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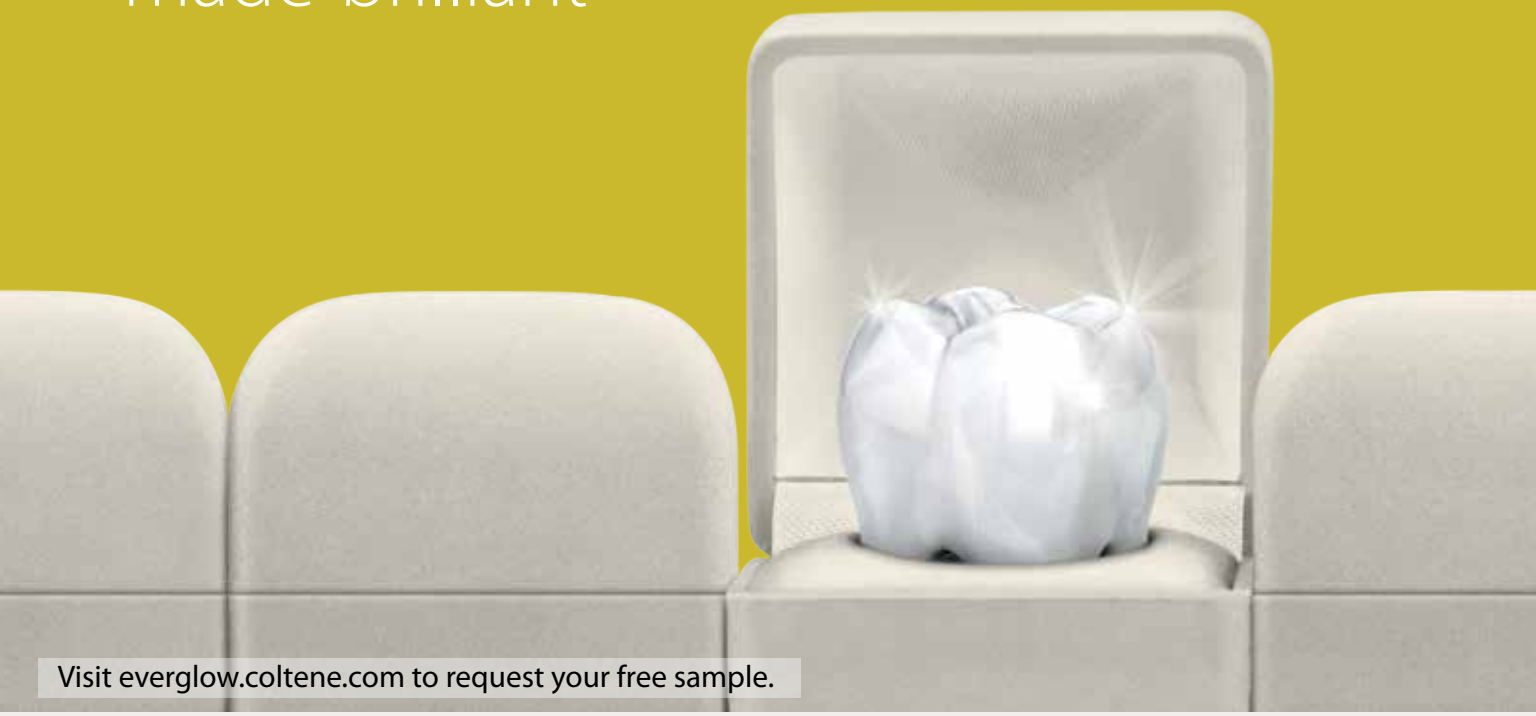

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Tackling Key DSO Trends

In this issue of *Efficiency in Group Practice* we have something for just about everyone who works in a DSO setting.

Our cover story features some great Q & A on technology for dental support organizations and group practices. *Efficiency* asked the Chief Information Officer of Great Expressions and Chief Technology Officer of Benevis what they look for when evaluating technology for their many member dental practices. Some of their feedback may make you wish that you chose a career path in technology and computer science because these areas are becoming extremely important to dental groups and DSOs. Patient outcomes are being tied to technology; it is not just about efficiency. Without great, consistent patient outcomes, efficiency and productivity increases mean nothing.

Investment in clinical and non-clinical technologies can also positively impact recruitment of new dental team members as well as a new patient generation tool. Read the entire article to find out how Great Expressions and Benevis determine exactly what technology is truly innovative.

In our DSO profile, we feature the fast-growing Dental Care Alliance. In 1994, Mitch Olan, CEO of DCA, joined founder Steve Matzkin, DDS, when DCA had four affiliated practices. Fast forward to today, Dental Care Alliance is supporting over 500 dentists in 240 practices along the East coast. Mitch gives our readers insight into DCA's growth strategy, as well as their core values.

In this issue, we also introduce our readers to the newest contributor to *Efficiency in Group Practice*, Dr. Katherine Schrubbe, RDH, BS, M.Ed, PhD. Dr. Schrubbe is the director of quality assurance at Dental Associates. *Efficiency* spoke with Dr. Schrubbe about her diverse dental background and her journey from private practice to academia, and then back to Dental Associates, which has transformed itself from a small practice to a group practice. Learn about Dr. Schrubbe in 'A Lifelong Learner', and look for her quality assurance and infection control column in future issues of *Efficiency*.

Whether you are interested in technology, growth, or quality assurance, you will find some important takeaways in those areas and many more in this issue of *Efficiency*.

Read on,
William Neumann

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ADSO Association of Dental Support Organizations

Mike Bileca looks to the future…

…And it's looking good for DSOs

Twenty-one years ago, Mike Bileca was working for Ernst and Young in its health-care division when a friend introduced him to a dentist and his partners who owned multiple practices in South Florida.

"They had recently opened a multispecialty practice and were struggling," says Bileca, an executive at Dental Care Alliance, and president and interim executive director of the Association of Dental Support Organizations.

"I spent some time understanding their challenges and saw an opportunity to streamline the business processes, implement better training and development programs, and integrate technology and systems that would alleviate a good amount of the in-practice 'headaches' for the dentists." He founded Towncare Dental Partnership.

"Over time, and through a lot of trial and error, mistakes and experimentation, we were able to create an effective approach that created a tremendous amount of value to supported practices. As we grew, we were able to augment our initial platform with additional resources in IT, marketing, insurance contracting and other areas. In 2012, we merged with Dental Care Alliance to be part of a larger platform that shared our philosophy and approach."

Bileca stepped into his role with ADSO in June, to help the organization in a period of transition in leadership.

"I am honored that my colleagues selected me to help lead ADSO through this great time for our industry," he says. "DSOs are serving a vital role at a time of incredible growth. I think our primary mission will continue to be to look for ways to add value to our member companies. We firmly believe the stronger each of our individual member companies are, the stronger we are as an industry.

"Our greatest opportunities lie in providing a forum and venue that allows for sharing best business practices and networking. Our challenges are continuing to get our story out about our industry to various constituencies. We have such a great story to tell; our goal is reaching out to as many constituencies as possible."

One of those constituencies – and an important one at that – are state lawmakers.

"I think the strength of our government affairs work at the state level has come from the coordination of the ADSO government affairs team with engaged member company executives and their teams," he says. "The time and dedication spent by our member company CEOs and their teams enables us to tell our compelling story in an impactful manner.

"We can't always predict when a state may start looking at the DSO model, but we have been very successful dispelling many of the myths and answering questions, which both educates and creates comfort for policymakers. In the end, we believe we provide the tools to our supported practices that enable them to lower the overall cost of dental care, provide greater patient access and allow dentists to focus on clinical care instead of spending their time and energy managing business functions."

In addition to his work at Dental Care Alliance, Bileca is a member of the Florida House of Representatives, and has been since 2010.


Mike Bileca

"Our greatest opportunities lie in providing a forum and venue that allows for sharing best business practices and networking."

"I ran unexpectedly, but had just reached a level of frustration with our political environment and the direction of our country," he says. "I decided that if I was unwilling to make a sacrifice and enter into the political arena, I could not expect that from someone else.

"Although it has been more of a time commitment than expected, I am proud of the work I have been able to do for the people in my district and for Florida. A lot of my focus is in areas outside of healthcare, such as education. Some of my proudest achievements in the legislature relate to my sponsoring and passing educational options for low income and special needs children."

Summarizing his thoughts about the role of DSOs in this country, Bileca says, "There are nearly 40 million Americans who don't see a dentist. If we are able to help reduce that number by supporting dentists who can lower costs and expand access, then we've done a very good thing." ■

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Balancing Act

Your hygiene schedules are your revenue solution

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.

This year, we have noticed more and more practices enjoying busy, booked-out hygiene schedules. I recently had an office proudly tell me they were booked out 13 weeks. Yes, this was a huge feat for this particular office, as they had finally bounced back after struggling for years.

However, their victory was also their biggest challenge. Their hygiene schedules were completely scheduled out for 13 weeks. They had no hygiene appointments available to address new patients or their periodontal patients. Their hygiene schedules and their revenue were completely locked down to their already scheduled recall prophy or periodontal maintenance patients for the next 13 weeks.

If the hygienist were to inform the patient of a periodontal infection, they were unable to get the patient in for non-surgical treatment for 13 weeks. As a result of this, the hygienists started to "watch and wait" with periodontal infections, because they had little chance of getting them back into the schedule for the necessary non-surgical treatment anyway.

Not only that, the front office refrained from working the recall list, because they truly had no place to put these patients.

The maxed out hygiene schedules were killing any opportunity for growth.

From maxed to margin

Does this sound like your office? If so, here is what I suggest you do.

No. 1: Add more hygiene hours or days to your practice. If your practice is booked out beyond six weeks with no open times for your periodontal or new patients, then you need to add more hygiene time. Your new patients should never have to wait more than two weeks for an appointment. This is especially true, if you are still focusing on building your practice.

Second, upon diagnoses of periodontal disease, your patients should be seen for their non-surgical periodontal therapy appointment within two weeks. Remember, infections need to be treated ASAP.

No. 2: Prioritize your time. Once you have added additional hygiene time, you need to go through your hygiene schedule and template it to include blocks for your priority patients – periodontal patients and new patients. Design these templates based on the goals for your practice, and the current demand using your periodontal percentage as your guide.

Yes, we all love to see full schedules, but we also need to ensure they are productive and are addressing the needs of the patient base and the goals of the practice.

Don't be afraid to add more hygiene time or hours to your schedule. Start conservatively and add days as you need. Remember, there are many hygienists looking for additional work, so you will have no problem finding a qualified candidate for your office.

Focusing in on your hygiene schedules will add massive revenue to your hygiene business. Adding hours, and creating more productive days!

Incremental steps

One of our clients was booked solid in hygiene for 12 weeks, with recall and periodontal maintenance patients.

There was no availability in the hygiene schedule to bring in new patients or non-surgical periodontal patients, so we had to add hygiene time to the practice. The doctor was concerned about adding too much hygiene time, so we started off with two days a month to open up the hygiene schedule to accommodate the periodontal therapy and new patients.

Within two weeks of opening up the two hygiene days a month, they were still booked out over six weeks. With some discussion, we added two more days, and they filled up, too. He has now added a total of six hygiene days a month and turned these hygiene days into extremely productive days through the addition of templated schedules.

With a committed effort to creating efficient and effective schedules, this practice was able to improve patient access, patient care and they increased their hygiene revenue by 48 percent in one quarter.

Without an adjustment in the hygiene schedule, their hygiene revenue would have been paralyzed. But now, they are prospering. And, the doctor has started to book out his schedule more due to the increased flow of patients and treatment plans from the hygiene chair. Truly a win-win. ■

How to Improve Productivity While Reducing Stress

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

We hold people accountable for executing our policies, but even well-intentioned employees can make a mistake or omit a step. If we blame and threaten them when that happens, they might panic, and even sugar coat the truth to protect their employment. That's when we cry "foul". We call it lying, we call it unforgivable. If this behavior continues, you can guess that relationships between employee and manager might deteriorate beyond repair.

That is certainly not what we expect from our management systems and our leadership style. Thankfully, there is a solution: blame systems, not people.

Why systems? In his book, *Out of the Crisis*, Dr. W. Edwards Deming attributes mistakes to the management system in 94 percent of the cases. Various factors, including (but not limited to) employee performance, he attributes mistakes in six percent of the cases. Consequently, when a mistake happens, wouldn't it make more sense to try to fix the system (the 94 percent) instead of blaming the employee?

A specialist in my area had created clear policies in his practice and trained specific team members to execute them. His policy states that, at the implant consultation appointment, the treatment coordinator should get the patient's commitment to pay in full at the next appointment, before the start of implant surgery. This policy had been followed for years with very few problems.

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– KAREN DAVIS, RDH, BSDH

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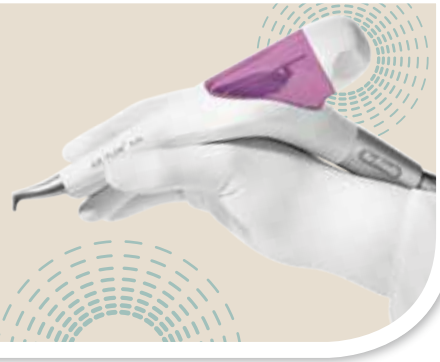

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Then one day, things got complicated. The treatment coordinator asked the dentist to authorize a payment plan for a patient who had just received two implants. "We do not make payment plans" he answered, "Hadn't you informed her that she needed to pay in full before the surgery?" "Yes!" she answered. "Then how come you allowed for the surgery to start without a payment?"

To that, she had no answer.

Suspecting that she was not telling him the whole story, he asked her to accompany him to the patient room. "Did anyone inform you that you needed to pay in full before we start the surgery?" he asked the patient. "No," she said. The specialist's doubts were now confirmed.

He notified the treatment coordinator that he would take charge personally of the situation from that point on. Her feelings hurt, the treatment coordinator decided to find another job.

The specialist asked me what I thought of the situation. It bothered him, more than the mistake itself, that his treatment coordinator lied about it.

"This coordinator has served you well in the last ten years. Does your office really want to see her go?" I asked.

"I would hate to see her go," he admitted, "but how can we resolve this issue first?"

To prevent the mistake from becoming a defect, the specialist decided to give a commitment paper, signed by the patient, to the appointment coordinator before she can make an appointment.

Preventing mistakes from becoming defects

Mistakes are human, according to Shigeo Shingo's terminology. Ultimately, we will not be able to completely stop them. However, if we allow a mistake to enter the system, it becomes a defect. Mistake-proofing means placing obstacles at different points of the work flow that prevent mistakes from becoming defects.

In this case, if the treatment coordinator asks the scheduling coordinator to make an appointment for a patient who has not explicitly agreed to pay in full before surgery, her request is called a mistake. As long as the appointment is not made, no harm is done. If the appointment is made, however, it means that the mistake has now entered to treatment flow; it becomes a defect.

To prevent the mistake from becoming a defect, the specialist decided to give a commitment paper, signed by the patient, to the appointment coordinator before she can make an appointment.

A second step in the sequence of treatment that could lead to defects is the moment the specialist is called to start the surgery. Again, if we call him to the room without making sure that the patient has already paid, it would be called a mistake. If he starts the surgery, it becomes a defect. A mistake has little harm on our operations; a defect causes harm. Placing an implant before a patient pays is not a clinical defect, but a managerial one. To prevent it from happening, the specialist decided that he would require to see a copy of the payment receipt before starting the surgery.

To increase productivity while preserving good relationships, we must embrace the idea that problems are systemic. We should not blame people for a system flaw; isn't that what created friction between two well-intentioned people, the specialist and his treatment coordinator? We need to go backward a few steps, look at the flow of work and see at what points the mistakes happened.

You might be thinking that you already make sure that treatment plans are signed by the patient before you start any work. But this article is about focusing on systems instead of people; mentioning that we need a signed treatment plan is just a way to make the point.

Mistakes happen mainly at handoff points. To prevent them from entering the system we need to go back to those handoff points and create checkpoints; preferably tangible like a piece of paper, and visual, so we can control them without additional effort.

In today's digital world, I have found that the possibilities for creating visible checkpoints are endless. However, in many cases, I find that when it comes to visual signal, a colored piece of paper can be more effective than a computer software. ■

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An Eye for Innovation

DSOs ensure their members are equipped with cutting edge technology.

By Laura Thill

There was a time when equipping dental practices with cutting edge technology and equipment was icing on the cake – a means of branding the practice as a market leader. For today's group dental practices, being technologically innovative is no longer a choice. Without the latest and greatest technologies, it's close to impossible to attract new patients and avoid costly downtime and lost productivity.

Today more than ever, dental service organizations must determine which technologies are truly innovative to ensure their practices remain efficient and provide the best possible patient care. *Efficiency in Group Practice* reached out to two industry experts for their perspective: Mark Blomquist, chief technology officer, Benevis; and Ken Strohschein, chief information officer, Great Expressions Dental Centers.

> "To sort through the hype, we evaluate the technologies based on whether they positively or negatively impact patient outcomes or provide a positive business case for investment."
>
> **– Mark Blomquist, chief technology officer, Benevis**

***Efficiency in Group Practice*: As we approach 2017, what are the top three technology innovations dentists should be aware of to ensure their multi-office practices continue to operate efficiently and cost-effectively, and provide great patient care?**

Mark Blomquist: First, centralized, cloud-based practice management and imaging platforms. Tech-savvy group practices are leveraging the economies and scale of public/private cloud computing on centralized practice management and imaging platforms. Cloud-based, centralized solutions maximize the availability of patient data between providers, provide real-time access to patient records, and ensure accurate, consistent quality reporting, payer audit support and compliance across locations.

Second, SIP/IP PBX-based telecommunications platforms. SIP/IP PBX-based telecommunications

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Mark Blomquist

Third, software-defined wide area networking (SD-WAN) and network function virtualization (NFV). By leveraging diverse commodity broadband connectivity, a dental office network can achieve the triple play of increasing network uptime, improving performance/bandwidth (particularly useful for digital image transfer) and decreasing circuit costs. NFV extends this flexibility and modularity to the data center, optimizing the use of centralized network equipment (e.g., routers, session border controllers, etc.).


Ken Strohschein

Ken Strohschein: Electronic data interchange (EDI) will have the greatest impact on the dental industry, particularly with regard to processing insurance claims. When the insurance company sends the dental practice a printed Explanation of Benefits (EOB) letting it know it has paid a claim, the office manager must go into the system and confirm the office has received the payment. Then, the patient must be found in the DPM system in order to apply the payment to the patient's account. This is all very time consuming. EDI will reduce, and sometimes eliminate, this administrative burden and give them more time to focus on patient care. As EDI technology continues to be developed, it will become more accessible to the large group practices.

Patient communications is also very important. Scheduling regular visits – and following up with patients – can be very time consuming, especially by phone. The process must become more electronic (e.g., texts and emails rather than phone calls). In addition, the communications must become two-way. In other words, it's just as important for the patient to respond to the texts/emails as it is for the practice to send them. Data shows that patients who rely on email reminders are less likely to cancel appointments compared to those who rely on phone messages.

Finally, micro-computers are becoming increasingly available. Smaller computers mean less office clutter. If an office is tech savvy, it will already have digital radiography, laser, etc. Now it will need micro-computers.

***Efficiency in Group Practice*: How does the DSO determine which new technologies are truly innovative and essential, and which are "me-too" technologies?**

Blomquist: There are a number of clinical and non-clinical technologies available in the marketplace – all with positive testimonials to back them. To sort through the hype, we evaluate the technologies based on whether they positively or negatively impact patient outcomes or provide a positive business case for investment.

Patient outcomes can be evaluated by reviewing published, peer-reviewed studies or by using analytics on patient data in the practice management system (e.g., using dental microscopes in the operatory setting for better outcomes). For clinical technologies, we compile all the information so that the dental leadership can make the final decision. A positive business case for technology investment could be illustrated by team members' productivity enhancements or ongoing cost reductions (e.g., a conversion from film X-rays to digital images, which reduces patient cycle time and lowers ongoing supply costs).

Strohschein: As a large organization, we are solicited with new products from our vendors and have an opportunity to evaluate it for its value. Sometimes, we test new equipment or technology in one of our dental member's office. Newer dentists are often eager to try new equipment. Some doctors are less interested in trying new technology than others. And, we respect the individuality of our members. Still, when it's time to adopt new technology, we need to move on.

***Efficiency in Group Practice*: How can the DSO help its dentists decide whether or when to replace old equipment or add new technology?**

Blomquist: First, it's important to keep in mind that as computing and dental equipment ages, the amount of

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downtime and lost productivity due to slowness and repair costs increases to where these costs exceed the depreciation cost of new equipment. Computing equipment from top-tier manufacturers has an expected lifespan of ~36 months. For second-tier and white box manufacturers, it can be half of that. A good indicator of expected life is the length of the warranty provided with the equipment; the manufacturer also knows how long the equipment will last until it becomes too expensive to maintain. A proactive stance on equipment refreshment can minimize the dental team frustration and patient dissatisfaction that come with a poorly operating computing environment.

"With any new technology, we'll do a thorough rollout process to align with doctors and office team members, explaining and showing the value-add to the practice. This is how we brought sensors and digital X-rays to all GEDC offices."

– Ken Strohschein, chief information officer, Great Expressions Dental Centers

For dental equipment, the expected lifespan can be much longer or even shorter, based on the type of equipment. Keeping track of repair work orders and maintenance expenses by item (e.g., handpieces, X-ray gear, chairs and sterilization), and identifying problem areas for selective upgrades, can keep the overall practice assets healthy with minimal downtime and patient delays.

Strohschein: We take time to educate our dentists and explain the value of new technologies. Dentists are clinically trained and tend to base their decisions on data. The front office and administrative staff must always be on board, as well. That said, while consistency throughout the DSO can be good, we don't want to force any new technology and equipment on our individual dentists. With any new technology, we'll do a thorough rollout process to align with doctors and office team members, explaining and showing the value-add to the practice. This is how we brought sensors and digital X-rays to all GEDC offices.

***Efficiency in Group Practice*: When adding new equipment and technology, what office design issues should dentists take into consideration?**

Blomquist:

- Ergonomic considerations (e.g., left-handed vs. right-handed dentists).
- Patient comfort and convenience (e.g., lobby kiosks, WiFi, patient "edutainment" displays in the operatory setting).
- Security (e.g., debit card machines in public areas).
- Office layout, lab area size and staff efficiency, and the impact on workflow.
- Installation considerations (e.g., technician access, construction/renovation costs to accommodate technology).

Usually, at a DSO-supported group practice, there are [a range of considerations depending on] the equipment age, the dental team's needs and the need for office expansion to add new services or patients. Taking best practices and lessons learned from many other similar upgrades or builds ensures that the dental practice will have the best outcome for their dental teams and patients across all locations.

Strohschein: The number one issue is wiring the dental office appropriately for growth and expansion. So much can be done with wireless technology today, but the stability that a hard-wired office offers is significant; there are much fewer interruptions compared to systems that rely only on wireless technology. Often, older offices are not wired properly. It's costly, but the DSO can help and it's a worthwhile investment. In addition, when expanding or building, dental practices often overlook the space required to house computer keyboards and monitors. These are small items, but they still require a space.

***Efficiency in Group Practice*: From an efficiency or cost perspective, how important is it to ensure that all offices within a group practice use the same technology?**

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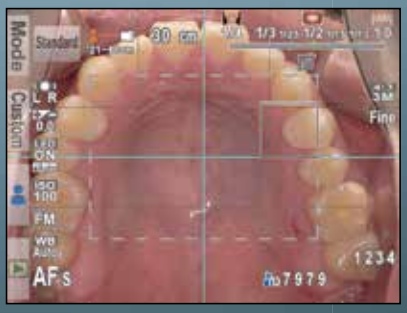

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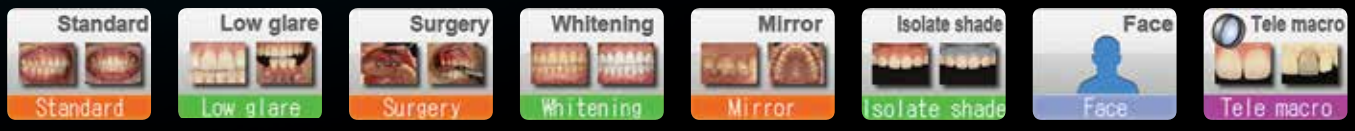

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Blomquist: There are significant benefits to standardizing the types of equipment used throughout a group of practices, especially if there is any centralization of business functions or support. For both the DSO and the practice, there are cost and service advantages of standardization. For instance, we are able to negotiate better contracts and bulk discounts with equipment manufacturers, suppliers and service organizations, as well as ensure the reliability and performance of a known set of equipment from trusted vendors. The overall organization also has much better peer and DSO support, since many other locations run similar configurations. Problem-solving equipment behavior or issues is much quicker in a standardized setup than attempting to support a one-off configuration.

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- Reduced end-of-life issues (e.g., removing a piece of equipment from one office creates spares for another, extending useful life).
- As technology evolves, we gain the ability to collapse functionality of multiple devices into one, minimizing cost and points of failure (e.g., incorporating basic routing functionality into branch office network appliances).

Strohschein: Consistency throughout a group practice is good from the standpoint of maintenance and repair issues. We help our members through network conversions, sometimes allowing them to maintain their old system for a while longer. But, our goal is ensure our members have proper licensing, and that the security and antivirus software, as well as the wireless network, is consistent throughout the organization. When we do this, we help reduce costs while keeping the office operationally effective to help patients get the best service and care.

***Efficiency in Group Practice*: What training and support do you offer your practices as their staff learns to use new technology?**

Blomquist: Having a similar footprint [across our practices] permits good pressure-tested SOPs for the offices to use. Written and instructor-led (in-person or online) training is available for the Kool Smiles-branded offices that Benevis supports.

Strohschein: Before a software, GEDC sends a training team on site to set up computers for each staff member and run them through training exercises. The actual conversion is done after hours to avoid disrupting the practice. Our training team remains on site the week following the conversion, and afterward, we offer remote, ongoing support services. ■

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The digital era

Ivoclar Vivadent delivers value to DSO members.

By Laura Thill

The digitization of dental technology has opened doors for increasingly sophisticated equipment and products, and dentists are finding they are able to provide higher quality care and a better patient experience than ever before. A surge in new technology, however, requires additional training for dentists and their staff to ensure they use new equipment properly, and that they and their patients fully benefit from its value.

Digital, digital, digital

The digitization of dentistry has brought several technologies to the forefront, according to Dr. Michael Gaglio, TITLE, Ivoclar Vivadent. "Enterprise solutions and office management systems have become a technological must," he says. "These systems must be able to handle all aspects of a dental practice, as well as all digital assets in a group dental practice." This is especially true for larger group practices, he notes. In addition, two-dimensional imaging has given way to three-dimensional imaging. "3D imaging today is used for both diagnostic and restorative dentistry," he says. Similarly, dentistry has seen the progression from analogue – or film-based – X-ray to digital X-ray and, today, cone beam and digital imaging, he points out.

In-office milling has also become increasingly popular, enabling dentists to fabricate chairside restorations, says Gaglio, noting the opportunity for Ivoclar Vivadent – maker of IPS e.max CAD, a monolithic restorative (in-office milling) solution – to partner with Sirona and Pacific Dental Services-supported practices. Sirona offers CEREC, while Ivoclar Vivadent provides high-quality material for milling, "permitting dentists to characterize and make restorations look beautiful," he says. Together, the two provided Pacific Dental Services-supported practices with a milling system to help facilitate greater office efficiency and patient satisfaction. "The system enables dentists to eliminate the patient's second visit for a crown restoration, increasing office efficiency and facilitating a cost savings," he explains. "And, the ability for a patient to have a crown made in a single visit saves him or her time, which is a commodity for people."

Indeed, while dental service organizations (DSOs) and their manufacturer partners are careful to recognize the individuality of their dental practices, they also appreciate the value of collaboration, or peer-to-peer sharing, which can lead to a more uniform approach by supported clinicians. "If you have various techniques used throughout the supported practices, it requires more – and different – training," says Gaglio. Collaboration among clinicians, on the other hand, can help simplify the training and education process.

This approach can be very practical for large group practices, he continues. "By using our IPS e.max CAD solution, Pacific Dental Services-supported clinicians can depend on quality patient outcomes across their dental practices. We bring a level of excellence to the field by working alongside dentists to ensure their final restoration outcome meets both the dentist's expectations and the patient's satisfaction."

The adoption of new technology has become critical to ensuring efficiency and productivity throughout a large dental group practice, says Gaglio. IPS e.max CAD – a product backed by 10 years of clinical support – has helped dentists make the transition.

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Ray Tai, CEO

Taking Care of Business

Dental Care Alliance supports affiliated dentists' focus on patient care.

Trying to compare today's dental industry to the market that existed 25 years ago is a matter of apples and oranges, as they say. Increased regulation, lightning-speed advances in technology, economic constraints and evolving doctor – and patient – demographics have drastically changed the playing field for practitioners. Yet, the mission of dental service organizations, such as Dental Care Alliance (DCA), has remained much the same: Provide dental practices with the support they need to stay focused on what they do best – provide top-notch patient care.

Indeed, the market has changed quite a bit, says Mitch Olan, CEO, Dental Care Alliance. But DCA's mission to provide back-office support, permitting dentists to focus on clinical care, has not. "Our motto has always been, 'We take care of the business so that you can take care of your patients,'" he says – a philosophy that dates back to the founding of DCA by Steve Matzkin, DDS.

A dentist of vision

The longer he practiced dentistry, the more Matzkin realized the challenges dentists faced managing their own practice, Olan explains. After all, they were educated and trained clinicians, but few – particularly 20 years ago – had any formal business training. So, long before the term dental service organization was coined, in 1991, Matzkin left his dental practice to start a dental practice management entity. "There was no formal name for such an organization back then," Olan explains. But, Matzkin was a progressive thinker, he notes. "Steve was a dentist with great business sense, committed to helping other dentists run their practice more efficiently. Today that support is needed more than ever as the challenges of running a dental practice have become even more complex.

"Prior to joining DCA, I worked with an orthodontic appliance manufacturer for 10 years," Olan continues. When he joined DCA in 1994, the goal was to marry Olan's marketing and operations experience with Matzkin's background running dental practices. At that time, DCA had four affiliated locations – a number they hoped would steadily increase. "Our goal was to help our affiliated dentists expand their practice by supporting their office/management needs, so that they could focus on the clinical side," he says. "We saw dentists making business decisions that were detrimental to

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their success. We would often hear them tell us they just wanted to practice dentistry."

Today, DCA is stronger than ever. "We currently support over 500 dentists in 240 practices throughout the eastern United States," says Olan. They plan to continue to expand organically, as well as through new affiliations. "We haven't changed the industry as much as we've addressed the changes within the industry," he adds. "DCA has continued to evolve for over 25 years to better meet the needs of the dental profession."

A league of their own

In Olan's experience, supporting the back office of a dental practice, regardless of its size or market niche, is similar from one practice to the next. At the same time, "we respect the individuality of our affiliated practices, which are built around the doctors," he says. "We work with a range of practices, including high-end, fee-for-service, insurance based, multi-specialty, multi-provider and urban. We can support all types of dental practices regardless of how they're positioned within the community."

> "Our goal was to help our affiliated dentists expand their practice by supporting their office/management needs, so that they could focus on the clinical side. We saw dentists making business decisions that were detrimental to their success. We would often hear them tell us they just wanted to practice dentistry."

As such, DCA strikes a balance between consistency and variance throughout its affiliations. "It's important to have the same patient management system in affiliated practices," says Olan. "In addition, affiliated locations benefit from marketing, accounting/finance, human resources, facility management, operations and IT support."

To keep doctors current on continual changes in technology, regulations and clinical innovations, DCA offers a wide menu of educational services and programs. "We bring continuing education to our affiliated providers," says Olan. This includes sharing best practices between locations, as well as engaging speakers and programs with specific expertise.

DCA also provides insurance contract negotiations and a central contact center to ensure new patient calls do not go to voice mail, says Olan. "Between 30-40 percent of calls to a dental practice go to voice mail, and when that happens, many times a new patient will call another practice to make an appointment. We also place a chat feature on affiliated practice websites, allowing prospective patients to get their questions answered online in real-time."

Continued growth

DCA's model is working well, says Olan – so much so that the organization has an aggressive growth plan in place. "We plan to continue growing, both organically and through affiliation," he says. "We constantly get calls from doctors looking to affiliate with us. They recognize the benefits of our support model embracing various types of practices, as DCA is not a one-size-fits-all service organization."

As dentists today continue to negotiate a rapidly changing industry, DCA plans to continue to grow its network of supported practices, thereby allowing dentists to focus on providing great patient care. "Between new regulations, a slow growth economy and changing graduate demographics and debt, it is more difficult than ever to open or run a successful dental practice," Olan says. "We have worked with doctors who have left a DCA-affiliated office, purchased their own practice and then returned to us after seeing how difficult it is to manage. Dentists can't always think about the business side of their practice." And, that's where DCA steps in. ■

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A Lifelong Learner

Dr. Katherine Schrubbe reflects on her 40-year career in dentistry, including her role in quality assurance.

Dr. Katherine Schrubbe, RDH, BS, M.Ed, PhD, is a firm believer in lifelong learning. So, it's no surprise that what began as a career in dental hygiene steadily evolved, as she completed several graduate-level degrees, became an expert on quality assurance and risk management, and eventually came full circle to her original place of employment, but in a new role.

Schrubbe joined Milwaukee, Wis.-based Dental Associates as a full-time hygienist nearly 40 years ago. Soon after, she joined the faculty at Marquette University School of Dentistry, Milwaukee, teaching part time while continuing to work in private practice. While at Marquette, she earned a master's degree, followed by a PhD, which she began in 2000. Her doctoral research focused on health disparities and an assessment of oral health in low socio-economic populations over a 100-year span. Toward the completion of her PhD, she accepted a full-time position at Marquette's School of Dentistry in the department of clinical services, with oversight of quality assurance, risk management and, shortly afterward, compliance. Following a 10-year administrative stint, in 2013 Schrubbe returned to private practice – and to Dental Associates, , by then a large group practice – with a new title: director of quality assurance.

Dr. Katherine Schrubbe

Efficiency in Group Practice spoke with Dr. Schrubbe about her career, the role of infection prevention in dentistry and the future of the industry.

***Efficiency in Group Practice*: How did you become interested in clinical regulatory compliance?**

Dr. Katherine Schrubbe: My responsibility for clinical regulatory compliance originally fell into my lap when I accepted my full-time position in the department of clinical services at Marquette University School of Dentistry. My own clinical education and training on compliance and infection control was sound, and I soon found myself enjoying teaching students and external practitioners about the importance of OSHA compliance, health and safety. I became more and more interested in the topic, and today I continue to provide continuing education programs on OSHA and infection control, as well as contribute to scientific journals on this content. In my role as director of quality assurance, I have oversight of clinical regulatory compliance, which is an integral piece of quality assurance and provides the foundation for safe patient care.

***EGP*: In your opinion, what progress has the dental profession made in infection prevention over the past 10-15 years?**

Schrubbe: I believe there has been steady progress for infection prevention in dentistry. The Bloodborne Pathogens Standard provides federal standards for healthcare worker safety and to reduce risk of disease transmission. The Centers for Disease Control and Prevention (CDC) has led the way in providing sound guidelines and recommendations for dental healthcare personnel health and patient safety, and the scientific

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literature is full of related information on this topic. In 2003, the third formal document outlining procedures and protocols necessary was published: *Guidelines for Infection Control in Dental Health-Care Settings*. Most recently, in March 2016, the CDC released Summary of Infection Prevention Practices in Dental Settings – Basic Expectations for Safe Care. The summary and checklist is a supplement and companion to the 2003 Guidelines and provides a method for assessment of administrative policies and dental team personnel. For today's dental practices, there is an abundance of resources on infection control and prevention.

***EGP*: What have you found most fulfilling about your work in the dental industry?**

Schrubbe: I have been fortunate to experience a lot of diversity in my dental career, with careers in clinical private practice, academia and currently in a corporate setting. In each of these environments, fulfillment comes in different ways, including working with an office team to help each patient achieve the best oral health possible; teaching students a new skill and watching them grow to master it; and, today, working with an excellent executive team to enhance the patient experience, as well as being a resource for our dental providers. At Dental Associates, our mission is – to improve our patient's quality of life through excellence in oral health care. Each day we strive to fulfill our mission, and fulfillment comes through positive feedback from our patients.

In my role as director of quality assurance, I have oversight of clinical regulatory compliance, which is an integral piece of quality assurance and provides the foundation for safe patient care.

***EGP*: How did you come to rejoin Dental Associates?**

Schrubbe: I returned to Dental Associates in 2013. I knew a lot about how the practice has grown, having worked there years before. And, I believed in their model of comprehensive dental care, where general dentists and specialists are able to confer and provide the best patient care under one roof. Dental Associates was established in 1973 and is Wisconsin's largest family-owned dental group practice, with 14 in-state dental centers. My team is comprised of a compliance specialist and three corporate trainers. My responsibilities include oversight of the practice's quality assurance, risk management and compliance programs, as well as continuing education programming and our corporate trainers, who provide all new staff orientation, on-boarding and other special training. As a large group practice, we are committed to efficiency and excellence in patient care. Dental Associates is nationally accredited by the Accreditation Association for Ambulatory Health Care (AAAHC), which means it has met the standards for providing high-quality patient care. More importantly, we demonstrate our commitment through on-going self-evaluation, peer review and education to continuously improve our services and care to patients. We take patient feedback very seriously. In 2014, Dental Associates received the Press Ganey Leaders in Transparency Award, which honors innovative healthcare organizations that have implemented solutions to capture the voice of patients and have shared patient experiences online.

***EGP*: What are the greatest changes we can expect to see in the dental industry in years to come?**

Schrubbe: While we can't anticipate everything, one

thing is for certain: The dental practice model is changing. Over the past few years, it is estimated that dental support organizations have grown between 20-25 percent The literature reports that by 2020, only about a third of dental offices are expected to be solo practices. Patients already have more options for obtaining dental care, and competition will continue to increase. The good news is that large group practices such as ours can be quite efficient. They have the infrastructure and key people in place to better ensure compliance to federal and state laws, as well as professional standards of care.

Along with changes in the practice models, there have been changes in provider types, such as the addition of mid-level providers. According to the American Dental Hygienist's Association (ADHA), there are about 13 States that have an Oral Health Workforce Model utilizing providers with titles such as, advanced dental therapist, advanced dental hygiene practitioner, advanced practice dental hygienist and more. The driving force behind this effort was a desire to better assist the nation's underserved dental population. The addition of this new provider in dentistry has changed the landscape, but it is difficult to assess the results and where mid-level providers will be most utilized in the future. ■

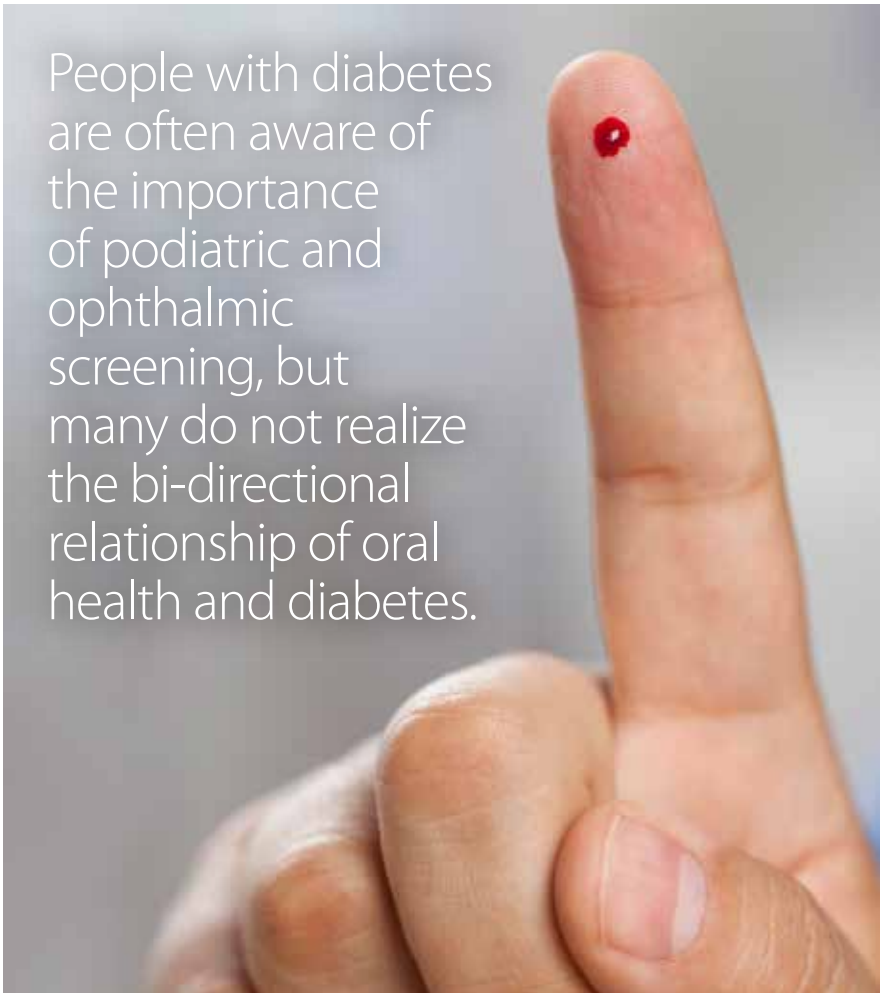
Patients already have more options for obtaining dental care, and competition will continue to increase. The good news is that large group practices such as ours can be quite efficient.

Editor's note: Look for Dr. Schrubbe's infection control column in future issues of *EGP*.

Diabetes and Oral Health

Working as a team, oral healthcare professionals, diabetes educators and primary care providers and endocrinologists can deliver services that result in better healthcare for diabetic patients.

People with diabetes have a marked increase in risk for periodontal disease, and experience almost three times more periodontal pathology than their non-diabetic counterparts, points out the Association of Diabetes Educators in its recent white paper, "Diabetes and Oral Health." "In fact, diabetes is the only recognized systemic risk factor for periodontal disease."



In turn, periodontal disease has been proposed as a sixth clinical complication of diabetes. Additionally, tooth loss is up to two times more frequent in people with diabetes than people who do not have diabetes.

For all those reasons, it makes sense for dentists and their staff, primary care physicians, and diabetes educators to collaborate for the sake and good health of their patients, conclude the authors of the white paper.

The diabetes educator

Diabetes educators are healthcare professionals – primarily nurses, dietitians and pharmacists, according to the AADE. Though not every diabetes educator is certified, approximately 86 percent of professionals in this group have earned the designation of Certified Diabetes Educator® (CDE®). Earning a CDE® requires at least two years of professional experience, a minimum of 1,000 hours in direct diabetes teaching experience, and successful completion of an exam administered by the National Certification Board for Diabetes Educators.

In most cases, it is the primary care physician or endocrinologist who refers the patient to a diabetes educator, the authors write. Such a referral pattern allows the primary care doctor to better facilitate the patient's multifactorial care. "It is essential that oral

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healthcare providers communicate with [primary care physicians] about their oral exam findings and make management suggestions based on those findings."

Diabetes educators seek to assess the patient's understanding of diabetes as well as identify risk factors for poor control or complications. Educators may review blood glucose logs and attendance at scheduled provider visits, screen for lipodystrophies, or perform basic foot exams.

"Assessing the patient is a critical first step in providing appropriate patient education and management," write the authors. "In the case of oral health, inquiring whether the patient has had a dental exam within the last six months or has a history of periodontal disease can begin the process. Additional information can be gleaned by simply observing the patient and assessing for missing teeth or inflamed gingival tissue. Educators can also inquire about available insurance, as many patients may not be aware of their insurance-provided dental benefits. Of those patients with dental benefits, patients may have limited coverage or may not appropriately utilize their covered services."

A new practice paradigm for oral health may involve assessing risk for diabetes – including asking the patient about family diabetes history – and, in the case of people with diabetes, metabolic control.

Patients may be unaware

The focus of diabetes educators is to provide patients with tools and resources to better understand and manage their disease, according to the AADE. "Patients are frequently unaware of the various manifestations of their disease. Educators have the ability to tailor education to the patient's specific needs and coach them in the skills needed to be able to self-manage their diabetes and its comorbidities."

Examples may include instruction regarding administration of insulin injections, how to use an insulin pump to manage diabetes, or setting individualized nutrition and lifestyle goals. Educators can also determine a patient's barriers to successful diabetes management and provide solutions that enhance successful outcomes. For instance, educators may inquire about economic hardship that may impair a patient's access to quality nutrition, or they may assess for vision challenges that result in difficulty administering the appropriate insulin dose.

"Educators can help patients move beyond feelings of guilt or associated depression to allow them to take ownership of their disease and become part of the decision-making process."

Another vital role of diabetes educators is alerting patients to the possibility of comorbidities the patient may have not considered to be related to their diabetes, the authors write. People with diabetes are often aware of the importance of podiatric and ophthalmic screening, but many do not realize the bi-directional relationship of oral health and diabetes. Patients may be unaware of the role of diet in the prevention of tooth loss. Educators can not only increase patients' self-management and knowledge, but facilitate appropriate referrals and, in some cases, suggest treatment plans to maximize the patient's health.

The oral healthcare professional's role

Dental exams are frequently performed in clinical settings that are isolated from where patients receive their medical care, point out the white paper's authors. Though oral healthcare providers regularly inquire about the patient's health history and medications, additional screening may improve the patient's overall health care.

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"A new practice paradigm for oral health may involve assessing risk for diabetes – including asking the patient about family diabetes history – and, in the case of people with diabetes, metabolic control. Assessing the patient's overall appearance and being alert for signs and symptoms of hypoglycemia are important when caring for people with diabetes. A number of studies have confirmed the effectiveness of screening for dysglycemia in the dental office. Determining whether a patient is already seeing a diabetes educator can provide added value to their care."

An important part of diabetes management is evaluation and treatment, as necessary, by an oral healthcare professional. "Unfortunately, a major hurdle to overcome is simply getting the patient to visit the oral healthcare professional," according to the AADE. "In the general population, only 35 to 45 percent of people 18 years or older see their dentist yearly, with older patients seeking dental care more frequently. More alarming are findings that people with diabetes tend to visit their dentist less frequently than people who don't have diabetes. Patients may be fearful or overwhelmed by the requirements of their diabetes management.

A patient may not be aware of the important role their oral health plays in diabetes care, but statistics show that receiving dental care reduces average medical costs – $2,800 per year in one study.

"A patient may not be aware of the important role their oral health plays in diabetes care, but statistics show that receiving dental care reduces average medical costs ($2,800 per year in one study)."

Referral mechanisms

To facilitate maximum utilization of resources for people with diabetes, appropriate pathways for referral must exist, says the AADE. Oral healthcare providers need to be made of aware of the availability of diabetes educators and how they work with primary care providers and endocrinologists.

Diabetes educators benefit from knowing which oral healthcare providers have the knowledge and willingness to care for people with diabetes. Finally, primary care providers need to be aware of the value of working with diabetes educators as well as the importance of enlisting the help of oral healthcare providers to maximize patient outcomes.

"Regardless of type, diabetes is a chronic, progressive disease. To best serve people with diabetes, all members of the health care team must unite to inform not only their patients, but colleagues, about the important interplay between diabetes and oral health. Working as a team, oral healthcare professionals and diabetes educators, alongside primary care providers and endocrinologists, can deliver services that result in better oral health care and, ultimately, better health outcomes."

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For over five years, Allied Dental has encouraged all of its practices to look to Dentsply Sirona for a number of products, including the company's Aquasil Ultra Smart Wetting® Impression Material. "Allied Dental is committed to using materials that provide optimal results for our clinicians and, by extension, our patients," says Dr. DiCesare. "Virtually all of our locations use Dentsply Sirona's procedural solutions because they see predictable, high-quality results." In addition, Allied Dental takes advantage of Dentspy Sirona's training program to ensure their clinicians "understand and incorporate best practices into their clinical routine," he adds.

Accuracy and detail

After testing other impression material solutions, it became clear to the doctors at Allied Dental that Aquasil Ultra was the ideal choice for their organization. "Accuracy and detail are the most important clinical benefits for our doctors, and we know that Aquasil Ultra will help us deliver beautiful, long lasting restorations for our patients," says Dr. DiCesare. "The materials are easy to use and deliver consistent results, reducing the risk of costly remakes and retakes. This has enabled us to minimize the amount of chairtime allocated to the crown insertion visit.

"At Allied Dental, our offices are focused entirely on enhancing the patient experience," Dr. DiCesare continues.

"Our partnership with Dentsply Sirona helps us deliver on that mission." Using Aquasil Ultra has led to "fewer errors, more accurate impressions and better fitting crowns, helping reduce unnecessary costs by reducing unproductive chairtime." Indeed, less time in the chair often means a more comfortable – and less expensive – visit for the patient. "We make it a point to pass our savings on to our patients," he says. "Everyone should have access to affordable, high quality dental care." ■

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Aquasil Ultra+ impression material's market-leading intraoral hydrophilicity and intraoral tear strength offer clinicians a no-compromise solution to their final impression needs. Its intraoral hydrophilicity is designed to help clinicians avoid trapping fluid when the material is syringed into a moist environment, helping reduce the risk of voids and bubbles at or near the margin. Its intraoral tear strength is designed to help clinicians reduce the risk of tears at the margin when the material is in thin cross sections and while being removed from the patient's mouth.

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The True Cost of Dental Equipment

To get your money's worth, look beyond the price tag.

If you're feeling pressure to get the most out of your equipment budget, it can be tempting to hone in on price alone when making a purchase. But as many have learned the hard way, "low price" and "excellent value" aren't necessarily the same thing. Saving a few dollars up front may not be the best practice for your organization.

Total cost of ownership

The true cost of dental equipment goes beyond the purchase price. A-dec calls it the "total cost of ownership." Think of it this way:

Cost of acquisition +
Cost of operation +
Cost of maintenance =
TOTAL COST OF OWNERSHIP

It can take a lot of time and research to find the right equipment. While initial discussions will likely be about the purchase price, consider reliability, maintenance, downtime, parts availability and lead times – all factors that contribute to the total cost of ownership. Ask if your dealer-partner is looking for the lowest price or the best long-term value. The answer can have a significant financial impact on your organization.

The value of reliability

A-dec equipment is legendary for its quality. In fact, dentists consistently rank A-dec highest for reliability, service and value.* When considering a long-term investment like dental equipment, ask yourself:

- Is there a local manufacturer's rep who will be your long-term partner?
- Can you integrate technology today – and in the future?
- Are parts readily available long after the warranty period?
- Has the equipment been tested to last at least 20 years?

A-dec equipment may pencil out to a few extra dollars a day – but with its superior reliability and performance, the total cost of ownership is lower in the long run.

The value of expertise

Even the best products in the world won't perform well without correct installation. A-dec invests more than any other dental manufacturer to train our authorized dealers, sales and service personnel. With the most territory managers in the field, your staff will get timely answers about the correct use and maintenance of the equipment. We'll even help you develop your own customized training program.

A-dec offers dental packages designed and priced exclusively for DSOs – with rich feature sets that support productivity and allow for easy integration of ancillary devices.

One final consideration

More than 90 percent of dental schools and government institutions in the U.S. and Canada choose A-dec equipment. These purchase decisions, usually made by large buying committees – and frequently after firsthand evaluation of equipment and rigorous scrutiny – are often highly price sensitive. A-dec is not a "low bid" product. Yet even institutions on fixed or very tight budgets select A-dec more often than any other brand, based on the combination of quality, reliability and low cost of ownership. It's simply a better total value.

Your partner in productivity

A-dec offers dental packages designed and priced exclusively for DSOs – with rich feature sets that support productivity and allow for easy integration of ancillary devices. Because just like you, A-dec is committed to giving dentists the tools to do what they do best. ■

Legal: *Based on a double-blind survey by Strategic Data Marketing (SDM), 2013

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Boot Camp

Have you made plans for the OSAP Dental Infection Control Boot Camp™, Jan. 9-11, in Atlanta? The OSAP Boot Camp is a core educational course covering the basics of infection prevention and safety. It is targeted to:

- Infection control coordinators in dental practices.
- Educators responsible for infection prevention and safety instruction.
- Compliance officers in group practices and on dental boards.
- Federal service employees responsible for infection control in their duty stations.
- Federally Qualified Health Center (FQHC) personnel responsible for infection control.
- Consultants and sales representatives who want to demonstrate a CORE level of infection control competency

Attendees will receive up to 24 hours of CE credits plus a resource binder, checklists, tools and more.

Courses include:

- Principles and history of infection control
- Patient safety: history, trends and consensus-building
- The infection control coordinator: role, job description, getting buy-in, etc.
- Compliance issues
- Microbiology: bacteria, viruses, fungi, process of disease transmission, etc.
- Antibiotic resistance/antibiotic stewardship
- Transmission of infectious agents in dental settings
- Exposure risk determination and post-exposure management
- Hand hygiene
- Personal protective equipment
- Sharps safety
- Dental unit waterlines
- Sterilization and disinfection of patient care items
- Operatory preparation

Hands-on training stations include:

- Chairside pre-cleaning and instrument transport
- Automated instrument washing & disinfection
- Instrument wrapping and chemical indicators/integrators
- Sterilizer loading and unloading
- Monitoring of sterilizers and documentation
- How to respond to positive spore test

The Boot Camp will also feature a vendor product fair.

Still not sure? Here's what a few attendees of last year's Boot Camp said about the experience.

- "This was the best course I have taken on the subject of infection control. I will highly recommend it to others!"
- "In all my years as a dental hygienist, this was the best dental meeting I ever attended. It was organized and the speakers were EXCELLENT. Thanks to all of you for a wonderful three days!!!!"
- "There was sufficient valuable information in the content provided which will assist me in moving forward with my employment as an infection control educator." ■

For more information on the Boot Camp, go to www.osap.org/?page=2017BootCampProgram

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Developing Others

What you should commit to while trying to bring out the best in your team members

The list of things leaders have to be very good at it just gets longer and longer. Some of the most important ingredients to a leader's success are bringing the right people on the team, on-boarding and developing those people, and knowing when to move on from those who are unsuccessful. In this column, we will focus on the key factors in developing others.

Perhaps the single most common mistake in this area is that leaders wait until there is a problem to try and develop someone. So often, by that point it is already too late. Development is best thought of as an ongoing, and proactive process. It is an elegant blend of support and challenge. Too much support creates no incentive to grow. Too much challenge overwhelms. When we wait until there is a problem, the challenge often exceeds the capacity.

Focus on the individual

When considering development, it is ideally focused on the individual, and not necessarily on the results. For example, you can challenge a sales rep by increasing expectations. And while that may be useful in some ways, by itself it is not developmental. If, however, you added something that addresses why this is a challenge, there is now a chance it is development. What are some potential underlying issues? It could be that the person lacks organizational skills. It could be that the person has

a pessimistic outlook. It could be the person doesn't fully understand your organization's strategy and offerings. The point is, unless you deal with the underlying issue, it's not true development.

There are several common explanations for what gets in someone's way. The first is that they lack competence. In many ways, this is the easiest to develop. It really may be that I just need to practice or learn something new. The second common reason is missing structure. This means that there are systems and processes that could be utilized to support the person. A simple example is a calendar, which is a system that could support someone who struggles with time management. Finally, the interference may come in the form of a lack of commitment.

Development is best thought of as an ongoing, and proactive process. It is an elegant blend of support and challenge.

So the first step in helping someone develop is to understand whether it is primarily a competence, structure, or commitment challenge. The plan you put together with that person will be very different depending on the answer. The second step is to make sure that the plan has a nice balance of challenge and support built in.

It is generally understood that the accountability for following through on development and a development plan belongs to the person being developed. At the end of the day, I am responsible for my own growth. However, in real life, it can be really important for the leader to be connected to and feel committed to that person's growth. That may show up in the form of asking questions, being curious, collaboratively tracking progress, and serving as a thinking partner. ■

ADA releases CDT 2017: Dental Procedure Codes

The American Dental Association (ADA) (Chicago, IL) has released CDT 2017: Dental Procedure Codes, the definitive manual of codes for documentation and reimbursement. This latest edition of CDT is designed to streamline coding and help maximize reimbursement by third-party payers. The new codes will go into effect on January 1, 2017. According to the ADA, CDT 2017 is the only HIPAA-recognized code set for dentistry. It includes 11 new "Code on Dental Procedures and Nomenclature (CDT)" codes, five revised codes, and one deleted code. It also builds on codes to fill documentation gaps, which can prevent rejected insurance claims. The ADA has also released the CDT 2017 Companion: Health Guide for the Dental Team, which contains codes organized by category with example coding scenarios and answers to common questions. Both manuals as well as other coding products will be available on September 9, 2016. They can be preordered at adacatalog.org.

Aspen Dental to open new practice in Muscatine, Iowa

Aspen Dental (Syracuse, NY) will open a new practice in Muscatine, Iowa on Thursday, September 8, 2016. The new practice will be led by Sejal Savani, DDS. Savani and her team will provide dental services ranging from dentures and preventive care to general dentistry and restoration. The Muscatine office is one of 17 Aspen Dental practices in Iowa. For more information, visit www.aspendental.com.

Great Expressions continues growth in Michigan with Westland affiliation

Great Expressions Dental Centers (GEDC) (Southfield, MI) announced its affiliation with Birchtree Dental Center, a privately owned dental office in Westland, Michigan. Birchtree Dental Center focuses on delivering quality care to informed patients in a comfortable and convenient setting – something patients can continue to expect following the affiliation. The practice will also continue to offer a wide range of dental services including preventive, restorative and cosmetic dentistry, prosthodontics, endodontics, periodontics, orthodontics and dental implants. New and existing patients will now have access to GEDC's extended hours, Invisalign and the Smile Protection Plan, dental insurance alternative for patients without insurance looking to live a healthy lifestyle while saving. The affiliation complements GEDC's more than 60 existing offices throughout Southwest Michigan.

Smile Brands acquired by Gryphon Investors

Gryphon Investors (San Francisco, CA), a private-equity firm, has re-acquired Smile Brands (Irvine, CA), a dental service organization (DSO). Gryphon previously owned Bright Now Dental from 1998 to 2005. Smile Brands has nearly 350 affiliated Bright Now Dental, Monarch Dental, and Castle Dental offices. Steven Bilt, current CEO of Gryphon's DSO, OneSmile, will again take on the role as CEO of Smile Brands. The financial terms of the acquisition were not disclosed.

CareCredit announces multi-year financing agreement renewals with four large dental clients

CareCredit (Orlando, FL), a provider of promotional healthcare financing, has received first-look, multi-year agreement renewals with four large dental organizations. These four agreements strengthen CareCredit's acceptance in more than 400 locations throughout the Midwest, Northeast and Southeast. The organizations are:

- Dentures & Dental Services in six U.S. states
- Mortenson Dental Partners in 10 U.S. states
- Sage Dental in Florida
- Dental Care Alliance in eight U.S. states

Marquee Dental Partners acquires Westen Dental Group

Marquee Dental Partners (Nashville, TN) entered into an affiliation agreement with Westen Dental Group (Bowling Green, KY), a general dentistry practice. By providing dentists with the support and the clinical autonomy needed to succeed, Marquee will enable the practice to focus its attention on providing the best oral healthcare services possible. From a patient perspective, the transition will be seamless and Tim Whitaker, DMD, founder of Westen Dental, will continue to be actively involved in the practice. Marquee Dental places heavy emphasis on dentists' clinical autonomy and will leave in place Westen Dental's dentists and staff.

Deca Dental Holdings acquires DSO Brush 32

Deca Dental Holdings LLC (Dallas, TX), a portfolio company of Blue Sea Capital LLC (West Palm Beach, FL), acquired Brush 32 (Austin, TX), further expanding the company's geographic footprint within Texas. DECA Dental is a dental services organization that supports dentists in providing a comprehensive suite of services, including general,

orthodontic, surgical, cosmetic and restorative dental treatments, across more than 40 affiliated practices with a leading presence across Texas. Brush 32 is a DSO with offices in Cedar Park and Round Rock, Texas. Following the transaction, DECA Dental will continue to provide dental services to existing patients and patients who are new Deca Dental. Services will be provided at the current locations under the Brush 32 brand. The acquisition of Brush 32 comes on the heels of the company's acquisition of Esteem Dental (Houston, TX), a DSO with four office locations.

Study finds that sealants may reduce caries by up to 80%

According to a study jointly published by the ADA and the American Academy of Pediatric Dentistry (AAPD), sealants may reduce carious lesions on the occlusal surfaces of permanent molars by up to 80 percent. The review aimed to summarize the available clinical evidence regarding the effect of dental sealants for the prevention and management of pit-and-fissure occlusal carious lesions in primary and permanent molars, compared with a control without sealants, with fluoride varnishes, or with other head-to-head comparisons. The authors conclude that sealants are effective and safe to prevent or arrest the progression of non-cavitated carious lesions compared with a control without sealants or fluoride varnishes. Further research is needed to provide information about the relative merits of the different types of sealant materials. To read the study, visit http://jada.ada.org/article/S0002-8177(16)30475-5/abstract.

OSAP offers "From Policy to Practice: OSAP's Guide to the CDC Guidelines"

The Organization for Safety, Asepsis and Prevention (OSAP) announced the release of an updated "From Policy to Practice: OSAP's Guide to the CDC Guidelines." The comprehensive workbook has been updated to reflect the recommendations from the CDC Guidelines for Infection Control in Dental Health-Care Settings-2003 and the 2016 Summary of Infection Prevention Practices in Dental Settings: Basic Expectations for Safe Care. The workbook costs $66 for OSAP members and $78 for non-members and is being released in time for Dental Infection Control Awareness Month (September). For more information and to purchase the workbook, visit osap.site-ym.com/store/default.aspx

The Upside of Rejection

By Dan Nielsen dan@americashealthcareleaders.com

As a leader, do you consistently teach, model and reinforce the upside of rejection? Without exception, every member of your team and every employee or associate within your organization will frequently encounter rejection, even when they are directly focused on carrying out the mission, values, strategic imperatives, and annual goals of your organization.

The upside of rejection can be consciously learned, remembered, and leveraged for the good of everyone involved, including your organization and the people you serve.

The upside of rejection is to purposefully and diligently capture and create opportunities for positive change and definitive improvements as the result of inevitable personal, professional and organizational rejection.

The benefits

Think about it. The huge – yes, massive – benefits and results of consciously and consistently leveraging the upside of rejection include:

- Better, more effective leaders throughout your organization (everything rises and falls on leadership)
- Smarter people and smarter teams
- More experienced and mature people and teams
- More effective people and teams
- More efficient people and teams
- More focused people and teams
- More confident people and teams
- Better results throughout your entire organization
- A more confident, courageous, and positive culture throughout your entire organization
- Stronger, more successful, more loyal people and teams throughout your organization
- A powerful, unstoppable culture driven by the courage and learning that results from purposefully and consistently teaching, modeling, and reinforcing the upside of rejection

If you take the time to prioritize and look, you and every leader throughout your organization will find hundreds of golden opportunities to teach, model and reinforce the upside of rejection!

If it's to be it's up to me – that means its up to you!

Dan Nielsen is the author of the books Presidential Leadership (2013) and Be An Inspirational Leader (2016). He regularly writes and speaks on the topics of Leadership Excellence and Achieving Greater Success, and is available to deliver keynote presentations or facilitate discussions for your organization. For more info, please visit www.americashealthcareleaders.com/speaking.

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