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PUBLISHER
Bill Neumann • wneumann@mdsi.org

ADVERTISING SALES
Monica Lynch • mlynch@mdsi.org

EDITOR
Mark Thill • mthill@mdsi.org

SENIOR EDITOR
Laura Thill • lthill@mdsi.org

MANAGING EDITOR
Graham Garrison • ggarrison@mdsi.org

ASSOCIATE EDITOR
Alan Cherry • acherry@mdsi.org

CIRCULATION
Laura Gantert • lgantert@mdsi.org

ART DIRECTOR
Brent Cashman • bcashman@mdsi.org

Wrapping Things Up

The last quarter of a year is a very hectic, stressful time for businesses. A dental practice is no different. It is typically crunch time for patients to use their dental benefits before they expire. End-of-year is also a time to make sure you are hitting your business goals for that year while planning, or trying to plan, for 2015.

Adding to the end-of year-work mix are the personal goals of enjoying family time and using any remaining vacation days for rest and relaxation.

After you've reflected on your business practices of 2014 and begun planning for 2015, grab a hot chocolate and enjoy some of the valuable and strategic content we are providing you in this issue.

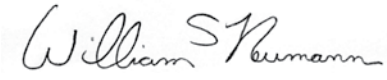
Dr. Quinn Dufurrena provides interesting insight into the growth of DSOs and the reasoning behind the ADSO name change. Find out more about Dr. Dufurrena and the ADSO on page 6.

Our cover story on office design delivers in-depth information and tips on cutting edge design and trends, both esthetic and practical. Read what Patrick Crowley and other experts have to say on page 20.

Wrapping up this issue of *Efficiency* is our article on nitrous oxide and its use in a DSO / group setting. Read all about it on page 30.

I would just like to say that 2014 has been an exceptional year for *Efficiency in Group Practice* and we appreciate the support of our advertising partners, our editorial board, and the group practice / DSO community. Next year should be an even better year and we plan to grow as our readership does.

Until next year,



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Quinn Dufurrena on DSOs

Dental Support Organizations help dentists respond to changing patient, payer demands, says ADSO executive director

Practicing dentistry in rural northern Nevada for 20 years gave Quinn Dufurrena, D.D.S., J.D., some perspective on the profession and strong ideas about its future.

Quinn Dufurrena

"When I think about the amount of time I spent on the business side of dentistry, I realize that if I had been able to give that to someone else, I could have seen a lot more patients. And that's what access is all about."

As the new executive director of the Association of Dental Support Organizations – formerly the Dental Group Practice Association – Dufurrena is in a position to advocate for just such an approach to dentistry.

Born and raised in Winnemucca, Nev., Dufurrena received his D.D.S. from the University of the Pacific in 1983, and his J.D. from Concord Law School in 2008. His scholarship at the University of the Pacific called for him to practice dentistry in a rural area for three years. He went back to northern Nevada.

As the only dentist in three counties, he had a busy practice. "I was just swamped," he says. After three years there, he decided to make a change in his life. "I decided to join the Navy to see the world," he says. "I loved it."

He was stationed at a clinic in Norfolk, Va., for six months, where he served alongside 50 other dentists. He spent six months aboard a ship off the coast of Central and South America, and three years at a combined U.S. armed forces base in Edzell, Scotland, where he helped care for servicemen and servicewomen, as well as their

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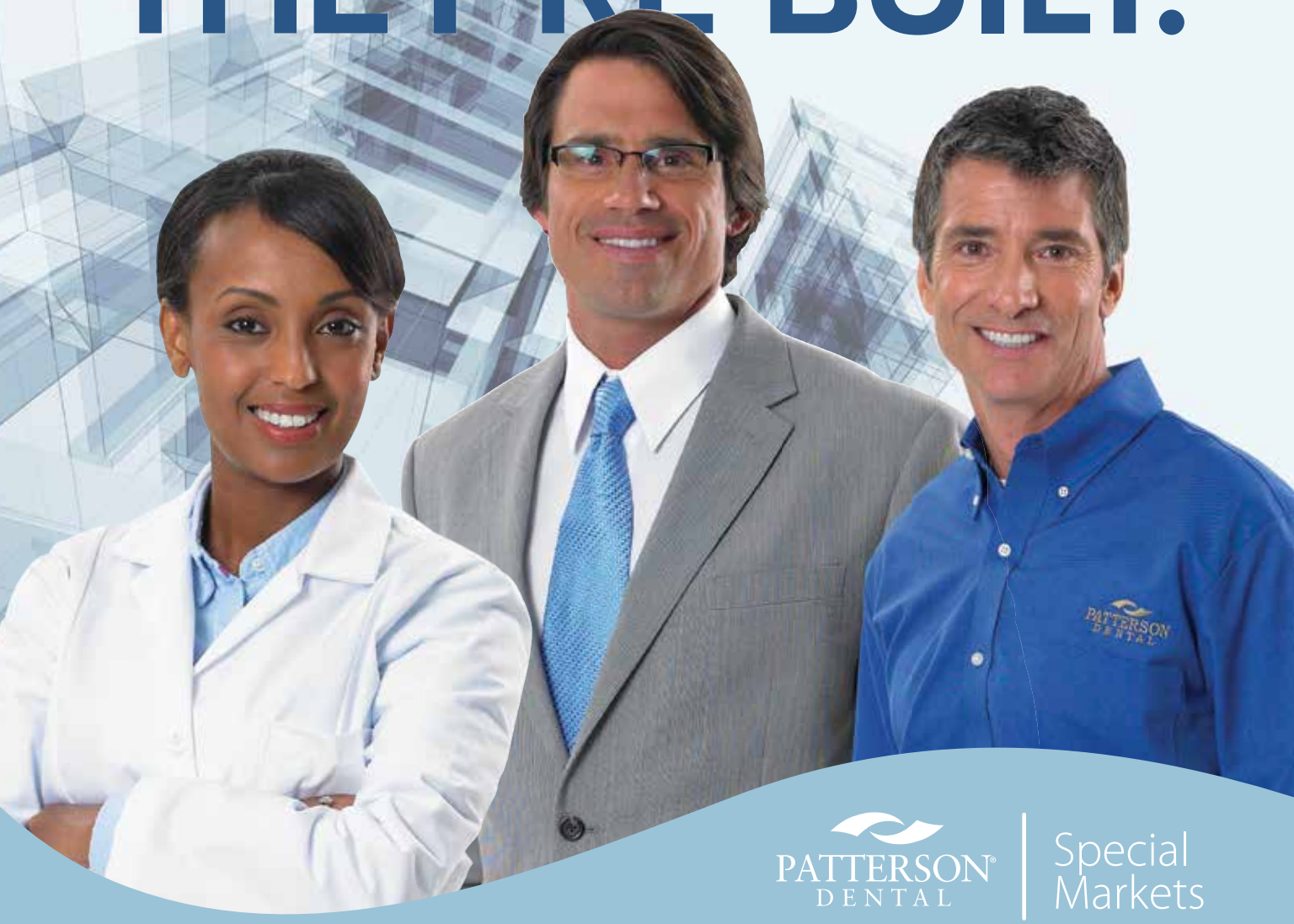

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dependents and spouses. After four years, he returned to rural Nevada.

After a total of 20 years in his rural practice, Dufurrena made another career shift. He worked at the American Dental Association as a Hillenbrand Fellow, then served as executive director of the Idaho State Dental Association and later, executive director of the Colorado Dental Association. Beyond his chairside duties, he served as associate professor at the University of Colorado School of Dental Medicine.

More than a name change

Just two months after joining the association, DGPA changed its name to the Association of Dental Support Organizations. The name change has more than symbolic significance, says Dufurrena.

"We really did it for clarity," he says. "We wanted to be able to show the separation between the business and clinical side of dentistry," something that the former name – Dental Group Practice Association – did not. "When you talk about DSOs, that's the business side, supporting the clinical side."

There's a big need for business savvy today, says Dufurrena.

"I was trained in dental school to do dentistry. I had no training in business, so I struggled with that part of it." That's OK, if one is practicing in a rural community, with a line of patients to be taken care of. But in competitive markets, like many urban areas today, it is not.

In the past, given a proliferation of patients, dentists could raise fees with little concern, he says. "That compensated for our lack of business skills. But since becoming executive director, dentists have called me and said, 'I don't have enough patients.' In years past, that didn't happen.

"It's difficult enough to do the clinical work we were trained in," he adds. "But to acquire the skill and knowledge needed on the business side while doing the clinical work – that is very difficult."

Yet today, business skills are more necessary than ever. When it comes to Medicaid, it's all about decreased reimbursement and increased accountability, says Dufurrena. Dentists are being called on to become more efficient, so they can serve more patients cost-effectively, while maintaining accountability, that is, quality dental care. "You can't take shortcuts, but you can create efficiencies. And those who get ahead of that, will get ahead of the game."

DSOs are in a good position to perform well on the business side, and because of that, can actually help dentists deliver better patient care, he continues. That's true for several reasons:

DSOs create standardized efficiencies. "By contracting with a DSO, the dentist has the ability to perform more clinical dentistry, so he or she can keep up their efficiencies and actually get better. After all, the more crowns I do, the better I get at it. It's like anything else: When you

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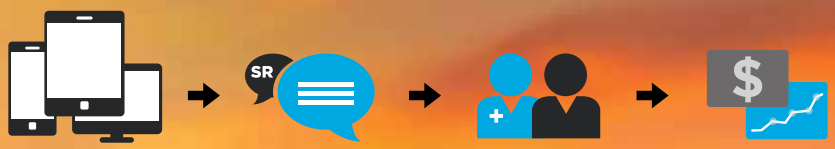

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have individuals doing specific jobs, they get better at it; they get faster. That's what efficiency is."

DSOs offer economies of scale. Because of their volume, they have the ability to acquire supplies and equipment at prices lower than those of the solo practitioner. That, in turn, allows them to acquire what Dufurrena calls strategic resources. "Technology is expensive, and as a solo practitioner, I may have difficulty justifying buying technology that can lead to better quality of care."

Large groups have the ability to measure things – that is, what's working and what's not – and develop better practices for patient care.

Growth of DSOs

If growth among DSOs is any indication, more dentists are buying the message that Dufurrena and ADSO are preaching.

> "By contracting with a DSO, the dentist has the ability to perform more clinical dentistry, so he or she can keep up their efficiencies and actually get better."

Solo and independent practitioners are still the majority in dentistry, but that's shifting. In 2010, 69 percent of dentists were solo practitioners, down from 76 percent in 2006. By comparison, group practices – many supported by DSOs – have increased by 25 percent from 2009 to 2011.

As of October of this year, ADSO members supported 33,000 staff, 8,000-plus dentists, and 4,000 to 5,000 hygienists. "Most important, they support about 30 million patient visits a year," says Dufurrena. And even though growth rates differ among the ADSO membership, industry studies show DSOs are growing at a rate of around 20 percent per year.

There remain obstacles to growth, of course. As executive director of ADSO, Dufurrena has a front row seat for some of them. "The biggest eye-opener for me has been how resistant to change many dentists in traditional solo practice are."

Many harbor misconceptions about DSOs. "Some believe DSOs influence clinical decisions; that's probably the biggest objection out there. There are so many good DSOs, who believe there has to be this separation between the business and clinical sides. DSOs that respect dentists and respect their clinical judgment and autonomy will thrive; those that don't will go away."

Further, to those dentists who believe that dentists in large practices and DSOs provide lower-quality care, Dufurrena says, "That's not true at all." He draws on his experience in the Navy in Norfolk. "There were 52 dentists in a big clinic," he says. They shared their knowledge, and in fact offered peer-led education sessions every week. "When you have that kind of mentoring and quality assurance, the quality goes up. That's different than the solo practitioner, who has nobody to mentor him or her, to look over their shoulder."

Future

"A growing percentage of patients are becoming more like consumers," he continues. "They're looking not so much for relationships, but for quality of care, convenience and affordability." Practitioners who can provide those things, and who have strong relationship-building and communication skills, will thrive.

"You'll still find those who love their dentists. But the key indicator is this: If their dentist stopped taking their insurance, would they stay with their dentist or would they go to see someone else?"

Optimism about the future was evident at ADSO's annual conference this fall, he says. "There's a huge amount of smaller groups that want to know how to create efficiencies and decrease their risks in this business environment." ADSO has created a new category for small group practices.

"There will be all kinds of models, but I think you'll see expansion of the larger, DSO-supported practices, because they can capitalize very quickly on changes." ■

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Growing Organically

How to achieve growth through your current patient base

Revenue growth by new patients is the focus of most dental practices across the country. According to *Dental Economics*, dental practices are spending more than a half-billion dollars on marketing each year to attract new patients into their practices.

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.

There is no doubt a new patient brings a high level of revenue growth to the dental practice, and should be a focus for every growing practice. But, what if you could experience more than 40 percent hygiene revenue growth, without relying solely on new patients to fuel your growth?

Digging into the details

Most dental offices report their existing patient pool has been completely tapped, and they need new patients in order to fuel revenue growth. While this may be partially true from a restorative standpoint, this is not true when looking from the hygiene perspective.

If you feel your group is struggling to grow hygiene revenue and challenged by the number of new patients you are bringing in, then it is time to dig into the details of your hygiene department. The best place to start is by collecting some data. Start by running a report commonly titled "Procedure by Provider Report" for your hygiene team. This report will show you the variety of services your hygiene team is charging out. There is often a common trend that will stand out to you, and one that we see from practice to practice. Your trend may look a lot like this. (See graphic on page 14.)

Existing patients are most commonly charged a prophy or a periodontal maintenance. In some cases this is probably suitable, but in most cases this provides us with a clue that we need to dig into the patient records to see what type of assessments were completed on each patient, and if the correct care was provided for each patient. You will most likely see that 90 percent of the time a comprehensive assessment has not been completed. No comprehensive periodontal assessment, no periodontal risk assessment, and no caries risk assessment. Without those assessments, how can you identify what the patient really needs?

Comprehensive assessments

Making assumptions without comprehensive assessment is a costly mistake. You must complete comprehensive assessments on each patient in your practice, regardless if they are new or they have been your patients for the past 20 years. Once you start doing this, you will find your patients have a large amount of needs.

According to the "ADHA: Standards for Clinical Dental Hygiene Practice," the

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dental hygienists should provide individualized and comprehensive assessments for every patient in order to provide optimal oral health to every patient.

These key assessments should be included at every appointment, for every patient.

1. Patient Medical/Dental History. Understanding each patient's specific history is important. Both periodontal and caries risk factors can be identified during this assessment. For example, asking patient questions about family history of periodontal disease or caries is important to identify risk. According to the ADA, 30 percent of people are genetically susceptible to periodontal disease. This risk factor needs to be identified during the medical/dental history.

2. The Comprehensive Periodontal Assessment is one of the steps that gets overlooked. The comprehensive periodontal assessment includes six-point probing, recession, furcation, mobility, exudate, and bleeding. This information should be collected at each dental hygiene appointment and documented in the patient record a minimum of once a year, (although, having it documented at each visit is strongly recommended.) Once the assessment is completed, you must identify and treatment plan accordingly to address the needs of your patients. Remember, just because they are an existing patient does not warrant the "wait and watch" approach. Treat disease when you see it, in order to reduce the long-term affects the patient could experience from the disease.

3. Risk Assessment. Building off the comprehensive medical/dental review and the clinical assessment, the risk assessment should be completed on each patient. During this assessment the dental hygienist should identify periodontal and caries risk factors. Based on current science, risk factors are the main driver in the susceptibility of disease. These risk factors can change frequently, thus the need for consistent and thorough assessments of our patients is warranted.

- **Caries Risk Assessment:** A strong Caries Risk Assessment (CRA) will help you identify if your patient is at low, moderate or high risk for caries. The caries risk is based on previous and current clinical and environment factors. Based on these risk factors, the dental team will recommend preventive measures such as fluoride, sealants, or other antimicrobials for the patients. Without a strong caries risk assessment, your patients will not receive the preventive care they want and deserve.
- **Periodontal Risk Assessment:** The periodontal risk assessment is also built off of the clinical and environmental risk factors that will be discovered through the assessments listed above. The periodontal risk assessment is crucial to understanding your patients' potential for periodontal disease, or how they respond to periodontal treatment. It also provides tools to help educate patients about optimal oral health and overall health. Current research is telling us the chronic inflammatory process and the pathogens that cause periodontal disease may contribute to systemic disease.

Group Procedure Totals

Adult Prophy - D1110	124
PED Prophy - D1120	2
Fluoride - D1206/D1208	13
Sealants - D1351	0
Quad SRP - D4341	15
1-3 SRP - D4342	0
Debridement - D4355	2
Arestin - D4381	1
Perio Maint. - D4910	24
Take Home Fluoride	1
Electric Toothbrush	0

Don't assume your existing patient base is "taken care of." Risk can change daily and the patient's oral and overall health can change quickly, as well. Completing a comprehensive assessment on every patient will open up doors for you to provide necessary care to each patient – new or existing.

One additional practice management note: Do not fall in the trap of placing your recall patients onto a 30- to 40-minute hygiene appointment. This appointment length will not allow your hygiene team to complete the necessary assessments, and thus limiting your hygiene team's growth, and ultimately the growth of doctor revenue too.

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First Things First

Waste removal makes room for what marketing will bring in

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

"It is amazing that you tackled practice management through operations!" a consultant remarked during a presentation on lean management. *"I've always done it through marketing,"* he added.

"You attract new patients through marketing, while I do it through treatment efficiency; two different approaches!" I replied.

Such remarks make you wonder whether marketing or operational excellence will be more effective at improving dental management. They are both major components of any business system and we might think that we are already focusing on operations and marketing at the same time. But a simple analysis might show we are not.

Does dentistry rely on marketing, operational excellence or both? The answer is likely to be revealed in the emails we receive regularly. As you already know, if an offer is repeated, it would mean that it's generating sales. One of those recurring offers is the promise to increase the number of new patients by 15 to 50 percent. That repetition indicates that a good number of dentists favor the marketing approach; otherwise, marketers would have stopped focusing on attracting new patients.

On the other hand, you will not find many emails that promise to teach us operational excellence. And the few that do, usually talk about creating a whole package of business systems to achieve operational efficiency.

The problem is that even when those systems are well managed, they are estimated to contain up to 80 or even 90 percent of process waste. Waste represents the gap between the current state of our processes and perfection. While its presence is undesirable, learning how to identify and eliminate it is a major opportunity for improving quality, cost, speed, productivity and moral.

Multiple systems present another problem; they tend to disconnect. Over time, they could even compete against each other. Lean managers avoid this problem by thinking of the whole business as a unique system in which all parts need to work in synchrony to maximize the performance of the business as a whole.

Now that we have discussed marketing and operational excellence, we wonder what the future holds for those who rely on marketing, and for those who rely on operational excellence.

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This was the trap

If we believe that history is a good forecaster, we will need to consider what Taiichi Ohno, the creator of the Toyota Production System, wrote in 1988. In his book "Just-In-Time for today and tomorrow," he explained why Toyota's competitors failed to sustain profits in times of economic crisis:

"… corporations that emphasized increased production felt that increased sales, rather than innovative methods to eliminate waste, reflected success. This was the trap. Wastes are direct obstacles to profit. No matter how high the sales, valuable profits can dissipate in the form of waste."

This could well be the most enlightening paragraph written in modern management (in my personal judgment, of course). Its value comes from being written in hindsight, after Ohno's success has provided every proof to back up his claim that increased sales could be a trap.

Relying on marketing alone is a trap because it works well in good times but fails in bad times, whereas relying on operational excellence works all the time.

To prevent confusion, I am not against attracting new patients. It would be risky, however, to attract them without improving processes through waste elimination. It would have implications at the promotional and the operational levels.

- At the promotional level, if operations fail to meet their standards, patients lose trust; all advertising efforts could turn against the practice instead of helping it. On the other hand, if operations exceed patients' expectations, advertising becomes much easier and more effective.
- At the operational level, as you remember, our motions generate either value or waste. Marketing increases value and waste simultaneously, causing us to work harder if we seek more results. To the contrary, Lean thinking reduces waste, allowing us to work less and still get more results (see figure 1).

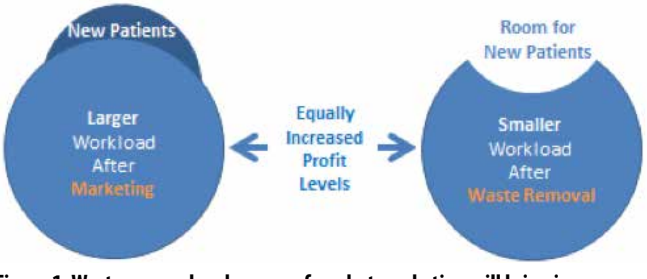

Figure 1: Waste removal makes room for what marketing will bring in

We should always start by reducing waste in our processes to generate more capacity. Consequently, we will create room for more new patients without adding staff members, and without straining the existing staff or systems. Only when that room has been created and we have put in place systems to constantly reduce waste and increase capacity, should we pursue an aggressive marketing strategy to attract new patients.

A paradigm shift is needed

I invite our profession to catch up with manufacturers and embrace the advancements in business management. Lean management is a paradigm shift that changed operations management starting in the 1940s, but a similar shift has not happened in dentistry yet.

Relying on marketing alone is a trap because it works well in good times but fails in bad times, whereas relying on operational excellence works all the time.

Instead of relying mainly on sales volume, Lean managers improves operations by removing waste. That is an important point, because when we rely on sales, we are virtually saying, *"Let's get the patients in; we'll figure out how to serve them later."* We usually end up working very hard on fixing unexpected problems. This approach resembles gambling with our most vital asset, our credibility.

But when we rely on operational excellence, we are virtually saying *"let's create good processes that will exceed our customers' expectations, then we'll invite them to use our services."* This approach is safe, solid and sustainable. It allows us to differentiate our practice and makes marketing so much easier that it could become unnecessary altogether.

Lean management has proven more successful than the current management systems. It has been successful with manufacturers like Toyota, with dental practices like Bahri Dental Group—where we were able to produce the same amount of dentistry using 40 percent fewer resources, and with healthcare institutions like Thedacare, Virginia Mason, the University of Pennsylvania Medical System and others.

Lean management's time has come; let us embrace it now and improve everyone's life. ■

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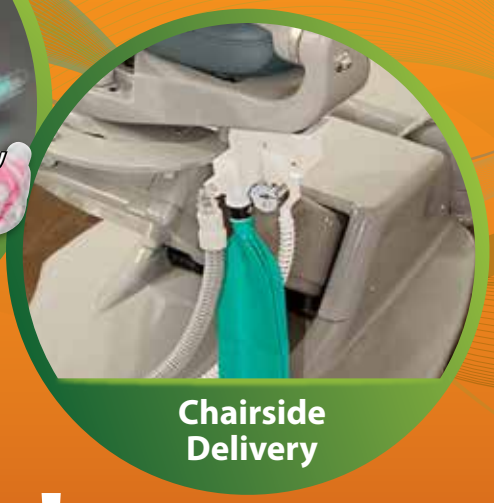

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Office Design

What's holding you back?

For many dentists, the cost of overhauling one office – not to mention multiple offices in a group practice – can seem overwhelming. "They are afraid it will cost way too much, and that they won't get enough return," says Inga Paul, senior interior designer for Goetze Design Services. Paul has been with Goetze Dental 16 years.

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Many dentists fear that the project will be long, drawn-out and expensive. "But you can do much of the back work and research before spending a lot of money," she says. "It's taking that first step that holds a lot of them back. It's a tough decision. [They wonder], 'What if I don't like it when it's finished?'"

Some dentists fail to see the need to undertake a project in the first place, she says. "They rarely come into their office through the front door. They don't spend a lot of time in their reception area. But if they walk through that area and see that the carpet's worn and the doors are a little beaten up, that's a heads-up something needs to be done. And it helps if someone they trust says to them, 'You know, it's time for us to do a little work.' And you don't have to spend a ton of money to spruce things up – a coat of paint, new carpeting – those are all things you can do before a renovation."

"If you're going to spend money to move into this space, you should love it and be happy to go to work there every day – and give yourself room to grow."

– Inga Paul, senior interior designer, Goetze Design Services

Planning for the future

Building and renovating an office is something most dentists do once or twice in their careers, notes Paul. "So we tell them, 'Don't shortchange yourself.'" Some try to acquire a small space to save on rent or leases. "But we tell them, 'If you're going to spend money to move into this space, you should love it and be happy to go to work there every day – and give yourself room to grow.'" As a rule, Paul encourages doctors to have one or two operatories into which they can expand should the practice grow. "If it's a doctor who's looking to sell his or her practice or have an associate come in, then we want to make sure they plan ahead for the next five years, so they don't have to move [prior to their retirement]."

The HGTV effect

"People have always come to us with piles of pages, 'I saw this lighting, this paint color, and I like it,'" says Paul. "But today, because of all the do-it-yourself activity, they give it more consideration. And they know it might not be as cost-prohibitive as they used to think." What's more, today's dental teams are open to bold design ideas; they're not tied to boxy, square plans.

Room by room

The lounge. "People are putting a little more thought and value into their employee lounge," says Paul. Dentists want to give their staff a pleasant and comfortable place to sit, keep their belongings, have lunch and conduct team meetings. There's a benefit for the dentist: When staff members feel comfortable eating lunch in the lounge, there's a better chance operations will gear up promptly in the afternoon.

Bathrooms. They're bigger than ever, partly because of the Americans with Disabilities Act.

Operatories. They continue to grow in size, though there are limits. Paul prefers operatories to measure between 10 to 10 and a half feet wide, to 11 and a half to 12 feet deep. They probably won't get much bigger, because instruments and equipment must be within arm's length of the dental team, she says.

Sterilization area. It's not a showroom, but neither should the sterilization area be hidden from view. Making the sterilization area pronounced and plainly visible to patients instills confidence that the practice is taking the necessary steps to ensure patient safety. What's more, making the sterilization room visible to all gives staff a reason to keep it clean and tidy.

Checkout. It's best to separate this area from reception, says Paul, not merely because of HIPAA regulations, but because "when you're talking about money, you don't want everybody to hear that conversation."

Storage. Bigger is better. And Paul prefers one large, centrally located storage area, rather than several smaller ones scattered throughout the office.

With the young doctor in mind

"Technology for young graduates is huge," says Paul. Dentists coming out of school tend to be more apt than their older colleagues to specify digital technology, such as imaging equipment and automated dental management systems. They don't want shelves of folders behind the front desk, and they have a difficult time coping with paper-and-pencil scheduling systems. As a result, the discussion about digital technology and the infrastructure to support it, such as conduit and ceiling mounts, should begin early in the redesign or renovation process.

The importance of pre-planning:

When Patrick Crowley, author of "Dental Office Design: 1001 Practical Tips for Creating Your Ideal Dental Office," began designing dental offices more than 20 years ago, he created a two-to-three-page questionnaire for his clients to fill out, to answer key questions about their practice and goals for the renovation/redesign/rebuild. Today that questionnaire is 14 pages. "It's probably the most important tool I have," he says. "I continually refer back to it throughout the project."

The detailed questionnaire is a logical first step for any project, he says. "I ask the dentist a lot of questions people have never asked him or her before." Examples:

- Do you own the property? Do you lease it?
- How are you financing the project?
- What are your staffing levels?
- How many patients do you see a day? What kinds of procedures do you perform? (This information will affect the size of the sterilization area, equipment needs, storage needs, etc.)
- Do you want cuspidors on the chairs? (If so, additional plumbing work will be needed; best to know that before work begins.)
- Will you be using a medical gas system?

Answering these questions – and many more – allows the dentist to reflect more closely on his or her goals. True,

"It's taking that first step that holds a lot of dentists back."

– Inga Paul, senior interior designer, Goetze Design Services

it takes time, effort and commitment on the dentist's part, he says. "Normally, they take a week or two to fill it out, and a lot of times, it comes back in dribs and drabs. But my job is to set the stage for the design phase." Responding to the questionnaire has the added benefit of getting more of the office staff involved, which is good for all concerned. "Sometimes the office manager has a better grasp of certain aspects of the practice, such as how many patients are seen per day," says Crowley.

Typical misconceptions

Many dentists feel that the design phase should be relatively brief, with construction constituting the major part of the job. Crowley disagrees. Hence the 14-page questionnaire. "Construction and mechanical installation should be a matter of creating the office that has already been designed," he says. Attention to detail upfront alleviates the need for change orders – something most contractors disdain. "Contractors like to be in the field swinging a hammer," he says. "They don't want to stop in the middle of the project and ask, 'Are these outlets supposed to be 42 inches high or 44 inches high?'"

Upfront planning cuts down on unpleasant surprises later, he adds. Example: If the doctor and design team fail to specify what type of baseboard should be used – wood, rubber- or vinyl-coated, or carpet base – the contractor may assume the client wants the most inexpensive one in mind. Meanwhile, the doctor has something else in mind altogether. "It's a matter of defining the project," says Crowley. "Crossing every 't' and dotting every 'i'. That's why we say the design phase should last longer than construction."

Too nice?

Clients must walk a fine line when remodeling their office, says Crowley. On one hand, they should bring very few things from the old office. If they insist on bringing old furniture, it should be reupholstered. Install new artwork, adopt new branding and logo, and consider new uniforms for the dental team, he advises.

At the same time, "they shouldn't install marble floors and crystal chandeliers," he says. "This is not a monument to themselves. It has to be a professional setting." That said, dentistry is often viewed as an elective procedure (even if, from a medical point of view, it's as essential as a visit to the internist.) For that reason, the office should be inviting. Scrap the harsh fluorescent lighting. "Make it feel more like a Starbucks or a nice hotel, to offer patients a more pleasant experience.

"I need to determine where the doctor is today and where he or she wants to be in five, 10 or 20 years," he continues. True, some cringe at the thought of thinking 20 years hence. But if the doctor is in his or her 30s or 40s, they need to make the effort. A skilled designer can greatly assist a dentist in this planning regard, he adds.

"In the past 18 months, I have done more 14-chair jobs than I did in the previous 25 years," says Crowley. Why? Crowley theorizes the trend represents dentists' attempts to provide as many services as they can – pediatrics, orthodontics, endodontics, oral surgery, etc. – under one roof. "They want to capture those patients and service their needs fully," he says. At the same time, patients don't want to get shuffled off to a specialist, either.

Dentists almost never say at the conclusion of a renovation or rebuild, "I bit off more than I could chew," says Crowley. In fact, most of the time, they say, "I wish I had done this years ago." Some dentists compare the process to firing an employee: "They'll say, it's not pleasant to fire someone, but I wish that person would have left earlier." Investing half a million dollars in a new office may be painful, "but they feel such relief when they get situated in it, and their practice benefits from a gain in revenue and more satisfied patients," he says. ■

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The Digital Resolution

Ensuring a smooth workflow throughout a dental group can be challenging. Digital radiography offers one solution.

The larger the group practice, the more challenging it can be to get every office on the same page. "Dentists put together protocols to ensure a smooth workflow among their various offices," says Frank Seipp, product manager, Air Techniques. Many of these protocols are centered on X-ray and digital radiography, he adds. The ability for multiple dental offices to share images and files is an advantage, he says, and companies such as Air Techniques now offer scanners and PSP plates that help make this possible. Dentists working in large group practices today can share one image among their archives, bringing other dentists in the group up to speed on a particular patient case, or they can place the image on a screen to assist with a patient consultation, among other things.

How it works

It can be helpful for dentists and their staff to have a basic understanding of how digital radiography works. A chairside digital radiography system produces immediate radiographs in nine seconds or less. The user must simply remove the flexible phosphor sensor from the patient's mouth, remove the sensor from the infection control barrier envelope and insert it into the slot at the top of the unit. The scanner develops the image, and the sensor is available for reuse.

There is no annual maintenance costs associated with Air Techniques' ScanX Swift. The system includes sensor cleaning wipes for cleaning the reusable phosphor sensors; a barrier film roll for adhering to the top of the scanner before inserting the PSP and removing between patients; and scanner cleaning sheets for keeping the system's rollers clean.

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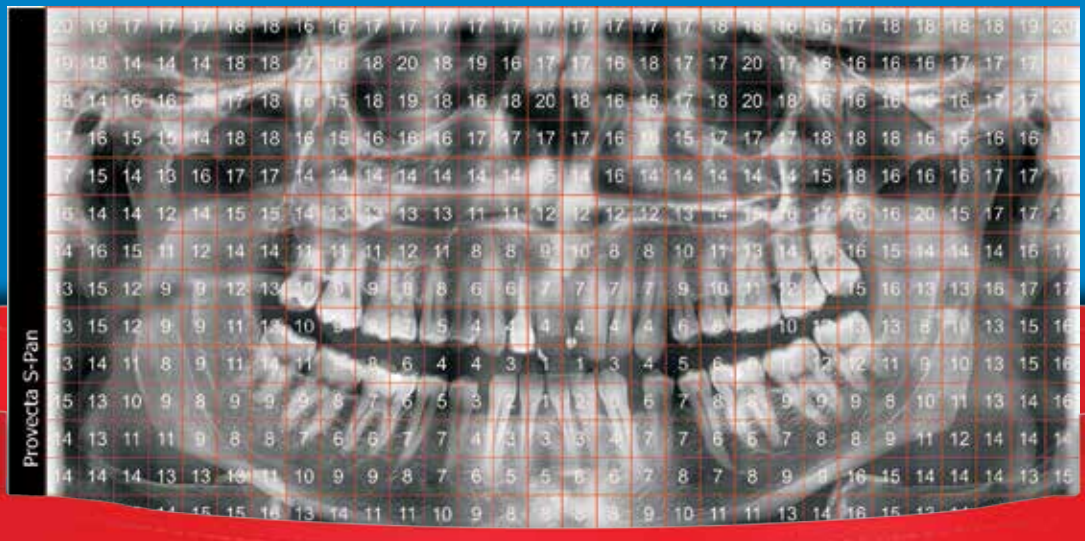

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Choosing the right plate

There is no right or wrong when it comes to selecting a plate to accommodate digital radiographs. Some dentists prefer to work with phosphorous plates, which work much like analog film, while others prefer using hard plate sensors.

Phosphorous plates:

- Digital twain image can be sent to the dentist's practice management software, archive or laptop, as well as to an insurance agency.
- Available in the same size as traditional X-ray film and, because they are similar to analog film, they are relatively easy for dentists and staff to learn to use.

Hard plate sensors:

- Must be fed into the X-ray machine differently and therefore require about 15 minutes of instruction prior to first-time use.
- The sensors are wired into a PC or laptop.

"The advantage of digital radiography is that it doesn't conform to a single format," says Seipp. "Digital IPEG images can be passed from one software system to the next and different offices can speak to one another." Some of Air Techniques' scanners are designed for chairside use, while other, larger systems are designed for large-volume workflow, he notes. But, all scanners are designed to communicate with the group's practice management software. Even when offices use different software packages from one another,

as long as the images are in standard format, all software systems will accommodate them, he adds.

A sound investment

Converting a group dental practice is an investment – but one worth making, note experts. "Scanners and plates cost tens of thousands of dollars," says Seipp. "However, when one reviews the time involved using traditional X-ray systems – including labor and maintenance – it's a worthwhile investment. There are dollars associated with maintaining traditional X-ray equipment, which requires special chemicals and supplies," he says.

There are several benefits associated with digital radiology. "Digital systems are faster and provide immediate feedback," Seipp says. Traditional X-rays can slow down the insurance billing process, and can end up delaying the patient's follow-up with the right specialist and treatment. Also, digital radiography takes up a fraction of the space that traditional X-ray systems do, he says. "There is no need to store the chemicals and supplies associated with traditional X-ray."

When it comes to digital radiography, there is no one-size-fits-all solution. "Some dental offices prefer using only digital radiography, while others rely on it for specific cases," says Seipp. "And, some practices still use traditional X-ray." Dentists and practice managers must consider the goals of the practice, he explains. "What goals is the practice looking to achieve in the near future? There is a wide variety of digital products available and one solution may suit one office's budget and workflow needs, while another system suits the needs of another office within the practice." But all digital solutions can communicate with one another, he says, no matter which system each office says.

"The initial setup takes time," he continues. But, the learning curve is small. And, given the end-of-year Section 179 tax incentives available to dental practices, for some, this might be a good time to move forward. ■

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Setting up nitrous oxide systems in your new office

By E. Daniel Shoemaker, national product trainer, Accutron Inc.

Outfitting a dental group practice with nitrous oxide calls for strategy and knowhow. First and foremost, safety must be taken into consideration. Patient and staff safety are of the greatest concern when medical gasses are being plumbed into a facility. The National Fire Protection Agency (NFPA) requires that the plumbers and installers of the actual piping system be certified as medical gas installers, and that each system be verified for safety by a third-party verifier who has no financial involvement in the sale or installation of any of the devices on the system. The verifier is the best friend to the dentist and others who may use the medical gas system, as he or she tests every function of the equipment and takes readings on the gasses coming out of every medical gas outlet. Every office should have a certificate of verification from a third-party verifier. This is of the highest safety priority and eliminates any chance of a crossed line, improper piping risers or other errors by the installers.

As group practices become larger, building planners are using the space provided to create multiple levels or multiple hallways of dental procedure areas. A few factors must be taken into consideration when planning these offices of the future. To begin with, the location of the medical gas storage room in relation to the dental procedure areas has a bearing on what devices are required. Automatic switchover manifolds are required in several scenarios. Even when they are not required, however, they are a tremendous advantage for the dental staff, as they have indicators to alert and warn the staff of the simplest need, such as reminding them to order a replacement cylinder when one is depleted of gas. Zones of dental procedure areas are established when separations are created by distance, levels (i.e., floors) and access doors. The NFPA 99 standard stipulates the safety devices that are required for all nitrous oxide/oxygen systems, particularly when complications of multiple zones of procedure areas are created.

The NFPA Category 3 permits up to two alarm panels and up to four multiple zone valves to share a single manifold system. This allows the facility to share a single manifold system between two alarm panel locations (e.g., floor 1 and floor 2, or hall A and hall B), as well as allows for multiple zone valve locations. These zone valve requirements may vary by local codes.

At some point in the design process, the dental team will ask itself an age-old question: "Do we set up all the rooms the same, or should we have special rooms for special procedures?" This is usually followed up with: "Should we furnish hygiene rooms differently than the doctor's rooms?"

A wise doctor once told me he set up his hygiene rooms as the nicest rooms in the office so that the one and only "first impression" of the office and staff would be his best foot forward. "The average new patient contributes a production level of approximately three times that of a current patient," he said. "That's why it's so important to make an excellent first impression. The patient sees that yours is a caring practice dedicated to providing excellent dentistry, and the patient in turn becomes dedicated to the practice."

Different rooms, same setup

Another trend is to set up all the dental equipment and facilities in the treatment rooms exactly the same. Hygiene rooms are decorated and set up typically as educational rooms, but when it comes to the chair, unit, light, nitrous equipment, etc., every room in the dental office is exactly the same. There is added efficiency of managing patient flow when all rooms are set up this way. Time is the one commodity that you can't replace or add to the practice. Equipment and practice techniques that can increase effective use of the practice's time have the potential to pay back and generate profit. Don Hobbs, VP of Equipment at Henry Schein, told *First Impressions* Magazine, a sister publication to *Efficiency in Group Practice*, "Dentistry has evolved, and now we recommend that all the rooms are consistent and designed as full treatment suites. That concept enables doctors to treat some patients immediately, as opposed to re-appointing. It is better for the patient, as they do not have to come back, and it is better for the doctor, as it leads to a more efficient and profitable practice."

With regard to specialties (e.g., endodontics, periodontics, orthodontics, implants, etc.), specialty carts can be outfitted to move between treatment rooms as needed, providing all the specialty devices necessary while bringing the specialty to the patient, no matter where he or she is seated in the office.

Infection control

There is seldom a single word used more frequently when discussing dental procedure room equipment than asepsis. The importance of wiping down or barrier-protecting any device in the range of the overspray from the patient's mouth is right up there with sterilization of instruments, handpieces, etc. It's all about cross-contamination control, and any device with dials, knobs, levers, switches or handles impedes the process. Nitrous delivery flowmeters that are mounted into the cabinetry or wall and that have flat screen controls help prevent cross-contamination between patients. The simple act of removing barriers from just one more added device, like the face of the flowmeter, only takes a few extra seconds and is so much more effective than cleaning around dials, knobs, levers, switches and handles.

Another element in asepsis control is that of the nasal hood that the patient breathes through. The need to wipe out a nasal hood with a four-by-four dipped in alcohol has been replaced by autoclaveable or disposable hoods. Think about how much time is required to wash and clean a nasal hood, let it dry, place it in a sterilization bag, make room in the sterilizer (usually accomplished by removing a tray, which reduces the amount of instruments the staff can sterilize in a cycle), pass it through sterilization and then return it to the operatory. Disposable nasal hoods are real time-savers.

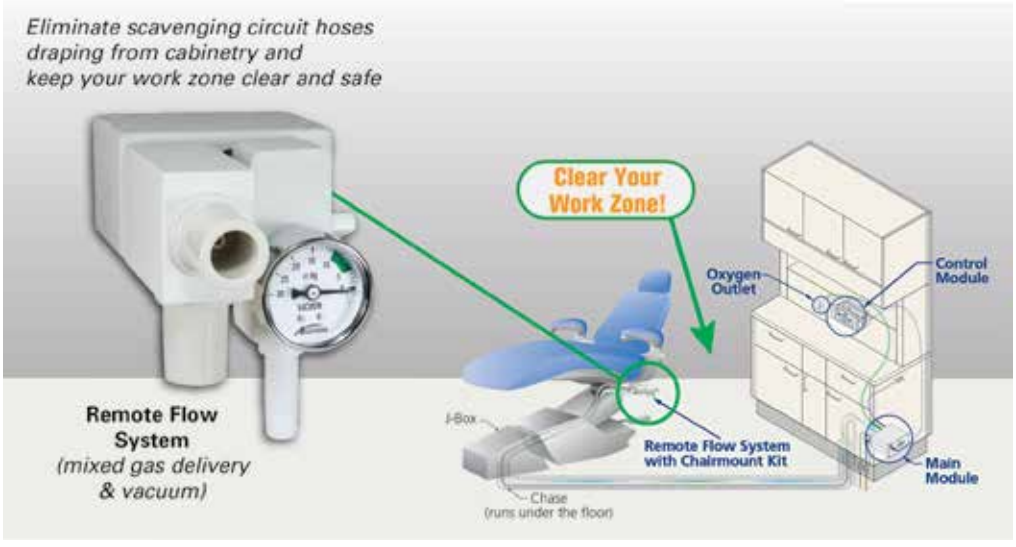
Today, the portions of the scavenging circuit hoses that actually touch the patient are autoclaveable. While changing out the mask is a good practice to prevent cross-contamination, the practice should consider establishing a protocol to clean and sterilize the portion of the hoses that come in contact with the patient.

Key considerations

Nitrous oxide plays an important role in the dental practice. Some key factors to consider when designing the operatory include:

- Compliance with NFPA codes and regulations.
- Installation of a central gas supply system.
- Selection of an automatic manifold system that allows for more than one alarm panel.
- Furnishing each operatory with the same fixed nitrous oxide flowmeter.
- Selection of flowmeters that are easy to disinfect or barrier-protect.
- Scavenging expelled nitrous oxide. (The size and force of the vacuum system needs to be adequate enough to support all operatories.)
- Consideration of including a Capnography monitor.
- Eliminating gas and vacuum hoses that drape from cabinetry, crowding the work zone. (It's important to locate the vacuum and gas delivery hoses at the patient chair.)
- Access to emergency oxygen equipment

As recent as January 2014, any procedure that includes levels of sedation that are moderate, deep or general requires the use of a capnography monitor to track end-tidal carbon dioxide (EtCO2). Various methods have been attempted to place the EtCO2 sample tube as near to the exhalation of the patient as possible, but Accutron Inc. has discovered that a short extension tube built into the nasal hood allows for the best fit of the mask, while providing the most accurate location for CO2 sampling.



Scavenging

While on the subject of hoses and masks, the other side of the medical gas delivery is the vacuum removal of the exhaled gas, titled "scavenging." Scavenging needs to be figured into the design of the dental vacuum system, usually figured as half of a "user." (A "user" is typically defined as a high-volume hose opening, and systems are designed by adding up the number of high-volume evacuators, saliva ejectors and nitrous scavengers that are in use at the same time.) The load isn't extreme, but it needs to be calculated into the design.

As dentists and hygienists incorporate the practice of minimal class movements, unencumbered access around the patient's head is required. Hoses and wires draped between the rear cabinetry can block or reduce access to the patient. A growing trend for nitrous oxide delivery hoses is to run the mixed gas and vacuum hoses from the cabinetry behind the head of the patient, through a conduit under the floor, and mount the delivery side of the system on the dental chair, draping the hoses under the back of the chair, up to the patient. This system gives the dentist unencumbered access to the patient.

As mentioned previously, the first concern in the building of a dental office is the safety of the patients and the staff. Although practices rarely must call for emergency services to assist with a patient or staff member, the office staff should all be CPR-certified and the proper emergency equipment should be on hand. A portable oxygen cylinder with a demand valve resuscitator constitutes the minimal safety equipment. Even if the central system has outlets that allow connecting into the oxygen for emergencies, the central system does not reach the bathrooms, hallways, waiting room, elevators, etc., and more heart attacks occur away from the operatory than in it. Centrally located automatic external defibrillators (AEDs) should be considered a must-have, and large group practices that span out or have multiple levels might require several. ■

Editor's note: E. Daniel Shoemaker joined the dental industry in 1974 and has held positions as technician, service manager, national service manager, manufacturer sales representative, field product manager, regional sales manager, and national product trainer for several companies. He has lectured at over 200 training meetings on various aspects of nitrous oxide use in oral sedation and has served on the NFPA 99 sub-committee on medical gas piping for the past 20+ years, participating in the establishment of safety standards in North America. In addition, he has presented at the national meetings for Medical Gas Professional Healthcare Organization, National Piping Engineers meetings, and several teaching institutions.

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Employed Physicians Like the Life

Physician survey shows that employed physicians are more positive, enjoy clinical autonomy

Dental professionals involved in group practices and DSOs might take note of a newly released survey of their physician counterparts.

"America's physician workforce is undergoing significant changes," Walker Ray, M.D., vice president of The Physicians Foundation and chair of its Research Committee, was quoted as saying, following the release of The Physicians Foundation's 2014 Survey of America's Physicians, conducted by Merritt Hawkins. "Physicians are younger, more are working in employed practice settings and more are leaving private practice."

The survey, conducted online from March 2014 through June 2014, measured responses from 20,088 physicians across the United States.

The majority of physicians 45 or younger (54.3 percent) described their morale as very or somewhat positive, compared to only 38.9 percent of physicians 46 or older.

Changing attitudes

Relative to the national surveys The Physicians Foundation conducted in 2012 and 2008, doctors are more positive in their outlook as their ranks change demographically and as their status rapidly shifts from that of independent practice owner to employee, according to Merritt Hawkins.

The 2014 respondents are younger, and more likely to work in employed settings (e.g., hospital systems), compared to those in earlier surveys. More are females, and more work in primary care. In 2014, the average age of the respondents is 50, vs. an average age of 54 in 2012. In 2014, 33 percent of the survey respondents are female, vs. 26 percent in 2012.

Younger physicians, female physicians, employed physicians and primary care physicians are more positive about the current medical practice environment than are older physicians, male physicians, medical specialists and practice owners (though the majority of almost all groups suffer from low morale and express doubts about the direction of the healthcare system).

Of particular interest to dentists might be the responses to a question about clinical autonomy: Employed physicians indicated their clinical autonomy is slightly less limited than practice owners, by a margin of 68.2 percent to 70.6 percent.

Regarding practice ownership:

- Only 35 percent of physicians describe themselves as independent practice owners, down from 49 percent in 2012 and 62 percent in 2008.
- Fifty-three percent of physicians describe themselves as hospital or medical group employees, up from 44 percent in 2012 and 38 percent in 2008.
- Only 17 percent of physicians indicate they are in solo practice, down from 25 percent in 2012.

Morale

Just more than half of employed physicians described their morale as very or somewhat positive, compared to only 33.1 percent of practice owners. The majority of physicians 45 or younger (54.3 percent) described their morale as very or somewhat positive, compared to only 38.9 percent of physicians 46 or older.

The relatively positive feelings expressed by younger physicians may be in part a result of the fact that most doctors under the age of 45 entered the profession when changes to physician practice structures and reimbursement already were underway, according to the researchers. Many have always been employed and have no basis for comparing the employed practice model to the independent model.

Autonomy in clinical decision-making

Fewer than one-third of physicians say they are free to make the best decisions for their patients, while 69 percent say their medical decisions are sometimes or often compromised.

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Employed physicians indicated their clinical autonomy is slightly less limited than practice owners, by a margin of 68.2 percent to 70.6 percent. This contradicts the widely perceived notion that physicians sacrifice clinical autonomy in order to become employees, while practice owners sacrifice security to preserve clinical autonomy, Merritt Hawkins researchers note.

In what may be another surprise to some, employed physicians report working more hours per week on non-clinical duties than do practice owners. Employed physicians report spending 10.63 hours per week on non-clinical paperwork, while owners report spending 9.79 hours. One of the presumed benefits of physician employment is that it frees doctors from the non-clinical duties of running a practice with which practice owners must contend, and therefore allows them to spend more time with patients. Both the 2014 and the 2012 surveys suggest this is not the case. ■

Hospital employment of physicians is a positive trend likely to enhance quality of care and decrease costs.

	45 or younger	46 or older
Mostly agree	11.7 percent	8.1 percent
Somewhat agree	35.7 percent	23.4 percent
Somewhat disagree	27.7 percent	29.3 percent
Mostly disagree	24.9 percent	39.2 percent

Source: 2014 Survey of America's Physicians, ©2014, The Physicians Foundation

Editor's Note: To receive a copy of the 2014 Survey of America's Physicians, go to www.physiciansfoundation.org

Owner or employee?

Among physicians who identified themselves as employees, 57.6 percent say they are employed by a hospital, and 42.4 percent say they are employed by a medical group.

Which best describes your morale and your feelings about the current state of the medical profession?

	Employed	Owner
Very positive	9.9 percent	6.2 percent
Somewhat positive	40.6 percent	26.9 percent
Somewhat negative	35.2 percent	40.7 percent
Very negative	14.3 percent	26.2 percent

Which best describes how you feel about the future of the medical profession?

	Employed	Owner
Very positive	11.2 percent	7.0 percent
Somewhat positive	42.0 percent	33.0 percent
Somewhat negative	38.3 percent	43.5 percent
Very negative	8.5 percent	16.5 percent

Hospital employment of physicians is a positive trend likely to enhance quality of care and decrease costs.

	Employed	Owner
Mostly agree	13.1 percent	3.2 percent
Somewhat agree	36.3 percent	13.5 percent
Somewhat disagree	28.7 percent	27.9 percent
Mostly disagree	21.9 percent	55.4 percent

Has your practice implemented electronic medical records?

	Employed	Owner
Yes	92.9 percent	73.5 percent
No	7.1 percent	26.5 percent

If yes, how has EMR affected your practice?

	Employed	Owner
Improved quality of care	36.1 percent	23.7 percent
Detracted from quality of care	23.1 percent	26.9 percent
Improved efficiency	25.3 percent	22.5 percent
Detracted from efficiency	45.0 percent	48.3 percent
Improved patient interaction	4.9 percent	4.2 percent
Detracted from patient interaction	46.6 percent	48.0 percent
Has had little to no impact on above	6.2 percent	9.8 percent

Source: 2014 Survey of America's Physicians, ©2014, The Physicians Foundation

Who's best for the patient…

Practice owner or employee?

A growing proportion of U.S. physicians are practicing as employees. Could this trend in medicine be a harbinger for the future of dentistry? And if so, is that good or bad?

Raul I. Garcia, DMD, MMedSc, professor and chair, Department of Health Policy and Health Services Research, Boston University Henry M. Goldman School of Dental Medicine, and president of the Santa Fe Group, poses these questions in a guest editorial in the October 2014 edition of the Journal of the American Dental Association.

Dentists face a changing environment, he says. Examples:

- A growing unmet need for dental care, brought about by anticipated growth in the U.S. population of racial and ethnic minorities and immigrants, who traditionally have a majority of the oral disease burden; and a decline in the proportion of Americans covered by dental insurance.
- A growing U.S. dentist workforce, because of new dental schools and increasing class sizes.
- Higher indebtedness among recent graduates.
- Greater interest in work-life balance.

Many dentists are responding by joining large group practices, he says.

"During the past decade, the types and number of large group dental practices have grown, and the number of dentists who are employees, as opposed to associates, partners or owners, also has increased.

"Less than 25 years ago, more than 90 percent of dentists were owners. That proportion has now declined to less than 85 percent, as increasing numbers of dentists work in a dental service organization (DSO) practice model or are employees in other types of practices, including public health settings. In particular, the number of dentists working in large group practices continues to grow, a trend expected to accelerate through this decade."

It's too early to tell whether large groups are directly competing with existing practitioners or serving an underserved segment of the population, notes Garcia (though with wider use of the ADA Health Policy Institute's newly proposed classification system for dental group practices, such data may become available).

However, it is clear that large practices enjoy economies of scale, purchasing power and access to capital, he says. By offering a lower-priced alternative and accepting more insurance, they pose stiff competition to traditional solo practices.

"During the past decade, the types and number of large group dental practices have grown, and the number of dentists who are employees, as opposed to associates, partners or owners, also has increased."

– Raul I. Garcia, DMD

And the impact on patient care? TBD, says Garcia.

"[I]n our current age of evidence-based practice and policy, a key question relevant to this discussion remains unanswered: To what extent do quality of care and patient-based outcomes differ in any important ways among practice types? We need the answer to this question to fully understand whether, and how, particular practice settings affect the quality of care delivered, and also to guide us in making the best policy decisions regarding the future of dental practice in America." ■

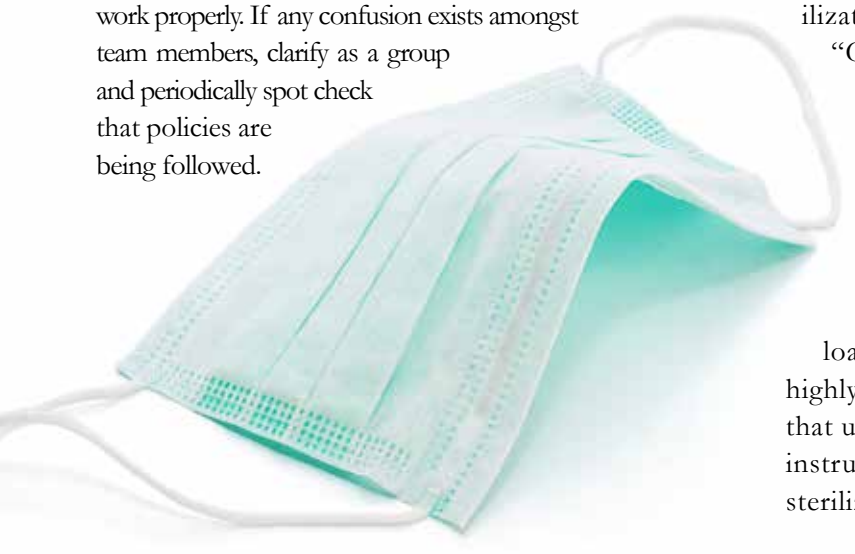
Best Practices in Infection Control

By Dr. John Molinari and Peri Nelson

Editor's note: *In Best Practices in Infection Control, with THE DENTAL ADVISOR, Dr. John Molinari and Peri Nelson will address common concerns related to Infection control in dental practices. Questions can be submitted at dentaladvisor.com, under the Ask The Editors tab.*

Q: I work in a large, busy practice where more than 200 patients are seen per day. It is difficult to get everyone on the same page in terms of infection control policies and procedures. There are a lot of team members cutting corners because we are so busy. We don't have a set system and this concerns me. What do you suggest?

A: Having a documented infection control program is key for any practice, large or small. The key point is that all employees must adhere to clear guidelines that are written down, taught, and periodically reviewed as a team. When infection control procedures are improperly completed, it increases the risk of disease transmission. Have a meeting with personnel, discussing ways to complete tasks in an organized and efficient fashion, using products and equipment that work properly. If any confusion exists amongst team members, clarify as a group and periodically spot check that policies are being followed.



Q: I recently read about a new type of sterilizer that dries instruments quicker. Our autoclave is constantly on overload, and instruments come out wet at the end of the cycle. Are the new sterilizers better at drying instruments?

A: The traditional sterilizers were gravity sterilizers. Because air entering the chamber mixes with air, cool air pockets can form within the chamber, which may result in extended times for sterilization of certain items. In addition, overloading this type of autoclave can lead to incomplete drying of sterilized instrument packs, resulting in the user commonly finding wet packages at the end of the cycle. Development of a new generation of autoclaves within the last two decades has added a new dimension to this heat sterilization modality. These autoclaves are classified as "Class B" sterilizers or "pre- and post-vacuum" steam sterilizers. The equipment is fitted with a pump that creates an initial vacuum in the chamber to ensure air is removed from the sterilizing chamber before steam enters. In contrast to a gravity displacement autoclave, this procedure allows faster and more thorough steam penetration throughout the entire load. The post-sterilization vacuum cycle also is highly efficient because it facilitates drying. Practices that utilize this type of sterilizer frequently report the instrument packs are "bone dry" at the end of the sterilization process. ■

Dr. John Molinari and Peri Nelson train dental professionals worldwide on Infection control products and procedures. The course "What's Bugging The Dentist?" is a popular hands-on, interactive program designed to assist in the selection, assessment, and use of infection control products in practice. Contact mary@dentaladvisor.com to schedule your event.

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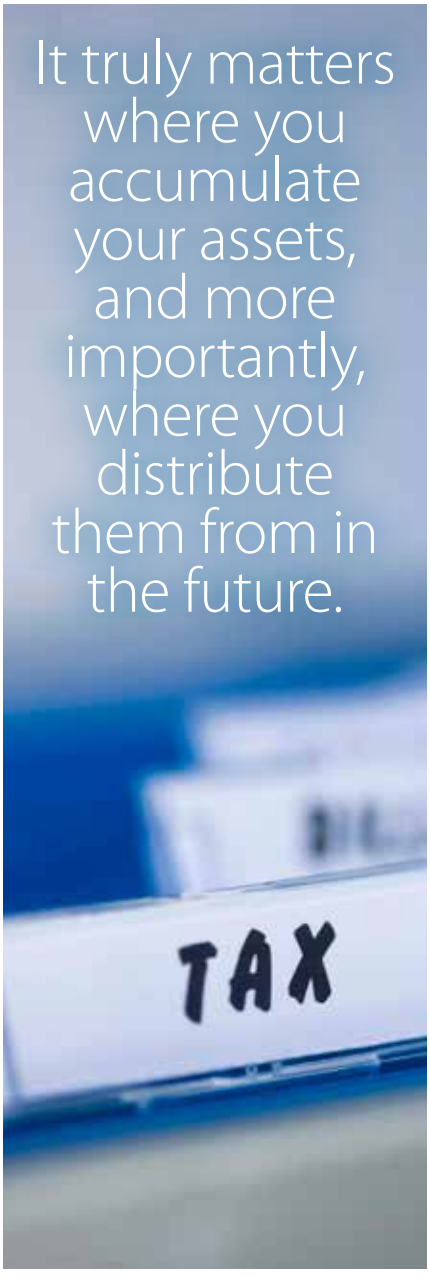
Taxed Never

Identifying and properly using Taxed Never investments

By Jared Thompson

Editor's note: *The following is part III in a series on understanding and effectively using Time-Tax Buckets*



You can pay taxes now, later, and never. Proper use of this knowledge will transform the way your future investments look.

In the two most recent issues of *Efficiency in Group Practice*, we built the foundation for what could be considered a well-diversified method of accumulating assets in the most tax efficient manner. Dentists can implement these simple principles right away to help avoid shocking amounts of taxes and fees. To review, the three buckets dentist clients of PersonalCFO use to accumulate assets are the:

1. **Taxed Now Bucket**
2. **Taxed Later Bucket**
3. **Taxed Never Bucket**

What if the least-funded bucket becomes the most valuable?

Most of the dentists we first begin to plan with have done a great job of filling the "Taxed Now" bucket, and usually an even better job filling the "Taxed Later" bucket. We love to see this kind of diligent saving, but is it enough to fully prepare you for retirement? Is your retirement really secure without using the "Taxed Never" bucket properly?

You're likely saying, "Jared, I'm a highly compensated professional. Does this advice apply to me? Am I even eligible to save in this bucket?" With the correct knowledge and a bit of effort, you most certainly are.

Most docs may not be aware of what qualifies as a Taxed Never investment. To truly be a Taxed Never investment, it must meet several withdrawal or distribution tests:

1. **It must be exempt from income tax.** Once eligible money has been placed into these types of savings accounts, the principal and any growth must not be taxed, regardless of one's income tax bracket. The type of accounts used (discussed a bit later) may have age restrictions on when you can withdrawal from them, but some Taxed Never accounts don't have any age restrictions.

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2. **It must not negatively affect Social Security benefits.** In retirement, when receiving Social Security benefits, did you know that all your income sources are tallied (including half of the Social Security benefit itself) and if the tallied income rises above a certain low threshold, up to 85 percent of your Social Security benefit can be taxed at your highest marginal tax rate?

   Yes, you read correctly. Working part time, receiving a pension, taking too much from certain savings or retirement accounts during retirement can cut your Social Security benefits by more than one-third. The $2,500 you may have been expecting from Social Security each month may now only be $1,650.

Most docs may not be aware of what qualifies as a Taxed Never investment.

3. **It must avoid distribution requirements at age 70 ½.** If you're fortunate enough to have a Taxed Never asset, the last thing you may want is to be forced to disburse your hard won funds at age 70 ½, or any other age. Only one of several Taxed Never accounts has this requirement, but it is totally avoidable … all you have to use is a simple strategy that we can teach you in a matter of minutes.

Taxed Never savings accounts

1. **Roth IRA.** This is my favorite Taxed Never account. I help young doctors all over the country establish private Roth IRA accounts for themselves and their eligible spouses or partners while their income is still low. Opportunities still exist for more seasoned docs to use these accounts, as well. Limitations exist on income amounts, however.

   For new money, called contributions, a doctor can only earn $181,000 (or $114,000 if single) before their eligibility begins to phase out. A total of $5,500 per eligible person can be added to their accounts each year if under 50 years of age. Or $6,500 if 50 or older.

   For old money, called conversions from IRA to Roth accounts, a doctor can earn any amount of money and still use this strategy. This was not always the case, and it may not last for long, but while it does, it may make sense to start converting some of those IRA dollars. All you have to do is pay tax on the portion that you convert and then those dollars transform into funds that can grow uninhibited: the dollars and growth avoid all taxes for their lifetime.

2. **Roth 401(k) or Roth 403(b).** If you're lucky enough to have a retirement savings plan that allows you to take advantage of the Roth, use it. If it's not available to you now, ask your plan administrator for it. A whopping $17,500 to $23,000 can be placed into a Roth 401(k) or Roth 403(b) each year, depending on your age. There are no income restrictions, either!

   Often times, if you place money into these accounts you may receive a match from the company – your own or the company you work for. Although the match goes into the traditional portion of the plan, this is still a great incentive. If you placed 3 percent of your earnings into the plan and you receive a 100 percent match on that first 3 percent, this is a 100 percent rate of return on your contribution! Can the markets beat that?

3. **Non-Deductible IRAs that will be converted to Roth IRAs.** For more seasoned or highly compensated doctors, this strategy may be worth a look. As long as you have earned income you are eligible to obtain a non-deductible IRA. There are no tax benefits to starting a non-deductible IRA (like the name implies, it is not deductible) but these accounts can be converted to Roth IRAs where only the potential gains are taxed upon conversion. PersonalCFO or most tax professionals can provide additional details.

4. Permanent Life Insurance. Insurance is Taxed Never? It is if arranged properly. Our most savvy and sophisticated dentist professionals love this strategy. Finding otherwise wasted dollars and using them to buy a low amount of insurance may afford our docs an asset class unlike any other. Typically, there are no income limitations, no age restrictions, generous contribution maximums, no distribution requirements, and a wide range of investment options. Used in conjunction with a trust, it may also be possible to build and grow assets outside of your estate to shield you from creditors, attorneys and predators. With lawsuits on the rise, this strategy may bring some needed peace of mind.

There are many advisors and CPAs out there that don't feel using Taxed Never accounts are necessary or worth it. Some even say, "It's too late to start now!" Likely, this is a silly notion. True planning looks at the big picture and encompasses 20 to 30 years of perspective. Paying a little tax today to utilize these strategies may avoid major taxation tomorrow.

So now that we've covered your Taxed Now, Taxed Later, and Tax Never Buckets, you may be seeing the delicate balance that needs to exist between the various types of savings vehicles. It truly matters where you accumulate your assets, and more importantly, where you distribute them from in the future. Best of luck! ■

For questions, copies of our prior articles or for expanded information, please write Jared at: jared@DoctorsPersonalCFO.com

Heartland Dental now supports 600 dental offices

Heartland Dental, LLC, recently reached its 600th supported office. "Starting out with a handful of supported offices 17 years ago, it has been amazing to see how far our organization has come since then," explained Rick Workman, DMD, founder and chief executive officer at Heartland Dental. "This milestone is a testament to the hard work and dedication of all Heartland Dental supported doctors and team members. They exemplify ideal leadership, openness and passion. With the combined efforts of so many, we have become the largest dental support organization in the U.S. and continue to make strides in our mission of becoming the leader in dentistry." Founded in 1997, Heartland Dental currently supports over 900 dentists and over 6,700 team members nationwide by offering continuing education opportunities, leadership training and non-clinical, administrative services. "Heartland Dental has always emphasized continual growth, and we are always looking for new ways to advance. With that mindset, we have supported hundreds of dentists and thousands of team members in discovering ideal dental careers," added Patrick Bauer, president and chief operations officer at Heartland Dental. "In the future, we look forward to supporting even more dentists and dental professionals in advancing themselves personally and professionally."

Research projects growth in number of dentists

New research briefs published by the American Dental Association's (ADA) Health Policy Institute shows the number of dentists in the U.S. will continue to grow over the next generation, according to a release. Under the most likely scenarios, ADA's model predicts that dental school graduations will exceed dentist retirements. The net increase of practicing dentists will exceed the corresponding growth of the U.S. population. The new report shows the number of dentists practicing per 100,000 people today has climbed more than 4 percent from 2003 to 2013 and is projected to climb 1.5 percent from 2013 to 2018 and 2.6 percent by 2033.

:DentalPlans launches resource center on impact of Affordable Care Act on dental coverage

:DentalPlans, a dental savings plan marketplace, launched a new resource center to help consumers and businesses navigate the Affordable Care Act's (ACA) impact on dental coverage. While the ACA now requires individuals to have health insurance, dental coverage is not required in that mandate, even though oral health is essential to achieving overall health and well-being. The ACA Resource Center, at www.dentalplans.com/affordable-care-act, details how the ACA does and doesn't affect dental coverage for adults, families, children, seniors, self-employed people, and small businesses.

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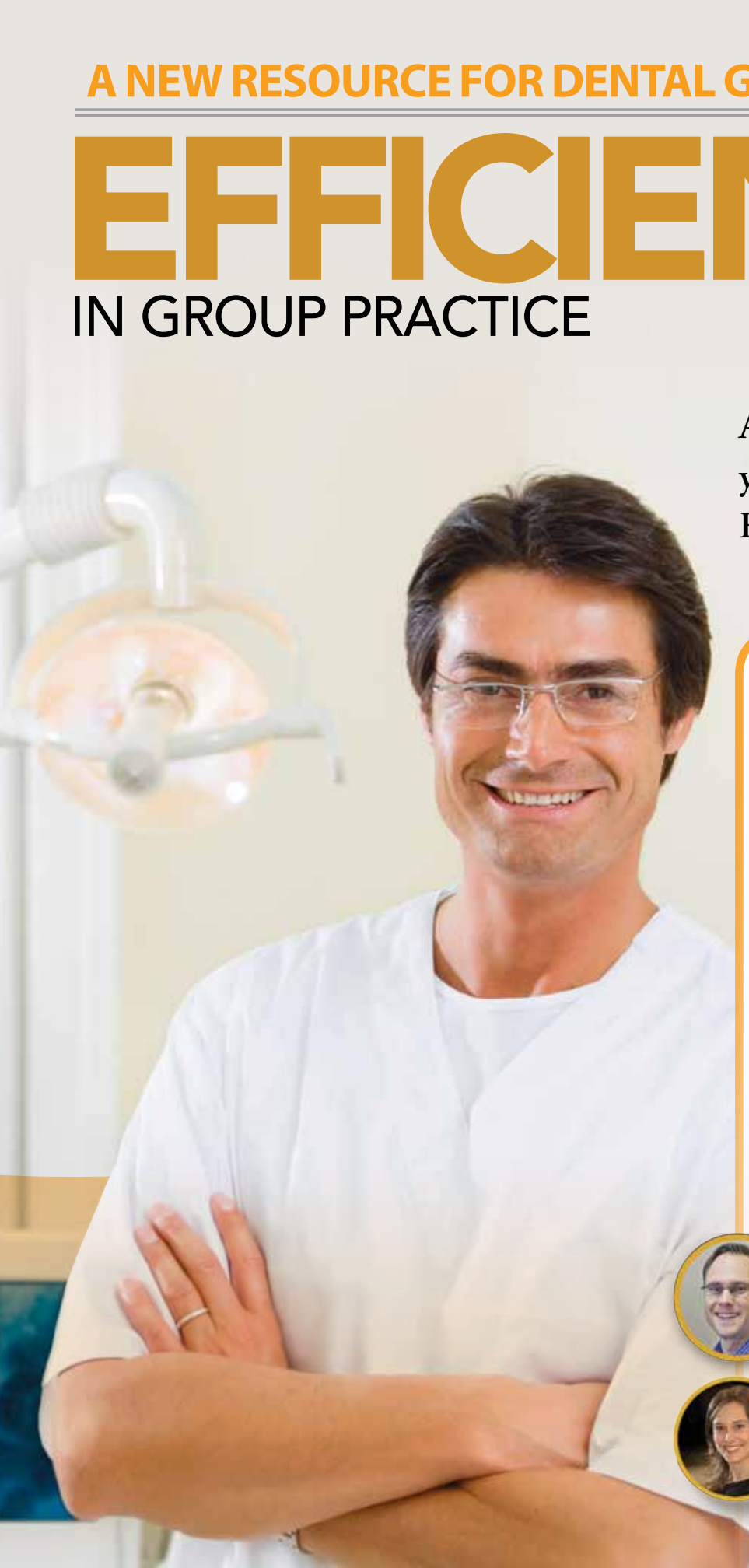

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Pediatricians play a role in children's oral health

In a revised policy statement, "Maintaining and Improving the Oral Health of Young Children," appearing in the December 2014 issue of *Pediatrics*, the American Academy of Pediatrics notes that pediatricians play an important role in improving oral health for young children. Over the years, oral health status for older children has improved or stayed the same. However, in children two to four years of age, the number of dental caries has increased significantly from 19 to 24 percent, especially in children from poor families. Young children often see a pediatrician more frequently in the first years of life than they would a dentist, putting pediatricians in a unique position to provide oral health counseling. Pediatricians should instruct parents on proper brushing technique, discuss the role sugary food and drinks play in the development of dental caries, and review recommendations for fluoride administration and supplementation. It is also important that pediatricians encourage parents to ensure their children have a dental home by the time they reach one year of age.

California approves dental telehealth program

California passed a new law expanding the Virtual Dental Home (VDH), a program that uses telehealth technology to bring dental services directly to patients in community settings, such as schools and nursing homes. The bill was the outgrowth of a demonstration project established in 2010 by Paul Glassman DDS, director of the Arthur A Dugoni School of Dentistry's Pacific Center for Special Care (San Francisco, Calif.). The law expands the scope of practice for dental hygienists and assistants and provides payment for telehealth-enabled dental services under California's Medicaid program. It uses dental hygienists to screen patients and send data electronically to dentists at clinics or offices who advise the hygienists which preventive and routine restorative care should be done. Services provided include cleanings, sealants, fluoride, X-rays, chart preparation, oral hygiene instruction, nutritional counseling, and placement of interim therapeutic restorations. Patients requiring more complex care are referred to dentists who review the records before an office visit.

Aspen Dental-branded office opens in Massachusetts

A new Aspen Dental-branded office is opened in Hadley, Mass., in November, according to a release. The practice will provide dental services that range from dentures and preventive care to general dentistry and restoration. Dr. Mahek Mehta, lead dentist at the Hadley office, looks

forward to meeting the Hadley community and providing much-needed access to dental care and education. The Hadley office, located in Hampshire County, is one of 29 Aspen Dental-branded locations in Massachusetts, a state where all of the 14 counties have dental health professional shortage areas as designated by the U.S. Department of Health and Human Services. According to a study conducted in 2013 by Syracuse University's Whitman School of Management, each new Aspen Dental-branded office supports local community growth by contributing more than $1.3 million in positive economic impact through job creation and capital investment. The local community benefits through investment in office construction, furniture and fixtures, jobs created and wages and benefits paid, taxes, and investment in marketing and advertising.

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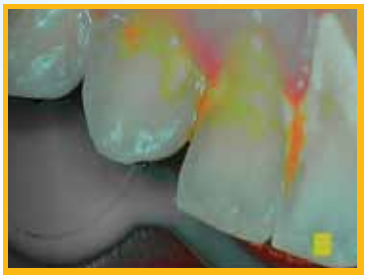

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