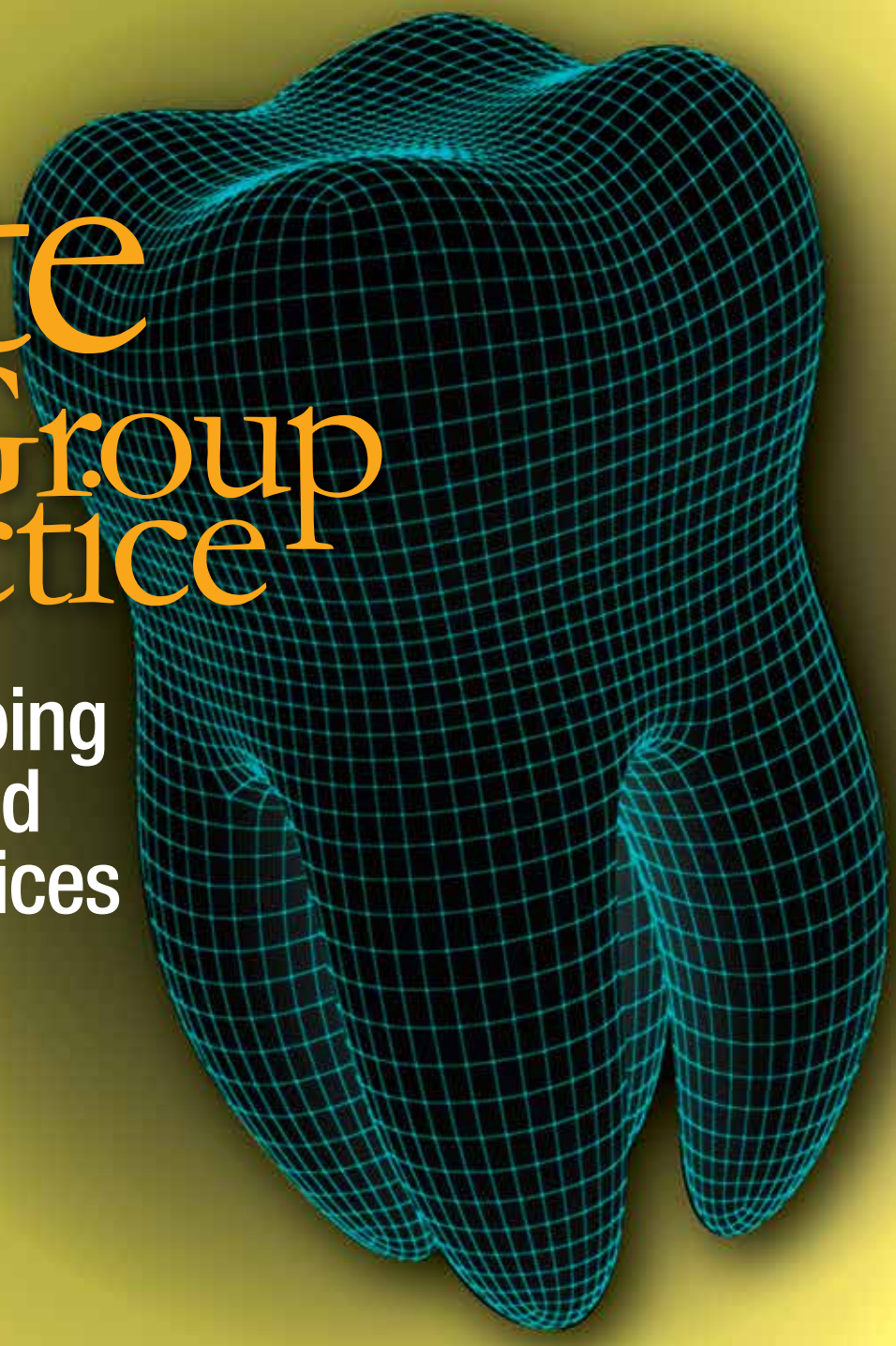
EFFICIENCY
IN GROUP PRACTICE
VOLUME 1 . ISSUE 5 . 2013

State of the Group Practice

Trends shaping dentistry and group practices



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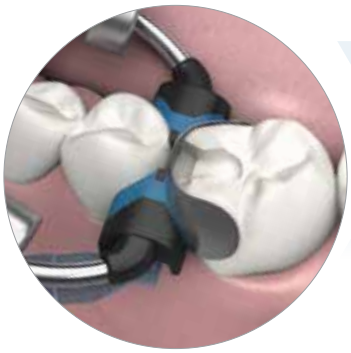

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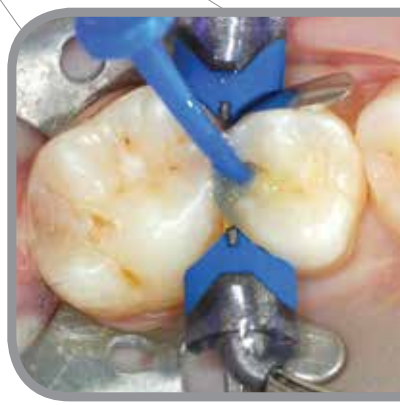

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Taking Stock

Holiday season is here.

This is always a busy time of the year. Thoughts of vacation and holiday cheer sometimes overtake dental business priorities. That's not a bad thing. This is also a time to review the current fiscal year and what has been happening in your practice(s). What has worked and what still needs some fine tuning. Equally important is to look forward toward next year and plan wisely.

With recent trips to the ADA in New Orleans and the Greater New York meeting, there's one thing that seems to stand out: the DSO/GPO market is continuing to grow in a flat dental economy. Whether it's private equity money or dental entrepreneurs in growth mode, "groups" continue to be the fastest growing business model in all of dentistry. Of course, within groups, that business model varies widely. All the evidence points to the group model gaining more and more dominance in a world once dominated by sole practitioners. Whether you're a clinician, or you are on the business side of a DSO/GPO, you can take pride in the fact that you're a pioneer carrying the dental industry into its next phase. I truly believe, and I am not the first to point this out, that the dental industry will not look anything like it does now in 10 years time. What will it look like? There are some valid hypotheses which will be explored in this issue of the magazine, as well as upcoming issues.

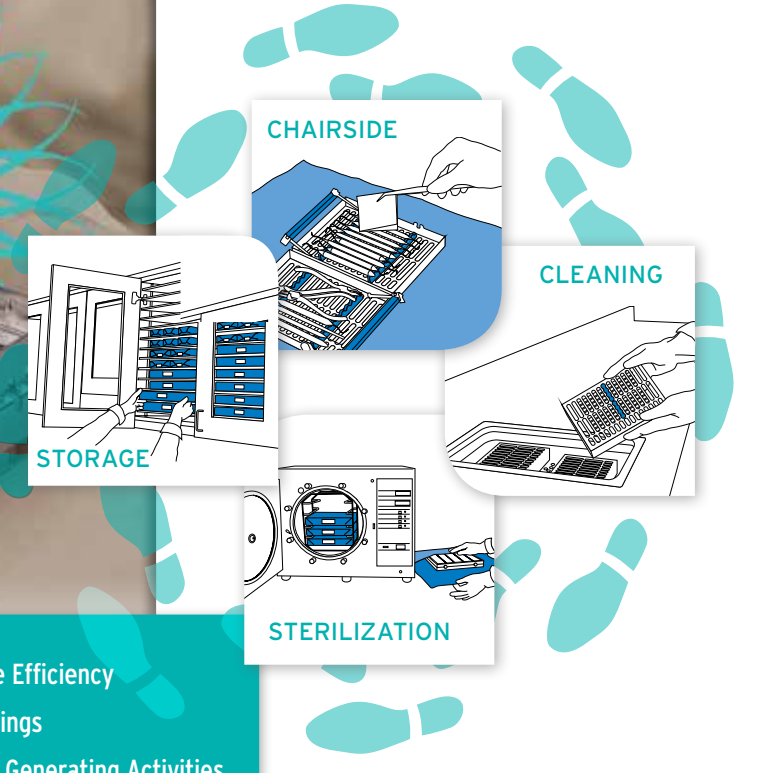
Please take some of this season's downtime to read many of the key forward-thinking stories in this issue of *Efficiency in Group Practice*:

- The Q&A with Dr. Edward Meckler, founder of Dental One Partners and founding member of the DGPA, gives real insight into the future of the DSO model.
- HIV, heart disease, Hep. C testing in the dental office? Dr. Barbara Greenberg makes a case for this in the chairside screening article.
- Dr. Charles Blair talks about the rise and challenge of PPOs.
- Lastly, we have yet another thought provoking and interesting Q&A. This time it's with Dr. Albert Guay, Chief Policy Advisor for the American Dental Association.

So as we ring in the New Year, know that *YOU*, our valued reader, are the future of the dental industry,

Bill Neumann
Publisher
EGP
wneumann@mdsi.org

PRACTICE MORE



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Hygiene Infrastructure

Creating a structure for success for your hygiene team

There are a number of factors that differentiate a successful hygiene team from another. One of the main differentiating factors in the dental group setting is the infrastructure they create to support their hygiene team.

By Heidi Arndt

Heidi Arndt, RDH, BSDH has worked in the dental field for 18+ years. Her experience ranges from working as a treatment coordinator, dental assistant, and practice manager before graduating from the University of Minnesota with a bachelor's degree in Dental Hygiene. In 2011, Heidi founded Enhanced Hygiene. She is dedicated to helping dental practices realize their total hygiene profit potential through the development of their hygiene team, quality patient care, patient-centric service and by empowering the entire team.

Infrastructure development and the use of organizational resources to improve efficiency and expand productivity is key to growth and ongoing success. This structure can be used to solve problems within the organization or as a way to analyze a process and find a more efficient way of doing it. Implementing a strong structure requires an investment of time and money. But when you understand its importance, you can justify the costs.

Hygiene brings 30 percent of your total group revenue, and will require a strong structure to operate successfully year after year. Whether you have two locations or over 10 locations, you must have these core components to your hygiene infrastructure.

Statistical dashboard

In order to understand your hygiene business you will need to create a series of reports and a dashboard. Your dashboard will provide you a look at the following key hygiene and key success indicators necessary to develop and growth a profitable hygiene department. Your dashboard should track items like:

- Total revenue
- Production per hour, or production per patient
- Periodontal %,
- Hygiene profit margin
- Additional clinical key success indicators you choose.

Having quality reports will help you plan, manage and coach your hygiene team. These reports will also help you identify potential issues or opportunities, well before you may feel the obvious impact in the practice itself.

Objectives and goals

Once you have the dashboard to guide the execution of your hygiene team, you can identify and set strong performance objectives and goals for your hygiene team. These objectives and goals will guide your hygiene

team, and clearly align them with where the business should go. Your dashboard will give you tangible information to hold your team accountable to these goals and objectives.

Clear protocols and systems

In order for your hygiene team to create consistency in patient care and performance, clear patient care protocols and patient care systems must be in place. These protocols will ensure patients are receiving a high level of clinical care. Again, your dashboard should include information that will help you track how well the hygiene team is following and adhering to the protocols and systems you have implemented. For example, based on a recent report from the CDC and the Academy of Periodontology, periodontal disease affects 1 in 2 American adults. With this information, you can expect to see 50 percent of your adult hygiene patients being treated for periodontal disease.

Social operating system

Frequent and regular communication with your team regarding their performance, goals and organizational updates is important to keeping your team motivated and happy. Creating a meeting and communication structure will help your team stay "in the know" and feel informed, engaged and accountable.

Orientation program

Whether you're growing by acquisition or growing your existing practices, you need to have an orientation program for the entire team, and one specifically for your hygiene team. This orientation should include ensuring all new team members are up to date with items related to Infection control (OSHA, etc.). You'll also want to ensure they are educated and well versed on the protocols, systems, objectives and goals of the group. Every team member should be fully introduced and educated before they see the first patient under their new role in your group.

Mentoring program

Mentoring and coaching programs have been used in dental groups for the past 10 years. American Dental Partners successfully uses a dental hygiene and doctor-mentoring program within their affiliated dental groups. These mentoring programs provide side-by-side support and training to the clinician, and the outcome from this program has been phenomenal. The dental hygienists and doctors enjoy the relationship they develop with their mentors. They feel connected, heard and supported in the dental group structure. As a result, these team members are committed to the dental group and become long-term, high-performing clinicians.

Mentoring and coaching programs will set you apart from many dental groups and practices in the marketplace; and will propel your dental hygiene team to be strong and committed partners in your practice.

Professional development

How will you continue to educate and expand the knowledge and skills of your dental hygiene team? With a quality professional development program. This program will be your continuing educational commitment for your team. Ideally, your group would create their own continuing education curriculum for your team. This can be done by first getting the AGD or CERP certification for providing continuing education for your team. Or, you can rely on external educators, speakers and product companies to help you create this type of support. With a quality professional development program for your clinical team, you can fuel your recruitment power in the community as well.

Peer review

Ensuring quality patient care is our most important task, but how can you truly ensure your team is providing the best care possible?

Implementing a strong peer review process is key. Your peer review process will include record audits to ensure proper care and adherence to protocol; and it will also be used to identify and help the provider that is providing sub-par care. Record audits should be completed on a monthly or quarterly basis, but could be sparked more frequently by a patient complaint, concerns from another provider, or outliers on the dashboard you create. Again, having a quality peer review process will set you apart from the crowd and provide you, your providers and your patients confidence in your quality standards.

A successful and profitable hygiene team does not happen by accident. The constant training and support they receive is the key to their success. Creating a structure to support your hygiene team is crucial to the success of your entire group. ■

Case Acceptance

Vital steps to successfully improve case acceptance in group practices

By Rhonda Mullins

Rhonda Mullins is a dental practice development strategist who combines business savvy, clinical aptitude, and transitional analysis to inspire successful changes for her clients. An L.D. Pankey Institute and Dawson Academy trained dental laboratory owner/technician, Ms. Mullins launched her consulting company in 1993 and today is an accomplished lecturer, educator, and consultant and has authored numerous articles in dental publications about achieving optimum results through practice transformations and incorporating Care-Driven® dentistry. For more information Ms. Mullins can be reached at: Rhonda@rhondamullins.com or rhomullins@gmail.com

Today's dental patients are more knowledgeable about the availability and importance of oral health care and those who provide it. It is therefore vital that patients emotionally desire to engage and remain with your practice, but developing that type of relationship involves conveying to patients information that demonstrates the added value and significance that you and your team provide. Case acceptance is impacted greatly by the level of trust, sincerity, expertise and patient care delivery you are perceived to provide, so it is important that it be experienced exceptionally.

Other factors influencing case acceptance are emotional and/or financial uncertainty from the patient or verbal/non-verbal cues from the provider delivering the treatment plan. Your team members may be excellent clinicians but poor communicators. If there is an inability on your team's part to communicate the necessity of the treatments they are able to provide, it is unlikely they will be given the opportunity to provide them. Additionally, if your team is not able to instill a feeling of trust as the brand insistence for the practice, your patients will be less receptive to being educated throughout the emotional vulnerability or financial uncertainties and fears they are experiencing. Fear is always the backseat driver to perfectionism in achieving optimum outcomes for the patient.

There are ways to ensure your practice is successful at gaining a greater edge in the trust arena with each patient and increased case acceptance. This article outlines vital steps toward obtaining a "yes" from your patients.

Case acceptance begins with a strong internal team

There are three basic types of leadership: laissez-fair; autocratic; and Design Office Collaborator. Laissez-fair is a French term that essentially means "hands-off" in terms of management styles. It implies that the leader – in this case, the practice owner/manager – feels their team is capable of completing all duties with minimal or no direction.[1] Autonomy is good, but too much can cause a lack of procedural protocol, which leads to an inefficient practice.[1]

Autocratic leadership is basically the opposite. The leader assumes their team is incapable of completing their duties without detailed instructions, and the leader's way is the only right way of doing things.[1] This causes team members to feel devalued, which decreases morale and, as a result, cooperation and commitment to the practice. The inefficiencies of this leadership style are caused by denying the viability of other's opinions or ideas, which may halt progress or even keep the practice from adopting innovations that could help them increase profits and provide higher-level care.

Design Office Collaborator (DOC) leadership is the style best suited to Care Driven® group practices. Leaders who understand this transformative role of design thinking and collaboration in the culture of their office embrace its traits and tenets. They can command in times of change. We call these leaders DOCs, and they are our new heroes.

When we think about design, our first association is change: change that responds to need embodies desire, pursues a stated direction, and reflects a shared vision. Those who are designers – either through training or by nature – actively engage and support congruency in collaborative change. Historically, design changed "things." More recently, it's changed services and interactions. Looking ahead, it will change the dental industry. The strength of a practice led by a design office collaborator leader is dependent upon the creative ideas, innovative thinkers, skills, and goals of all team members and doctors being shared and considered on a platform of equals. When a team member knows their opinions and thoughts are truly being heard, and that their talent and skills are being utilized and optimized, it boosts confidence, performance, and a renewed sense of passion for enhancing the changes of the practice.[2]

You can use your status as a leader to create a positive atmosphere for your team members. According to job satisfaction surveys, workers leave employers, not the place that employs them.[3] Human psychology dictates that emotions or moods are proximal, and that we unintentionally affect those around us. Due to the fact that most waking hours are spent at the workplace, team members will be the most notably affected by the mood of their boss. Be aware of your attitudes and actions and consider the effect they will have on the rest of the team.[4] Build a strong relationship with your team based on trust and credibility,[5] and demonstrate integrity in all situations in your practice: morally; ethically; and honestly.[6] Once your leadership and team have coalesced, you are ready to implement the Care Driven® approach in your practice.

Concierge Extraordinaire Responsibilities

- Set the tone for expectations of care and exceeding those expectations.
- Tell the patient who will greet them and what they will experience at their first reserved appointment.
- Listen carefully and document all of the patient's previous experiences, expectations, fears, etc. and extract the specific information that will allow the entire team to over-anticipate patient needs.
- Walk the patient through completion of all paperwork and why it is needed.
- Offer website for directions and confirm date and time of the next appointment.
- Share the doctor's standards, education, qualifications, training, and passions to instill confidence that the right choice in practices has been made by the patient.

Your patient's decision about whether or not to proceed with treatment will ultimately rest in the hands of their emotions, not their finances.

Contact

Step one is making meaningful contact and beginning to establishing a relationship with the patient. Multidisciplinary practices accomplish this through a Concierge Extraordinaire. Hire or appoint one or two top-line team members to handle these responsibilities (see Concierge Extraordinaire Responsibilities). Your Concierge must also be certain that patients know what to expect, or how to prepare for, an extraordinary experience with a comfortable, open atmosphere during future appointments. The Concierge's thorough Pre-appointment Discovery meeting with the patient provides useful information for the team, but also builds relationship equity with the practice from the very beginning.

Clarity

Step two is creating a value proposition opportunity to learn more about any patient and where they are in terms of medical, emotional, clinical and financial status. Using supporting technology that the patient experiences with the Concierge as a guide, conduct an inner-view verses an interview in which you engage in open-ended questions. These should invite patients to talk about their needs, wants, and life circumstances and what led them to desire your expertise and care. This will ensure that the answer you receive in the end is a "yes" to your case synopsis treatment recommendations for their desired outcome.

This is also the time to tailor your strategy for interacting with patients based on whether they are new to the practice, an emergency patient, or an existing patient. The new patient approach is discovery-driven. For this type of patient, you and your team are gathering information about their overall and oral health, as well as their esthetic goals. Do they desire to re-create a smile they had or design a new smile? Listen intently to their words, and watch their face and body language for reactions. The more the patient says and you hear, and the more the patient does that you observe and record, the more thorough your data collection will be. Accurate and complete notes will provide a better basis for the multi-disciplinary doctors and team members' clarity about the patient and their needs.

The emergency patient approach is need-driven. These patients have an immediate treatment that must occur, after which the new patient approach can be implemented. The existing patient approach is maintenance-based. This type of patient will have a comprehensive treatment plan in place, but in the event a trauma or other changes occur, they may need sequencing modifications or updated treatment recommendations. If this occurs, take them through the new patient approach and anticipate optimum results based on their continued care behavior and updated treatment plan.

All three types require a baseline record and risk-assessment performed that include medical and dental history forms, a question and answer session, X-rays, camera/digital/CEREC images, intraoral/extraoral imaging, oral cancer screening, models (face-bow, etc.,) and risk

Risk Assessment: Checkpoints and Documentation

1. Periodontal Assessment
2. Gingival
3. Attachment Loss
4. Restoration Enhancement

Biochemical Assessment

1. Determine Restoration Design

Functional Assessment

(involves teeth, joints, and musculature)
1. Control
2. Comfort
3. Stabilization

Dentofacial Assessment

1. Tooth Display
2. Tooth Position
3. Gingival Architecture

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assessment checkpoints and documentation (see Risk Assessment: Checkpoints and Documentation).

Create risk assessment, care plan, and present

Step three is presentation of your Multi-Disciplinary Team Approach and detailed treatment recommendations to the patient. It is important that top-line internal team members engage at the touch-point moment (especially the financial facilitator) at the diagnosis's. You will need to outline the specific direction and process necessary to deliver the best results possible. If you consistently under-promise and over-perform, then the patient's transformation will appear much more measurable to them, since you will have delivered a higher level of care than expected. You can deliver optimum results to your patients in the four areas of oral health that you and your team assessed for risk: periodontal; biochemical; functional; and dentofacial (see Optimum Outcome Treatment Options). By clearly explaining the available treatment options and their benefits, realistic expectations can be established for a well-delivered Care Driven® plan.

Commit

During step four, present your Care Driven® plans (one or two), including financial investment. A Care Driven® plan not only increases your patient's understanding of what is involved in their transformation, but also enhances their understanding of how this transformation is an investment in their present and future health.

This is the integral conversion moment and value proposition. Your patient's decision about whether or not to proceed with treatment will ultimately rest in the hands of their emotions, not their finances. That is why it is paramount at this stage to promote the value-added benefits of your brand, reputation, and expertise that this transformation will provide, such as greater self-worth, confidence, and whole-heartedness. This will lead them to greater achievement and success. Patients will find money for treatments they want, but may find excuses to delay treatments they need. After hearing and processing all the information you and your team have presented, your financial facilitator and concierge will be able to walk the patient through the rest of the process (see Financial Facilitator/Concierge Role in Patient Commitment).

Optimum Outcome Treatment Options

Periodontal
1. Maintenance Interval
2. Extraction
3. Surgical Correction
4. Orthodontic Correction
5. Other
6. Multi-Disciplinary Specialist Referral

Biochemical
1. Alloys
2. Composites
3. Root Canal Therapy
4. Foundation Requirements
5. Other
6. Multi-Disciplinary Specialist Referral

Functional
1. Occlusal Adjustment/Contour/Alteration/ Appliance Therapy
2. Extraction
3. TMJ Stabilization
4. Surgical
5. Orthodontic
6. Periodontal

Dentofacial
1. Color of Smile
2. Facially-related Tooth Position
3. Intra-arch Tooth Position
4. Gingival Tissue Assessment Results

Care Driven® Appointment Sequencing

Step five involves scheduling each patient's appointments in a prescribed manner according to:

1. Concierge Extraordinaire Touch Plan (Introduction and Interview)
2. Care Driven® Risk Assessment and Care Driven® Plan
3. Multi-Disciplinary Team / Specialists
4. Re-appointments
5. Active Care Completion
6. Post-activity Re-assessment (Metrics)
7. Case Completion
8. Maintenance and Preventative Care

The Care Driven® approach is superior to other practice models because the patient feels seen and heard, efficiently cared for, and valued, which positively affects the practice. There is an increased attendance to follow-up, hygiene, and maintenance appointments. More patients refer their friends and family because they feel it is a creative culture for care. Treatment acceptance increases because patients trust and value in a greater capacity what the practice is providing and do not feel as though they are being pressured through proceedings. Additionally, unlike the way some practices undertake the maintenance care of completed cases using a "clean and screen" method, Care Driven® practices see this as yet another opportunity to provide above-and-beyond total care to the patient, ensuring they feel satisfied with their transformation both emotionally and physically.

A better patient experience

Patients demand the best available treatments and want to feel truly cared for in their chosen dental practice. When patients choose a Care Driven® multidisciplinary practice, they should know from the first phone call or meeting with the Concierge Extraordinaire that they can expect a better experience throughout their treatments and maintenance care.

The core of attaining increased case acceptance is presenting like a professional. This is accomplished through Design Office Collaborators (DOC) best suited to a Care Driven® group practice. Remember, these leaders understand this transformative role throughout these 5 steps of engagement because of design thinking and collaboration with each patient's individual needs. They are tomorrow's new heroes in group practices.

You and your Multi-Disciplinary Specialist Team must demonstrate exemplary clinical aptitude and relationship investment in your patient's well being. This is especially important because patients base decisions more on emotion and desire than on how effectively information has been conveyed to them. This Care Driven® Plan strategy is most effectively implemented after completion of the Kois Center Treatment Planning Course I.[7] ■

Financial Facilitator/Concierge Role in Patient Commitment

- Be the bridge of communication working with the patient for and among all doctors and team members.
- Know how to ask for feedback from patients about their Care Driven® plans to enhance their optimum results.
- Recognize and offer workable solutions to patient barriers (financial, emotional, etc.).
- Assist the patient through the full process of obtaining third-party financing or understanding and fully utilizing their insurance benefits.

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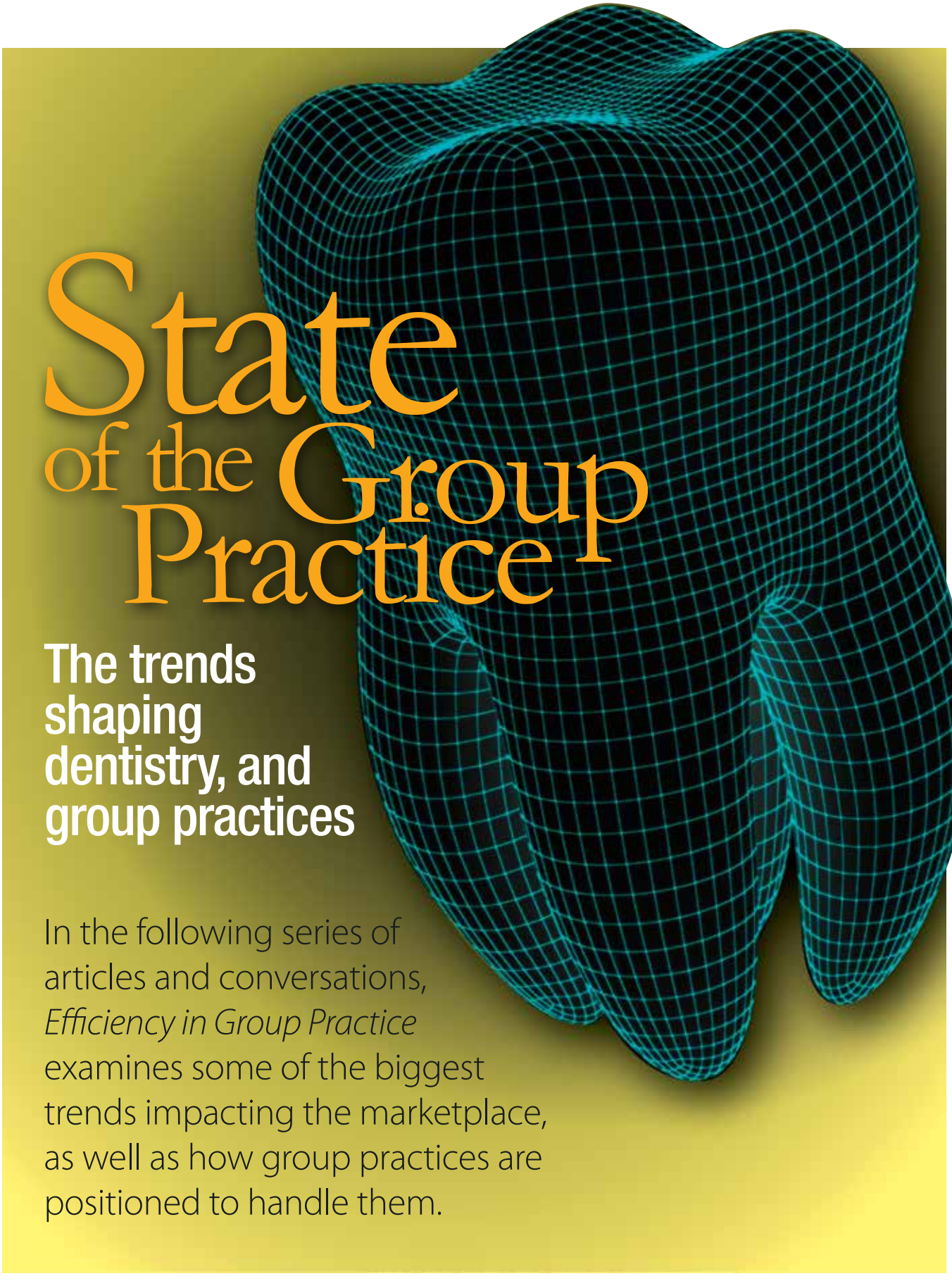

State of the Group Practice

The trends shaping dentistry, and group practices

In the following series of articles and conversations, *Efficiency in Group Practice* examines some of the biggest trends impacting the marketplace, as well as how group practices are positioned to handle them.

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Marketwatch

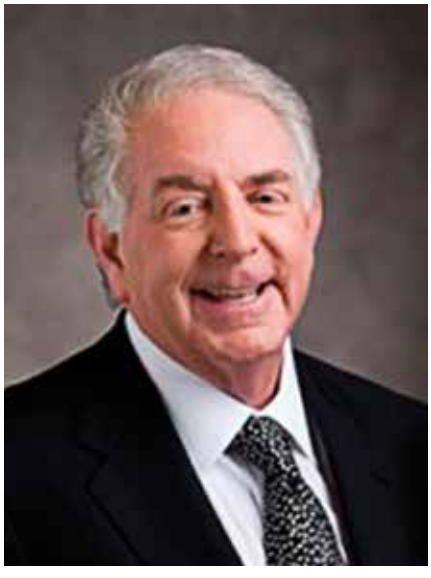
A conversation on trends, and the future of dentistry, with industry thought leader Dr. Edward Meckler

Editor's Note: Dr. Edward Meckler is the Founder and Chairman of Dental One partners, one of the founding member organizations of Dental Group Practice Association. Most recently, Dr. Meckler played a key role in forming a dentist-led group called Dentists for Oral Health Innovation.

Efficiency in Group Practice: **How have you seen the marketplace for dental practices and groups change in the last 5-10 years?**

Dr. Edward Meckler: The marketplace for dental group practices or Dental Support Organizations (DSOs) has grown significantly over the past 5-10 years and we anticipate that it will continue to evolve as a valued option for future practitioners. The American Dental Association (ADA) recently released a report on the changing dental landscape that found dentists who had completed their dental education within the past ten years were three times more likely to be part of a larger dental practice than those who completed their education more than ten years ago.[1] Additionally, the ADA's Health Policy Resources Center found that large dental practices have increased by 25 percent in just two years.[2]

It is imperative to also look at the larger state of dental care in the United States. Lack of access to dental care has become an epidemic. It's estimated that 47 million Americans have little or no access to affordable dental services, and many, regardless of whether or not they have dental insurance, live in areas of the country with few (if any) dentists. Most states



have just 65 dentists per 100,000 people, fewer than the number of physicians for that same number of people.[3]

As the nation continues to address the complicated issues of health care, DSOs offer important, sustainable solutions that significantly benefit dentists and, more importantly, their patients. DSOs enable dentists to devote more time to treating patients who need care and less time to paperwork and other aspects of running a business. This model also allows dentists to refine their skills as clinicians and maximize their professional potential. Overall, it has become a very attractive option in recent years.

Efficiency: **How are group practices positioned in the current marketplace? How does this compare to the individual dental office?**

Meckler: DSOs are very well positioned in the current marketplace. The DSO model provides its affiliated dentists with non-clinical administrative support services, enabling dentists to spend more time on patient care, not paperwork. There is value in the support DSOs provide affiliated practitioners, and as I noted prior, dentists are attracted to the business model, from seasoned professionals interested in an alternative model that affords them a better quality of life to younger dentists dealing with the financial hurdles of dental school debt.

The private practice model, of course, continues to be a viable option for new dentists. According to the ADA, 92 percent of the 190,000 practicing dentist across the U.S. are in private practice, with more than 80 percent being practice owners.[1] Dentists enjoy the independence of owning and managing a business. Despite its commonality, there are major challenges for the private practitioner, from financial hurdles to juggling the backend tasks of owning a company. It's estimated that dentists invest

up to 30 hours per week to manage business details, taking away valuable chair-side time with patients. Additionally, starting a private practice can be cost-prohibitive, particularly for those faced with significant amounts of school debt. The average dentist leaves school with debt ranging from $150,000 to $300,000, and technologies such as digital radiography can cost a practice $52,000 per year to remain competitive.

Efficiency: **What are some of the best practices you've seen from leading DSOs?**

Meckler: The best practices I have seen, and continue to see, is the ongoing dedication from DSO affiliated dentists serving communities where residents often lack access to convenient, affordable quality dental care. DSO affiliated dentists often partner on initiatives that support communities at home, across the United States, and around the world.

It's estimated that DGPA member organization affiliated dentists, from DSOs such as Heartland Dental, Pacific Dental, Smile Brands, Aspen Dental and Great Expressions, have provided millions of dollars in free care annually to patients nationwide and abroad, through activities ranging from mobile dental clinics to free in-office weekend visits.

Strengths of the DSO

More time chair-side.
DSOs' efficient administrative practices enable dentists to accept a greater number of insurance plans and enable them to spend as much time as possible chair-side with their patients.

More time for charity.
Many DGPA member companies have a strong commitment to philanthropy, and encourage their dentists to identify underserved populations within their communities and to offer free dentistry.

DSOs enable dentists to provide services in communities that need it through the support services they offer. Dentists benefit from using the administrative support services of DSOs for tasks including facility maintenance, supply procurement, and scheduling support. By contracting with DSOs for non-clinical administrative services, these dentists expand access to dental care by devoting more of their time to the delivery of high-quality, cost-effective care to patients and less time to administrative duties.

DSO affiliated dentists are also given buying power to obtain the newest in dental equipment, helping them stay ahead of the curve with the ongoing changes taking place in dentistry. This is important not only for the dentist, but the patients they serve as well.

Efficiency: What are the biggest challenges facing group practices today?

Meckler: The United States is facing a serious dental divide, with an estimated 47 million Americans having little or no access to affordable dental services. Many patients face a number of barriers to oral health access, whether geographical, financial, or educational. The Department of Health Resources and Services Administration found that some states have just 65 dentists per 100,000 people – fewer than the number of physicians for that same population.[4] Additionally, as many as 130 million Americans live without dental insurance coverage, with many Americans not understanding the integral role oral health plays in general health.[4] This is a major challenge we are facing now and DSO affiliated dentists are dedicated to bridging the dental divide and improving patient access to quality care.

47 million

The number of Americans who have little or no access to affordable dental services

Edward H. Meckler, DMD

Executive Director, Dentists for Oral Health Innovation
Chairman and Founder, DentalOne Partners
Associate Professor, Case Western Reserve University School of Dentistry

Dr. Ed Meckler serves as executive director of DOHI. He is also the chairman of the board for DentalOne Partners Inc., a position he has held since 1981.

Dr. Meckler holds a number of positions in organized dentistry. Notably, he previously served as the executive director of the Dental Group Practice Association. He is also a member of the American Dental Association Business Enterprises, Inc. Board, a past delegate and a current alternative delegate to the Ohio Dental Association and a past alternate delegate to the American Dental Association. He is a member of the Advisory Board to Case Western Reserve School of Dental Medicine and is a Fellow in the International College of Dentists. He is also a member of the Dental Honor Society of the Pierre Fauchard Academy.

Dr. Meckler is a strong advocate for improving education in dentistry and serves as an associate clinical professor at Case Western Reserve School of Dental Medicine. He received his DMD from Case Western Reserve University School of Dental Medicine and his BS from Ohio State University.

***Efficiency:* Has there been any impact in regards to health reform?**

Meckler: While the ACA does expand access for dental services under Medicaid, for children and some adults, it is universally regarded as falling short in trying to meet our country's oral health care needs both through funding and policy changes. The ADA Health Policy Resources Center issued a policy brief stating that the quality of dental benefits and access to dental care that adults will receive as a result of ACA will not be sufficient to promote good oral health.

The DSO model is critical to helping address these issues in dentistry and help meet those challenges. DSOs allow new dentists to enter the marketplace and set up practices in regions where it may otherwise be difficult for a solo practitioner. DSOs' efficient administrative practices enable dentists to accept a greater number of insurance plans and enable them to spend as much time as possible chair-side with their patients. And many DGPA member companies have a strong commitment to philanthropy, and encourage their dentists to identify underserved populations within their communities and to offer free dentistry.

***Efficiency:* What about customer expectations, have they changed?**

Meckler: No. Patients always want quality dental care. That expectation has never changed. The DSO model has been designed to enable dentists to refine their skills as clinicians and maximize their professional potential, resulting in quality patient care.

***Efficiency:* What will be some of the leading themes, and challenges, in the next 5-10 years?**

Meckler: As noted earlier, the ADA's Health Policy Resources Center found that large dental practices have increased by 25 percent in just two years.[2] So as we look at the next 5-10 years in dentistry, this rapid growth indicates that DSOs – while not the only practice model – will continue to represent a significant sector of dentists. ■

Sources:

1. http://www.ada.org/sections/professionalResources/pdfs/Escan2013_Diringer_Full.pdf
2. http://www.ada.org/news/6947.aspx
3. Henry J. Kaiser Family Foundation – Oral Health in the US: Key Facts – June 2012
4. http://www.hrsa.gov/shortage/

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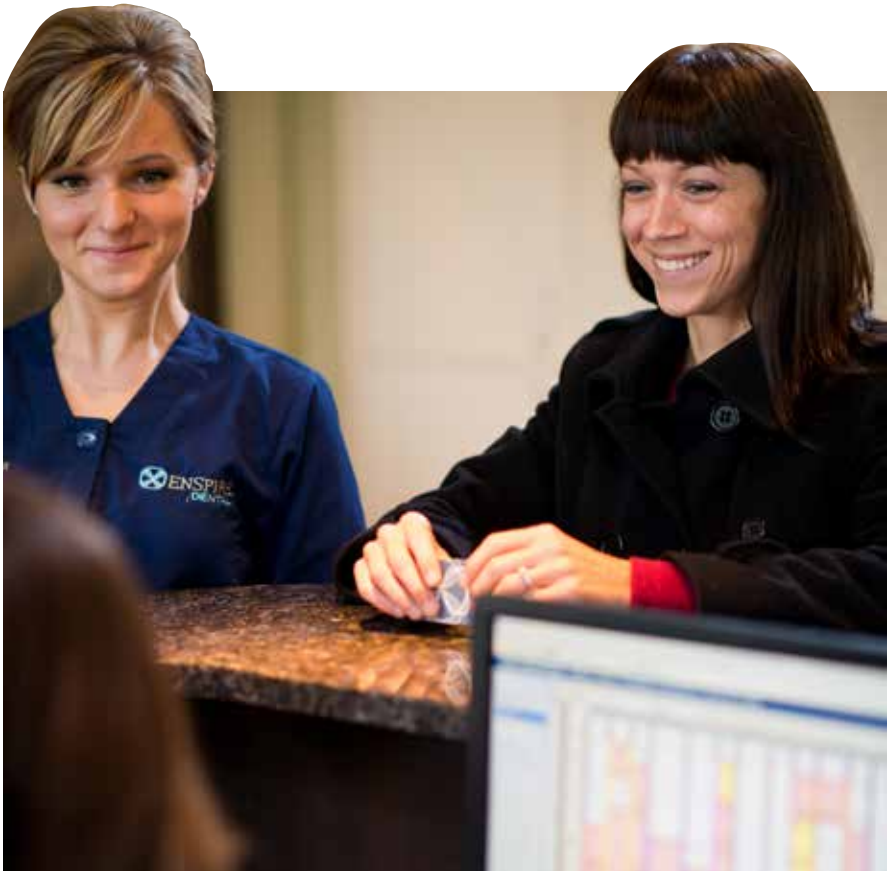
A New and Evolving Dental Marketplace

A conversation on trends, and the future of dentistry, with the ADA

Editor's Note: The following is a conversation with Albert H. Guay, DMD, Chief Policy Advisor, Office of the Executive Director, American Dental Association



Efficiency in Group Practice: **How have you seen the marketplace for dental practices and groups change in the last 5-10 years?**

Albert H. Guay, DMD: Groups in all fields of healthcare have been traditionally organized for a number of reasons, primarily to integrate care, to be a part of larger organizations (mainly hospitals), and to accommodate the need of 24-hour, seven-days-a-week availability. Now, a major factor in dentistry at least, is the need for greater business efficiency as a way to control healthcare costs. New groups are forming and existing groups are expanding to respond to the consolidations that have occurred in the payer community. For various reasons, group practices have found a pool of new dentists and pre-retirement dentists available as associates in their practices.

Efficiency: **How are group practices positioned in the current marketplace?**

Guay: The majority of Americans are well served by the current structure of our dental care system. The segment of our population that is ripe for expansion is the lower socio-economic stratum. The numbers are large and access to dental care for that group is an issue. Group practices that are efficiently managed may be able to economically accommodate the underserved. The number of dentists available for employment by large group practices will likely increase or remain stable in the near future.

Efficiency: **What are the biggest challenges facing group practices today?**

Guay: Some of the challenges facing group practices, especially large group practices, are: the tradition of dental offices being located "where the patients are;" centralization of treatment facilities may be resisted since the opportunity or acquisition costs to patients may be unacceptable

to some; the personal relationship between dentist and patient, which is a strength of individual practices, may be reduced if patients see different dentists in a practice. Group practices will most likely be subjected to increased scrutiny, especially from government assistance programs, due to negative news stories about their medical services.

Efficiency: **What are some of the best practices you've seen of group practices who are having success?**

Guay: Success has been related to economies of scale in purchases, etc. (but not to the degree that one would assume without actually examining the numbers) as well as efficient centralized management such as increased marketing, more effective use of facilities and on-going collection and analysis of meaningful practice data.

Efficiency: **Has there been any impact in regards to health reform?**

Guay: The most significant impact of health care reform is the mandated increase in the number of children who will qualify to receive dental benefits. Many of those children could become patients of dentists working in group practices.

Efficiency: **What about customer expectations, have they changed?**

Guay: It's hard to detect any changes in patient expectations, since this is a new and evolving dental marketplace. We know that the public expects that good dental care be available to all children. We'll have to wait and see what happens. ■

ADA: Be Proactive

Dental group practices, and the dental industry in general, need to have a "proactive" strategy in order to successfully navigate the current and future trends in the marketplace. This is according to a comprehensive analysis the American Dental Association conducted in a report titled, "A Profession in Transition: Key Forces Reshaping the Dental Landscape." The report summarizes important findings of an environmental scan carried out by the ADA as part of the ADA's 2015-20 Strategic Plan development process.

"Given the significant environmental changes on the horizon, including expected changes in the dental care delivery system, this analysis shows that the dental profession must prepare by shaping a proactive strategy to navigate the challenges and opportunities ahead," said Dr. Robert A. Faiella, ADA president.

Key findings

According to the ADA, some of the key findings include:

- While more children have been visiting the dentist, primarily due to the expansion of public insurance programs, dental care use has declined among working age adults, particularly the young and poor, a trend that emerged prior to the recent economic downturn. Dental benefits coverage for adults has steadily eroded in the past decade.
- Total dental spending in the United States slowed considerably in the early 2000s and has been flat since 2008. This trend is expected to continue, resulting in dentists looking for more efficient ways to serve their patients, as well as a likely increase in consolidating dental practices.
- The Affordable Care Act (ACA) is expected to expand children's dental benefits, both public and private, but it does not address the many key access-to-care issues facing adults.
- The ACA is also expected to promote increased coordination of care, providing an opportunity to bridge the gap between dental and general health.

For the full report, visit: http://www.ada.org/sections/professionalResources/pdfs/Escan2013_ADA_Full.pdf

From Oral to Overall Health

Dentists can play a crucial role in a patient's health

Most dentists feel that screening their patients for risk of certain medical conditions – e.g., high blood pressure or diabetes – would be a valuable service to offer. Most patients would willingly participate, and they have indicated that their feelings about their dentist in terms of knowledge, professionalism and compassion would improve. And primary care physicians think it's valuable for dentists to screen for medical conditions, and are willing to accept patient referrals from the dental office.

That being the case, why isn't it being done more often? The answer could be as simple as, it's not been traditionally done. But that could be changing.

Barbara Greenberg, Msc, PhD, is among those who believe oral healthcare providers can and should assume a larger role in identifying patients at increased risk for developing diseases of public health significance, such as heart disease, diabetes, HIV or hepatitis C; and identifying those with undiagnosed diseases. She spoke on the topic at the 2013 Symposium of the Organization for Safety, Asepsis and Prevention, or OSAP.

Greenberg is chair of the department of epidemiology and community health and professor, New York Medical College, School of Health Sciences and Practice. She has more than 15 years of research experience working in infectious diseases, focusing principally on the areas of immunology, nutrition and HIV/AIDS. During the last eight years, her interest and commitment has expanded to encompass the oral healthcare setting.

The need

Dental-office screening makes sense for a lot of reasons, says Greenberg. Between 60 percent and 70 percent of adults visit their dentist in a given year, and between 10 percent and 24 percent of them haven't seen a physician in the same time period.

Screening can be most effective for diseases with modifiable risk factors, that is, behavior or characteristics that can be changed, such as smoking or a change in diet, says Greenberg. Examples: coronary heart disease, diabetes, HIV and hepatitis C.

Screening for these four diseases makes sense for other reasons as well: 1) They are of public health significance, that is, they affect a lot of people; 2) onset of disease can be delayed or prevented altogether with early identification; and 3) simple, validated CLIA-waived point-of-care tests are available.

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Who should be screened? Greenberg recommends dentists consider implementing the following criteria:

- **For heart disease and diabetes:** Screen patients 45 years of age and older, and who haven't seen a primary care physician for a year or more.
- **HIV:** Follow United States Preventive Services Task Force guidelines, which call for screening all people aged 15 to 65; older adults who are at increased risk for HIV infection; and pregnant women.
- **Hepatitis C:** Follow United States Preventive Services Task Force guidelines, which call for one-time screening of all adults born between 1945 and 1965 (aka Baby Boomers), as well as persons at high risk for infection and those who received a blood transfusion prior to 1992.

Discussing results

Greenberg emphasizes that she is talking about screening patients for risk of disease, not diagnosing disease. "Dentists can't diagnose," she says. Dentists should refer patients who screen positive to a physician for diagnosis and medical follow-up. They can also speak to their patients about behavior changes, such as quitting smoking, getting more exercise and maintaining a healthy weight. Even patients who screen negative, but who haven't seen a primary care physician for a year or more, should be encouraged to engage with a primary care doctor, she adds.

Dentists will more than likely find their patients are open to the process. "Behavioral literature shows that patients see their dentist as a respected professional they can trust," Greenberg says. "A special relationship exists between them and their dentist," as it does between them and their physician.

Surveys indicate physicians are open to accepting referrals from dentists, she adds. "Part of [the challenge] is figuring out mechanisms to get that communication going." Once that is established, dentists can fax the test results to the physician, or give the patient a copy, which he or she can bring to the doctor. In an ideal world, doctors and dentists would be connected via an electronic health record; but that situation is still rare in today's healthcare world. Patients on Medicaid may be referred to a local community health center.

"Patients see their dentist as a respected professional they can trust."

Hurdles

Dentists may very well see the wisdom of screening, but roadblocks exist, says Greenberg:

- They may be uncomfortable doing the tests, and need training.
- They may fear additional liability.
- Those who implement screening need to make sure that staff who do the actual testing – e.g., hygienists or assistants – get reimbursed for their time and effort.
- They may have to speak to patients about conditions – e.g., HIV – to which some social stigma is still attached.

There is also, of course, the question of reimbursement. Surveys indicate most patients would be willing to pay $10 to $20 for screening, says Greenberg. And insurers? That's a work in progress. "I think the insurance companies want to see there's a demand from patients and dentists to do this," she says.

As healthcare reform matures, insurers may become more eager to come to the table, says Greenberg. That's true for two reasons. First, healthcare reform emphasizes overall health, well-being and prevention. Chairside screening fits into that model.

Second, healthcare reform is nudging healthcare providers and payers toward a more integrated system. "Thinking of each of these domains as isolated is problematic," she says. What's more, the literature shows an association between oral health and diabetes, cardiovascular disease, even HIV, though the cause and effect relationships aren't quite clear, she points out. "My goal is to see the [dental team] as an integrated part of the healthcare team, looking at health not just from an oral health perspective."

Chairside screening could be an integral part of that approach. ■

CLIA and the dental office

What is CLIA?

The Centers for Medicare & Medicaid Services regulates all laboratory testing (except research) performed on humans in the United States through the Clinical Laboratory Improvement Amendments. CLIA was established to strengthen federal oversight of clinical laboratories to ensure the accuracy and reliability of patient test results.

What is the definition of a lab?

A laboratory is defined by CMS to be a facility that performs certain testing on human specimens in order to obtain information that can be used for the diagnosis, prevention, or treatment of any disease or impairment of a human being; or the assessment of the health of a human being; or procedures to determine, measure or otherwise describe the presence or absence of various substances or organisms in a human body.

What are CLIA-waived tests?

Tests are categorized as waived, moderate complexity or high complexity. To receive a certificate of waiver under CLIA, a lab must only perform tests – such as the glucose meter test – that the Food and Drug Administration and the Centers for Disease Control and Prevention have determined to be so simple that there is little risk of error. (For a list of CLIA-waived tests, go to http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Downloads/waivetbl.pdf.)

What is required of a lab that wants to perform CLIA-waived tests?

Waived laboratories must meet only the following requirements under CLIA:

- Enroll in the CLIA program;
- Pay applicable certificate fees biennially ($150 every two years for a CLIA-waived lab).

CLIA-waived tests are exempted from most CLIA requirements, and the laboratories that perform them receive no routine inspections. ■

The case for chairside screening

- 60-70 percent of adults visit the dentist in a given year.
- 10-24 percent of those have not see a physician in the same time period.
- 41 percent receiving first HIV diagnosis between 2006-2009 had no history of HIV testing.

Importance of screening for chronic heart disease and diabetes mellitus

- Undiagnosed prevalence:
  - 29-71 percent CHD (depending on specific risk factors)
  - Approximately 30 percent DM
- Primary prevention:
  - CHD: 21-37 percent reduced incidence
  - DM: 51 percent reduced incidence

Regarding hepatitis C:

- Baby boomers (born 1945-1965) are six times more likely than others to be infected with hepatitis C.
- One and a half million may be unaware of their infection.
- 37 percent will die without treatment.
- New treatments can provide viral cure for up to 90 percent of those treated. ■

Elements of effective chairside screening

- Purpose is to delay onset, control severity or monitor.
- Most effective for diseases with recognized modifiable risk factors.
- Success also requires simple, cheap, effective screening tools.
- Most useful for prevalent diseases with high morbidity and or mortality. ■

Fact, not fiction

Here's how a success story might read: Dental staff screens patient. Results indicate patient is at risk of developing diabetes. Dentist talks to patient about lifestyle changes (e.g., change in diet) and refers him or her to physician. Patient makes the changes, avoids onset of disease.

Turns out the story isn't fiction.

A review of published evidence found that comprehensive lifestyle changes can reduce the incidence of type 2 diabetes in high-risk patients, according to a study in the Annals of Internal Medicine. (Evidence was not strong enough to determine if patients already diagnosed with type 2 diabetes could benefit from such interventions.)

Researchers reviewed available research to assess the effects of comprehensive lifestyle interventions in the prevention of diabetes in adults who have been identified as high-risk (having metabolic syndrome or prediabetes) and the prevention of diabetic complications in adults diagnosed with type 2 diabetes. All lifestyle interventions studied for both groups included a diet and exercise component and were supported by individual, group, and/or telephone counseling. Other lifestyle interventions included a smoking cessation course, regular blood glucose and blood pressure monitoring, and stress management. ■

See the article at http://www.annals.org/article.aspx?doi=10.7326/0003-4819-159-8-201310150-00007

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The Elephant in the Operatory

There is an elephant in the operatory, and it's presenting all kinds of challenges for dentists, says Charles Blair, DDS, of the consulting firm Dr. Charles Blair and Associates, Belmont, N.C. That elephant is the preferred provider organization, or PPO.

PPO plans accounted for 77 percent of commercial dental benefits by plan type in 2011, compared to just 42 percent in 2002. Indemnity plans went the other way: Thirty-five percent of commercial benefits by plan type were indemnity plans in 2002, but just 9 percent were in 2011. The result? "There has been a spiraling downward of contracted fees, and I'm not sure we've reached the bottom yet," says Blair.

Dental practices face another threat from payers – fee-capping, that is, the practice whereby insurers (or self-funded plans) cap the fees dentists charge not only for covered services, but those not covered by the plan as well. (Though more than 30 states have passed laws forbidding fee-capping, the federal government – which regulates the self-funded industry – has not.)

80

More than 80 percent of dentists are contracted with at least one PPO. Dentists and practices who resist the trend and are out of network will continue to lose patients, says Blair

Successful strategies

Some dental professionals are ignoring the larger trends, or are simply too busy working at the chair to take it all in. But others are rising to the challenge. Some examples of successful strategies:

- Some dentists and practices have developed their own in-house discount plans for those without insurance, whereby they offer enrolled individuals and small employers discounts on their services. Half the population has no dental insurance, and dentists offering discount plans will dramatically increase, says Blair.
- Many dental professionals are investing in technology in order to become more efficient and productive, and in order to perform procedures that they used to refer out to specialists in the past. "If I'm able to work in a couple more procedures a day in an unbooked operatory, that's the difference between a $600,000 practice and an $800,000 one," says Blair.
- More dentists are recognizing the need to take full advantage of the skills of properly trained staff to increase productivity and patient throughput. In the long term, the count for mid-level providers will increase, says Blair. Laws and regulations must be changed in order for the dentist to be more productive with the dental team in a PPO environment, with less reimbursement.

Traditional approach won't work anymore

Dental professionals might look to their medical counterparts for a glimpse into the future, says Blair. The medical market is dominated by PPOs today. In response to reduced profit margins, physicians have moved from solo practices, to small-group practices, to large group practices. Hospitals have been on a physician-practice acquisition binge, and the hospital industry itself is undergoing rapid consolidation. In fact, it is estimated that hospitals or hospital systems employ half the physicians in the United States, and may employ as many as 70 percent in three years.

More than 80 percent of dentists are contracted with at least one PPO. Dentists and practices who resist the trend and are out of network will continue to lose patients, says Blair. Like physicians before them, dentists are joining forces with others and extending office hours in order to stay competitive. Many are joining group practices or alliances.

Over the next 10 years or so, corporations could comprise 20 percent to 25 percent of the market, says Blair. In addition, multi-doctor practices will dramatically increase while the solo count will plummet.

Throw in an influx of dental schools (non-profit and for-profit), rising levels of student debt, and a glut of dentists in metropolitan areas (though not in more remote locations), and the future looks hazy. "I have been looking at some of the online dentistry message boards, and I see pre-dental students wondering, 'Is it worthwhile becoming a dentist?'" says Blair. No doubt dental school applicants will decrease with the growing uncertainty.

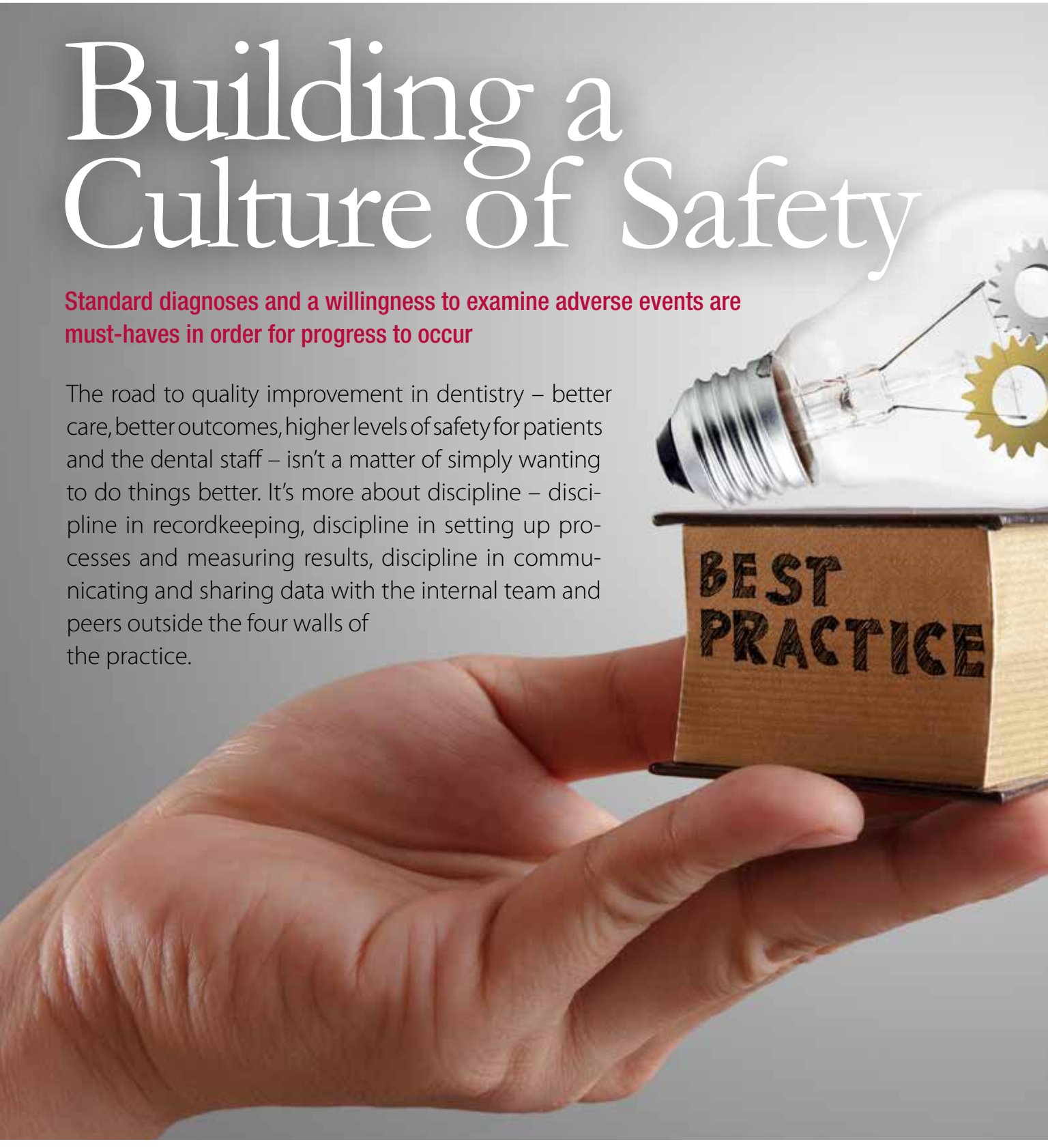
Group practice presence

Over the next 10 years or so, corporations could comprise 20 percent to 25 percent of the market, says Blair. In addition, multi-doctor practices will dramatically increase while the solo count will plummet.

Building a Culture of Safety

Standard diagnoses and a willingness to examine adverse events are must-haves in order for progress to occur

The road to quality improvement in dentistry – better care, better outcomes, higher levels of safety for patients and the dental staff – isn't a matter of simply wanting to do things better. It's more about discipline – discipline in recordkeeping, discipline in setting up processes and measuring results, discipline in communicating and sharing data with the internal team and peers outside the four walls of the practice.



Medicine might have the jump on the dental profession in these matters, but dentistry is making up for lost time, says Elsbeth Kalenderian, DDS, MPH, chair, oral health policy and epidemiology, Harvard School of Dental Medicine, and chief of quality at Harvard Dental Center, who spoke on the topic of quality improvement at the 2013 OSAP Symposium.

"My field of interest is quality and quality improvement," says Kalenderian, who is currently involved in developing a patient safety system through a five-year NIH/NIDCR grant. "When I came back to dentistry – I was in the hospital world for quite awhile – I could see we have some catching up to do."

Documenting diagnoses

Two things need to occur in order to measure and hence, improve, the quality of dental care, says Kalenderian. First, the profession needs to document diagnoses in a standardized way. Second, adverse events must be acknowledged and tracked.

Without standardized diagnoses, you can't measure the effectiveness of outcomes, she says. "If I say, 'We took out 50 wisdom teeth,' but didn't include diagnoses, the only thing I can measure is, 'Did I take them out?' or 'Did I take them out [without an adverse event]?' but not, 'Did I take them out for the right reason?' For quality reasons, it's really important we get the diagnosis piece in. Medicine figured this out in the 1880s."

Acknowledging and tracking adverse events gets to the issue of culture, that is, building a culture of quality improvement and patient safety, says Kalenderian, who has worked on this issue in the medical field. "If you want to fix any issues – any – you need to have a culture in which it's possible to do that." The key is getting people to trust that measuring and examining adverse events isn't about assigning blame and punishment. "When people see they won't get fired after reporting, true root cause analyses can be done, and you can feel the atmosphere change."

Measuring adverse events

The reason that examining adverse events is so important is simple: You can't improve patient safety if you don't know what's going wrong, says Kalenderian. Dental professionals know about wrong-side dentistry, or jaws that were broken during an extraction. "But we don't have a real inventory, or a taxonomy, of adverse events, as medicine does." Only with such an inventory in place can research be done on the causes of such events, and hence, potential solutions.

"We can start measuring how often [adverse events] occur," she says. "What we will find is that some things don't happen as often as we thought, and other things are happening that we didn't have a clue about. That's when we can start thinking about solutions and game-changing ideas."

This "inventory" of adverse events needs to reside in a central location, or data repository, she adds. And that means the industry needs to create a centralized reporting system, one with which dental professionals feel comfortable sharing their data.

These steps can be tedious and time-consuming, says Kalenderian,

who has had conversations on the topic with Lucian Leape, MD, Harvard School of Public Health, and a member of the Institute of Medicine's Quality of Care in America Committee, which authored seminal works on patient safety: "To Err is Human" in 1999, and "Crossing the Quality Chasm" in 2001. But they are necessary steps in the quality improvement process.

EZCodes

In order to get reimbursed for their services, medical doctors must note in a standardized format not only the procedures they perform (using the CPT code), but their diagnoses as well (with the ICD-9 coding system). But dentists need only note the procedure code (CDT), not a diagnostic one. The diagnosis field may be left empty.

"This doesn't mean dentists don't diagnose," says Kalenderian. "Every dentist diagnoses. But where they document that diagnosis, and how they document it, varies." Diagnoses may be buried in treatment notes, and what is precisely written for the same ailment varies from doctor to doctor, perhaps even visit to visit, or patient to patient.

Kalenderian has done much work in developing standard diagnoses for the dental profession, through developing the so-called EZCodes diagnostic terminology. The system may be an alternative for practices that feel that, with more than 7,000 codes, existing coding systems – SNOMED (developed by the International Health Terminology Standards Development Organization) that includes SNODENT (the American Dental Association's dental diagnostic coding system) – are too complex. "They are very difficult for the chairside dentist to manage, even with great search functions in the EHR," she points out.

EZCodes represent a practical alternative, or what Kalenderian calls a practical bridging or interface terminology, with the ability to interface with other terminologies required by law or regulation.

To date, 15 dental schools, some large group practices and even some countries in Europe have begun implementing EZCodes, she says. A number of EHR vendors are examining how their software can accommodate them. "I don't think we're yet at the tipping point, but there is clear interest," she says.

How are dental practices doing?

Just how safe – or unsafe – are dental practices? Data is scarce, but studies comparing the performance of a number of dental schools with medical offices show the former coming up short. There are a number of potential explanations, says Kalenderian, including:

- The dental-related information came from dental academic centers, whereas the medical data came from non-academic settings.
- Dental work tends to be more procedural, while medicine has a greater emphasis on examination.
- Medicine has a more mature patient safety culture, having been at it since at least 1999, than the dental profession.

Though the study did have its bright spots from the dental profession's perspective, including high marks for teamwork in the dental practice, it was "a clear call to action to improve patient safety activities and cultures," says Kalenderian. Academic institutions can play a big role. "Schools and institutions can not only share data, but they can share how they're working on some of these areas and getting better.

"We have a pretty big workgroup, with over 20 dental schools; that's the exciting part," she says. More exciting is the possibility of young graduates bringing the principles of patient

Acknowledging adverse events.

"If you want to fix any issues – any – you need to have a culture in which it's possible to do that." The key is getting people to trust that measuring and examining adverse events isn't about assigning blame and punishment. "When people see they won't get fired after reporting, true root cause analyses can be done, and you can feel the atmosphere change."

safety to the practices they join or open up.

The investigative process

At the OSAP Symposium, Kalenderian pointed to the value of "focused chart reviews" rather than random reviews, as a tool to identify issues that might compromise safety. "The focused chart is what's called a 'trigger tool' that you run against your EHR" or paper-based system, she explains. It means pulling and examining records based on specific reasons, rather than picking charts at random. "That's more of a witch hunt," she says of the latter approach. In hospitals, for example, only charts of patients who received Narcan® (naloxone) to reverse an accidental drug overdose during the course of treatment might be examined. "I look for similar triggers [in dentistry]," she says.

After adverse events have been logged, the researcher asks, "Do I see more systematic issues, or was it just one issue?" If an event appears to be an isolated one, the practitioner should be made aware of the finding, not to blame or shame, but to inform and help improve patient care, says Kalenderian. "But most of what you find are system issues. And you might have to wait for three months until you find systematic patterns. Those you bring to the quality committee, so that a root cause analysis can be conducted to start the learning process."

Changing the culture

Are dentists likely to begin building cultures of safety? "It has to do with how open the individual is to the process," says Kalenderian. "Some will be early adopters. But it will take time."

Many medical doctors have come to accept that adverse events occur and that together, they can figure out how to learn from them, she continues. "So when they occur, most know what to do. They have connected with [colleagues] or the hospital system to work through these events. Then they try to implement system changes. That is my hope for dentistry."

Progress may take years, and it might occur more swiftly in large group settings, she continues. But small dental practices can also begin changing their practices and, more important, share data and solutions with other practices. "Some will be excited at being part of [networks] that report dental adverse events in a safe, anonymous way that doesn't lead to punishment."

But even if they just monitor their own practices, using so-called trigger tools, and work to institute change with their teams, dental practices of all sizes will make progress. "Nobody wakes up in the morning and says, 'Today, I'm going to make a mistake,'" she says.

Yes, concerns about malpractice suits and liability must be addressed, as they have in medicine, she continues. "This is where the educational piece needs to happen. But that can only happen if we continue to have the conversations, and move dentists as well as insurance companies toward understanding that even though risk management is important, it is always a part of quality improvement.

"Medicine has shown that good adverse events management decreases the doctor's chance of being sued," she adds. ■

Progress, large and small.

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Adults on board

Teens aren't the only ones on board with smartphone and tablet technology, according to a recent online survey by *The Harris Poll*. About 52 percent of U.S. adults own or use smartphones, while 33 percent own or use tablets. These ownership figures rise for parents of children under 18: 69 percent own smartphones and 44 percent use tablets. Indeed, smartphone and tablet technologies are becoming a parenting tool for some: For parents with children under 18, 47 percent surveyed admitted to using a smartphone – and 44 percent a tablet – to keep their children entertained. Nearly 18 percent have used a standard mobile phone and 17 percent an eReader. About 20 percent claim to have not used any device to occupy their children. At the same time, parents with children under 18 appear to be more likely to use their smartphones or tablets for:

- Mapping or navigation functions
- Social media
- Locating restaurants
- Watching videos
- Purchasing goods or services.

26 million

The estimated number of bags that go missing at airports every year.

Not your loss

Tired of travel hassles? You're not alone, according to Vanguard ID Systems, which notes that some 26 million bags go missing at airports every year. In response, the company has introduced its E-Ink based ViewTag® with a display that changes via the traveler's phone. The tag acts like a digital license plate, allowing fliers to control the process of checking bags at home by using their cell phone through the tag's QR Code or embedded NFC module. Fliers are notified via text message where their bags are located throughout their trip. Fully customizable to include logos and personalized artwork, the ViewTag® reportedly is created with an environmentally safe material and currently holds numerous RFID (radio-frequency identification) related patents for RFID Tags.

Smokin' alarm

Miniature smoke alarm First Alert® Atom™ was recently named a 2013 Chicago Innovation Award winner. The alarm measures 1.5 inches in diameter and weighs less than two ounces, and is available in a number of decorative finishes.

Smart sharing

Fasetto LLC, an application developer, announced Pretty Darn Quick, its new family of patent pending applications designed to enable fast, secure file sharing across any device, anytime online or off. PDQ breaks down all manufacturer, carrier and platform file transferring walls, such that files of all sizes can be sent in seconds to anyone, anywhere, at any time. Users can share videos, pictures and files (reportedly without compromising the file quality) and send them securely in seconds across all platforms. A strong data or Internet signal is not necessary to send the file, and users do not use their data plan. PDQ also enables users to send secured transmissions, texts, phone calls, files, pictures and videos without a SIM card or Internet service.

Facebook, anytime

American smartphone users may have to wait awhile, but users in Africa can now access Facebook on any mobile phone, without Internet or data connectivity, using Facebook USSD, from Singapore-based mobile technology startup U2opia Mobile. Availability of the service with MTN Nigeria is said to have brought U2opia Mobile's African footprint to nearly 100 percent.

About 52 percent of U.S. adults own or use smartphones, while 33 percent own or use tablets

Mind games

Personal Neuro Devices Inc., a developer of mobile neuro applications, has launched Neuronauts, a free online multiplayer game powered by neurofeedback. The game is designed to combine a 1950s science fiction look with modern gameplay. In addition to touch and tilt controls, the game relies on neurofeedback, with a Bluetooth headset that picks up a player's neural activity, enabling players to control the speed and actions of their space ships with the power of their minds. Neuronauts has three gameplay modes: Solo, Local Multiplayer and Online Multiplayer. Local Multiplayer mode allows two players to compete with each other on the same mobile device, using two Bluetooth headsets. To download Neuronauts from Google Play, visit https://play.google.com/store/apps/details?id=com.personalneuro.gatecrasher.

Picture perfect

The *Polaroid* iM1836 Android™-powered compact interchangeable-lens smart camera, launched at CES 2013, is now available exclusively at Walmart and Amazon.com. The camera reportedly features D-SLR quality and flexibility and point-and-shoot camera technology, and allows users to share photos instantly to any social media network. The *Polaroid* iM1836 Android™ includes a 3.5-inch touch screen LCD display and comes standard with a 10-30mm optical zoom lens. At press time, an additional 500mm telephoto lens was expected to be available in November, and a 50mm lens was expected to be available in early 2014.

BYOD

Huawei, a global information and communications technology solutions provider, announced the launch of its one-stop, bring-your-own-device (BYOD) mobile office solution. The company's BYOD solution offers one-stop services and products for enterprise network, security and devices, as well as management platforms. It is said to facilitate flexibility and consistency among enterprise customers.

Home entertainment

Polk recently announced two new wireless speaker offerings – the Camden Square and Woodbourne – from its Heritage Collection of personal and portable audio. The Camden Square features a 24-hour battery life and DJ stream app (compatible with iOS and Android devices), which permits music to stream through the speaker from multiple sources. The DJ Stream app is free for download, and the Camden Square speaker costs $299.95. The Woodbourne, which utilizes Bluetooth® and AirPlay® capabilities, costs $699.95 and features 180 watts of wireless audio, and optical and analog inputs.

Wakeup call

Could there be a more relaxing way to start the day than to the blare of an alarm clock? Phillips believes so. The company recently introduced its Wake-up Light, designed to simulate the sunrise for a more natural wake-up experience. The Wake-up Light is available in four different models, ranging from $69.99 - $169.99. Each model can serve as a bedside lamp, with 10-20 different light settings.

Henry Schein, E4D Technologies sign agreement to roll out CAD CAM technology to Aspen Dental practices

Henry Schein, Inc., and E4D Technologies announced a new agreement that will bring the latest in CAD CAM technology to select Aspen Dental practices across the United States. Under the new agreement, the E4D Restorative System will help enhance the care that Aspen Dental providers deliver to patients.

The E4D system, created by E4D Technologies and exclusively distributed by Henry Schein, will provide the dentists who own and operate these Aspen Dental practices the ability to scan, design, and mill restorations right in the office with exceptional precision, speed and patient comfort.

"CAD CAM technology is an integral component in today's dental practice, and we believe the E4D System will excel at helping the dental practitioners at these Aspen practices deliver the highest quality patient care," said Dr. Arwinder Judge, vice president, clinical support, Aspen Dental Management, Inc. (ADMI). "We have partnered with Henry Schein for years to provide the dentists of Aspen Dental with the broadest selection of products and services, and believe they offer the best choices in technology-driven solutions, as well as the comprehensive support needed to optimize this technology in Aspen offices throughout the country."

Heartland Dental Care to acquire My Dentist Holdings

Heartland Dental Care, LLC ("Heartland Dental") a leading dental support organization in the United States, announced that it has signed a definitive agreement to acquire My Dentist Holdings, LLC, ("My Dentist"), an Oklahoma City based dental support organization, which is affiliated with 55 My Dentist Complete Care Dentistry offices in Oklahoma, Missouri, Texas, Kansas and Arkansas. My Dentist's predecessor company was founded in 1983 by Dr. Pat Steffen. The My Dentist branded affiliated dental offices provide general dentistry services, along with specialty care in orthodontics and oral surgery. With the passing of Dr. Steffen in August 2012, Dr. Jennifer Chambers, Chief Dental Director and Kevin Offel, Chief Executive Officer and President of My Dentist, assumed active leadership roles within the organization. During their tenure at My Dentist, they have

Wisdom Tooth Project launches

The American Dental Hygienists Association (ADHA) (Chicago, IL) partnered with Oral Health America (OHA) (Chicago, IL) on the creation and launch of a web portal for the Wisdom Tooth Project, a program that aims to educate older Americans and their caregivers on the importance of oral health. Although the web portal will be hosted by OHA, ADHA will provide content and access to member experts to add information when needed. For more information, go to oralhealthamerica.org/programs/wisdom-tooth-project/

achieved major benchmarks, including expanding the number of affiliated dental offices from 30 to 55 locations and growing its infrastructure. My Dentist, together with its affiliated dental practices, has 805 employees, including 109 dentists and 71 hygienists.

Dr. Rick Workman, founder and Chief Executive Office of Heartland Dental stated, "We are excited to have this opportunity to affiliate with such a significant dental support organization which is not only in our footprint, but also shares so many of our core values and beliefs. Heartland Dental is comprised of exceptionally talented individuals who are sincerely passionate about our company's vision. Similarly, the My Dentist team works tirelessly for the well-being of their doctors, patients and employees. The future is bright for My Dentist and Heartland Dental as we join together to support each other in becoming industry leaders. It's an honor that we will have them on our team."

Enrollment for commercial dental benefits increases in 2012

By the end of 2012, more than 187 million Americans had dental coverage, marking an increase of 11 million people when compared to the previous year, according to the recently-released 2013 NADP/DDPA Joint Dental Benefits Report: Enrollment. Since 1994, the National Association of Dental Plans (NADP) (Dallas, TX) has conducted an annual enrollment survey with information on Dental HMO, Dental PPO, Dental Indemnity and Discount Dental enrollment at the state and national levels. Most of the reported growth in dental benefits enrollment was projected in the 2013 NADP State of the Dental Benefits Market Report and can be attributed to an increase in employment. The 2013 NADP/DDPA Joint Dental Benefits Report: Enrollment is available for purchase in the Knowledge Center section of the NADP website, www.nadp.org.

OHA says *Fall for Smiles* Campaign a success

Oral Health America (OHA) announced its annual *Fall for Smiles*® campaign has come to an end, educating hundreds of thousands of American about the importance of maintaining good oral health through daily brushing and flossing, regular visits to the dentist, eating healthy foods, and avoiding tobacco. This year's campaign "would not be possible without the generous support of lead sponsors 3M ESPE, Crest + OralB, Oral Healthcare Can't Wait and Patterson Dental," OHA said in a release.

"We appreciate the support of all our *Fall for Smiles* sponsors for allowing us to reach Americans with valuable health resources," said OHA President and CEO Beth Truett. "These companies recognize the importance of oral health for all Americans and understand that *Fall for Smiles* is an important step in making sure everyone has a healthy mouth."

Dental professionals and families helped spread the campaign's message of the importance of oral health by utilizing the resources available on the *Fall for Smiles* webpage. Parents and caregivers downloaded tip sheets that provided tips for teaching kids how to take care of their teeth and advised older adults how to address their unique oral health needs. Dental companies posted *Fall for Smiles* buttons and banners on their websites for the duration of the campaign. And Americans from all over the country shared messages about oral health on social media.

ADA offers mobile app with 2014 dental procedure codes

The American Dental Association (ADA) is offering the newest Code on Dental Procedures and Nomenclature (CDT codes) with the CDT Code Check mobile app. It contains the latest CDT codes, including 29 new procedure codes, 18 revised procedure codes, four deleted procedure codes, and seven changes to subcategories and their

descriptors. The app is a handy practice management tool for dentists and dental staff who travel between offices. Features include: a complete listing of 2014 CDT codes; a list of new, revised, and deleted codes with tracked changes; and codes that are searchable by three categories: code number, keyword, and category of service. The CDT Code Check app sells for $19.99 for Apple mobile devices via the App Store and Android mobile devices via Google Play.

Dental Quality Alliance approves initial set of performance measures

The Dental Quality Alliance (DQA) (New York, NY) released its first set of performance measures for oral health care, "Dental Caries in Children: Prevention and Disease Management." The set includes 10 tested and validated performance measures in oral healthcare, including: use of services; preventive services; treatment services; oral evaluation; topical fluoride intensity; sealant use in 6-9 years; sealant use in 10-14 years; care continuity; usual source of services; and per-member per-month cost. The DQA was established by the American Dental Association (ADA) (Chicago, IL) to develop performance measures for oral healthcare. The DQA collaborated with the University of Florida Institute for Child Health Policy (Gainesville, FL) to evaluate and test the feasibility, validity, reliability and usability of each measure before issuing final approval, with partial funding through a grant from the American Dental Association Foundation (Chicago, IL).

Dental care for the young

About half of Michigan's Medicaid-eligible children and young adults now qualify for dental coverage thanks to the Healthy Kids Dental program in the state budget that took effect on October 1, 2013. The program is available to a half-million enrollees under age 21 in 78 of Michigan's 83 counties. It remains unavailable to nearly a half-million poor kids in heavily populated Wayne, Oakland, Macomb, Kent, and Kalamazoo counties. Republican Governor Rick Snyder's administration and Delta Dental of Michigan (Farmington Hills, MI), the insurance company that administers the Healthy Kids Dental program, celebrated the addition of three counties during a news conference at a Lansing elementary school. Dental visits are 50 percent higher for children who are enrolled in the program, which began in 2000, and has been singled out as a model for improving access to dental care for low-income children. Michigan spent roughly $100 million on the Healthy Kids Dental program in the last fiscal year, and roughly a third came from the general fund.

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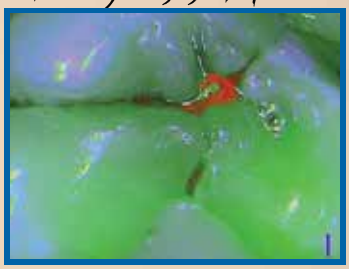

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