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MAY/JUNE · 2017

Progress Report

DSOs: An Industry Update

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Where We Are Headed

Last issue's Publisher's Letter focused on the DSO event lineup for Q1. Due to the magazine's deadline, I was unable to include an analysis of the largest DSO event of the year – and most likely the largest DSO event ever – the ADSO Summit. With close to 900 attendees from DSOs across the globe and their dental industry partners, the always exciting meeting was held in Orlando at the Swan Hotel.

What struck me as different this year was the variety of dental group practices that attended the event. As one might expect, there were the larger, ADSO-member DSOs. However, I also talked with many smaller, emerging dental group practices. I believe that some of these new attendees were driven by the ADSO's new focus on emerging dental group practices, as well as some of the content that was geared specifically for smaller dental groups. Dr. Mark Cooper's half-day program at the beginning of the Summit was designed for new or small group practices looking for direction and education on how to scale their businesses. The rest of the event was full of great networking opportunities, in addition to a variety of breakout sessions, and of course several inspiring speakers. For more detailed information on the ADSO Summit, make sure you read our recap piece in this issue. Furthermore, make sure to read upcoming issues of this magazine as the ADSO has mentioned there may be a second meeting this year focused exclusively on emerging groups.

Our big story in this issue of *Efficiency* is our DSO Progress Report. This is an extensive piece that reviews DSO model momentum, market share gains, and market movement. We asked experts at Benevis, Great Expressions and Dental Care Alliance to give us their impressions of where we are as an industry, and where we are headed. The piece addresses challenges and opportunities with our panel of DSO experts.

One of the biggest takeaways I got from the experts is that the DSO model is still the exception to the rule. Other healthcare vertical business models have already matured, while dentistry is still primarily made up of solo practices. The popularity of DSO business models is growing, but DSOs, the ADSO, and publications like *Efficiency in Group Practice* need to continually educate dentists, dental staff, and patients so they can make an informed decision as to what type of practice is best suited for their specific needs.

Read on, we have some great content in this issue.

Bill Neumann

INCREASE YOUR PRODUCTIVITY

Time is one of your most valueable resources....

What would you do if you had more time in your day?

Generate more productivity per chair by reducing procedure times or allowing for more procedures in one visit

Surpass your production goals with increased flexibility in patient scheduling

Help your office manage challenging or difficult patients with reliable clinical results

Increase patient retention through greater patient comfort and satisfaction

Free up your assistants to focus on more productive activities

Optimize hygiene appointments to allow the team to stay ahead of schedule

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ADSO Association of Dental Support Organizations

2017 Annual Summit

The ADSO 2017 Annual Summit held March 7-10 at the Walt Disney World Swan Hotel in Lake Buena Vista, Fla., was *the* event for DSOs, with close to 900 attendees. The meeting attracted leadership from over 120 dental service organizations and group practices, as well as a dozen international groups from Australia, Canada, Denmark, Netherlands and New Zealand, and provided ample opportunity for networking with industry leaders, as well as education on important topics and issues.

The Summit agenda began with a half-day DSO and Industry Partner Pre-conference, during which time the DSO members and industry partners conducted prearranged, 15-minute, one-on-one roundtable meetings. There was a welcome reception for premium sponsors and DSO CEOs, as well as dinner for CEO leadership, sponsored by Henry Schein Special Markets. Other evening events throughout the week included two large networking receptions:

- Opening night at Disney Pavilions, sponsored by Patterson Dental.
- Epcot reception, sponsored by 3M, Carestream, CareCredit, DDS Lab and Align Technology.
- Special viewing of the Epcot Illuminations Display, sponsored by Houlihan Lokey.

Experts, speakers and panelists

Over 60 industry experts – all representing leadership, C-level executives and successful professionals in the DSO community – served as speakers and panelists for the 35+ breakout sessions scheduled throughout the Summit. The keynote speakers featured included Chip Madera, sponsored by Dentsply Sirona, and George Blankenship, sponsored by Align Technology.

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Among the many speakers who captured attendees' attention were:

- Dr. Rick Workman, Heartland Dental
- Steve Bilt, Smile Brands
- Dr. Cari Callaway, PDS
- Mitch Olan, Dental Care Alliance
- Ken Cooper, North American Dental Group
- Dr. Gregory Heintschel, My Community Dental Centers
- Geoff Ligibel, Gentle Dental
- Scotte Hudsmith, Smile Doctors
- Dr. Scott Leune, Breakaway Practice
- Dr. Sulman Ahmed, DECA Dental
- Dr. Marc Cooper, Mastery Company
- Mike White, MKW Advisors
- Don Moody, Waller
- Rich Agabs, Jefferies

The ADSO 2018 Annual Summit is scheduled to take place next April 17-20 in Austin, Texas. For more information contact Andrea Watkins, director of marketing & membership, ADSO, at awatkins@theadso.org.

Top sponsors

Leading sponsors of the ADSO 2017 Annual Summit in Lake Buena Vista, Fla., included:

"Thank you to our generous sponsors!" says Andrea Watkins, director of marketing & membership, ADSO. "Without them, this great event would not be possible!"

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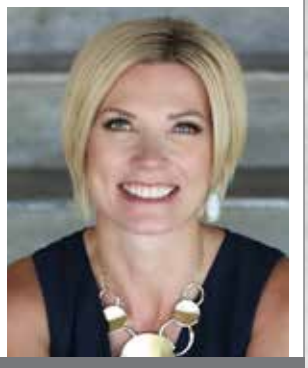

By Heidi Arndt

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.

Most dental groups today have a nice collection of protocols or Standard Operating (SOPs) procedures in place. They are typically well-crafted and tucked away for the team to access whenever needed. Teams are aware of the protocols and systems as they are often discussed during staff meetings or throughout the day. Yet, many of these dental groups are wondering why their team is not performing to these standards.

I was recently working with a group that had spent considerable time developing and communicating their clinical protocols and SOPs to their team. They had monthly team meetings where they would review their performance dashboards with the team and tried to motivate them to take "bigger" action toward meeting their associated goals. However, they were frustrated with the results. They would see a small uptick in performance and then an immediate flattening once the message wore off.

Unfortunately, most dental groups experience this phenomenon with their teams, and many have come to believe this is normal behavior.

The truth is, I struggled with the same issue early on when I was mentoring dental hygienists and doctors. I would review our protocols repeatedly, only to see minimal compliance and commitment to the process. I was frustrated at their lack of commitment to my crafty protocol, and continuously tried to find a way to engage them and get them focused on the results of the intended protocols.

After months of trying different methods and approaches, I found the following four steps made all the difference in the world. I experienced an engaged hygiene team, we saw unbelievable results, and we could maintain them year after year.

First, I think it is important to understand change management and that most of the changes you are trying to obtain are behavioral in nature. Essentially, you are trying to change your team's mindsets and/or the way they work. This change cannot be achieved without the following steps.

1. **Teach them how to do it.** Often, we ask our team members to change without showing them how to adapt the protocol into their individual way of practicing. For example, you may tell your hygiene team that you need to provide more fluoride to their patients, but you do not show them how to communicate it to the patient, when to discuss during the patient appointment, etc. All while understanding that each provider may have a different way of communicating the need to their patient.

> If there is one thing I have learned in my 15 years of training and coaching dental teams, sometimes you need to go slow to go fast. Long-term results depend on a solid foundation – that is not created overnight.

2. **Measure performance.** At Enhanced Hygiene, we are big believers in measuring performance and meeting the goals of your organization. There are several performance indicators we monitor for the hygiene teams we partner with.

3. **Don't overwhelm with goals.** We have many goals we want our teams to focus on. It is important to narrow your focus to the top priority and not a whirlwind of goals. The more goals your team must focus on, the less likely they will master any one of them. Humans are hardwired to bring their best effort to one thing at a time. When we overwhelm them with numerous goals, it is less likely they will master any one of them. As you have probably heard, too many goals = mediocre performance. This is especially true for dental hygiene teams.

4. **Stay focused and be consistent.** Once you train your team, you set a mechanism to measure their performance, and you set and communicate the goal. Then the work begins. Your team is expecting you to either forget about the goals you stated or change it up. Why? Because that may be how you have done it in the past. Instead, you need to stay focused on your intentions and your goal. Keep it in your everyday discussions and do not lose sight of it. Report back to them on weekly basis on how they are doing with the goal. If they are falling short, you must ask them how they will meet this goal. Do not tell them, we need to get away from "telling" people how to do it. If you have trained them well and given them the tools to be successful, they will understand how to meet the goal. If they are struggling to find a solution, then you can provide them guidance around how to approach it. This is done in a mentoring sort of fashion. Remember, we are working through a behavioral change, and to make these changes, the individual needs to own their change and success. In other words, ruling with an iron fist is not the way to improve performance.

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Lasting change

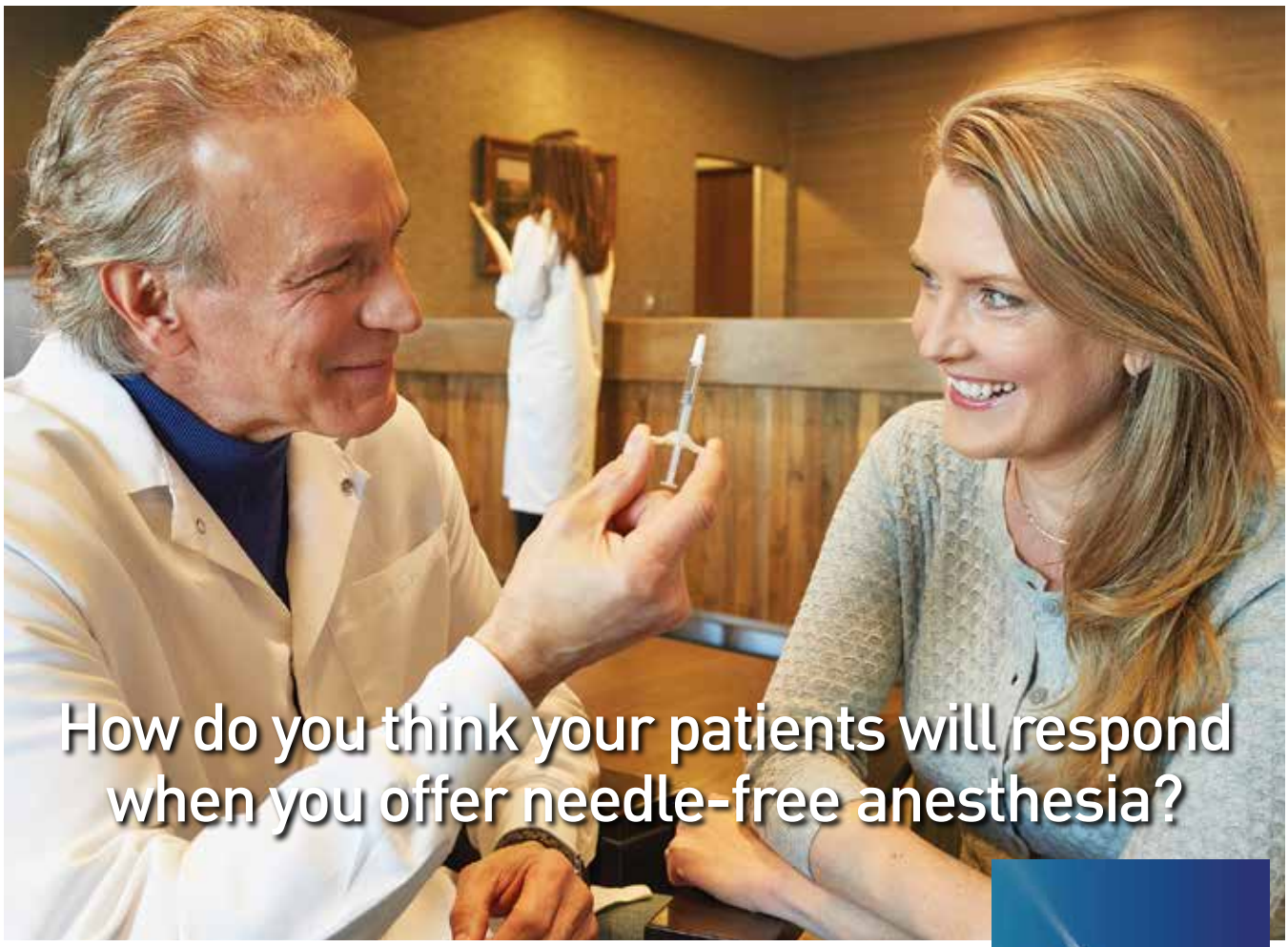
Let's go back to the group I mentioned earlier in the article. When I asked the leaders of the organization what they wanted from their hygiene team they stated one central goal – improve hygiene revenue. Based on their performance dashboard, they knew they needed to improve periodontal treatment, preventive treatment, their re-appointment rate, their radiograph rate, and the list went on.

I then asked what they had communicated to their team to date. They told me that they provided an in-service meeting to review their protocols and system and even showed me the neat little binder they gave each hygienist. They also conducted weekly meetings with their hygiene team to review eight key indicators they had for hygiene. At each meeting, they felt the hygiene team did not take them seriously and went back to work without changing a thing. They were very frustrated, and could not understand why their team would not listen to them. So, in the depths of frustration they cancelled the weekly meetings and allowed their hygienists to operate at status quo.

Their pain is like what we see every single day. There are so many things we are trying to accomplish and master every day. However, to make lasting change, we need to focus on the key drivers and then work to fully execute. When you are trying to improve hygiene revenue, we suggest you focus on one driver that will support revenue growth. In the case above, we chose to focus on caries prevention with our main goal of achieving fluoride acceptance in the practice. We knew that if we could move that needle, the group would achieve a healthy 40 percent revenue growth immediately. We also added this discussion to their morning huddles and re-implemented bi-weekly check-in meetings with the hygiene team. The group was instructed to keep this goal their focus for a minimum of one quarter before adding in another goal. Yes, we want all other areas to grow, but if we want to master prevention, then we need to have an all hands-on deck approach to making it happen using the four points above.

If there is one thing I have learned in my 15 years of training and coaching dental teams, sometimes you need to go slow to go fast. Long-term results depend on a solid foundation – that is not created overnight.

We hope you take this into consideration when working with your dental teams. However, if you need help making these changes with your organization, contact the Enhanced Hygiene team at hello@enhancedhygiene.com. ■



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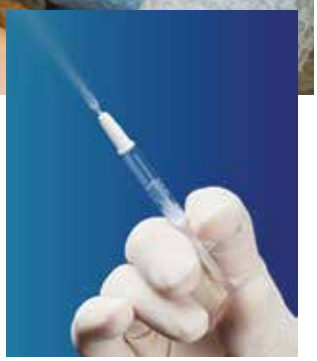

Kovanaze® is the first FDA-approved Nasal Spray indicated for regional anesthesia when performing a restorative procedure on teeth 4-13 and A-J in adults and children who weigh 40 kg or more. And as its name implies, Kovanaze Nasal Spray is *needle-free!*

IMPORTANT SAFETY INFORMATION: Use in patients with uncontrolled hypertension or inadequately controlled active thyroid disease of any type is not advised. Tetracaine may cause methemoglobinemia, particularly in conjunction with methemoglobin-inducing agents. Use of KOVANAZE in patients with a history of congenital or idiopathic methemoglobinemia is not advised. Methemoglobinemia should be considered if central cyanosis unresponsive to oxygen therapy occurs, especially if methemoglobinemia-inducing agents have been used. Confirm diagnosis by measuring methemoglobin level with co-oximetry. Treat clinically significant symptoms of methemoglobinemia with a standard clinical regimen. Allergic or anaphylactic reactions can occur. If an allergic reaction occurs, seek emergency help immediately. KOVANAZE is contraindicated in patients with a history of allergy to tetracaine, benzyl alcohol, other ester local anesthetics, p-aminobenzoic acid (PABA), oxymetazoline, or any other component of the product. Some clinical trial patients experienced an increase in blood pressure so blood pressure should be monitored. In addition, patients should be carefully monitored for dysphagia. KOVANAZE is not recommended for use in patients with a history of frequent nose bleeds. Concomitant use of monamine oxidase inhibitors, nonselective beta adrenergic antagonist, or tricyclic antidepressants may cause hypertension and is not recommended. Discontinue use of oxymetazoline-containing products 24 hours prior to KOVANAZE administration. Avoid concomitant use of intranasal products. The most common adverse reactions to KOVANAZE occurring in >10% of patients include a runny nose, nasal congestion, nasal discomfort, sore throat, and watery eyes.

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INDICATIONS AND USAGE

KOVANAZE contains tetracaine HCl, an ester local anesthetic, and oxymetazoline HCl, a vasoconstrictor. KOVANAZE is indicated for regional anesthesia when performing a restorative procedure on Teeth 4-13 and A-J in adults and children who weigh 40 kg or more.

CONTRAINDICATIONS

KOVANAZE is contraindicated in patients with a history of allergy to or intolerance of tetracaine, benzyl alcohol, other ester local anesthetics, p-aminobenzoic acid (PABA), oxymetazoline, or any other component of the product.

WARNINGS AND PRECAUTIONS

Risk of Hypertension: KOVANAZE has not been studied in Phase 3 trials in adult dental patients with blood pressure greater than 150/100 or in those with inadequately controlled active thyroid disease. KOVANAZE has been shown to increase blood pressure in some patients in clinical trials. Monitor patients for increased blood pressure. Use in patients with uncontrolled hypertension or inadequately controlled active thyroid disease of any type is not advised.

Epistaxis: In clinical trials, epistaxis occurred more frequently with KOVANAZE than placebo. Either do not use KOVANAZE in patients with a history of frequent nose bleeds (≥ 5 per month) or monitor patients with frequent nose bleeds more carefully if KOVANAZE is used.

Dysphagia: In clinical trials, dysphagia occurred more frequently with KOVANAZE than placebo. Carefully monitor patients for this adverse reaction.

Methemoglobinemia: Tetracaine may cause methemoglobinemia, particularly in conjunction with methemoglobin- inducing agents. Based on the literature, patients with glucose-6-phosphate dehydrogenase deficiency or congenital or idiopathic methemoglobinemia are more susceptible to drug-induced methemoglobinemia. Use of KOVANAZE in patients with a history of congenital or idiopathic methemoglobinemia is not advised. Patients taking concomitant drugs associated with drug-induced methemoglobinemia, such as sulfonamides, acetaminophen, acetanilide, aniline dyes, benzocaine, chloroquine, dapsone, naphthalene, nitrates and nitrites, nitrofurantoin, nitroglycerin, nitroprusside, pamaquine, p-aminosalicylic acid, phenacetin, phenobarbital, phenytoin, primaquine, and quinine, may be at greater risk for developing methemoglobinemia. Initial signs and symptoms of methemoglobinemia (which may be delayed for up to several hours following exposure) are characterized by a slate grey cyanosis seen in, e.g., buccal mucous membranes, lips and nail beds. In severe cases, symptoms may include central cyanosis, headache, lethargy, dizziness, fatigue, syncope, dyspnea, CNS depression, seizures, dysrythmia and shock. Methemoglobinemia should be considered if central cyanosis unresponsive to oxygen therapy occurs, especially if methemoglobinemia-inducing agents have been used. Calculated oxygen saturation and pulse oximetry are inaccurate in the identification of methemoglobinemia. Confirm diagnosis by measuring methemoglobin level with CO-oximetry. Normally, methemoglobinemia levels are <1%, and cyanosis may not be evident until a level of at least 10% is present. Treat clinically significant symptoms of methemoglobinemia with a standard clinical regimen such as a slow intravenous infusion of methylene blue at a dosage of 1-2 mg/kg given over a 5 minute period.

Anaphylactic Reactions: Allergic or anaphylactic reactions have been associated with tetracaine, and may occur with other components of KOVANAZE. They are characterized by urticaria, angioedema, bronchospasm, and shock. If an allergic reaction occurs, seek emergency help immediately.

ADVERSE REACTIONS

The most common adverse reactions occurring in >10% of patients include runny nose, nasal congestion, nasal discomfort, sore throat, and watery eyes. Transient, asymptomatic elevations in systolic blood pressure
(≥ 25 mm Hg from baseline) and diastolic blood pressure (≥ 15 mm Hg from baseline) have been reported.

DRUG INTERACTIONS

Monoamine Oxidase Inhibitors: Use of KOVANAZE in combination with monoamine oxidase inhibitors (MAOIs), nonselective beta adrenergic antagonists, or tricyclic antidepressants may cause hypertension and is not recommended. Alternative anesthetic agents should be chosen for patients who cannot discontinue use of MAOIs, nonselective beta adrenergic antagonists, or tricyclic antidepressants.

Oxymetazoline-containing Products: Concomitant use with other oxymetazoline-containing products (such as Afrin®) has not been adequately studied. Use of KOVANAZE with other products containing oxymetazoline may increase risk of hypertension, bradycardia, and other adverse events associated with oxymetazoline. Discontinue use 24 hours prior to administration of KOVANAZE.

Intranasal Products: Oxymetazoline has been known to slow the rate, but not affect the extent of absorption of concomitantly administered intranasal products. Do not administer other intranasal products with KOVANAZE.

USE IN SPECIFIC POPULATIONS

Pregnancy Risk Summary: Limited published data on tetracaine use in pregnant women are not sufficient to inform any risks. Published epidemiologic studies of nasal oxymetazoline used as a decongestant during pregnancy do not identify a consistent association with any specific malformation or pattern of malformations. In animal reproduction and development studies, oxymetazoline given subcutaneously to rats during the period of organogenesis caused structural abnormalities at a dose approximately 7.6 times the exposure of oxymetazoline HCl at the 0.3 mg maximum recommended human dose (MRHD) of KOVANAZE. In a pre- and post-natal development study, oxymetazoline given subcutaneously to rats caused embryo-fetal toxicity manifested by reduced implantation sites and live litter sizes at approximately 1.5 times the MRHD and increased pup mortality at 6 times the MRHD. No adverse developmental effects were observed following subcutaneous administration of tetracaine HCl only to rats and rabbits during organogenesis at 32 and 6 times, respectively, the estimated exposure of tetracaine HCl at the 18 mg MRHD of KOVANAZE. In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2 to 4% and 15 to 20%, respectively.

Lactation Risk Summary: There are no data on the presence of tetracaine, oxymetazoline, or their metabolites in human milk, the effects on the breastfed infant, or the effects on milk production. Detectable levels of oxymetazoline, tetracaine and the major metabolite of tetracaine, *p*-butylaminobenzoic acid (PBBA), were found in the milk of lactating rats following subcutaneous administration of oxymetazoline HCl in combination with tetracaine HCl during the period of organogenesis through parturition and subsequent pup weaning. Due to species-specific differences in lactation physiology, animal data may not reliably predict drug levels in human milk.

The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for KOVANAZE and any potential adverse effects on the breastfed infant from KOVANAZE or from the underlying maternal condition.

Females and Males of Reproductive Potential:
Infertility: No information is available on fertility effects in humans.

Females: Based on animal data, KOVANAZE may reduce fertility in females of reproductive potential. In female rats, decreased fertility noted as a decrease in litter size occurred at 0.7 times the oxymetazoline AUC exposure at the MRHD of KOVANAZE. It is not known if the effects on fertility are reversible.

Males: Based on animal data, KOVANAZE may reduce male fertility. In male rats, decreased sperm motility and sperm concentration occurred at approximately 2 times the oxymetazoline AUC exposure at the MRHD of KOVANAZE.

Pediatric Use: KOVANAZE has not been studied in pediatric patients under 3 years of age and is not advised for use in pediatric patients weighing less than 40 kg because efficacy has not been demonstrated in these patients.

Geriatric Use: Clinical studies of KOVANAZE did not include sufficient numbers of patients aged 65 and over to determine whether they respond differently from younger patients. Other reported clinical experience has not identified differences in responses between the elderly and younger patients. Monitor geriatric patients for signs of local anesthetic toxicity, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy.

Of note, comparisons of KOVANAZE safety and efficacy results were generally similar among dental patients who were > 50 years old (n=66) and ≤ 50 years old (n=148). However, a trend toward a higher incidence of notable increases in systolic blood pressure was observed in dental patients > 50 years of age compared with patients ≤ 50 years of age (16.6% vs 1.4, respectively). These increases in blood pressure measurements were generally asymptomatic and transient in nature, and all spontaneously resolved without the need for medical intervention.

Hepatic Disease: Because of an inability to metabolize local anesthetics, those patients with severe hepatic disease may be at a greater risk of developing toxic plasma concentrations of tetracaine. Monitor patients with hepatic disease for signs of local anesthetic toxicity.

Pseudocholinesterase Deficiency: Because of an inability to metabolize local anesthetics, those patients with pseudocholinesterase deficiency may be at a greater risk of developing toxic plasma concentrations of tetracaine. Monitor patients with pseudocholinesterase deficiency for signs of local anesthetic toxicity.

OVERDOSAGE

No addictive properties have been reported in the literature for either tetracaine or oxymetazoline, but there have been numerous case reports of unintended overdose for both compounds. Side effects in adults and children associated with oxymetazoline overdose include dizziness, chest pain, headaches, myocardial infarction, stroke, visual disturbances, arrhythmia, hypertension, or hypotension. Side effects of tetracaine overdose include rapid circulatory collapse, cardiac arrest, and cerebral events. Possible rebound nasal congestion, irritation of nasal mucosa, and adverse systemic effects (particularly in children), including serious cardiac events, have been associated with overdosage and/or prolonged or too frequent intranasal use of oxymetazoline containing agents. Accidental ingestion of imidazoline derivatives (i.e., oxymetazoline, naphazoline, tetrahydrozoline) in children has resulted in serious adverse events requiring hospitalization (e.g., coma, bradycardia, decreased respiration, sedation, and somnolence). Patients should be instructed to avoid using oxymetazoline-containing products (such as Afrin®) and other α-adrenergic agonists within 24 hours prior to their scheduled dental procedure. Management of an overdose includes close monitoring, supportive care, and symptomatic treatment.

HOW SUPPLIED

KOVANAZE Nasal Spray is a pre-filled, single-use, intranasal sprayer containing a clear 0.2 mL aqueous solution at pH 6.0 ± 1.0 comprising 30 mg/mL of tetracaine hydrochloride and 0.5 mg/mL of oxymetazoline hydrochloride (equivalent to 26.4 mg/mL tetracaine and 0.44 mg/mL oxymetazoline). Each nasal spray unit delivers one 0.2 mL spray. Each 0.2 mL spray contains 6 mg tetracaine hydrochloride (equivalent to 5.27 mg tetracaine) and 0.1 mg oxymetazoline hydrochloride (equivalent to 0.088 mg oxymetazoline). NDC: 69803-100-10

STORAGE AND HANDLING

Store between 2° and 8°C (36° and 46°F); excursions permitted between 0° and 15°C (32° and 59°F) [see USP controlled cold temperature]. Discard any unused solution. DO NOT use if drug is left out at room temperature for more than 5 days.

PATIENT COUNSELING INFORMATION

Inform patients of the likelihood of expected side effects (including runny nose, nasal congestion, mild nose bleeds, dizziness, and/or a sensation of difficulty in swallowing) that should resolve within the same day. Instruct patients to contact their dentist or health care professional if these symptoms persist.

Advise patients to inform the dental practitioner if they are taking monoamine oxidase inhibitors (MAOIs), nonselective beta adrenergic antagonists, or tricyclic antidepressants.

Instruct patients to avoid using oxymetazoline-containing products (such as Afrin® and other α-adrenergic agonists) within 24 hours prior to their scheduled dental procedure.

Advise patients of the signs and symptoms of hypersensitivity reactions and to seek immediate medical attention should they occur.

Manufactured for: St. Renatus, LLC, Fort Collins, CO 80526

Rev. 11/2016

Safest Dental Visit™

Antibiotic Use in Dentistry

In September 2016, the Organization for Safety, Asepsis and Prevention (OSAP) a growing community of clinicians, educators, policy makers, consultants and industry representatives who advocate for the Safest Dental Visit™, celebrated the second annual Dental Infection Control Awareness Month (DICAM) to focus on the importance of infection control in dentistry. In this month's *Efficiency in Group Practice*, we look at the importance of best practices to ensure responsible antibiotic use in dentistry.

Researchers and clinicians have long agreed that a substantial percent of outpatient antibiotic prescriptions – as much as 30 percent – is unnecessary. Due to barriers in data collection, however, it has been unclear exactly how much unnecessary antibiotic prescribing takes place in dentistry. Still, there is concern that unnecessary and inappropriate prescribing is common in dental offices. Data show that primary care dentists – not including dental specialists or surgeons – write approximately 10 percent of all antibiotic prescriptions filled in outpatient pharmacies each year. That equates to nearly 26 million prescriptions.

The Centers for Disease Control and Prevention (CDC) and the Organization for Safety, Asepsis and Prevention (OSAP) recently collaborated on an article – Considerations for Responsible Antibiotic Use in Dentistry – published in The Journal of the American Dental Association (JADA) concerning responsible antibiotic use in dentistry. Authors Marie T. Fluent, DDS; Peter L. Jacobson, PhD, DDS, Dip ABOM; and Lauren A. Hicks, DO, point out that "misuse and overuse of antibiotics have contributed to selective pressure on bacteria to adapt to the antibiotics intended to kill them; antibiotic resistance is now one of our most serious global health threats. Every year in the United States, at least two million people become infected with antibiotic-resistant bacteria, and approximately 23,000 people die as a direct result of these infections."

Best practices

In an effort to improve antibiotic use in dentistry, several professional organizations have developed best practices to guide dentists through the entire antibiotic prescribing process, including pretreatment, prescribing and patient and staff education. Pretreatment steps involve establishing a correct diagnosis, reviewing the patient's pertinent medical history and considering whether therapeutic management of a local bacterial infection with a procedure may be more appropriate than using an antibiotic. Dentists should base their prescribing decisions on evidence-based medicine. Additionally, they should educate patients to take antibiotics exactly as prescribed – and only if prescribed for them – and to not save unused antibiotics for future use. Lastly, dentists and staff should stay current on optimal antibiotic prescribing practices through continuing education opportunities.

Dental organizations such as OSAP and the American Dental Association (ADA), have committed to improving antibiotic prescribing in order to maximize patient safety and reduce antibiotic overuse and misuse. Antibiotic overuse and misuse have been known to contribute to the development and spread of antibiotic resistance and the occurrence of adverse events, such as the sometimes-deadly diarrhea caused by Clostridium difficile. These best practices will be a resource for dentists to consult when prescribing antibiotics to ensure patients are prescribed antibiotics only when the benefits outweigh the risks.

OSAP will feature a session on antibiotic stewardship in dentistry at its annual conference June 22-25 in Atlanta, Ga. For more information visit http://osapconference.org.

Editor's note: To review the article visit http://jada.ada.org/article/S0002-8177(16)30409-3/abstract?rss=yes. OSAP looks forward to continuing to work with the CDC to help advance its antibiotic-resistance initiative. To learn more, visit the CDC Safe Healthcare Blog: http://blogs.cdc.gov/safehealthcare/addressing-antibiotic-resistance-in-dentistry-what-can-we-do/.

Progress Report

DSOs: An Industry Update

By Laura Thill

Editor's note: *Progress comes in many shapes and forms. Advances in technology and an evolving focus on the patient experience have raised the bar for clinicians, as they hustle to stay at the forefront of an industry marked by lightning-speed growth.*

Determined to be a leader, the dental industry has taken significant steps these past 10 years to ensure it offers more and better services to patients. With that has come the growth of dental service organizations. In fact, for many dental professionals, DSOs have made it possible to stay focused on patient care rather than getting swept up by the demands of their business.

Efficiency in Group Practice reached out to several industry experts to discuss the evolution of the dental service organization: the factors that have impacted their growth, the challenges they have faced and the changes that lie ahead.

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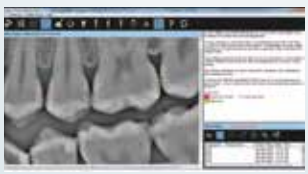

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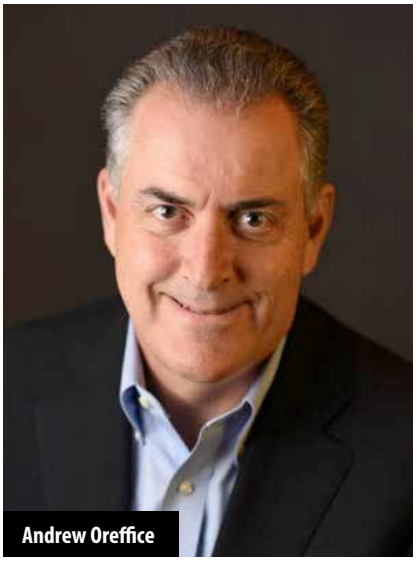
Andrew Oreffice

Benevis Practice Services

***Efficiency in Group Practice*: How have dental service organizations, including your own, grown over the past 10 years?**

Andrew Oreffice, senior vice president of compliance & government relations: DSOs have grown in size, influence and sophistication throughout the past decade as more dentists have opted for a practice model that allows them to focus on what they went to school to do – practice dentistry. Nearly 7 percent of dentists in the United States are now affiliated with a DSO, according to the latest data from the ADA Health Policy Institute, and that percentage almost doubles for dentists under the age of 35. Today there are hundreds of DSOs that range in scope and size. At Benevis, we've grown from 14 affiliate dental practices in 2006 when I joined the organization to more than 150 affiliate practices in 2017. Part of this growth is due to the increasing popularity of DSOs among new dentists. We've also invested in award-winning technology and industry-leading compliance programs that make our practice support services especially attractive to established dentists and group practices.

"DSOs have grown in size, influence and sophistication throughout the past decade as more dentists have opted for a practice model that allows them to focus on what they went to school to do – practice dentistry. Nearly 7 percent of dentists in the United States are now affiliated with a DSO, according to the latest data from the ADA Health Policy Institute, and that percentage almost doubles for dentists under the age of 35. Today there are hundreds of DSOs that range in scope and size."

– Andrew Oreffice, senior vice president of compliance & government relations, Benevis

***EGP*: What factors – economic, legislative, social, etc. – have impacted this growth?**

Oreffice: Increased regulation and administrative bureaucracy, technology changes and economic factors have made it more difficult for dentists to run financially viable private practices. Increasingly, established dentists and group practices are partnering with DSOs to manage the non-clinical aspects of running a busy practice. They do this to alleviate themselves of the hassles of things like HR, payroll and marketing, and also to tap into the DSO's buying power and economies of scale for equipment and technology purchases. Younger dentists – often saddled with student loan debt and seeking professional growth opportunities – are attracted to DSO-affiliated practices because they offer competitive wages and benefits, clinical training, professional development and a modern, sophisticated practice setting that does not require a large startup investment or additional loans to build.

EGP: **What have been some of the greatest challenges facing DSOs, and what strategies have proved successful for addressing them?**

Oreffice: As is the case with any innovative and disruptive industry model, there has been some skepticism about – and resistance to – DSOs from the dental establishment, state and federal regulators, lawmakers and payors. This is changing as more stakeholders become educated about the DSO model and see the benefits – particularly a better quality of life for dentists, improved dental health outcomes for patients and lower costs for payors. It is hard to dispute data, which is one of the reasons Benevis has invested in electronic health records and comprehensive quality and compliance programs. Our own internal data, as well as publicly available government data, consistently shows that our affiliate providers like Kool Smiles are leading the way in providing conservative care, improving patient health outcomes and lowering costs for government payors like Medicaid. We also do a lot of outreach to stakeholders to educate them about the DSO model, share our success stories and best practices, and give voice to the growing number of dentists who have found their clinical home with a DSO-affiliated provider.

EGP: **In your experience, is it easier or more difficult for DSOs to do business today compared to past years?**

Oreffice: In some ways it is easier for DSOs to do business today due to changing perceptions about the DSO model and its growing popularity. Of course, these positive trends also mean that the DSO sector is more competitive than it was 10 years ago. Like the rest of the dental industry, DSOs will need to continue innovating and evolving to stay competitive in the years ahead.

EGP: **What is the biggest change we can expect to see in dental healthcare in the next several years, and what will this mean for DSOs?**

Oreffice: The biggest change we can expect to see in dental healthcare is the shift from fee-for-service to pay-for-performance models, both among public and private payors. Rather than paying providers for volume, pay-for-performance models will reward preventive care, cost-effective management practices and improved oral health outcomes. With their industry-leading EHRs and quality and compliance systems, DSOs like Benevis are uniquely positioned to help dentists demonstrate value and outcomes, so we expect that even more dentists and group practices will enlist the expertise and resources of DSOs as they navigate this new payment paradigm in the years to come.

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Efficiency in Group Practice: **How have dental service organizations, including your own, grown over the past 10 years?**

Greg Nodland, COO: Through the years, we have seen an increased awareness, understanding and acceptance of the DSO model. Today we see greater coordination among specialists, leading to better clinical outcomes, as well as a more rewarding clinical environment for our doctors. For instance, at GEDC we created a Doctor Career Path – a way for doctors to have a long-term career with growth vs. going to individual practice and doing associate work then moving to the next practice. We want our doctors to know that their career can flourish and grow at GEDC and there is a path to help them reach the heights they want to achieve. An increased level of sophistication has driven

Greg Nodland

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efficiencies in claims administration and adjudication. In addition, an increasingly coordinated approach to dental healthcare has ensured the highest level of safety and compliance with laws across all offices, exceeding the industry norm. DSOs overall are focusing on the measurement of the patient experience, which goes beyond great clinical care and patient service. Many are trying to figure out how to enhance the patient experience.

***EGP*: What factors – economic, legislative, social, etc. – have impacted this growth?**

Nodland: For one, complexities in insurance plans and shrinking benefits have made it imperative for dental organizations of all sizes to work efficiently to manage their business. Cutting clinical corners is not an option. Also, the economics for dentists relative to debt out of dental school continues to create challenges for them in their practice or within a DSO.

Legislatively, with the growth of the DSOs, to a degree there is an unknown as to how they operate and their place within organized dentistry. With that there has been a lot of activity and discussion within various states. DSOs in particular have organized via ADSO to fill this knowledge vacuum, working directly with legislative members to address concerns. And as the COO, I meet with anyone at the political/legislative level who wants to learn about the DSO model and how it is helping patients from all walks of life get the care they need for them and their family.

Socially, as with all medical verticals, dentistry is going through some consolidation. We've seen it in pharmacies, hospitals, dermatology, etc. As this change progresses, both doctors and patients have become more familiar with the DSO model. Whereas a patient may not have gone to a DSO-affiliated office 10 years ago, this mindset is changing quickly. People are busy, and they are looking for a dentist who can accommodate their schedule, is affordable and offers quality care. That's something organizations like GEDC bring to current and future generations of patients.

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>
> **– Greg Nodland, COO, GEDC**

***EGP*: What have been some of the greatest challenges facing DSOs, and what strategies have proved successful for addressing them?**

Nodland: Some of the biggest challenges have included educating the public about the role and purpose of a DSO within the dental industry; developing efficient business models as dental groups expand geographically and in size; and educating the public that seeing the dentist before a problem occurs is best for one's health.

ADSO has been instrumental in educating the dental community, state and local governments and the public. Likewise, through GEDC's continued involvement in professional organizations, such as the ADA, AAO and state societies, people can learn about GEDC and we can better understand their concerns and thoughts. In addition, GEDC has become increasingly involved with dental schools to meet with the deans, faculty and students. We are committed to hiring experienced managers to help with growth; developing robust training and development programs; investing in information technology to ensure patient flow is efficient in the office and allowing the clinical and business management team to see all data points; and investing in our doctors and office team members with leadership training and continuing education.

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***EGP*: In your experience, is it easier or more difficult for DSOs to do business today compared to past years?**

Nodland: It has become easier, particularly as the role of the DSO is better understood and financial and political challenges have continued to hit the industry. Dental professionals are much more open to joining a DSO, as they appreciate and understand how DSOs can provide a great work/life balance and a great clinical environment in which to provide care to their patients.

***EGP*: What is the biggest change we can expect to see in dental healthcare in the next several years, and what will this mean for DSOs?**

Nodland: Besides the expanded role of DSOs as a percent of the industry, the biggest changes will include the ever-changing insurance environment, increasing coordination between dental and traditional medical care and improving clinical technology and methods allowing general practitioners to expand their range of services. In addition, we will see more DSOs appear and earn a larger share of the market. I believe we also will see more transparency in healthcare overall, including dental, as people become more involved with their insurance and, by default, understand it better. We have seen innovation in the dental industry, with products like Invisalign, and moving forward I think we will see even more, further enhancing the patient experience.

Mike Belica

ADSO Association of Dental Support Organizations

ADSO

***Efficiency in Group Practice*: How have dental service organizations grown over the past 10 years?**

Michael Bileca, ADSO President: The number of practices supported by DSOs has grown considerably over the past 10 years. Along with that growth, DSOs have implemented strategies and systems to further refine how they perform non-clinical back-office support services. For example, over the past 10 years, many practices supported by DSOs have benefited from investments made by DSOs in technology, non-clinical staff training, the latest clinical equipment and other areas. As part of this growth, DSOs have been able to further lower costs of supplies, equipment and other items used in dental practices due to the increased purchasing power they have to benefit the practices they support. The increase in growth has also increased the retention rate of non-clinical professionals and specialists who, in turn, have increased the level and quality of services provided to supported practices.

***EGP*: What factors – economic, legislative, social, etc. – have impacted this growth?**

Bileca: There are a number of factors that have impacted this growth, from the increased awareness of the impact of oral healthcare on other areas of the body, to the debt that many dentists incur by the time they graduate from dental school. Increased awareness of the connection between a person's oral health and his or her overall health has driven legislators and policy makers to consider their constituents' access to quality dental care. Since DSOs address the non-clinical aspects of dental practices for dentists (which can account for as high as 30 – 40 percent of a dentist's time in a traditional practice), those dentists are able to spend more time with their patients, increasing access to oral healthcare. In addition, the cost savings realized by practices supported by DSOs on their non-clinical activities permits those dentists to pass along the savings to their patients in the form of lower costs, which also increases access.

At the provider level, the huge economic costs incurred by dentists in dental school, which is often financed by student debt, leaves many graduating dentists without

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"Dentists who choose to hire a DSO to help with the non-clinical aspects of their practice are provided the capital necessary to own their own office. This provides dentists who otherwise could not afford to open their own practice with a path to ownership."

– Mike Bileca, ADSO President

the credit capacity to start their own practice. A typical dental practice can cost between $500,000 - $750,000 or more to start. Those graduating dentists are left with few professional options other than practicing as another dentist's associate. Associate dentists often earn far less than dentists who own their practice, making it difficult or impossible to open their own practice after payment of the ongoing debt obligations from their education. However, dentists who choose to hire a DSO to help with the non-clinical aspects of their practice are provided the capital necessary to own their own office. This provides dentists who otherwise could not afford to open their own practice with a path to ownership. Those additional practices, in turn, help increase access to dental care by increasing the number of clinical hours available for patients, increasing competition and passing along savings that the supported dentists achieve on their non-clinical costs in the form of lower patient fees.

***EGP*: What have been some of the greatest challenges facing DSOs, and what strategies have proved successful for addressing them?**

Bileca: While the number of dental practices supported by DSOs over the past 10 years has grown substantially, they still account for less than 20 percent of the total number of practicing dentists, leaving them a substantial minority compared to the number of dentists who have chosen to practice in a traditional or other way. (Traditional practitioners – along with local, state and national dental associations – are commonly referred to as organized dentistry.) Dentists supported by DSOs often provide care to patients who, for one reason or another, are not receiving care from traditional practitioners. For example, the Federal Trade Commission has noted that due to the cost savings that supported practices of DSOs realize, they are often able to accept the lower fees offered by state Medicaid programs and profitably provide care to those otherwise forgotten patients.

Organized dentistry is very powerful. In some states, the political action committees of state dental associations are in the top 5 of political action committees in their respective states. Some members in organized dentistry have attempted to pursue anti-competitive legislative agendas aimed at eliminating the ability of DSOs to conduct business or reducing the ability of dentists to hire DSOs. Earlier this year, the American Legislative Exchange Council (ALEC) released a study entitled, "Overregulation Threatens Market-Driven Solutions in Dentistry," which highlighted the concerns around the anti-competitive, anti-consumer nature of over-regulation in the healthcare industry. To date, none of those of those efforts have been successful. Once legislators learn how DSOs function and become aware of increased access to quality dental care to their constituents from DSO-supported dentists, they often back down from supporting anti-competitive legislation supported by organized dentistry.

The DSO business model is one where the more often things are done the right way, the more successful the practice owner's business is. DSOs provide efficiencies to their supported dentists, which are passed along to patients in the form of lower fees and increased access. Since supported dentists do not have to trade their valuable clinical time to run the business side of their practices, they are able to provide quality dental care to more people, compared with dentists who choose to practice in a traditional setting.

Educating legislators and other opinion-leaders about the many benefits of DSO-supported dental practices has helped overturn adverse legislation and increase awareness of why it's important to allow dentist to choose what works best for them. This year, Arkansas became the first state to pass affirmative legislation protecting the rights of dentists to hire DSOs, as well as for DSOs to provide their services to dentists. The DSO industry remains hopeful that this signifies movement towards greater acceptance in organized dentistry of the benefits provided by DSOs.

***EGP*: In your experience, is it easier or more difficult for DSOs to do business today compared to past years?**

Bileca: Both. Years ago, when DSOs and the dentists they supported were small in number, they were able to operate without issues relating to organized dentistry. As time went on, dentists and their patients better understood the benefits offered by DSOs, and more dentists chose to hire DSOs to support their practices. This made some in organized dentistry uneasy, and opposition to DSOs became more organized, coalescing into anti-competitive legislative activity in a few states.

However, over the same period of time, both dentists and patients became increasingly familiar with the benefits provided by DSOs. As such, more and more dentists have taken a hard look at how they have set up the business-side of their practices, and many of those dentists are seeking out DSOs for the benefits they provide. Even though DSO-supported dentists account for less than 20 percent of all dentists nationwide, in many ways DSOs have come to offer a mainstream approach to addressing a practice's business needs compared to the traditional practice structure.

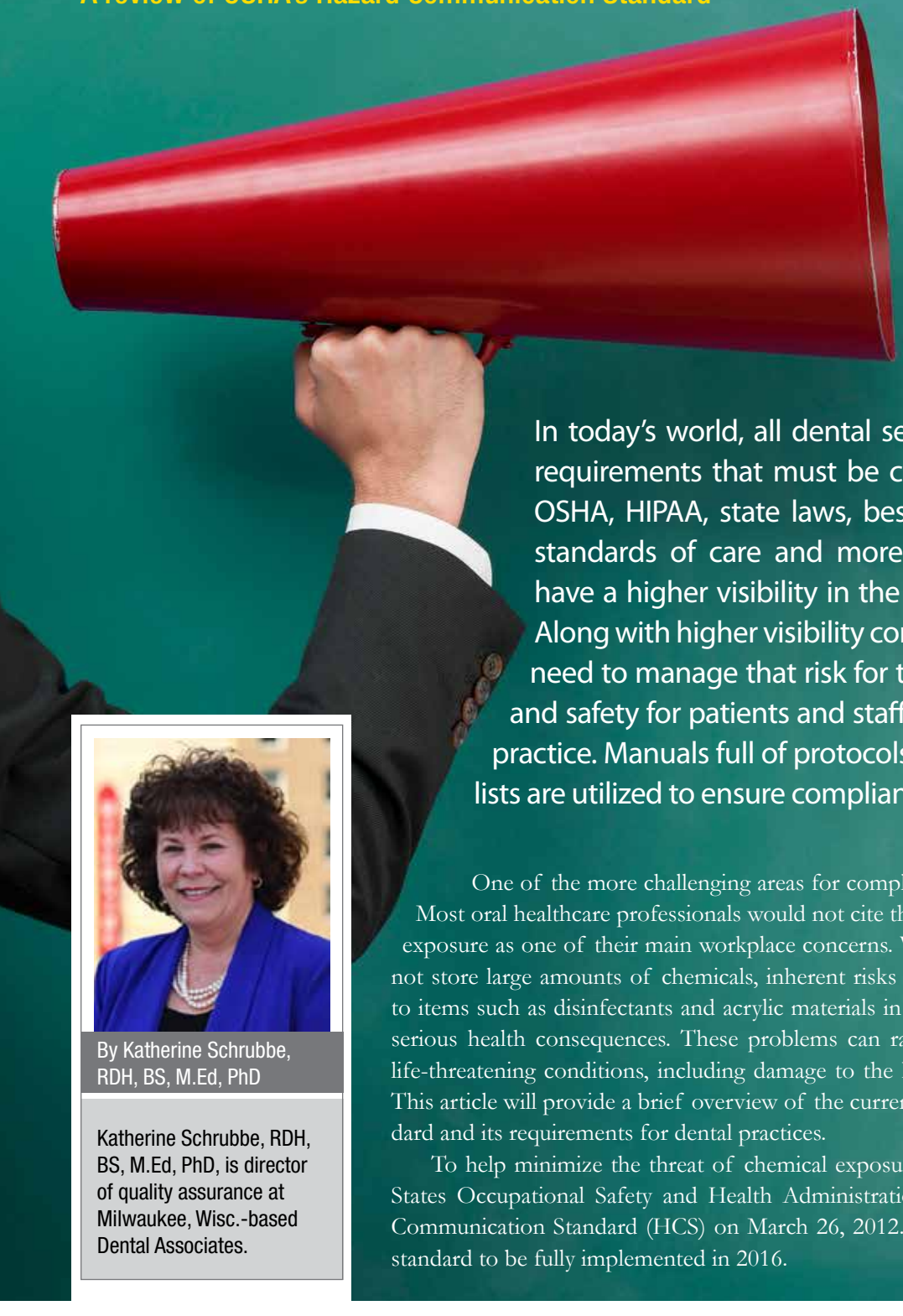
***EGP*: What is the biggest change we can expect to see in dental healthcare in the next several years, and what will this mean for DSOs?**

Bileca: Dentistry is one of the few areas of healthcare where insurance is less prevalent than in medicine. It is reasonable to expect that the number of practitioners who accept dental insurance will likely increase over the next several years, although reimbursement rates to practitioners may continue to be flat. This increased acceptance of insurance will drive dentistry to become more efficient in the way care is provided to patients. Since DSOs are a driving force in increasing the efficiency of a practice's non-clinical activities, we believe that more dentists who practice in a traditional structure will seek out the efficiencies offered by DSOs, making it possible for them to accept the lower insurance reimbursement rates and still remain profitable. DSOs have been leading the change towards increased efficiency in dentistry, and market forces that place a premium on efficiency will result in a significant growth in dentists hiring DSOs to achieve those efficiencies.

Dentistry is the last major area of healthcare to fully modernize its non-clinical support services. Healthcare, optometry and pharmacy all have similar administrative support structures provided by organizations similar to DSOs. Dentistry is 15 to 20 years behind the rest of healthcare in terms of operating in a modern business climate. Is there a physician in this country who does his or her own billing or office leasing? Despite the myriad benefits of DSOs, more battles are likely to ensue. However, the inevitability of progress and the ultimate benefits to patients provided by DSO-supported dentists will win out. ■

Standard of Communication

A review of OSHA's Hazard Communication Standard



In today's world, all dental settings have a myriad of requirements that must be complied with, including OSHA, HIPAA, state laws, best practices, professional standards of care and more. Large group practices have a higher visibility in the community they reside. Along with higher visibility comes a higher risk and the need to manage that risk for the practice. Compliance and safety for patients and staff are the pinnacle for the practice. Manuals full of protocols, procedures and checklists are utilized to ensure compliance to set standards.

By Katherine Schrubbe, RDH, BS, M.Ed, PhD

Katherine Schrubbe, RDH, BS, M.Ed, PhD, is director of quality assurance at Milwaukee, Wisc.-based Dental Associates.

One of the more challenging areas for compliance is hazard communication. Most oral healthcare professionals would not cite the risk of injury due to chemical exposure as one of their main workplace concerns. While dental offices typically do not store large amounts of chemicals, inherent risks still remain. Chemical exposure to items such as disinfectants and acrylic materials in the clinical setting can result in serious health consequences. These problems can range from short-term issues to life-threatening conditions, including damage to the heart, kidneys, liver, and lungs.[1] This article will provide a brief overview of the current Hazard Communication standard and its requirements for dental practices.

To help minimize the threat of chemical exposure in the workplace, the United States Occupational Safety and Health Administration (OSHA) revised its Hazard Communication Standard (HCS) on March 26, 2012. This was a three-year phase-in standard to be fully implemented in 2016.

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The changes brought the United States into alignment with the United Nations Globally Harmonized System of Classification and Labeling of Chemicals, further improving the health and safety protections for American workers. The revised standard is expected to prevent an estimated 500 injuries and illnesses and 43 fatalities annually.[2]

Designed to ensure that information about chemical threats and associated protective measures are broadly disseminated, the HCS requires chemical manufacturers and importers to evaluate the hazards of the chemicals they produce or import. They must then provide information on the labeling of their shipping containers, as well as more specific details via safety data sheets (SDSs) to the end users. Employers such as dental practices, with hazardous chemicals in their workplaces must prepare and implement a written hazard communication program, ensuring that all containers are properly labeled, employees have access to SDSs and workers are effectively trained to respond to chemical exposure.[3]

Dental practice settings are required to comply with the directives outlined in the HCS, as there is a high risk of exposure to the chemicals used in the delivery of oral care, as well as during the cleaning and disinfection of the clinical setting and instruments.

Effective Completion Date	Requirement(s)	Who
December 1, 2013	Train employees on the new label elements and SDS format.	Employers
June 1, 2015* December 1, 2015	Comply with all modified provisions of this final rule; except: Distributors may ship products labeled by matufacurer under the old system until December I, 2015.	Chemical manufacturer importers distributors and employers.
June 1, 2016	Update alternative workplace labeling and hazard additional communication program as necessary, and provide additional employee training for newly identified physical or health hazards.	Employers
Transition Period	Comply with either 29 CFR 1910. 1200 (this final standard), or the current standard, or both.	All chemical manufacturers, importers, distributors and employers.

Table 1. Phase-in dates under the revised Hazard Communication Standard

Classification

The first change to the HCS is related to hazard classification. Today, definitions of hazards must provide specific criteria for classification of health and physical risks, as well as chemical mixtures.[4,5] These criteria are intended to ensure that evaluations of hazardous chemical effects are consistent among all manufacturers, improving the accuracy of labels and SDSs. The U.S. Environmental Protection Agency designates which chemicals are hazardous.[6] But the initial identification, evaluation and notification of chemical hazards is the manufacturer's responsibility. This information is then disseminated to those parties who have purchased the chemical.[4]

Labeling

The second modification to the HCS is labeling. Manufacturers and importers are now required to provide labels that will list the product identifier; include a hazard statement or a short phrase that describes the nature of the hazard; use a harmonized signal word, such as "danger," to alert users of the severity of the hazard; include a precautionary statement that explains how to handle, store and dispose of the hazard; and include a new pictogram that represents a specific message about the chemical.[4,5]

By June 1, 2015, all labels were to appear like the example in Figure 1.[6] Today, labels must contain a pictogram, consisting of a symbol on a white background framed within a red border, representing a distinct hazard(s).[7] The pictogram on the label is determined by the chemical hazard classification, as seen in Figure 2.[4,7] This change will indirectly affect the dental health team and office staff, as employers now are responsible for maintaining easy-to-read labels on containers. According to OSHA, employers have the option to create their own workplace labels with the required information per the current HCS.[8]

Safety Data Sheets

Another major change to the HCS requires manufacturers, importers and distributors to provide end-users with an SDS for each chemical. These updated information sheets appear in a new 16-point uniform format.[4,9] Employers must obtain a specific SDS for each chemical present in the dental practice, and it cannot be generic. For instance, if an office uses three different types of amalgam, three specific SDSs must be kept on file.[4] Employers must ensure that SDSs are kept either as hard copies in a binder or in an electronic format that is consistently backed up and readily accessible to all employees.[9] The new SDS format helps clinicians keep up to date with the sections that are necessary for follow-up in case of patient or provider exposure.[9]

Training

Training is essential in the dental practice in order to increase staff knowledge on an area of importance. Hence, the last major change to the HCS is related to training. A written hazard communication program is required in all workplaces where employees are exposed to hazardous chemicals, including dental settings. This plan describes how the HCS will be implemented. Employers must provide training to employees at initial hire and/or when a new hazard is introduced in the workplace. As such, annual HCS training is recommended.[4]

Conclusion

The revised HCS is intended to reduce confusion about chemical hazards in the workplace, facilitate safety training and improve understanding of chemical use and its inherent risks.[8] Although dental team members may minimize the danger of chemicals in their day-to-day practice of dentistry, risk does exist. Since 1970, OSHA's mission has been to protect all American workers from hazards encountered in the workplace.[10] The current HCS is another example of this, and it is critically important that all dental team members recognize, understand and mitigate the risk of chemical exposure in their workplace. Large group practices can be the role model and can continue to set high standards for required compliance. ■

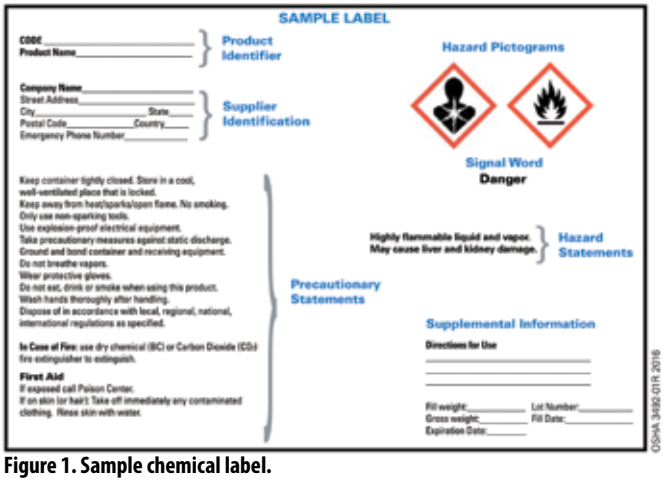

Figure 1. Sample chemical label.

Figure 2. HCS pictograms

References

1. Kehe K, Reichl FX, Durner J, Walther U, Hickel R, Forth W. Cytotoxicity of dental composite components and mercury compounds in pulmonary cells. Biomaterials. 2001;22:317–22.
2. United States Environmental Protection Agency. Globally Harmonized System for Classification and Labelling of Chemicals. Available at: https://www.osha.gov/dsg/hazcom/HCSFactsheet.html. Accessed March19,2017.
3. US Department of Labor. What Is Hazard Communication? Available at: www.osha.gov/dsg/hazcom/whatishazcom.html. Accessed March 19, 2017.
4. Miller CH, Palenik CJ. Infection Control and Management of Hazardous Materials for the Dental Team. 5th ed. St. Louis: Mosby Elsevier; 2013;246–263.
5. US Department of Labor. Hazard Communication. Available at: www.osha.gov/dsg/hazcom/index.html. Accessed March 19, 2017.
6. US Department of Labor. Hazard Communication Standard Labels. Available at: https://www.osha.gov/Publications/OSHA3492QuickCardLabel.pdf. Accessed March 19, 2017.
7. US Department of Labor. Hazard Communication Standard Pictogram. Available at: https://www.osha.gov/Publications/HazComm_QuickCard_Pictogram.html. Accessed March 19, 2017.
8. US Department of Labor. Frequently Asked Questions: Hazard Communication (HAZCOM). Available at: https://www.osha.gov/Publications/OSHA3636.pdf. Accessed March 19, 2017.
9. US Department of Labor. Hazard Communication Safety Data Sheets. Available at: https://www.osha.gov/Publications/OSHA3514.html. Accessed March 19, 2017.
10. US Department of Labor. About OSHA. Available at: https://www.osha.gov/about.html. Accessed March 19, 2017.

Overtime

The Department of Labor's recent ruling can potentially extend overtime pay to dental employees

By Stuart Oberman, Esq., Oberman Law

The Fair Labor Standards Act provides for a federal minimum wage, a standard 40-hour work week and pay at time-and-a-half for all overtime hours. Almost all hourly workers in a dental practice get paid – or should get paid – time-and-a-half for any hours over 40 per week. However, many salaried employees in a dental practice do not get the same protections as in other professions.

That said, individuals who are considered executive, administrative or professional employees, are not entitled to premium pay for overtime work, according to the Act. Traditionally, employees of a dental practice who make more than $23,660 annually and whose primary duties are executive, administrative, or professional have not had to be paid time-and-one-half for overtime hours. The Department of Labor's new rules have nearly doubled this compensation threshold to $47,476.00, which may impact the number of employees in dental practices who are eligible for overtime benefits.

Take stock

Dental practice owners may be significantly impacted by the Department of Labor's new rules. Since many employees have likely been affected, practice owners may have to pay substantially more to employees than has been required under the Fair Labor Standards Act to qualify for an overtime exemption. Practice owners who are forced to comply with the new rules can choose from different options, however these options will vary from practice to practice.

One such option is to raise employees' salaries to the exemption threshold. Practice owners may be able to raise the salaries of affected employees in order to meet the new minimum standards provided for under the new rules.

Another option is to pay overtime, in addition to the employees' current salary, when necessary. Practice owners are only required to pay overtime to an employee who works more than 40 hours in a week. This makes the most sense for employees who make far less than the proposed new salary basis.

A third option is to limit the hours of current employees of the practice and hire more part-time employees. This will split job duties between multiple employees and limit the amount of overtime allowed.

If they have not already done so, practice owners should determine which of their employees are impacted, analyze the hours they have worked and determine which option is best for each of them. Now is the time to act to be in compliance with the new rule change. ■

Editor's note: Stuart J. Oberman, Esq. handles a wide range of legal issues for the dental profession including employment law, practice sales, OSHA and HIPAA compliance, real estate transactions, lease agreements, non-compete agreements, dental board complaints and professional corporations.

$109,570

is how much Dr. Kim Lucas Benton's hygiene production increased in 10 months. Imagine this number multiplied by the number of offices in your organization!

"Since implementing DenMat's STM program, we have noticed **a major improvement in compliance and the overall oral health of our patients** and our hygiene department has skyrocketed from $2,835 per month to $13,792 per month!"

– Kim Lucas Benton, DDS

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- To improve patient communication and acceptance
- Ways to incorporate new technologies to increase productivity

Daily Outcome per RDH	Hygiene Day*	Soft Tissue Management Day*
Hours Worked	8	8
Number of Patients	8	6
Number of Procedures	3	7
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*Simulation only. Actual mix of patients, procedures & production will fluctuate for any RDH and/or office. The figures within this simulation reflect a more diverse and comprehensive treatment offering within the Soft Tissue Management (STM) model, as compared to a traditional Hygiene model. Contact DenMat today and inquire about an STM production simulation for your practice.

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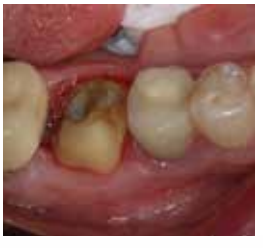
Strength and beauty

Zirconia is quickly proving to be a leader in restorative materials.

An increasingly popular choice of restorative materials among dentists, zirconia is proving to offer a dynamic combination of strength and aesthetics. The introduction of the newest zirconia materials have led to aesthetically pleasing, strong and dependable restorations – an advantage over traditional ceramic restorations.

Growing clinical applications

Since its introduction to the dental industry years ago, zirconia has evolved into a diverse, reliable material suitable for a wide range of clinical applications. Compared to the early years, when fewer products were available to achieve proper bonding, today's full-zirconia crowns offer physical properties and a level of strength and aesthetics said to surpass that of ceramic crowns. Whereas early zirconia restorations were limited to those with proper retention, since the introduction of primers containing MDP, the chemical bond to zirconia has been completely achievable.



Indeed, as more and more clinicians become aware of proper bonding protocols to zirconia surfaces, a growing number of patients are benefiting from efficient, successful restorations. Dental organizations can offer significant support to dentists in the way of educational materials and tools.

For excellent results

For best results, some clinicians are relying on TheraCem, a self-adhesive, resin-based cement that contains MDP. TheraCem offers an optimal bond to both zirconia and the tooth structure, without the need to apply a primer prior to cementation. TheraCem releases calcium and fluoride to the tooth structure, providing transitions from acidic to alkaline ph.

When the preparation has little or no retention, an adhesive procedure is required. The use of an MDP-containing primer such as Z-Prime Plus, which is specifically designed to achieve a chemical bond to zirconia, will provide the best chemical bond to the zirconia surface. A compatible adhesive-cement system is also likely to positively impact the clinical performance of the restoration. All-Bond Universal and Duo-link Universal products are compatible with one another, and the clinical use of this product combination is designed to provide excellent bonding results.

The ability to chemically bond to zirconia will minimize the likelihood of restorations falling off or de-bonding. Not only is less material required, patients will experience minimal chair time. And great results are certain to lead to enhanced patient satisfaction. ■

Editor's note: Sponsored by Bisco, Inc.

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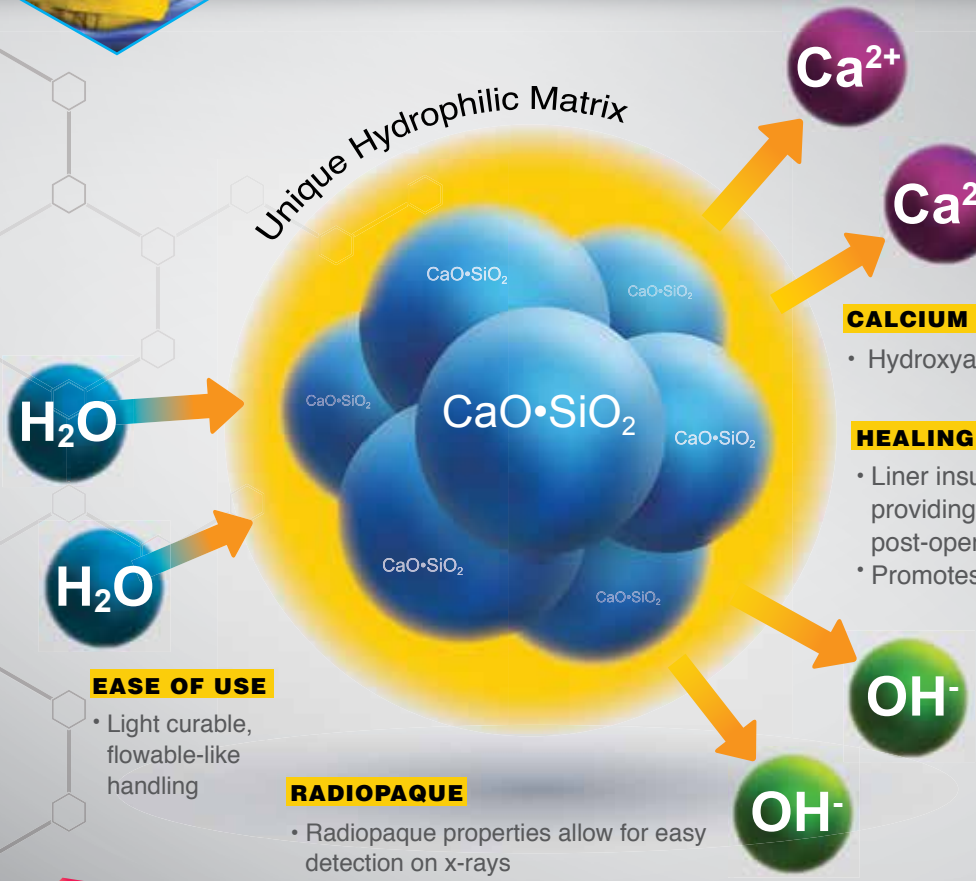

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[1] ADA definitions for direct and indirect pulp capping at http://www.ada.org/en/publications/cdt/glossary-of-dental-clinical-and-administrative-ter

[2] Apatite-forming Ability of TheraCal Pulp-Capping Material, M.G. GANDOLFI, F. SIBONI, P. TADDEI, E. MODENA, and C. PRATI J Dent Res 90 (Spec Iss A):abstract number 2520, 2011 (www.dentalresearch.org)

[3] Selcuk SAVAS, Murat S. BOTSALI, Ebru KUCUKYILMAZ, Tugrul SARI. Evaluation of temperature changes in the pulp chamber during polymerization of light-cured pulp-capping materials by using a VALO LED light curing unit at different curing distances. Dent Mater J. 2014;33(6):764-9.

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Life-changing Dental Care for Those in Need

Explore volunteer opportunities through Dental Lifeline Network and make a difference for vulnerable individuals in your community

When Juanita walked into Dr. Ashleigh Harrison's office, City Park Dental Group and Orthodontics, a practice supported by Pacific Dental Services® (PDS®) in Denver, it had been a long time since she smiled. The 54-year-old had been suffering from failing teeth her entire life – living with pain and having difficulty chewing food. Her gums would often swell and bleed, making eating a very difficult task.

In addition, Juanita was suffering from other illnesses, including asthma, lupus, diabetes, fibromyalgia, and neuropathy. When her symptoms increased, she had to stop working and participating in activities she enjoyed, including volunteering with senior citizens in her community. Managing the symptoms and costs of all of her ailments were taking its toll on her health, her psyche, and her pocket book. She couldn't afford to address her dental needs.

Volunteers, Dr. Ashleigh Harrison (PDS-supported owner dentist) and team member Jennifer Hess of City Park Dental Group and Orthodontics sit with a very grateful patient, Juanita, and her brand new smile.

Over the years, Juanita stopped smiling. Her deteriorating teeth were impacting her health and her quality of life.

"I was unable to go out in public," Juanita said. "My social life was a disaster. I was ashamed to open my mouth because of my broken, decaying teeth. It was not a very nice sight to see."

Help came in the form of a generous volunteer program and a national nonprofit dedicated to serving people with special needs. Juanita was connected with PDS-supported owner dentist Dr. Ashleigh Harrison through Donated Dental Services (DDS), a program of Dental Lifeline Network (DLN).

Dr. Harrison met with Juanita and discussed the need to remove the remainder of her teeth and get her a full set of dentures. Thanks to DLN

and Dr. Harrison, they were able to restore Juanita's mouth – and ultimately, her pride.

"Once Juanita had her teeth back, she could not only chew, but was able to start interviewing for jobs," said Dr. Harrison. "That is what dentistry is all about – getting people out of pain, but also restoring their confidence."

To this day, Juanita is extremely grateful for the dentists and surgeons involved in her care.

"I can't thank them enough!" she said. "Before, I would not smile or talk – now I can't keep my mouth closed! Since getting my new teeth, I have lost 43 pounds, I am off at least one third of my medications. I am more active and more social."

Thousands more – like Juanita – are on wait lists for the DDS program. You have the power to help change lives for good.

"I signed up online and was contacted within a few weeks. It's similar to the mission work I've done, but I was helping people right here in my community. I think it's incredible that Dental Lifeline Network exists."

– Dr. Ashleigh Harrison

Easy to volunteer

Consider joining other DDS program volunteers across the country to help vulnerable people with no access to dental care. Providers can choose to treat one patient a year or more. Dr. Harrison was surprised at how easy changing a life could be.

"The process was so convenient," she said. "I signed up online and was contacted within a few weeks. It's similar to the mission work I've done, but I was helping people right here in my community. I think it's incredible that Dental Lifeline Network exists."

DLN makes it easy for you to volunteer:

- Patients are prescreened
- You review the patient profile in advance and choose to see or decline any patient
- See patients in the office on your schedule
- You determine a treatment plan
- Never pay any lab costs
- No extra paperwork for you or your staff

In 2015-2016, 7,100 individuals who are elderly, have disabilities, or are considered medically fragile have received services thanks to volunteer dentists and laboratories.

Dental Lifeline Network (DLN) is a charitable affiliate of the American Dental Association. DLN serves patients in all 50 U.S. states through more than 15,000 volunteer dentists and 3,700 laboratories.

To volunteer, please contact Dental Lifeline Network at 303.534.5360 or visit www.DentalLifeline.org. ■

5 reasons to volunteer for DLN

1. **Give back locally**
   DDS Program Coordinators screen applicants prior to making a referral, ensuring that patients are local and the most in need.
2. **Create a great staff experience**
   All dental office staff members can be involved in the DDS experience; it's a great way to build team connections and boost employee morale.
3. **Help someone in need smile again**
   DDS patients are truly in need and very grateful. All patients either have a disability, are elderly, or are medically fragile and lack access to desperately needed dental care.
4. **Change a life for good**
   Dentists can establish a complete treatment plan in order to restore someone's oral health from start to finish. This work will bring someone dignity and health.
5. **DDS makes it easy to give back**
   Dentists can choose to see or decline any patient, treat patients in their own offices, and develop the treatment plan. The DDS Program Coordinator also arranges specialists and lab fabrications, if necessary. It's so easy and convenient to make a difference.

Effective Leadership: Motivational or Inspirational

By Dan Nielsen, dan@americashealthcareleaders.com

A key topic I address in the beginning of my new book, *Be An Inspirational Leader: Engage*, Inspire, Empower, is the difference between inspirational and motivational leadership. While the terms are often used interchangeably, there are a few key differences, and I believe one leadership style is vastly more effective than the other in the long run.

Inspirational leaders are intentional in using their position to inspire, change lives, and leave beautiful and lasting legacies. It is amazing to witness the ripple effect of a truly great inspirational leader, and in the book I share many first-hand accounts of people who have had the opportunity to work under these leaders.

Differences between motivational and inspirational leadership

1. **External vs. Internal:** The first key difference is while motivation is typically accomplished through external factors, inspiration is an internal force. Wayne Dyer puts it this way: "If motivation is when you get hold of an idea and carry it through to its conclusion, inspiration is the reverse. An idea gets hold of you and carries you where you are intended to go."

2. **Duration and Effectiveness:** Since inspiration is an internal force, it lasts longer and is more effective. Motivation, particularly when connected to a system of external rewards, is only effective as long as you are able to keep the system of rewards consistent. Inspiration has deeper roots; its

WHAT'S THE SAYING?

There's strength in a group committing to its community?

influence sticks with you and propels you further than mere motivation can.

3. People's Responses: People respond to inspirational leadership exponentially better than they do to compensation or coercion. People are always more eager to do something when it is an idea they feel connected to and invested in. While external forces can be a key motivator, people will react far better to a personal investment.

Alan Cherry, who contributed some excellent comments to the book, beautifully summed up the difference between motivational leaders and inspirational leaders like this:

"Ultimately, the only thing that separates inspirational leaders from all the rest is that at his or her core, inspiring leaders seek to inspire others just as they have been inspired …They find reasons to stir their followers to action because those followers have become inspired and can no longer abide inaction."

How do you lead? Do you depend on a system of compensation and coercion, or do you inspire, leading the people in your organization to genuinely desire to accomplish the same mission? I encourage you to evaluate your leadership style and remember that true inspirational leadership is vastly more effective and impactful than any external motivators. ■

"If motivation is when you get hold of an idea and carry it through to its conclusion, inspiration is the reverse. An idea gets hold of you and carries you where you are intended to go."

– Wayne Dyer

The Four Pillars of Extreme Productivity

By Dr. Sami Bahri, DDS

Dr. Sami Bahri is the author of "Follow the Learner: The Role of a Leader in Creating a Lean Culture," and of the DVD "Single Patient Flow: Applying Lean Principles to Heathcare". The book won the 2010 Shingo Prize for Research and Professional Publication and the video won the same award for 2013. The Shingo Prize Conference also recognized Bahri as the "World's First Lean Dentist." He is a sought-after speaker and lecturer nationally and internationally on implementing Lean management in dentistry. Dr. Bahri can be reached at Sami@bahridental.com

If you want to maximize productivity, reconsider how you organize work. Instead of thinking of what the workers are doing, think "what is happening to the patient's treatment?" Is it continuous (one-patient flow), or is it stop and go, spread over several appointments?

Make it continuous whenever possible. Then constantly shorten the time from the start of treatment until the full mouth is healthy – which is called treatment "lead time." But beware! Any time spent between appointments counts in the lead time. If two appointments are separated by two days, the lead time would be two days. If they are separated by two weeks, the lead time would be two weeks. That makes it essential that we minimize the

Figure 1: The only four factors you need to know in order to reduce Treatment Lead Time

number of appointments instead of spreading the treatment over several shorter appointments.

To shorten the treatment "lead time" consider these four lean strategies. Every effort to increase productivity in the practice falls into one of these categories:

Leveling the schedule

Leveling the schedule is an ideal state of operations where the amount of work is equalized every hour of the day during the entire year.

To achieve leveling, we need to analyze the procedures performed during the previous year, and distribute them evenly over the projected time for the coming year. All of this should be reflected in the schedule. Making the work even every day reduces the need for resources, and utilizes fewer people, thus less money, less space and less effort.

One-patient flow

One-patient flow is an ideal state of operations in dentistry where we hope to treat everything we diagnose in the same visit. For instance, if we find that the patient needs an exam, three fillings, two crowns, and a root canal, in an ideal "one-patient flow" world, all of that is done immediately, in the same visit.

That is certainly not always possible; that is why we call it a True North goal – a goal that is not fully reachable, but gives you direction. As long as you are moving in that direction, you will know that you are doing the right thing.

As you strive to improve, you will be able to add more and more procedures to "one-patient flow." For example, if you cannot finish a crown in the same visit because you send it to a dental lab, adding CAD/CAM technology to your practice would allow you to finish it in the same visit, adding the crown procedure to the "one-patient flow."

In "one-patient flow," not only is the treatment supposed to be finished in one appointment, but also all the supporting activities; the insurance claim should be filed, the notes written in the chart, the lab scripts filled, the payment collected, the next appointment scheduled, etc.

Quick room turn over and quick set up turn over

When pursuing "one-patient flow" in a given visit, we will perform a variety of procedures from a simple cleaning moving through simple and complex composite fillings for example, to veneers or crowns. The materials and instruments for those procedures need to surround the operator ergonomically, allowing to move seamlessly from one procedure to the next; and ideally, without the help of an assistant.

We also need to set up the rooms and turn them over between patients quickly. To that end, based on the Single Minute Exchange of Dies created (SMED) created by Shigeo Shingo, we think of setup in two terms.

> Experience has revealed that if we utilize our resources only when they are needed, not before or after, we can save a remarkable amount of time, money and efforts. Just-In-Time is the least expensive way to perform any task.

- The first is called **external setup:** activities that can be performed even if the patient is still in the chair. An example would be moving the instruments that are no longer needed to the sterilization area. External setup is what we need to strive for. We need to clean everything we can clean and reorganize everything we can reorganize while the patient is still in the chair, so we can turn the room over as quickly as possible.

- The second term we need to be familiar with is **internal setup:** activities that cannot be performed unless the patient is outside the room. An example would be to change the plastic cover of the chair; this cannot be done unless the patient is out of the chair.

As we analyze the different activities belonging to the two kinds of setups, we will see that with a little analysis, some of the internal setup steps could be transformed into external setup, allowing to turn the rooms over much faster.

Synchronization

Synchronization means directing the different providers to where they are needed exactly at the time they are needed – not before or after (this is called Just-In-Time). Experience has revealed that if we utilize our resources only when they are needed, not before or after, we can save a remarkable amount

of time money and efforts. Just-In-Time is the least expensive way to perform any task.

To coordinate the movement of providers in our office, we utilize a sheet of paper that we call Kanban – Japanese for signal. We are not trying to be fancy here by utilizing Japanese terminology, but because when I was studying the Toyota production system, I found that American engineers have adopted the term in their daily language. To stay true to the management environment and to avoid confusing any person trying to research the subject, we decided to use the original Japanese term, Kanban.

The importance of Kanban is that it directs the providers to their next movement. If you always know your best "next move," you can go through your day in the most efficient manner.

But for everyone to know their best next move, someone needs to think for us. It is said for example, that President Carter relied on his staff to inform him where he should be and what he should be doing at any moment. Similarly, we have created a position (that people are starting to utilize in hospitals,) called "Patient Care Flow Manager." The flow manager's job is to supervise patients, not workers, and make sure that they are receiving value-added work all the time. If the assistants are busy, the flow manager starts helping the patient until someone is freed up to take over.

Another important aspect of the flow manager's job is to constantly watch for anything that frustrates providers and constantly improve it. She corrects any conditions causing frustration, like excessive walking or missing instruments and materials from the operatories, or mistakes in the patient's file and in insurance claim filing, etc.

If you want to improve productivity, it is important to know how to organize work around the patient, not the operator.

Continuous improvement

In conclusion, if you want to improve productivity, it is important to know how to organize work around the patient, not the operator. In dentistry, we try to perform "one-patient flow." In an ideal world, everything is diagnosed and treated in the same day. But, since we know that in many cases that is not possible, we utilize continuous improvement and problem-solving techniques not described in this article, to remove any obstacles preventing us from performing "one-patient flow."

Over time, these techniques help us reduce the treatment lead time, a major factor in productivity improvement. However, before those techniques can be used, we have to prepare the field by organizing the work around the four principles mentioned in this article. This kind of organization makes problems more visible, allowing us to resolve them one by one and leading to unlimited productivity improvements. ■

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*Center for Disease Control and Prevention. Summary of Infection Prevention Practices in Dental Settings: Basic Expectations for Safe Care. Atlanta, GA: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Oral Health; March 2016.

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INDUSTRY NEWS

Great Expressions opens office in Wixom

Great Expressions Dental Centers (GEDC) (Southfield, MI) expanded its reach across the state of Michigan with an office opening in Wixom. The opening increases the total number of offices in the U.S. to 334. GEDC's Wixom office provides quality and affordable dental services for the entire family, including general dental care, orthodontics (braces), pedodontics, periodontics, endodontics and oral and maxillofacial surgery. Consistent with all GEDC locations, the organization's Smile Protection Plan, a dental insurance alternative for patients without insurance looking to live a healthy lifestyle, and Invisalign will be offered to patients.

NIH awards $1.5M to Case Western Reserve University for HIV oral inflammation study

The U.S. National Institutes of Health (NIH) awarded Case Western Reserve University (Cleveland, OH) researchers $1.5 million over five years to study HIV-related inflammation in the mouth and throat. The team of scientists will study the mechanisms some white blood cells use when battling HIV in oral and throat tissues. The ultimate aim is to increase the number of beneficial cells and decrease the number of dysfunctional ones that lead to chronic inflammation.

Delta Dental makes leadership changes in California, Kentucky

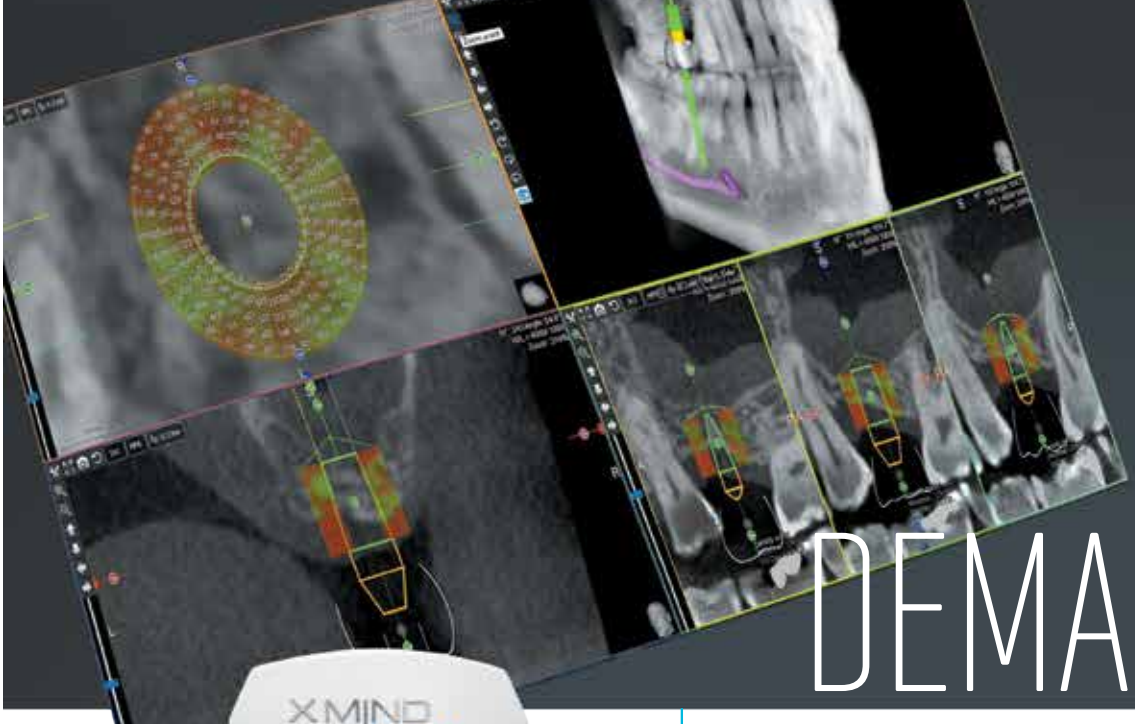
Clifford Maesaka Jr., DDS, who has been CEO of Delta Dental of Kentucky since 1995, resigned March 30. No reason for the resignation was given. The company named Jude Thompson as interim CEO. Thompson has been a member of the organization's board since 2009. Additionally, Delta Dental of California named Kevin Jackson as SVP of strategy. In this role, Jackson will be responsible for developing and steering the company's corporate strategy and developing new revenue sources for the company's existing business lines. Jackson has worked for the company for 31 years.

State of California awards $150M to local dental pilot projects

The California Department of Health Care Services (DHCS) in February announced the 15 selected proposals for Local Dental Pilot Project (LDPP) funding, with awards totaling $150 million over four years. Local Dental Pilot Projects are one of the four domains of the "Dental Transformation Initiative" and part of California's 115 waiver, or Medi-Cal 2020. The goal of the Dental Transformation Initiative is to increase access to care, identify and treat dental disease, and incentivize continuity of care for the approximately five million California children enrolled in the Denti-Cal program. The selected proposals use strategies focused on urban or rural areas, care models, delivery systems, workforce, local case management initiatives and/or education. Progress toward reaching pilot project goals and objectives will be measured, tracked and reported by selected applicants with the potential for regional and statewide expansion of pilot projects demonstrating a positive impact on the oral health of target Medi-Cal populations. For more, and to see the list of winning proposals, visit www.cda.org/NewsEvents/Details/tabid/146/ArticleID/3765/State-awards-150-million-to-local-dental-pilot-projects.aspx

Western Dental acquires 14 Smile Wide practices

Western Dental (Orange, CA) has completed the acquisition of 14 Smile Wide (Irvine, CA) practices. This is the first acquisition the company has made in more than a decade. The 14 Smile Wide offices are located in the Southern California cities of Anaheim, Bellflower, Carson, Costa Mesa, Garden Grove, Irvine, Loma Linda, Long Beach, Los Angeles, Lynwood, Riverside, and Van Nuys. Western Dental is an integrated, full-service dental and orthodontics organization that offers convenient, affordable, high-quality care to patients of all ages and incomes. It is the largest orthodontics provider in California and Arizona, and an orthodontics leader in Texas through its affiliated Brident Dental & Orthodontics offices. Terms of the acquisition were not disclosed.



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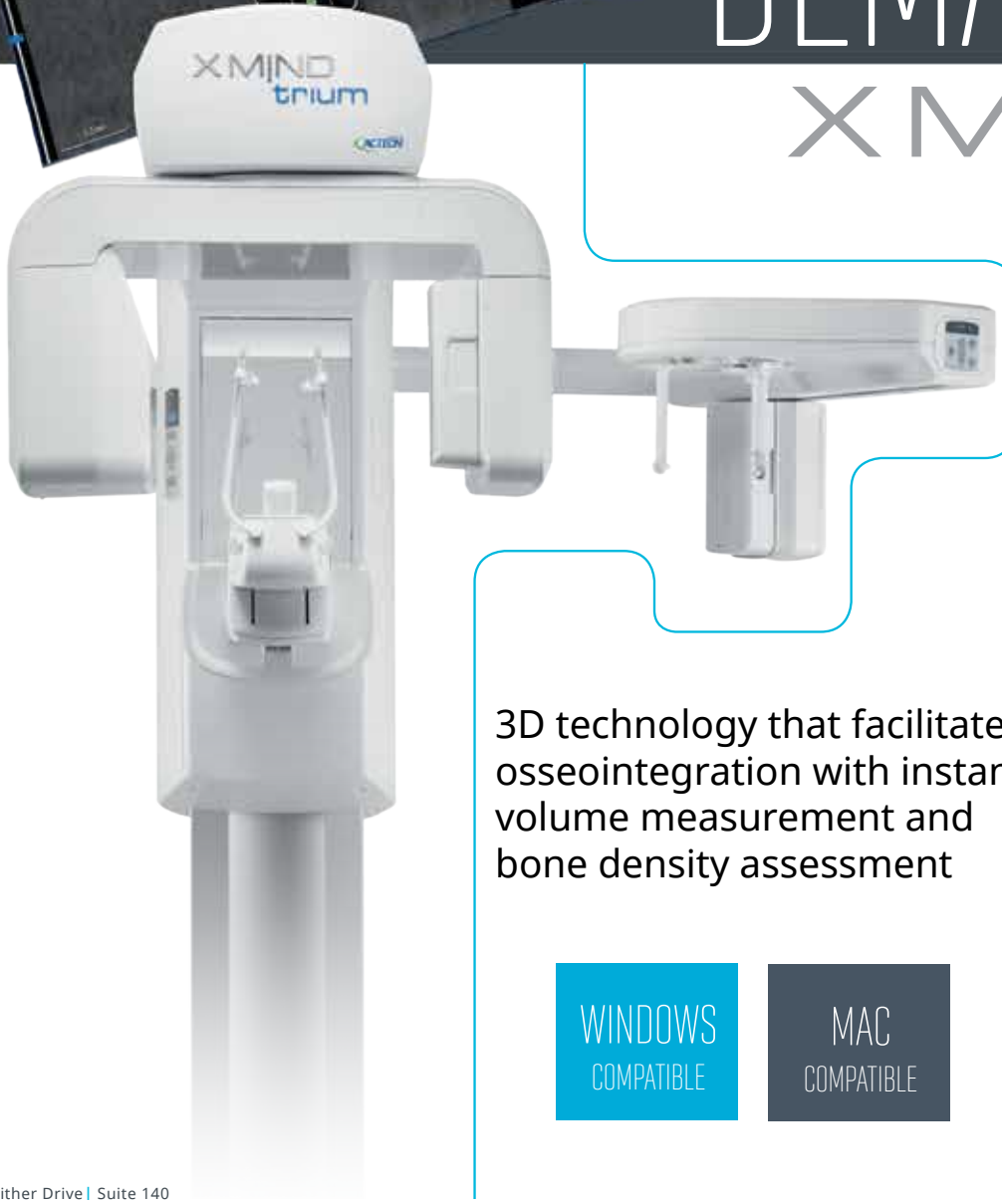

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