know about it.

Enveloping me now is my 10th decade. It's akin to feeling momentarily safe in the eye of an Oklahoma tornado. My father used to claim 90 was the best of times; you could do or say *anything*. If there is an upside to old age, he asserted, this is it; eccentricity is not only tolerated, it is expected. He did his best to uphold the tradition.

He claimed in a voice that could be heard clearly throughout the retirement home where he lived in his last years, *"Old women are nuttier than old men and there are more of 'em."* He often advised me, *"What will be, will be, even if it never happens."* There are medications for this, but they may involve intensive paperwork and, of course, consequences, side effects and collateral wackiness.

So, that's definitely my plan. I'm going for crotchety curmudgeon, maybe throw in a little weird — I can do that. But first, I've got to solve the problem of older men's pants. Something happens to most men sometime between *Geezer Plus* and *Super Geezer*. It's a guy thing and I'm tired of my wife pointing this phenomenon out to me on a daily basis as if it were my fault.

What happens is, one night, or maybe over a single weekend, a man's belly expands like he was nearing the end of his third trimester. At the same time, his rear end diminishes in the same proportion. Cruelly referred to as a "beer belly" and a "cracker bottom," even though the victim may never have consumed either commodity in his lifetime, this anatomical metamorphosis results in a major trouser problem.

He buys a pair of pants that seem to fit reasonably well in the little fitting room with the flimsy curtain that never quite covers the door opening. He adjusts them to what he thinks is his waist, trying to recall from memory just where that is. The definitive landmarks appear to have vanished. The cuffs break nicely over his shoes so he's out of the cubicle before some other guy parts the curtain to reveal him in his underwear.

Like water seeking its highest level, pants on a geezer seek their lowest within 15 minutes of donning them. That is, the belt drops down under the belly. It has no choice. It's a size 36 trying to cope with a size 44 abdomen. Viewed in profile, the belt has assumed a 45 degree angle to the floor, the pant legs are now four inches too long, the crotch is just above his knees and there is enough room in the seat to accommodate a couple of watermelons.

This is the *Geezer Look* and pants manufacturers seem at a loss to address the problem. In warmer climes, we geezers have sought to resolve at least part of the error by wearing shorts. Because this frequently reveals knees that blouse, it has brought us up against comedic tradition that requires us to wear black socks and dress shoes. And a hat. Geezers are great for hats — baseball caps if worn backward are usually a reliable clue of early onset dementia — fedoras, Panamas, Greek fisherman caps — it doesn't matter, as long as it is inappropriate for the occasion.

It is this mean-spirited media portrayal, when coupled with that of the lady geezer stereotype featuring the all-purpose muumuu that looks as if it came with a center pole and stakes as matching accessories that tarnishes the luster of the Golden Years.

So what can I tell my son? He doesn't get all misty-eyed when he hears *Sunrise, Sunset* from *Fiddler on the Roof*. Barbra Streisand doesn't appeal to him with *The Way We Were*. Even Doris Day fails to get through with *Sentimental Journey*. Perhaps when his descendants begin to outnumber his friends like mine do, he will understand that axiom of Geezerhood: "It's not how old you are, but how you are old." He may even figure out what to do about the belt. ■■■■

We're Taking Your Requests

If you have a favorite Dr. Bob column you want to see again, send an email to Publications Specialist Andrea LaMattina at andrea.lamattina@cda.org. We will oblige by reprinting those requested favorites interspersed with any new Dr. Bob submissions.

CDA JOURNAL, VOL 41, Nº12

Geezer

Like water seeking its highest level, pants on a geezer seek their lowest within 15 minutes of donning them.

Robert E. Horseman, DDS

ILLUSTRATION BY VAL B. MINA

Growing old has one advantage: You'll never have to do it over again — Methuselah

It's good to reach a hale and hearty old age except for seeing your children become depressingly middle aged. That's where I am now. My son has officially entered Geezerhood, a harsher, but more descriptive word than senior. There's a pink area appearing on his scalp at the crown just as mine did and my father's before me. As a rite of passage, it falls disappointingly short of a first kiss or being granted the keys to the car for the first time.

I asked him, "How does it feel to be in your 60s?" He replied, "How does it feel to have a 60-year-old child?" We fell silent, each of us thinking regretfully of all the sins we hadn't committed. Too late, we decided.

Consequences — a cruel fact that we seldom considered when we were young enough to not worry about such realities. Oh, temptation is probably still there, lurking in the background, but we decline, because consequences disguised as intelligence hopefully protects us from pain and incarceration, the sequelae of native male stupidity.

In my 60s, if anyone called me a sexagenarian, it sounded like flattery.

CONTINUES ON 945

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