BULLETIN OF THE SAN FERNANDO VALLEY DENTAL SOCIETY

Dental DimensionS

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Spring 2015

- A Future Look at Solo and Group Practice Models
- Leadership Education Conference
- Veterans' Smile Day

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Dental Dimensions

In This Issue

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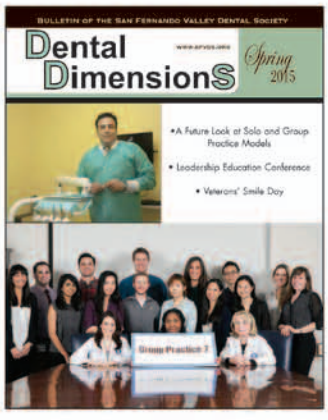
Call for Submissions

Do you have an unusual case study or an interesting article you would like to have published? Dental Dimensions is looking for articles from our members so we can share our collective knowledge. Articles should be 500-1000 words with references where applicable and photos if possible. Send your submissions to:
shukandds@gmail.com
or contact the dental society office at 818-576-0116



On The Cover.....

Photos of a solo practitioner & a large group practice used to illustrate the three articles in this issue focused on the rise of large group practices.

Photos courtesy of:
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From the Desk of the Editor

A Greek philosopher, Heraclitus had the wisdom to say this around 500 BC, "The only thing that is constant is change." This applies to our profession more so than ever with the health care reform act, increasing dental school tuitions, the dentists graduating with massive debts and the group practice model slowly but steadily growing while the solo dental practice model is declining. The millennials prefer a collaborative work environment and value work-life balance, and the flexibility and predictability that comes from employment in larger organizations.

So, how do you like the idea of practicing in Walmart? Last year Walmart Supercenters authorized www.SmileShapers.ca to offer 25 brand new, turn-key dental franchises. "Smile Shapers Dental Clinic" under their roof, to serve the dental needs of Walmart shoppers at the convenient store location they are already familiar with," reads the commercial. This idea is not so novel after all; dentistry is finally catching up to optometrists and pharmacists!

After the 'Great Recession', the job market for a new dentist right out of residency back in 2009 (the year I graduated from residency) was very bleak, especially when he/she was away in another state for the specialty training. With hardly any practices hiring an associate and zero connections in the state, it was anything but a walk in the park. You'd be fortunate if you had part-time employment in one of the established practices within an hour driving distance. Even the couple of days of work would be sparsely filled with patients; the recession had hit the parents hard after all! "Corporate Dentistry" was the only road left unexplored and sooner or later one would stumble upon it.

While I no longer practice as part of a larger corporation, I continue to practice in group practice settings, some of which would qualify as smaller corporations with more than one office location. My brief personal experience working at these corporations was mixed, partly because five years ago, some of these offices were barely figuring out how to incorporate pediatric dentistry into their model. The major pitfalls included a high turnaround of staff, a lack of communication, fragmented care, and difficulty understanding the role and titles of the "multitude of the corporate employees". As a newer dentist in the system, there was lack of consistent support with glitches in missing supplies, sub-par laboratory support, chair side assistance, or any other issues with no clear "go-to person". The benefits were the ability to practice to the standard of care with flexible hours and without having to worry about a full schedule of patients, management or business aspects of dentistry. While there are some corporations that will cut corners with the materials and equipment, there are others that are constantly improving and keeping up with the latest technology in dental practice.

I, like many others, have had the vision of providing the best oral health care to every patient through evidence-based dentistry within a group practice setting with collaboration and integrity as the core values binding the team. Ideally, this model would involve the patients' physicians and all other health-care providers under one roof with truly patient-centered care. Until recently, I had only "imagined" this model in my mind. Well, it turns out that Permanente Dental Associates (PDA), an offshoot of Kaiser Permanente (KP) in the Pacific Northwest is an epitome of this model. PDA is an essential part of an integrated system that KP promotes in their marketing and advertising campaigns around total health. With convenient patient-centered care in a personalized environment and rewarding career opportunities for the dentists, it seems to be a win-win arrangement.

In our current newsletter highlighting the corporate dentistry model, we are pleased to present varied and interesting viewpoints in this rapidly evolving aspect of dentistry. I invite our members to engage in a meaningful discussion and share your experiences or comments in this area in the "Letters to the Editor" format and we will be happy to publish it in the upcoming newsletter.

Yours truly,
Shukan Kanuga DDS, MSD.
Board Certified Pediatric Dentist.

From the Desk of the President

Michael S. Simmons, DMD

The presidents on Mount Rushmore was a topic of conversation at the mid-March CDA Leadership Development Conference held in Irvine. This course was chaired by our own board member, Karin Irani, DDS, and it was full of gems to help attendees lead teams, whether it be a dental office, dental association, sports team or even a country. But why were these four presidents immortalized and what was their best remembered contribution? It is true that this country has been an independent nation for more than 200 years and has had 44 different men serve as presidents. Didn't each leave a legacy and what was it? Historians have captured much of this information before it was lost in time.

But did you know that the SFVDS has had even more presidents and that they have not been limited to the male of our species. Each president brought with them changes and growth, and each has left a legacy. Sadly, this information has not been documented and with the recent passing of our component's first president, Bill Holve, DDS, much of this early SFVDS historical information is lost.

Fortunately, it is not too late to start a tally of our history and many stories are out there waiting to be retold, and perhaps some of the early documents can be dug up and shared. As current president, I am asking you to help contribute to the documentation of our component society's past. We, on the board of directors, are asking for your help! If you have some old documents, some old stories or have even served as one of our past leaders, please send your recollections to our new home in Chatsworth or e-mail it to our executive director at exec.sfvds@sbcglobal.net. If you are a past president we ask you for a brief summary of your legacy to add to our collective history as a contribution to our new library.

Your board and executives have been hard at work these past few months. There has been a retreat with updated development of the strategic plan as well as policy manuals and further development of our foundation. Yes, the SFVDS has a foundation that is proud to offer free dental care to the needy that fall between the cracks of current programs. This includes children, war veterans, homeless and also those confined to their homes. Many of you have volunteered in the past and we thank you most sincerely. We encourage you and others that would like to also help to let us know your availability for the future.

Each year our foundation holds a gala to help fund these programs to help the underserved and you are asked to save the date and commit to attend. This year the gala is to be held on October 24th and there will be notable famous people to meet, of the non-dentist breed, as well as great entertainment and the opportunity to hob nob with your engaged colleagues. Our component is also co-sponsoring a dental education meeting with neighboring components on September 18, with an optional hands on follow-up course on September 19th in the increasingly popular field of Dental Sleep Medicine. The cost is much lower than the typical courses and the experts are truly frontline experts. Proceeds from this course are going to various dental society foundations including our own. Don't miss out on this golden opportunity to learn and also to help your foundation.

We are also looking for members that are seasoned to act as mentors for our younger new dentist group. If you have something to give back and share with someone early on in their career, this is the time to let it be known so we may help match you up. Who knows, it may lead to a lasting relationship or a buy/sell for your office when you are ready to hang up your drill or take down your shingle!

So what else is new and exciting in your leadership? Well for one thing we are exploring more activities to engage members that we do not see at our CE meetings and events. We are looking to gauge member's interest in a poker night, table tennis club and ladder, yoga classes and other shared activities. How about learning Zumba as well as CPR? Below is a list of contemplated new activities to keep our members at the top of their game, whether it is practicing dentistry or keeping their bodies and minds sharp. Please respond to the list of areas of interest that will be e-mailed to you so we can gauge which activities to incorporate in our new home office.

Potential New Activities:
1. Poker night 2. Table tennis night 3. Yoga class
4. Zumba class 5. Other suggestions:_____

_____

CE TEST QUESTIONS

By: Robert L. Merin, DDS

To earn 2 CE credits from reading last issue's "Repair of Peri-Implant Bone Loss After Occlusal Adjustment", please answer the below questions & fax the completed questions to 818-576-0122 with your name and license number.

1. The reported incidence of peri-implantitis is:
A. 5.5% of implants.
B. 9.6% of implants.
C. 12.2% of implants.
D. 19.2% of implants.

2. What are the signs of peri-implantitis?
A. Progressive bone loss greater than physiological bone remodeling.
B. Bleeding or suppuration on probing.
C. Pocket depths greater than 4 mm.
D. All of the above.

3. The case described did not show all the signs of peri-implantitis. What symptoms were missing?
A. Radiographic bone loss greater than physiological bone remodeling.
B. Bleeding on probing.
C. Pockets greater than 4mm.
D. Both B and C
E. Both A and C

4. This patient lost some of her natural teeth due to:
A. Fractures and caries
B. Periodontal disease
C. Endodontic failure
D. Root resorption

5. The primary cause of peri-implantitis is generally attributed to:
A. Bacterial challenge
B. Occlusion
C. Metal fatigue
D. Mucogingival defects

6. There is limited data on the cause and effect relationship of bruxism and implant failure because:
A. Most implant clinical trials have excluded participants who have bruxism.
B. There are few implant clinical trials.
C. Case controlled studies are rare.
D. Studies are too short to draw conclusions.

7. There are many articles which recommend management protocols for implant patients with bruxism. These articles are based mainly on:
A. Multi-center double blind studies
B. Animal studies
C. Expert opinion and case reports
D. History studies

8. Which of the following are true?
A. Integrated implants do not need maintenance therapy.
B. Dental implants require periodic maintenance.
C. Dental implants require periodic x-rays.
D. B and C
E. A and C

9. The bone loss in the case presented was discovered because of:
A. Subjective patient symptoms
B. Swelling and redness of the gingiva
C. Periodontal probing depths
D. A periodic dental x-ray

10. The case presented was unique because:
A. The bone loss resolved with antibiotics.
B. The bone loss resolved with bone grafting.
C. The bone loss resolved with only occlusal adjustment.
D. The bone loss never resolved.

Trustees' Report

By: Martin Countney, DDS

As you read this the California Dental Association (CDA) is moving toward another great member benefit that is anticipated to rival TDIC! The formation of TDIC, your professional liability insurance company, came about due to unrestricted increases in premiums that far outpaced inflation and reasonableness. After early struggles TDIC became more than a professional liability carrier, now standing as the premier company for dentist related insurance needs. The revenue from TDIC covers many programs keeping your CDA dues as low as possible.

Today unrestricted pressures on private solo and smaller group practices are expanding at a pace similar to the increase in malpractice premiums of the 1970s. These practices face incredible challenges in keeping current with governmental regulations, analyzing and managing 3rd party payer agreements, staffing their offices, maintaining a healthy overhead, marketing their services, and obtaining quality continuing education. Currently, help is found at the CDA Practice Support Center for some of these challenges. It is the right time for The Dentists Service Company (TDSC). Last year the CDA House of Delegates approved formation of TDSC. In January of this year, The Board of Trustees (BOT) approved movement of the Practice Support Center to TDSC. Later this month the Board will review the business plan and finalize the start up activities of TDSC. It is expected that in June there will be a special House of Delegates to review and approve the TDSC governance structure, business plan and start up activities. As the board and CDA move forward with this company it is critical to include those services you, the members of CDA, feel most strongly will help your practice thrive. Please email me with any ideas for services that TDSC should offer.

CDA continues to fight for fairness for Delta Premier providers. As reported on the CDA website, the San Francisco Superior Court judge presiding over the CDA vs. Delta Dental case issued her tentative ruling at a March 18 hearing denying Delta Dental's motions attempting to have the case dismissed. While her rulings in open court are currently tentative, the judge stated that she would issue a final order soon and it would be consistent with these tentative rulings. This is positive news for CDA and CDA member Premier providers, however, there is still a long way to go in the litigation.

At the March BOT meeting the board reviewed and approved the evaluation of CDA Executive Director, Peter Dubois. CDA continues to advocate for improvements in the Denti-Cal system. We continue to generate more attention from policymakers to the state's audit of the Denti-Cal program. Two weeks after a four-hour hearing on how reimbursement rates are affecting access to care that was dominated by discussion of Denti-Cal, the Joint Legislative Audit Committee, the Assembly Health Committee and the Senate Health Committee held a three-hour joint oversight hearing focused exclusively on the audit's findings and how the state should address them. As a reminder, the audit found that more than half of enrolled children are not receiving any dental care, the majority of counties have an insufficient number of Denti-Cal providers, reimbursement rates for the top 10 pediatric services are only 35 percent of the national average, and the Department of Health Care Services (DHCS) has not been conducting required program oversight.

Legislative Committee Report

By: Jim Mertzel, DDS

COVERAGE VS CARE

Millions of Californians are obtaining much needed dental coverage through the Affordable Health Care Act and the partial restoration of adult Denti-Cal benefits. However, limited economic reimbursement to providers has resulted in not having enough dentists to provide service for the eligible recipients.

According to a state audit, 56 percent of the 5.1 million children enrolled in the state's Denti-Cal program did not receive any dental treatment in 2013.

The problem in California is that the state has not raised reimbursement rates for Denti-Cal providers since 2000 and, in fact, actually cut the rate by 10%. In addition, many of the programs offered under some of the Affordable Care Act dental programs have very low rates. These rates are among the lowest in the nation. This has resulted in a very limited number of dentists willing to provide services to the great number of individuals enrolled in the programs being offered.

CDA is well aware of the problem and has lobbied our legislators to find a way to resolve the limited access to dental care for so many of the citizens of our state. Unfortunately, the 2015-16 State budget does not include any new funding to resolve this issue.

Furthermore, although effective in May of last year, some limited treatment was authorized for adult eligible Denti-Cal patients, there are some glaring omissions in the authorized treatment, specifically scaling and root planning and partial dentures.

HEALTH CARE REFORM

Pediatric dental services are one of the essential health benefits mandated by the Covered California Exchange. This year the medical exchanges are required to include dental benefits. CDA has been successful in monitoring these plans to assure that the plans have a sufficient number of dental providers to provide timely access. CDA is advocating that in 2016, stand alone family dental plans will be available so that adults will be able to obtain dental benefits through Covered California.

DENTAL HYGIENE OVERSIGHT (AB 502)

This bill, sponsored by the California Dental Hygienists Association, proposes to expand the scope of practice for dental hygienists. **CDA opposes this bill.**

The bill proposes eliminating the current requirement for registered dental hygienists in alternative practices to require a dentist's prescription to continue providing a patient's treatment after 18 months. There are some areas in the state designated as Dental Health Profession Shortage Areas (DHPSA), where RDAHAPs are currently allowed to practice. AB 502 would allow hygienists to continue to practice in those areas even if the DHPAS designation was eliminated.

VIRTUAL DENTAL HOME GRANT PROGRAM (AB 648)

The Virtual Dental Home (VDH) model allows dental hygienists in certain community settings to provide basic care for patients under the diagnosis and directions of a dentist using tele-dentistry technology to help expand access to care in underserved communities. AB 648 would establish VDH grant program to expand the model into the state's greatest area of need.

DENTAL PLAN ACCOUNTABIITY (AB 1962)

This bill was passed last year and will bring transparency and accountability to dental insurance plans in California. It will allow a study to help determine how much of the patient's premium for their dental insurance plan can be applied to administrative costs as opposed to how much of the premium will go to pay for dental services. The standard medical loss ratio (MLR), which CDA is advocating for, is 20% for administrative costs and 80% for dental services

TOBACCO USE

CDA is supporting Legislation that would remove tobacco products from baseball stadiums in California and increase the state tax on cigarettes by $2.00 per pack. The current tax on cigarettes is $0.87 per pack, ranking CA 33rd among states. CA has not increased this tax since 1998. All forms of tobacco use increases the risk of oral, throat and esophageal cancer and contribute to gum disease and tooth discoloration. Tobacco use costs California more than $9.1 billion in medical expenses every year. The cost of lost productivity in California due to tobacco use also adds an estimated $8.5 billion to the annual economic consequences of smoking.

WARNING LABELS ON SUGARY DRINKS (SB 203)

CDA supports Senator Monning's bill. Sugar sweetened beverages are the single largest source of added sugar in the American diet. The acidity, carbonation and sugars in these drinks creates a high risk of dental caries and demineralization of dental enamel, and makes consumption of these beverages one of the most significant contributors to dental decay.

As in the past, I encourage every one of you to get involved in the political process. This is the time when candidates for state and federal government are seeking your support. Your early involvement in their political race will afford you, in the future, to be able to effect changes in legislation regarding issues about which you are concerned. If you are a dentist who wants to run for political office in your community, our society encourages and offers support for your candidacy.

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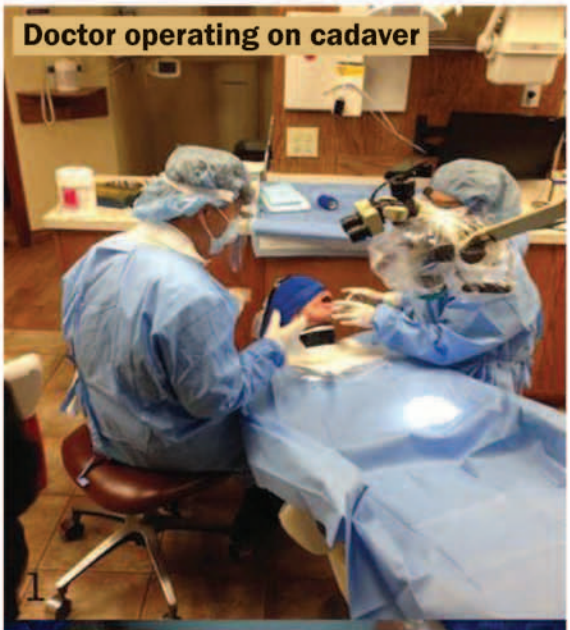

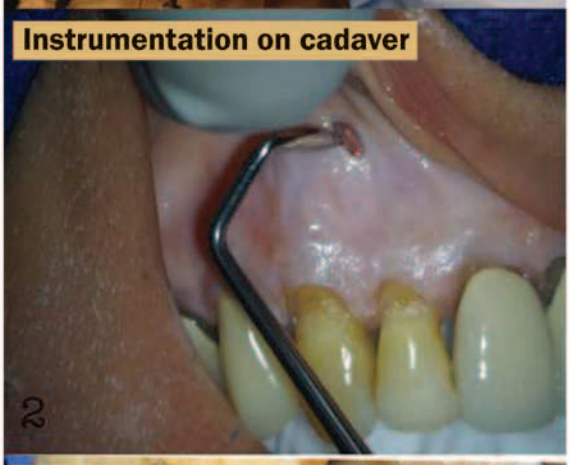

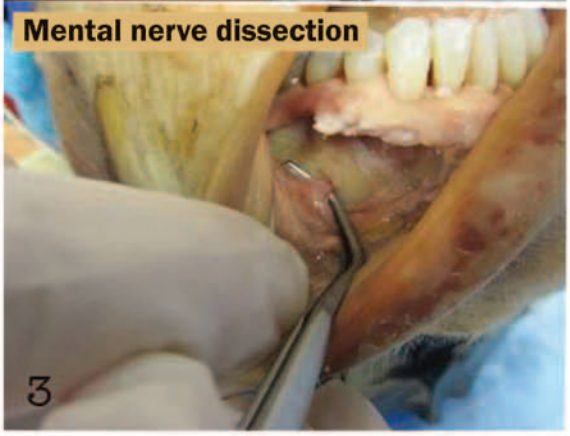

Pinhole Seminar Cadaver/Donor Training Highlights:

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(Chao J. Int J Periodontics Restorative Dent 2012; 32: 521-531. a retrospective study)
Patented by John Chao, D.D.S., J.D.

☐ March	27-28,	2015	☐ June	12-13,	2015
☐ April	10-11,	2015	☐ July	24-25,	2015
☐ April	24-25,	2015	☐ August	7-8,	2015
☐ May	15-16,	2015	☐ August	21-22,	2015
☐ May	29-30,	2015			

All seminars are held on Friday & Saturday

***Method Patent No. US 8,202,092 B2**

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2015 Programs for the Membership

Dr. Alfred Penhaskashi
2015 Program Chair

Dear Colleagues,

It is my great privilege to be the program chair and a privilege to be working closely with the program committee team who dedicate time outside of their office and family to ensure that we provide an outstanding education program for our dental society members.

We have had a fantastic start this year with our dental society general continuing education meetings. It started with an amazing and detailed restorative presentation by Dr. Brian Lesage. Then we had an impressive presentation on "Do's and Don'ts" in surgical implant dentistry by Dr. Hessam Nowzari. Also we had an outstanding presentation on oral surgery and dental emergency management by Dr. Alan Felsenfeld who graciously donated his honorarium to the CDA foundation.

The program committee has been working hard for you to put on more hands-on and interactive courses, which were very well attended and received in 2014. In response to requests for additional training in dental emergencies, we arranged a four hour intensive and interactive course on April 11th. This will be followed on June 20th by another interactive four hour Invisalign review program. On October 3rd we have arranged a hands-on, interactive, Air Abrasion Technique course. We are actively engaged to provide even more educational events to benefit our dental society members.

As you can see we have selected and lined up more amazing meetings this year for our members. We know that you'll be able to pick up some very valuable information from the presentations and we look forward to seeing you.

General Meetings -Preview

June 10	**Parish Sedgizadeh, DDS**	**Oral Pathology and Medicine**
Sept 16	**Bob Hale, DDS**	**Reconstructive Surgery**
Oct 14	**BJ Moorhead, DDS**	**Technology & a Paperless office**
November 18	**Raymond Bertolloti, DDS**	**Dental Materials & Bonding**

General Meeting Review

Brian LeSage, DDS

Jan 14 Minimally Invasive Dentistry: Everyday Systems for All Ceramic Restorations

This lecture covered the proper use of smile design principles to achieve desired white and pink esthetics. Four veneer provisional techniques were covered in depth to guide the clinician to the patient's desired outcome. Discussion included diagnosis and treatment planning, color and adhesive principles, all with esthetics in mind.

Hessam Nowzari, DDS

Feb 11 Implant Failures and How to Avoid Them

This lecture provided insight into implant dentistry whereby different aspects of dental implantology were objectively evaluated and criticized. Topics discussed included Peri-implant turnover, tissue enhancement and preservation, a decision-analysis approach and implant associated complications, prevention and treatment

March 11 Complications of Dentoalveolar Surgery and Medical Emergencies in the Dental Office

Alan Felsenfeld, DDS

This course was designed to help the dentist minimize the frustration in dentoalveolar surgical procedures. The course reviewed ways to recognize and understand the variety of problems that can be encountered in dentoalveolar surgery, to develop several techniques for treating complications of dentoalveolar surgery, and to be aware of relative means of preventing or minimizing complications. In addition, the speaker reviewed the most common medical emergencies that occur in a dental office and how best to deal with them.

April 15 CA Dental Practice Act and Infection Control

Nancy Dewhirst, RDH

This course reviewed the highlights and updates of the Dental Practice Act, the scope of practice for dentists and allied dental health personnel, license renewal requirements, continuing education, laws governing citations and fines, laws pertaining to prescriptions, dental record keeping, and acts in violation of the Dental Practice Act including unprofessional conduct. In addition, the course reviewed state licensing requirements for infection control.

SFVDS leadership attend CDA's Leadership Education Conference

By: Karin Irani, DDS, SFVDS Treasurer, CDA Chair, Leadership Development Committee

CDA's 2015 Leadership Development Committee

SFVDS treasurer & Leadership Development Committee chair, with Dr. Rick Nagy of Santa Barbara lead the crowd in the Saturday 'fun' activity.

Two hundred and ninety-five dentists, dental students and staff members from all California dental societies attended the CDA Leadership Education Conference on March 13-14, 2015. Sixty dental students were sponsored by CDA to attend this conference. In the spirit of leadership, SFVDS sponsored USC dental student Jeff Davies to attend. Jeff is a third year student at USC dental school who later said: "I met a lot of great people that are doing some amazing things in the profession. I had a chance to sit next to Michael Simmons, SFVDS President and Andy Ozols, SFVDS Executive Director at lunch. Michael and I talked a lot about the profession and my experiences with school and jobs coming out of school. He was very nice to talk to and had lots of good information. It was also very nice to meet some of the dental students at some of the schools around here. I believe these types of connections are some of the most valuable things you can get".

Attendees pose with their "famous foursomes" headbands

CDA Leadership Development Committee organizes this conference every other year to provide leadership education to component leaders in CA.

SFVDS' President-elect Anita Rathee & Treasurer Karin Irani

Members are able to earn CE units, network and meet CDA leaders.

This year's conference focused on the changing of the economy, politics and practice environment. LDC brought an EPIC experience to our members; "Experiential, Participatory, Image-rich and Connection-focused". Attendees heard from renowned speakers such as keynote speaker, Mike Robbins, the author of "Nothing changes until you do". He encouraged the attendees to embrace change, have the courage to be vulnerable and think out of the box. Every morning, attendees were able to start the day with fitness activities such as Zumba (taught by our own Editor, Shukan Kanuga), Yoga and group walks.

The conference then continued with breakout sessions ranging from workshops on principles of leadership to forecasting the future! Attendees had a chance to network and meet members from other dental societies at the all-attendee dinner, finding the members of the "famous foursomes" such as Beatles; I love Lucy, Wizard of Oz and Star Wars characters. This activity continued on the next day when the "foursomes" were prompted to write a skit to include what they learned from the keynote speaker and the breakout sessions. Attendees had a great time performing their skits in front of their peers, some singing, some acting, overall recounting their take-aways in a creative way.

This conference is best described in what one of our attendees who just joined his component board and who has not been active in organized dentistry in 38 years said: "I can't believe how amazing these people are and how much fun they have! I want to be the CDA president!"

The Leadership Development Committee having a fun pose outside of the hotel

Veterans' Smile Day

San Fernando dentist and SFVDS Member, Dr. Sean Naffas with veterans he cared for.

Dentists in communities throughout the country provided free dental care during Veterans Day weekend on Nov. 7 & 8, 2014 to those who have served in the military. Veterans often face difficulties in accessing dental benefits, which are much more limited than medical benefits, through the U.S. Department of Veterans Affairs (VA). In order to be eligible for VA dental benefits, a veteran must be a former prisoner of war or have service-related disabilities rated 100 percent or more, according to the VA.

Last November, dentists in Massachusetts, California, Arizona, New Jersey, Florida and Connecticut hosted their first Veterans' Smile Day, which connected veterans and their families with local dentists to provide comprehensive examinations and basic preventive and restorative dental care. This project is an initiative of the ADA Institute for Diversity in Leadership Alumni, including Karin Irani, DDS, SFVDS Treasurer.

By: Karin Irani, DDS, SFVDS Treasurer

"This project really took form after I spoke with a friend, Dr. Deryck Pham, a New Jersey dentist who also happens to be a veteran," said Dr. Irani. "He contacted me last year and said that he hosts a local 'day-of-care' event each year and he wanted to know if I might be interested in helping make this a national event."

Dr. Pham, a lieutenant in the Navy, who served as a combat dentist during Operation Iraqi Freedom, created "Serving Those Who've Served" 3 years ago to help his fellow veterans.

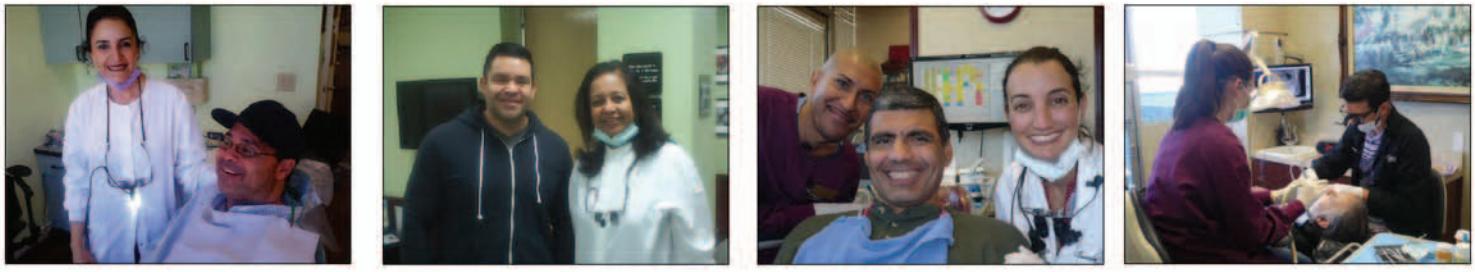
The U.S. Department of Veterans Affairs plays an active part in the effort to provide access to dental care for a limited number of veterans. However, the access to care issue for all veterans is a problem that requires the cooperation and participation of community organizations and individual citizens alike.

All veterans were eligible, provided they could show proof of their service. Dentists addressed the most urgent concerns. Services included: exams, oral cancer screening, fillings, cleanings, extractions, root canal therapy, scaling/root planning, and even crowns.

We recommended that the dentists refer patients to free clinics for follow-up treatment or provide follow-up treatment at a discounted rate. Last year, throughout the national Veterans Smile Day event more than 80 dentists provided care for about 600 veterans. Procter & Gamble and Henry Schien, provided basic supplies for participating dentists.

We want to bring awareness to veterans' needs. Our hope is that the dentists participating in this program will be able to provide continuing care for veterans who need it. If you are interested to participate in this year's Veterans Smile Day on Nov 13-14, contact Dr. Karin Irani: ddsusc03@gmail.com

Thank you to Rhyse Saunder's New Dentist Blog for his help with this article



(L-R) Member Doctors serving veterans: Mahrouz Cohen, Nita Dixit, Michelle Frawley and Deryck Phan of N.J.

Supported Dentistry - One Solution

By: Jennifer Bryant, Esq.
Pacific Dental Services

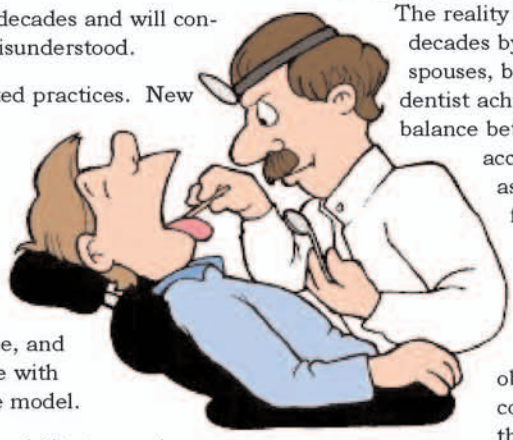
The dental industry has largely remained unchanged throughout history: a multi-billion-dollar industry comprised of individual offices with dentists performing multi-function operations and oral healthcare services for patients while juggling the business aspects of running a dental office. But with recent changes in healthcare, the world of dentistry is undergoing some adjustments as well.

The overwhelming market forces are indicating that the traditional model of dentistry is not sustainable. In fact, a study for the ADA concluded "The trend toward larger, multi-site practices will continue, driven by dental plan pressures for smaller provider networks, practice patterns of new dentists and increased competition for patients."

The newly graduated dentist is looking for something different. The supported practice model is one solution for these dentists and others who have practiced for years. The model involves dentists hiring dental support organizations (DSOs) to obtain business services. History refers to this as "corporate dentistry." In reality, DSOs support dentists; they do not practice dentistry.

The supported model has been around for decades and will continue to evolve—however, it is still largely misunderstood.

The data shows dentists flocking to supported practices. New graduates are applying for associate dentist positions at these practices at a significant rate. These organizations are reporting that for every position available, candidates submit hundreds of applications.



With these demands bearing down on the dental profession, change is inevitable and desperately needed. Competition is fierce, and the traditional model is not able to keep pace with advantages offered by the supported practice model.

One advantage of supported dentistry is the ability to purchase dental supplies, equipment, insurances and services for a high volume of offices, resulting in lower costs. Further, aggregating functions such as accounting, billing, and collections for hundreds of offices results in efficiencies that patients, dentists and payers all appreciate.

Additionally, these economies of scale are often able to support technology advancements and dental education. Digital x-rays (reports of 90% less radiation for patients), digital charting and CAD-CAM technology are just a few.

The Legalities of Supported Dentistry

The main objections for the supported dentistry model are rooted in the basic prohibition against a "for-profit" corporation driving patient treatment decisions. Supported dentistry does not violate this premise. Dentists make all treatment decisions and critical business decisions. Critics would like us to believe that dentists cannot make their own decisions regarding patient care, that supported dentists are not ethical and that they are unable to judge the impact of their business support on their clinical decisions.

However, most dental support organizations are structured in a perfectly legal manner. Licensed dentists often own one-hundred percent of a professional corporation. The professional corporation is engaged entirely in all aspects of patient care, including employing dentists and hygienists, entering into contractual relationships with dental insurance plans, creating patient records, deciding patient care and treatment plans, scheduling, determining appropriate billing codes, billing and collecting for services, and maintaining relationships with patients. The professional corporation enters into a contract with another entity for business support services. Business support services include non-clinical front office and back office staff employment, human resources, payroll, billing and collections, information technology systems and infrastructure, equipment purchasing, dental lab negotiations, accounting and finances, marketing, maintenance and much more. All of these services are provided subject to the ultimate approval and oversight of the professional corporation (dentist owners). In addition, these contracts require that the business entity never interfere with patient care decisions.

Dentists Are Ethical Professionals

The reality is that dentists have been pressured for decades by outside influencers, including employers, spouses, bankers, etc. If a corporation can help a dentist achieve more time to treat patients, greater balance between work and family life, and more open access for patients, then why wouldn't we assume that the dentist will do the right thing for patients?

If there is still concern, these strong ethical commitments on the part of dentists can be strengthened. Dentists can be further educated and informed about their obligations or be required to do two hours of continuing education on ethics. Many of these continuing education classes should focus on the importance of dentists doing what is best for patients regardless of the pressures.

The economic realities mandate that the supported practice model will continue to exist and evolve. There is no question. The supported practice model is not going to disappear—it will strengthen. But we are stronger together than divided. Working together, rather than against each other, as well as working towards continuous innovation and collaboration, is essential to the future of dentistry.

About the Author:
Jennifer Bryant joined Pacific Dental Services, LLC in 2002. As Vice President, Associate General Counsel, Jennifer is responsible for the legal and compliance functions for Pacific Dental Services (PDS). During her time at PDS, Jennifer has assisted the growth of PDS from 20 supported offices in California to more than 400 supported offices in 14 states. Prior to joining PDS, Jennifer held various positions as attorney with companies in the petroleum industry. Jennifer received her Bachelor of Arts from University of California, Los Angeles and her law degree from University of the Pacific.

The Rise of Managed Group Practices

By: Eric K. Curtis, DDS, MA, MAGD

There was a time when you refueled your car at a service station, and the station owner's name—identifying an actual person, likely someone who lived in the neighborhood— would be displayed over the door. You would glide up to the pump, and a uniformed attendant (invariably a man, and if you're old enough, a man sporting not only an embroidered patch bearing his name but also a bow tie) would appear at your window.

He would fill the tank with your choice of regular or ethyl, lift the hood to check the engine oil (displaying the dipstick, like a sommelier brandishing a wine label, for your approval), measure the air pressure in your tires, and wash your windshield. If the attendant suspected a problem, he would offer advice or refer you to the mechanic on duty. He would process your payment, issue a receipt, and possibly even dispense a sheet of trading stamps, redeemable for exciting merchandise. You would never have to step out of your vehicle.

These days, fuel consumption has long since moved on to the gas station, where you pump your own octane selection, check your own tires, wash your own windshield, and swipe your own credit card. (In some states, attendants still pump your gas—by dint of law, not market forces.) The transactional burden has shifted to the customer for one reason: commoditization.

As markets mature, competitors copy each other, eroding the differentiation of goods and services. Gas is gas, no matter where it comes from, as generic and interchangeable as multivitamins, computer memory chips, or cell phone minutes. Price, not service, has become the determining factor in the sale of petroleum products.

Many observers see a similar evolution looming in dentistry. Dentists take pride in their individual craftsmanship and problem-solving skills, as well as the relationships they cultivate with the people they treat. But patients, encouraged by deteriorating insurance coverage to select a dentist based primarily on cost, may see only a commodity. Patients are consumers and, to some of them, one dentist is indistinguishable from another.

Attitudes on dentistry's supply side also have shifted. New dentists, saddled with hundreds of thousands of dollars in debt, stagger from the cave of their educational experience into the blinding light of the marketplace and wonder where the money is. Experienced dentists, inundated with ads promoting expensive coursework or equipment implicitly promising to reverse the tide of commoditization, wonder whether to take on the risk of any expansion, much less an associate, in a time of dwindling patient bases and crumbling profit margins.

The rise of professional management in three models

Entrepreneurs have found opportunity amid the confusion, organizing business models of dental care delivery that separate the business of dentistry from its practice. Commonly referred to, collectively, as corporate dentistry or managed group practice, these systems have capitalized on dentists' uncertainty, spurred by such trends as steep dental education costs; a decade long slump in dental utilization rates, inflamed by the 2008–2009 recession; and low Medicaid reimbursements, which threaten the vitality of traditional private practices and precipitate practitioner maldistribution.

Corporate dental systems administer business services through professional management companies, variously called dental service organizations (DSOs), management service organizations (MSOs), or dental management service organizations (DMSOs). Assigning the burden of administrative support to outside professionals, the thinking goes, frees dentists to focus solely on treating patients.

In its 2013 "Investigative Report on the Corporate Practice of Dentistry," the Academy of General Dentistry (AGD) Practice Models Task Force describes a range of corporate organizational patterns, of which three dominant templates

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emerge. One model, the DSO with internal management, designates dentist owners as sole shareholders responsible for developing and carrying out management activities. A second model, the DMSO without outside equity ownership, focuses on professional corporations that oversee multiple practices and manage the organizational aspects through business service contracts with a single third-party MSO. Dentists or non-dentists may own the MSO. A third model, the DMSO with outside equity ownership, depends on support from outside investors or equity firms that seek to maximize the value of the enterprise. Equity-backed DMSOs aim their advertising at the public, while DSOs and non-equity-backed DMSOs market to dentists.

Both the labor pool (dentists) and consumers (patients) have responded with enthusiasm. In 2009, the American Dental Association (ADA) Health Policy Resources Center estimated that large group practices would command 11.2 percent of the market by 2015, compared to 3 to 5 percent now. The Association of Dental Support Organizations (ADSO) projects a 30 percent compound annual growth rate for its members from 2010 to 2015, in contrast to a 6.75 percent compound annual growth rate for the dental industry generally.

The appeal of managed group practices

Consumers are attracted to lower costs, as well as branding that suggests a predictable experience. According to the July 1 ADSO white paper "Toward a Common Goal: The Role of Dental Support Organizations in an Evolving Profession," a 2012 Duke University study found that managed group dental practices charged, on average, 11 percent less than traditional solo practitioners.

Supporters argue that DSOs operate more efficiently by consolidating the activities of multiple practices to reduce fixed costs. Bulk purchasing of supplies and materials allow such organizations to enjoy economies of scale unavailable to mom-and-pop dental offices, and deeper pockets facilitate the acquisition of state-of-the-art digital technologies, offering dentists access to fully equipped facilities. Thanks to organizational consistencies, DSOs also may be better prepared than solo practices to ensure and report compliance with increased regulatory requirements and outcome-based payment and incentive programs.

Advocates also believe that, because of quality assurance parameters, DSOs are more likely to terminate unskilled or unethical dentists than solo private practices, where significant damage may already be done to patients before the state dental board receives multiple complaints. DSO-supported practices, proponents say, also are more likely to be located in underserved areas, where they can care for lower-income populations without relying on government assistance.

The labor side of the equation is often equated with financial security. According to a 2012 ADA group practice survey, dentists join corporate dentistry to lock in a guaranteed salary. Allison House, DMD, now in her own private general practice in Phoenix, worked as a corporate associate dentist from 2000 to 2003. "Corporate dentistry provides a 'dentist-size' paycheck from Day 1," she says. "For some new graduates, there is really no other choice, especially if you owe your first-born child to the student loan people."

"It is not surprising to me that so many recent graduates are seeking employment in corporate dentistry," says Myron Bromberg, DDS, AGD Advocacy-Representation Division coordinator, of Reseda, Calif. "Given student debt is in the $300,000 range, promises of salaries in the $150,000 to $200,000 range sound pretty appealing, particularly considering that employment opportunities in the private practice sector are minimal."

The ADA survey also revealed that dentists are attracted to a corporate system's social and intangible advantages, including work-life balance, a flexible schedule unencumbered by after-hours interruptions, camaraderie with other dentists, and less interaction with insurance companies, all without dotted-line demands for loyalty to the sponsoring company beyond the standard at-will terms—considerations that, according to the AGD task force, easily overshadow student loan debt.

"In corporate practice, I met some wonderful dentists my age who went on to own practices here in Phoenix," Dr. House says. "In corporate practice, I learned how to spot a good hygienist and a good assistant. I learned about efficient scheduling. I learned a great deal about insurance and how it works."

New dentists aren't alone in their interest. Experienced dentists looking for a bridge to retirement are drawn to corporate structures that promise cash-out value for their existing practices, along with an opportunity to keep working. In fact, the AGD task force concluded that it is managerial complexity—above all other factors—that drives dentists to consider a move to external administration. A dentist who owns a traditional solo dental practice must wear many hats: CEO, human resources manager, chief financial officer, and clinician. Indeed, few other entrepreneurial situations combine the disparate roles of manufacturer, salesperson, and supervisor with such concussive dissonance. At the same time, practice management training in dental schools can be abysmal—as few as six hours in an entire four-year curriculum. In the face of diverse leadership pressures, for which many dentists are conspicuously ill-prepared, the road to corporate dentistry comes paved with the promise of practice management relief.

Criticisms of external administration

Rather than opportunity, many dentists see managed group practices as a threat to the profession. In fact, for some managed
group practice supporters, issuing threats may well be a marketing tactic. "During several so-called panel presentations—which only included dental corporations—I heard the same scripted comments, such as, 'Get on board or be run over,' and 'The practice of dentistry as we know it is over,'" says AGD President W. Carter Brown, DMD, FAGD, of Greenville, S.C. "I have concerns when the best marketing tools some can come up with are threats and misinformation."

Some threats may indeed merit consid-

Questions That Dentists Considering Affliation With a Managed Group Practice Should Ask

1. Who is my employer?
2. Who can create or edit a treatment plan? Who is responsible for the treatment plan? Do I have the authority to disagree with or change a treatment plan?
3. Who owns the dental professional entity? Who owns the business entity?
4. What is the governance structure of the dental professional entity? Of the business entity?
5. Does the business entity have a relationship with any outside investors, such as an equity firm or public company?
6. Is there a management services agreement? If so, does that agreement comply with state laws?
7. What are my employer's expectations regarding my productivity, patient volume, and revenue? For example, may I take two hours to complete a crown prep?
8. What formula is used for dentist compensation? That is, to what degree is my remuneration based on my productivity?
9. What is the relationship between my compensation and that of the business entity?
10. Who owns the lease agreements for the building? For the equipment? If I buy a practice, will I have the opportunity to own the equipment in full, or will I rent the equipment perpetually? If I can own the equipment, what is the lease term, and is there a separate agreement for a lease-to-own opportunity?
11. May I use any vendor for supplies? Is there a cap on the volume or type of supplies available?
12. May I use a dental laboratory of my choosing? How are lab costs ascertained and apportioned?
13. Who has control over revenue stream distribution, and how is the revenue stream distributed?
14. Who owns patient records? Upon termination, would I have access to patient records? If so, to what extent? Is there a procedure for accessing these records?
15. How are after-hours emergencies addressed?
16. Who makes hiring and firing decisions? Are there any protocols or guidelines for these decisions?
17. May I have access to all contracts and other documentation upon which the above answers are based, so that I may share them with an independent attorney, accountant, or professional adviser?

Source: Executive Summary, Investigative Report on the Corporate Practice of Dentistry, Academy of General Dentistry Practice Models Task Force, 2013

eration, particularly those that are commercial in nature. Asks AGD Treasurer Mohamed F. Harunani, DDS, MAGD, of Rockford, Ill.: "Can a solo private practice really compete with corporations that are better funded, better organized, and better able to understand and implement processes?"

Yet the vaunted corporate processes themselves scream caveat emptor. "Upfront expenses are handled by the corporations, and often so are hiring and firing, supply choices, and time allocations for procedures," Dr. Brown says. "These all have an impact on financial decisions and work models."

These systems may disregard the fine-tuned personal judgments that good dentistry often demands. "A highly structured environment with pressure to produce means treatment can't be easily personalized," Dr. Bromberg says.

The machinery of efficiency may crush thoughtfulness, a manifestly unquantifiable element that requires time and space to nurture. One-size-fits-all managerial expectations may ignore a particular dentist's skills and weaknesses, especially if the dentist lacks experience. "Supporters see the rise of managed group practices as a financial issue," Dr. Brown says. "They say that patients are now consumers, looking for fast, cheap, and convenient care. But I believe that most patients are not big-box consumers. Most patients want quality, and they still see dental care primarily as a patient-doctor relationship issue."

Dr. House left her corporate position after three years. "The downside [of external management] is that you have no control," she says. "On your very first day, there may be an anterior bridge case or full-mouth extractions or a maxillary first molar root canal on your schedule. You are expected to do the work on your schedule with the materials and staff provided. All of these things can challenge the quality of your work. At this point in my career, I think I am more capable than I was back then to use less refined materials and utilize team members who are not well-trained. I also know my limits better."

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The Rise of Managed Group Practices

When quality-of-care issues arise, external management apologists point out that licensed dentists, not managers, deliver care. Yet, especially in systems that impose quotas or award production incentives to managers, dentists in the trenches may feel vulnerable to manipulation. In the organization for which she worked, Dr. House recalls a mix of isolation and pressure. No senior doctor was available for clinical advice if a procedure went wrong. Moreover, she says, "It was a bad idea to disagree about a diagnosis, as dentists were fired often for not doing the work. We also were held responsible for things that we didn't see or participate in, like sterilization procedures and billing."

Many observers—including, recently, congressional investigators—express concern that managed group practices will make the bottom line their bottom line. In June 2013, Sen. Max Baucus (R-Mont.), then chair of the Committee on Finance, and Sen. Chuck Grassley (R-Iowa), ranking member of the Committee on the Judiciary, released the "Joint Staff Report on the Corporate Practice of Dentistry in the Medicaid Program," which questioned whether short-term profits come at the cost of quality care and long-run sustainability.

Case in point: In March 2014, the U.S. Department of Health and Human Services named dental management company CSHM LLC ineligible for Medicaid reimbursement, its main revenue source. The company, operating 53 low-income clinics for children across the country, most under the name Small Smiles, was previously investigated by the U.S. Department of Justice (DOJ), according to an NBC News report, for "unnecessary and substandard procedures." In 2010, the company paid state and federal government entities some $24 million due to the DOJ findings. A separate 2012 NBC News investigation of Small Smiles found "persistent allegations of abuse, including unnecessary root canals, shoddy work, and insufficient anesthesia."

Doubts about the long-run viability of equity-based DMSOs often focus on investor influence. The very purpose of equity participation may incite eventual market instability, in that the typical DMSO practice of publically projecting enterprise value alone—ignoring the cost of supplies, equipment, administration, and overhead to boost sales appeal—may misrepresent the company's true value. Repeatedly inflated valuations over the course of multiple sales may create a market bubble. "The drive to maximize enterprise value is inherently at odds with the provision of quality care," the AGD task force writes in its report, "and it is unclear how to bridge this gap for the benefit of both over a sustainable long-term future."

Dr. Brown worries that dentists looking for career changes or promised debt relief may misunderstand the mechanics of external management, and that corporations trolling for labor may do little to clarify their options. "In their presentations, I have seen corporate groups tell new graduates that it's impossible to have their own practice," he says. "In reality, banks are beginning to make loans again, and the numbers often do work out in order for new graduates to open a practice."

Dr. Brown notes that, while many corporations also offer "ownership," the term often means only the possession of patient records, rather than any tangible assets that can be depreciated and valued to gain loans from banks. "The 'You are a doctor, and you deserve this now' message that some corporate organizations push to recruit dentists may seem attractive, but the realities of those offerings can be different from what the dentist envisions," he says.

Even in an age of instant gratification, the impulses of which might steer dentists to investigate managed group practices, many still regard private practice as the ultimate goal. "Most dentists will realize they can make more money by purchasing a traditional dental practice netting 40 percent on average than they can earning the average dental management company compensation rate of about 25 percent," says Joseph A. Battaglia, DMD, MS, FAGD, chair of the AGD Legislative & Governmental Affairs Council, of Wayne, N.J.

Management organizations, in the meantime, have become sensitized to negative publicity. "Some corporations have changed the meaning of the DSO acronym," Dr. Brown says, "using DSO to stand for dental support organization rather than the actual meaning, dental service organization." Explaining that lawsuits brought against certain dental corporations have revolved around the service component, Dr. Brown surmises that the switch may represent a subtle public relations effort. In its white paper, the ADSO dismisses terms such as corporate dentistry and private equity as "inflammatory phrases" that "cloud the discussion" of dental management arrangements.

Projections of future managed group practice growth

In spite of conditions that have encouraged fewer traditional private practice buyers, some observers hesitate to forecast steady growth for the managed group practice industry. "Levels of dental insurance market share and insurance reimbursement will drive the future business models of dental delivery," Dr. Battaglia says.

Market unknowns increase unpredictability. In addition to the potential of a DSMO-created bubble, Patient Protection and Affordable Care Act-driven implementation of health care exchanges and enforcement of essential health benefits (which include pediatric dental services, but not adult services) may drive DSOs to focus on adults who are neither Medicaid-eligible nor employer-insured.

Several other elements hint at limitations to corporate growth. With no say in whom they work with; limited control over supplies, materials, labs, and radiographs; and schedules imposed by managers who get a percentage of production, dentists involved with managed groups may take a short view of their employment. Indeed, little evidence exists to indicate a trend toward dentists making a career in managed group practices. Instead, as Dr. House's experience suggests, many seem to be using corporate employment as a springboard for eventual independent private practice, or, in their later years, as a transition to retirement.

In the face of diverse leadership pressures, for which many dentists are manifestly ill-prepared, the road to corporate dentistry comes paved with the promise of practice management relief.

Given the resulting revolving door effect from high staff turnover, some question whether, lowball pricing or not, patients will remain comfortable in externally managed settings where they perpetually see new dentists. "Dentists perform services in a very personal and intimate part of the human body often associated with great emotional consequences," Dr. Bromberg says, "and that intimacy is not easily transferred to strangers, particularly when dental fees do not have the devastating potential effect that medical costs incur."

Media coverage of conflict surrounding management organizations—from North Carolina State Board of Dental Examiners litigation alleging DSO-based illegal ownership, fee-splitting, and false bookkeeping to the U.S. Senate investigation into charges of overtreatment and low-quality care—also may make the public wary. "Given the recent negative publicity surrounding corporate dentistry, patients may choose to stay with their own dentists," Dr. Bromberg says.

"Many indicators show that the growth will experience a plateau effect," Dr. Brown says. "Two main drivers of the plateau are, one, the manner in which practices are valued, especially for equity investors. This is creating a bubble market, which, like the housing market, is not sustainable. Two, the rapid employee turnover is such that the reloading of personnel has a critical mass that will stop the growth potential."

What general dentists should bring to the discussion

Some observers point out that, more than a simple triumph of improved organization, the rise of managed group practices also represents the failure of traditional private practice. Many solo dentists have not reinvested in their practice, which hinders their ability to mentor, invest in, and train associates to whom they can transition the practice.

They may hire an associate, for example, but continue to perform high production cases themselves, leaving the new dentist with less productive and more difficult "leftover" cases. "If there were anything that would keep small private practices viable,"

Dr. House says, "it would be teaching senior doctors how to create a win-win situation with an associate doctor." Dr. House says this to dental students: If, as a new graduate, you are in a financial position to take a job with someone in private practice, you should. Listening to and watching an excellent dentist deliver care teaches you how to be a good dentist. You learn what to say and how to say it.

But the truth is that many private practice dentists who want an associate are not prepared to have one. They have not thought through how to keep another dentist productive—busy, perhaps, but not necessarily productive. The result may be that, for new dentists, working for a private practice dentist involves a lot of down time, hours that don't generate income. "The knowledge you gain may be priceless," Dr. House says, "but it doesn't make your student loan payment."

Dr. House also has some advice on how to approach an associateship discussion with a senior doctor. The ideal time, she says, is when the student is a year away from graduation. Also, it is important that the senior doctor evaluate such questions as where the new graduate will get patients; how work will be divided; who will check hygiene; whether or not the new graduate can do some hygiene; and if the graduate will be seating crowns, bridges, or dentures for the senior doctor, how that will be compensated.

Given the dearth of traditional associateships, Dr. Harunani believes managed group practices can offer genuine opportunities for new dentists. "Like a residency, corporate dentistry can be a great place to start," he says. "It can be a place to learn management skills and refine technical skills. But dentists must make sure that the group's philosophy of care is in tune with their own clinical, ethical, and moral standards."

Because there are many variables, each external management system must be evaluated individually, says Dr. Harunani, based on his extensive experience in both solo private practice and a successful DSO.

"Corporations are neither a good nor bad thing," he says. "There are great models and not-so-good models. Some are dentist owned, and some are not."

Regardless of who pays the utility bills and keeps the computers working, Dr. Harunani believes licensed dental professionals must retain control over the quality and delivery of their care. Non-dentists should not be able to set or change a treatment plan, dictate that one doctor can make a diagnosis and another one render treatment, or prohibit a treating dentist from selecting the dental materials or techniques to be used in a given case.

"My primary concern for associates and employees lies in the decision making," he says. "Who is planning treatment and choosing materials? Are those decisions based on sound clinical evidence, or are they financially driven?"

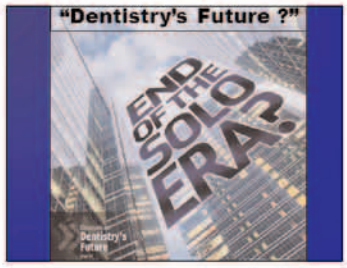
The fundamental exercise of professional control, Dr. Harunani believes, lies in diagnosis. "No one other than a dentist should be able to render a diagnosis," he says. "Even if it's just for sealants or fluoride, if we abdicate our power to diagnose and prescribe, we don't have a profession."

Eric K. Curtis, DDS, MA, MAGD, is the AGD associate editor, as well as an adjunct associate professor at the University of the Pacific. Dr. Curtis holds a certificate in professional writing from the University of Arizona and is certified by the Board of Editors in the Life Sciences. He maintains a private general dental practice in Safford, Ariz. To comment on this article, email impact@agd.org.

Reprinted with premission from the Academy of General Dentistry

The Current And Future State Of The Solo And Group Dental Practice

Dr. Doherty



Dr. Cooper

Dr. Doherty: *My passion has always been dentistry and my commitment is focused on how I can enable the members of our dental profession to be successful. My travels have taken me to all 50 states and every major meeting. I am honored to present my interview with one of the true masters of the dental world, Dr. Marc Cooper, founder and president of The Mastery Company. The focus of your company over the past six years has been on group practice of all sizes.*
The context of dentistry has changed. Dr. Cooper you have stated that we have reached a "break point" and it's not going back to the way it was. What makes you confident that you are correct about the future of dentistry?

Dr. Cooper: My background includes working in a number of other industries. I've worked in healthcare, hospitals and Fortune 500 companies. So, I am able to look at the future from a different perspective, which allows me to look from the outside in, giving me a perception of the future from a meta view. Most consultants look from the inside out; they've only been inside the dental industry. Therefore, I feel I can predict the future; specifically what will happen, probably not. But in general, where things are going to change? Absolutely.

Dr. Doherty: *What is the future of solo practice?*
Dr. Cooper: There will be a definite change in how the business of solo practice is performed. For the last 100 years, dental practice has been performed in small solo practices, with maybe one partner. That was sufficient in the system or the context that it was in. But the context has changed, and context is decisive. With the changed context, the system has changed. Solo or small partner practice will no longer have the viability that they did in the old context. In the old days, any dentist could just put up a sign and they were in business. Not anymore.

Dr. Doherty: *Okay, so where is dentistry today?*
Dr. Cooper: Today dentists are holding tightly on to the past, hoping that things will get better. But it's not going to get better. The changes that are occurring are dramatic and irreversible. When was the last time you saw a pay phone? It's been a while, right? So what happened? It's outdated. The current way solo doc's are practicing dentistry will soon be outdated. They can't practice like they did yesterday. What's going to occur is that the economy and the dental healthcare system are going to call for a greater capacity to treat more patients more efficiently, which simply can't be done within the solo practice model.

Dr. Doherty: *Are dentists getting ready to change their performance and learn what's necessary to practice dentistry in the future?*
Dr. Cooper: Unfortunately, no. My experience is that there is huge resistance to change. This is painfully evident when I am in front of an audience talking about future strategies for the dental profession. I truly feel the unrest that exists within the audience. They reveal their upset and anger when I present the news about what's happening with regard to dentistry's system, the new context and the new competition. Their reaction to these predictions of the future creates a lot of resentment in the room and the volume of their responses is overwhelming.

Dr. Doherty: *Why are most dentists not ready for your message?*
Dr. Cooper: They're afraid of the change. In Stephen Covey's book, Seven Habits of Highly Successful People, the first habit, "Be Proactive," needs to be read and re-read. The truth is, dentists don't want to hear that, but it is a truism that must be endorsed and repeated often. "If they want things to change, they have to change themselves."
Change is difficult and it's upsetting. The first slide in my PowerPoint presentation is one about the difference between the messenger and the message, because they really need to get the message. Dentistry has been permanently altered; it's changed and it's not going to go back to the way it was.

Dr. Doherty: *What makes you different from the other consultants?*
Dr. Cooper: Great question! The bene-

fits of our consulting are numerous. We have a whole orchestra of business resources that we can utilize. Other consultants have maybe one instrument and they have only one tune. Many consultants attempt to "fix" practices, but The Mastery Company is about the transformation of dentists as leaders and owners. I define transformation as the ability to think beyond your past, your identity and your personality, to think new thoughts, to provide a new way to see the future. We make every effort to assist our clients to develop strategies that will help them be successful in the future.

Dr. Doherty: *Is the objective to get doctors to think bigger? Larger? Help them have a larger vision?*
Dr. Cooper: Our relationship is like being a committed partner. Many clients have gone from single providers to multiple provider group practices with my coaching. Having taken this particular path, some end up with 7-8 practice locations. Therefore, I am engaged in various ways throughout the growth period of their transition from solo practitioner to group practice.

Dr. Doherty: *What is the vehicle that you utilize to convey your information to make these transitions a reality?*
Dr. Cooper: We have a curriculum called Get Smart in which we break them up into learning groups. Each learning group learns to operate as a Board of Directors. We train them how to think like a director. Not like an owner of a small business, but like a director of a major, for-profit corporation. At the end of the Get Smart program they are required to present a strategic plan, as a CEO of a large company. They are required to generate a model that is going to generate $25 million a year in business. Now the prize for this small group will be in terms of their ability to capitalize their futures. There is an awful lot at stake in this game.

Dr. Doherty: *Do you think you have the answers to change the world of dentistry implementing the different breeds of managed group practices?*
Dr. Cooper: Yes and no. There is no right answer. One size doesn't fit all. The variations in group practice are massive. I do think I have a way of coaching people to be able to see and act in a way that changes their future and enable them to create a group practice that fits their values and their region. It's about them, not about me. I am committed and convinced that I can help turn it around utilizing different models of managed group practice. I have done this with success.

Dr. Doherty: *Who is the typical client and what are the different services you offer?*
Dr. Cooper: I don't have a typical client, but I do have a range of clients. In addition to dentists, I coach and consult large group practices, insurance companies, biotechnical firms and companies throughout the supply chain in the area of dentistry. My typical client, though, is as much as anything else committed to success. Their driving intention is to make a difference with their lives and with their work.

Dr. Doherty: *How do you go about advising, consulting and coaching your clients to be successful?*
Dr. Cooper: We offer monthly coaching, some formal programs, in-house programs and education via the Internet. We have a pretty broad range of vehicles in which we deliver our consulting. I have also written several books. One of the most important books I have written is entitled "Mastering the Business of Practice". I also have clients learn from other masters such as Jim Collins, because it gives them a different perspective of what they're working on. I find that in dealing with doctors across the board, they will read business books and study business methods and strategies.

Dr. Doherty: *Describe the profile of your most successful practitioners?*
Dr. Cooper: We have discovered that the most successful practitioners are those that are the most coachable. With clients that are very coachable, I can predict that in the end their efforts will be rewarding. I find if you ask what's typical about the clients I work with, whether it's a third party, a technical firm, or a small concierge practice, they are great learners and they are coachable.

Dr. Doherty: *What's your success rate?*
Dr. Cooper: My success rate goes up and down the scale. You don't stay in this business unless you're successful. It's usually word of mouth that generates the referrals and the clients coming to us. So, helping dentists from solo practice to group practice is what I do. I am proud of our current record.

Dr. Doherty: *Let's jump into the future of dentistry. Where is it going and what are you doing to prepare dentists for that?*
Dr. Cooper: The future of dentistry is large managed group practice. Right now, if you go on social media or Dental Town, where you find conversations amongst dentists, most are very much opposed to managed group practice. The truth is that dentistry is going in that direction and they don't want to go there. They like working alone. Dentists are like eagles and eagles fly alone

Dr. Doherty: *Who and what are the major forces reshaping dental practice?*
Dr. Cooper: The amount of revenue generated in dentistry this year was $106 billion. It's a remarkable amount and more than the GDP of many countries. When you consider the money that is spent on dentistry, and the fact that it's going up 5-6% a year and is recession resistant, there is huge poten

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tial for the future of dentistry. The money markets see dentistry as a good place to put their money. Investors understand that larger group practice entities have a greater profit margin than the smaller solo practices. Also, they have a capacity to generate a greater market share. Therefore, the money from capitalists is beginning to rapidly move into dentistry, mostly into group practice formation and management.

Dr. Doherty: *How soon do you believe that's going to happen?*
Dr. Cooper: What will happen is that these larger entities (group practices) will force the little guys, the solo practice, out of existence. They are like a Home Depot, Costco or Walmart, who killed the mom-and-pop stores.In dentistry it's happening right now. There are entities called MSOs that have 300-500 practices under management and are acquiring or building 70-100 additional practices per year. It's ambitious; it's everywhere.

Dr. Doherty: *What are the options available to dentists?*
Dr. Cooper: Let's look at the dentist as an entrepreneur. Our Get Smart program, which I mentioned previously, is a transformational exercise where we take the small groups of dentists who generally think in terms of "I" and enable them to think "we."

Dr. Doherty: *Why aren't dental schools teaching their students entrepreneurship?*
Dr. Cooper: I was involved in teaching dental students and their capacity to take all this in is nil. Information without experience has no power. They have to be working in a practice to understand the game of business. And they have to have something at stake. When you're in dental school, the business of practice exists way over there. But when you're in practice and you have bills to pay and staff to pay, then this stuff has a deeper meaning and penetration.

Dr. Doherty: *Can this process be an easy transition, to bring on a partner or two partners?*
Dr. Cooper: It will be if you have the right structure, the right foundation, the right know how and utilize coaching with starting a business relationship. When you have money, ego and psychology in the game, it's tough. I have only found it to be easy when the commitment is larger than the individual. If it is about something that is beyond each individual, the answer to your question is, yes. If they are in it for the right reasons: not just to make money, but also to help people, it will be successful.
Take a look at Zappos, Intel and Starbucks. They are about something beyond the individual. They are about making an impact, generating something that leaves a legacy. If dentists can have that kind of character in their game, the transition is much more likely to be successful.

Dr. Doherty: *Do you operate like a dental specialist, to show dentists how to get it all together to form a managed group practice?*
Dr. Cooper: When I am speaking to a group of solo dentists and developing the idea of future strategies, I ask them, "How much money do you think is in this room?" People look around a bit absently because I'm asking them to consider a bigger picture. But for the purpose of the exercise, most practices generate between $800K-$1.2 million. Then I ask, "How many employees do you think you have?"
With these simple questions I can demonstrate to them that sitting in the room is the foundation for a $20-25 million company with 200 employees. This simple exercise demonstrates the potential they have access to with substantial money and resources behind them. And the collective result that could be accomplished over what the individuals in the room are currently doing.

Dr. Doherty: *Describe some of the other resources that are necessary to form a managed group practice.*
Dr. Cooper: Solo dental practices as small businesses cannot hire executive talent. They don't have the money. But in larger groups they can bring on CEOs, CFOs and human resources. They are able to bring in a potency that small businesses cannot. That's why the larger businesses, like the group practices, are going to gain momentum in the future of dentistry.

Dr. Doherty: *What about those dentists sitting around waiting or ignoring the problem?*
Dr. Cooper: Basically, they are blind. Solo practices with their business numbers are decreasing all over the place. I know regular guys who are successful clients in group practices that have figured it out. They understand now that working with ten to twelve to fifteen doctors, with access to larger facilities or a network of locations, they can access the potential and capacity to reach every economy, and get good high-paying executive talent as well. And they can generate the money.

Dr. Doherty: *Is insurance a major force that is going to reshape the dental practice?*
Dr. Cooper: Insurance companies are under the same influences as medical insurance companies. The purchaser now is the employer and they want to know what they are getting for their insurance investment. Now they are asking dental insurance companies to give them the same thing, so there's an influence about results and outcomes that never had to be reported before by dentists to third parties. The influence

of these insurance companies is very strong and will only get stronger.

Dr. Doherty: *What should tenured dentists do now?*
Dr. Cooper: Those doctors are looking for an exit strategy. Their only realistic exit strategy might be these large DSO corporations who are buying/purchasing dental practices. So, right now, they have a pretty good opportunity. Lots of practices are going this way, so it's not a seller's market any longer. The final glitch is that younger dentists are freaked out because of their student debt which on the average is about $250-300K and less than 20% of dentists that get out of school are seeking ownership.

Dr. Doherty: *Are you optimistic about future of dentistry?*
Dr. Cooper: I think the future is going to be fabulous. By 2019, this is going to be a $180 billion industry. There are still 100 million people that don't even get care, so if access to care starts happening more and more, dentistry will be a good profession to be involved in. There are seven new dental schools and they are graduating dentists more than ever, but the population is growing faster than the number of dentists being produced. So, there will be more pressure and more market share available for dentists than ever before.

Dr. Doherty: *For doctors reading this interview, how do they go about getting involved with you?*
Dr. Cooper: I offer a free consultation to find out if what we do is a good fit. I want to know whom I am dealing with and whether the person is up to a game worth playing. If it's only about their survival, there are other ways to go about doing this. But what I am really looking for is people who are up to making a difference and changing the face of dentistry. I can be reached at info@masterycompany.com

About The Doctors

Dr. Marc Cooper's professional career includes private periodontist, academician, researcher, teacher, practice management consultant, corporate consultant, trainer, seminar director, board director, author, entrepreneur and inventor. Dr. Cooper is founder and President of the MasteryCompany.com and his client experience in dentistry includes solo private practice, small-partnered practices, and managed group practices. Dr. Cooper has authored seven successful books; his electronic newsletter reaches thousands of subscribers in 31 countries. Dr. Cooper also co-developed a suite of online dental practice management assessment tools. You can contact him at 425-806-8830.

Dr. Hugh Doherty is a Certified Financial Planner, national speaker, author, business and financial coach to the dental profession. He founded and is CEO ofBusiness of Dental Practice LLC, a company dedicated to coaching only dentists to develop and implement cutting edge business strategies. His varied background in the field of dentistry, years of research and study at Harvard University Graduate School of Business and the College of Financial Planning, make him uniquely qualified to educate in all aspects of the business and financial world. He can be contacted by email, hughdohertydds@comcast.net.

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Receive $200 through member referral program

Dentists who refer a new tripartite member to CDA can receive a $100 check from CDA and a $100 American Express gift card from the ADA.

The $200 reward is part of the Member Get a Member campaign, which provides incentives for every CDA member dentist who refers a new member to the tripartite membership (for a total maximum of $1,000 per referring member).

The combined campaign lasts through Sept. 30, after which time members will still receive $100 from CDA.

To receive credit for a referral, applicants must include the name of the member who referred them to membership on a CDA membership application.

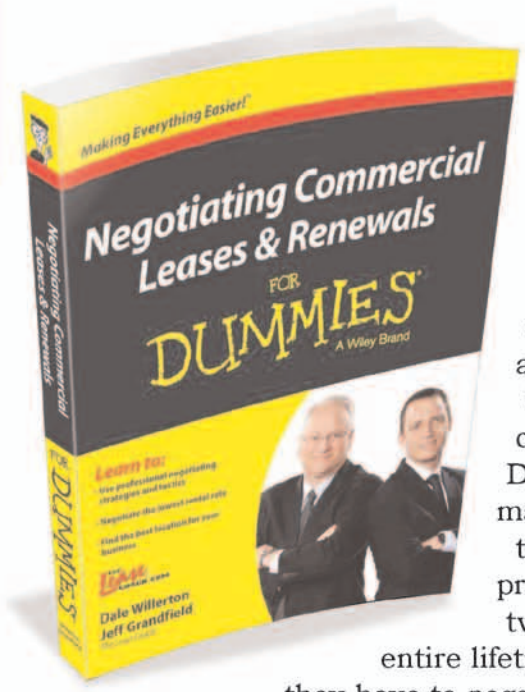
There are many advantages to being a part of organized dentistry, but here are a few key benefits:

- Legislative advocacy;
- *CDA Presents* continuing education — free admission for the San Francisco and Anaheim meetings;
- TDIC insurance — member-only access and risk management hotline;
- Practice support services — cda.org/practicesupport; and
- CDA publications.

To find out if a dentist is a current tripartite member, visit cda.org and search under "Find a CDA Dentist."

- **For more information on Member Get a Member**, visit cda.org/mgm.

Negotiate Your Dental Office Lease or Renewal



For many dentists, negotiating a good lease or lease renewal against an experienced agent or land lord can be challenging. Dental tenants may go through the leasing process once or twice in their entire lifetime – yet they have to negotiate against seasoned professionals who negotiate leases routinely for a living.

Here are some tips:

Negotiate to Win: Often, dentists enter into lease negotiations unprepared and don`t even try winning the negotiations. Without negotiating to win, you won`t. With big commissions at stake, you can be sure the landlord`s agent is negotiating fiercely to win. Remember it's okay to negotiate assertively.

Be Prepared to Walk Away: Try to set aside your emotions and decide objectively. Whoever most needs to make a lease deal will give up the most concessions. A good dental office in a poor location may not achieve its full potential.

Ask the Right Questions: Whether it's a new lease or a renewal, learning how much rent other tenants are paying or what incentives they received will position you to get a better deal. Consider that your landlord and his agent know what every other tenant in the property is paying in rent, so you must do *your* homework too.

Brokers ... Friend or Foe? Real estate agents and brokers typically work for the landlord who is paying their commission. The higher the rent you pay, the more commission the agent earns. When researching multiple properties, try to deal directly with the listing agent for each property, rather than letting one agent show you around or show you another agent`s listing. Your tenancy is more desirable to the listing agent if he can avoid commission-splitting with other agents.

Never Accept the First Offer: Even if the first offer seems reasonable, or you have no idea of what to negotiate for, never accept the leasing agent`s first offer. In the real estate industry, most things are negotiable and the landlord fully expects you to counter-offer.

Ask for More Than You Want: If you want three months free rent, then ask for five months. No one ever gets more than he/she asks for. Be prepared for the landlord to counter-offer and negotiate with you as well. Don`t be afraid of hearing `no` from the landlord – counter-offers are all part of the game.

Negotiate the Deposit: Deposits are not required and are negotiable. The Lease Coach is frequently successful in negotiating for the dental tenant's deposit to be refunded upon a lease renewal.

Measure Your Space: Some dental office tenants are paying for phantom space. Most tenants are paying their rent per square foot, but often they are not receiving as much space as the lease agreement says.

Negotiate, Negotiate: The leasing process is just that – a process, not an event. Too often, tenants mistakenly try to hammer out the deal in a two- or three-hour marathon session. It is more productive to negotiate in stages over time.
Educate Yourself and Get Help: Unless you

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have money to throw away, it pays to educate yourself. Taking the time to read about the subject or listen in on a leasing webinar will make a difference. And, don`t forget to have your lease documents professionally reviewed before you sign them.

For a copy of our free CD, *Leasing Do's & Don'ts for Dental Tenants,* please e-mail your request to DaleWillerton@TheLeaseCoach.com.

By: Jeff Grandfield & Dale Willerton

Dale Willerton and Jeff Grandfield - The Lease Coach are Commercial Lease Consultants who work exclusively for tenants. Dale and Jeff are professional speakers and co-authors of Negotiating Commercial Leases & Renewals For Dummies (Wiley, 2013). Got a leasing question? Need help with your new lease or renewal? Call 1-800-738-9202, e-mail DaleWillerton@TheLeaseCoach.com or visit www.TheLeaseCoach.com.

California Supreme Court Decision Preserves MICRA cap

By: CDA Staff

In March, the California Supreme Court sent a clear message that it will not be accepting arguments on the constitutionality of MICRA's non-economic damages cap at this time. This is very good news for CDA and other members of a statewide coalition that played a significant role in the November defeat of Proposition 46, an attempt to significantly increase the $250,000 cap on non-economic damages in medical malpractice lawsuits.

The California Supreme Court sent a case that had been pending prior to the election, challenging the constitutionality of the MICRA cap, back down to the appellate court. The case, Hughes v Pham, is a medical professional negligence case in which MICRA's non-economic damages cap was applied. The plaintiff challenged the constitutionality of the cap but the Fourth District Court of Appeal upheld the cap as constitutional.
The plaintiff then petitioned the California Supreme Court to review the case. The Supreme Court issued a "grant and hold" order on the petition pending its decision in Rashidi v Moser, a case with similar issues.

CDA participated in the coalition's filing of an amicus ("friends of the court") brief in both cases supporting the cap's constitutionality. When the Supreme Court's "grant and hold" order was issued in Hughes, the trial lawyers proclaimed that the order meant that the Supreme Court was going to review the constitutionality of MICRA's non-economic damages cap.

Last week's order from the Supreme Court makes clear that that the trial lawyers were wrong. The constitutionality of MICRA's non-economic damages cap remains intact.

For more information on how CDA members helped defeat Proposition 46, read this article from November (http://www.cda.org/news-events/cda-members-help-defeat-proposition-46).

Antelope Valley Report

By: Kathy McKay

Hi Desert Childrens Dental Clinic to benefit from the 21st Annual Thunder on the Lot Event.

Each year Kids Charities hosts the Thunder on the Lot event. Kids Charities now serves more than 30 local children's charitable organizations. The organization's goal is to help the children in the community who need it most. Since its inception, Kids Charities has raised more than $4 million dollars to assist Antelope Valley children. Kids Charities has five primary functions:

1. Fundraising to raise money and in-kind donations efficiently
2. Community Service to promote and coordinate volunteer support of service providers.
3. Fund Distribution to distribute charitable funds to the most effective service providers.
4. Community Building to build alliances among charities, businesses and other entities in support of the community.
5. Publicity to execute support through events, promotions and awareness campaigns.

DATES OF EVENT: JUNE 27 & 28, 2015
TIME: SATURDAY – 2:00 PM – 11:00 PM
SUNDAY – 10:00 A.M. – 6:00 PM
EVENT LOCATION: LANCASTER CITY PARK
43011 10TH STREET WEST
LANCASTER, CA 93534

For more information on this event go to:
www.thunderonthelot.com

Glendale/Burbank/Foothills Report

By: Chi Leung, DDS

Happy Spring!

This has been an exciting new season and we've made significant progress this month in the Glendale/Foothills area. I've been continuing our efforts to visit more dentists in the area. One of my recent trips included a visit to members Dr. Bruce Johnson in Montrose, and Dr. Vahik Paul Meserkhani in Glendale. For the past 15 years, Dr. Meserkhani has been teaching for the Zimmer Implant Company.

We're also planning to have a Speed Pairing session in Burbank on June 4, which is a great opportunity for members looking to either buy or sell a practice. Just like 'speed dating', this 2-hour program allows potential buyers and sellers to meet one another and find that right chemistry to start a negotiation and ultimately close the deal with each other.

We're also working on a CPR class for dentists and staff members in the Glendale area - stay tuned and watch your emails from the central office for dates and locations!

Dr. Bruce Johnson and Dr. Chi Leung, the Glendale/Foothills Liaison to the SFVDS Board of Directors at Dr. Johnson's office in Montrose.

Welcome New Members

Jangsook Kim, DDS
23501 Cinema Dr. Ste 114
Valencia, CA 91355
661-253-3030
General
USC, 1999

Vanessa Sanderson, DDS
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General
661.947.9990
Universidade Guarulhos, Brazil, 2001

Maral Khazali, DDS
General
USC, 2012

Jeremiah Beisel, DDS
General
UCLA, 2013

Michael D'Egidio, DDS
21029 Devonshire St.
Chatsworth, CA 91311
818.998.6446
General
USC, 1980

Ram Saravanan, DDS
16311 Ventura Blvd. Ste. 200
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General
818.789.0555
USC, 2006

Joseph Morcos, DDS
Periodontics
Boston University, 2013

Navid Zamani, DDS
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Sherman Oaks, CA 91403
818.788.7711
General
Tufts, 1995

Vicken A Derbalian, DDS
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Tarzana, CA 91356
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General
USC, 1987

Hyungrim Oh, DDS
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General
Chosun University, Korea, 1996

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General
UOP, 1991

Ramya Chelimela, DDS
General
University of Colorado, 2013

Barry Margolis, DDS
General
Tufts University, 1982

Jeremiah Beisel, DDS
General
UCLA, 2013

Christy Lee, DDS
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Lancaster, CA 93535
661.942.1179
General
Nova Southwestern, 2013

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