December 2013
Volume 88 Issue 12

OHIO DENTAL ASSOCIATION
Informing - Representing - Serving

ODA Today

A publication of the Ohio Dental Association focusing on dentistry in Ohio

QuickBites

dentistry in 2050

This month, the "ODA Today" is taking a look at the future of dentistry. Throughout this issue, you will find columns, articles and a Q and A about what dentistry will look like in 2050.

Although no one knows what the future holds, our columnists all speculate about what awaits the profession in 2050.

To read what they have to say, see page 12.

Inside

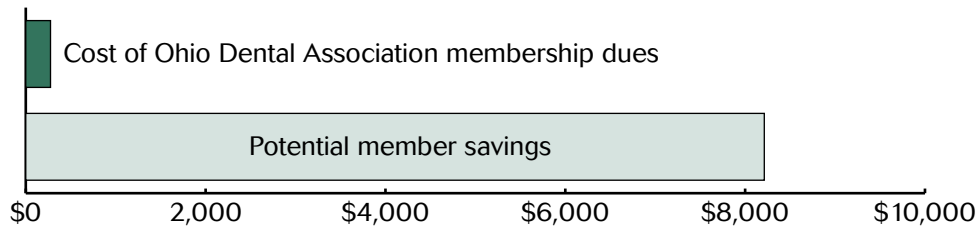
Cost-benefit analysis: ODA dues save members money

By ODA Staff

The Ohio Dental Association has the second lowest dues rate in the country at $275 for active members.

The cost of state dues range from $210 in Utah to $1,205 in Alaska, and the average cost of state dues is $500.

In return for such low dues, ODA members receive a wide range of benefits that save them money. Members can save enough money to more than cover the cost of their dues, including local society and American Dental Association dues by taking advantage of all options listed below. In total, ODA member dentists could save up to $8,213 annually.



Recent advocacy initiatives alone have been able to save dentists in Ohio $2,900 in potential costs.

See SAVINGS, page 11

Potential savings available to ODA Members

ODA advocacy initiatives that save you money

Initiative	Estimated Savings	Details
Prevented implementation of new taxes	$1,000	Based on stopping a proposal to extend sales tax to certain dental services
Maintained Exemption for Small Generators of Waste	$1,000	Based on the cost of waste hauler fees
No Statewide Mandate for Amalgam Separators	$700	Based on the cost of an Amalgam separator
No New License for Terminal Distributor of Dangerous Drugs	$150	Based on the cost of proposed licensing fee
No New CE mandates in Human Trafficking	$50	Based on the cost of mandatory CE course
	Total: $2,900	

ODA services that can save you money

Service	Estimated Savings	Details
Insurance Contract Analysis Service	$400	Based on an estimated cost of an analysis from an attorney
General Legal Guidance from ODA Staff	$200	Based on the average cost per hour of an attorney
Continuing Education	$350	Based on a $250 savings for members at Annual Session, plus up to a $100 discount for an Annual Session course
Classified ads	$33	Based on cost for members versus non-members
"ODA Today"	$100	Based on yearly subscription fee for non-members
	Total: $1,083	

An example of ODASC products that can save you money

Product	Estimated Savings	Details
Health Insurance	$300	There is no monthly billing fee so an office can save $25 a month without even accounting for individual plan savings
Professional Liability Insurance	$75	5 percent annual discount. Average annual premium $1,500
Disability Insurance	$400	10 percent annual discount. Average annual premium $4,000
Credit Card Processing	$1,200	Average office savings of 23 percent annually
Electronic Claims Processing	$600	Based on 200 claims per month X .25 per claim savings
Automated Patient Communication System	$360	$30 per month discount on Lighthouse 360 monthly fee
Website	$465	ProSites offers members a 25 percent discount on website building;savings based on basic website priced at $1860
Workers' Comp Group Rating	$495	Based on maximum discount for an office of six staff
Personalized Whitening Gel Syringes	$200	Compared to similar products (46 kits annually)
SUV Disinfectant	$50	Free shipping and spray bottles
Sterilizing Test Strips	$85	Compared to the cost of similar services
	Total: $4,230	

Total savings available to ODA Members: $8,213

These savings are an example based on a typical office. Depending on the size of your office and other circumstances, savings may vary by practice.

ODA members attend ADA Annual Session, ODA director of public service receives Give Kids A Smile award

By ODA Staff

Kathy Woodard, Ohio Dental Association director of public service, received the 2013 Jeffrey Dalin, D.D.S. Give Kids A Smile Volunteer Award at the American Dental Association Foundation's Give Kids A Smile Gala during the ADA's Annual Session in New Orleans on Nov. 1.

The award recognizes the winners' efforts to expand the GKAS program to reach even more underserved children.

Woodard received the award from the ADA for her work over the past 11 years to provide support services to volunteers who donate care to underserved children in Ohio through the Give Kids A Smile program, according to a news release from the ADA.

She organizes the resources that help make Give Kids A Smile events happen, freeing dentists and their staffs to focus on providing care. From working with a site to find uninsured children in need of dental care, to contacting legislators and media to

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Photo by EZ Event Photography, courtesy ADA News. © 2013 American Dental Association

Kathy Woodard, ODA director of public service, receives the 2013 Jeffrey Dalin, D.D.S. Give Kids A Smile Volunteer Award. Presenting the award to her are from left Dr. David Whiston, ADA Foundation president; Steven W. Kess, Henry Schein Inc.; John Stefanick, 3M ESPE.

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www.oda.org

The Director's Chair

David J. Owsiany, JD
ODA Executive Director

Organized Dentistry: Past, Present and Future

I read with great interest what the other "ODA Today" columnists predicted regarding what the dental profession will look like in 2050 (see pages 13-14). While I am not exactly sure what dentistry will look like in 37 years, I know the Ohio Dental Association will still be thriving by representing the interests of dentists and their patients.

The ODA was founded in 1866. Over its 147 years of existence, the ODA has changed along with the dental profession because it has been led by its member dentist leaders, who are committed to protecting dentists and their patients and profession.

The dentists of Ohio came together to create the Ohio State Dental Society, as it was called back then, for the following purposes:

- to foster "mutual fellowship and recognition" within dentistry,
- to promote "the honor, usefulness and recognition of the profession,"
- to advance and cultivate the "professional science and literature" of dentistry,
- to encourage a "more thorough professional education" for dentists, and
- to enhance "protection of the public."

These goals are still the goals of organized dentistry today. At the Ohio State Dental Society's founding, Ohio's dentists drafted and adopted one of the first written codes of ethics for the dental profession. This code directed dentists to treat patients with sympathy, respect fellow dentists and protect the public from charlatans.

This ethical code began the process of putting the dental profession on the road to becoming the respected and trusted profession it is today. Two years later, the Ohio State Dental Society worked to get the Ohio legislature to pass one of the first dental laws. The new law sought to "do away with quackery," which apparently was quite a problem back in 1868. Many of the leaders of the Ohio State Dental Society served on the original board of dental examiners, which was created by the new law.

Establishing formal dental education programs was a priority for the Ohio State Dental Society back then. In the 1800s, many dentists had no formal training and learned as apprentices. By 1901, Ohio boasted as many as five dental schools, but many were financially strapped and poorly run proprietary schools. The Ohio State Dental Society, working with the board of dental examiners and established universities, sought to stabilize and formalize dental education to ensure the art and science of dentistry were being advanced and taught competently to students. This effort helped lead to the creation of the dental schools that currently exist at both Case Western Reserve University and The Ohio State University.

As dentistry became a more formal and respected profession, dentists needed more information about dental regulations and advancements in dentistry. Accordingly, to meet the needs of Ohio's dentists, in 1927 the Ohio State Dental Society began publishing and distributing bulletins and a journal to "place in the hands of our members, items of general interest" related to dentistry. The ODA continues to place such items of general interest into our members' hands today through publications like the "ODA Today," and our electronic communications, including the "NewsBytes" email newsletter, "generationD" for Ohio dentists out of dental school 10 or fewer years and our social media platforms, including ODA's Twitter feed. And, just like dentists from a century ago, ODA members continue to appreciate these publications today. According to our most recent membership survey, the "provision of information" is the second most valued membership benefit (just behind legislative and regulatory advocacy). We consistently get feedback from our members on how valuable the information we provide is.

Scientific evidence in the first half of the last century suggested that fluoride in drinking water prevents tooth decay. In 1950, the ADA passed a resolution encouraging water fluoridation. Over the next two decades, local dental societies in Ohio and the Ohio State Dental Association (in 1947 the Ohio State Dental Society became the Ohio State Dental Association and the name was again changed in 1967 to the Ohio Dental Association) advocated to fluoridate water systems across Ohio. In 1969, the state legislature enacted a law requiring municipalities to fluoridate their water systems unless they opt out via a local ballot issue. Today, more than 90 percent of Ohioans live in communities with fluoridated water systems, which is well above the national average of 66 percent. Organized dentistry in Ohio was a leader in encouraging water fluoridation, which has been recognized by the Centers for Disease Control and Prevention as one of the top 10 greatest public health achievements of the 20th Century.

In the 1970s, dental insurance and other dental benefit plans emerged as significant players in the marketplace, and organized dentistry responded by working to ensure that insurers do not interfere with the dentist-patient relationship and to educate dentists to ensure they understand the impact of any decision they make related to dental benefit plans.

In the last half of the 20th Century, research on infectious diseases and appropriate sterilization in the dental office led organized dentistry to push for the adoption of infection control laws, regulations and standards that ensure the provision of dental care in America is the safest in the world. Over the last several years, sensational media stories – both in Ohio and nationally – surfaced questioning the safety of dental care and dental materials. In each instance organized dentistry was able to point to these standards to demonstrate that dental care in Ohio and across the country is the safest in the world.

As the practice of dentistry has changed over the last several decades, so has the role of auxiliary personnel in the dental office. One hundred and fifty years ago, dentists provided their services with little or no professional assistance in the office. Technological advancements and the accessibility of dental assisting and dental hygiene education have enhanced the dental team, making the delivery of care more efficient and effective. By the 1970s, Ohio became one of the first states to authorize the use of Expanded Function Dental Auxiliaries to assist dentists in performing restorative procedures. Over the years, the ODA has worked to ensure

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that Ohio's laws allow dentists to utilize dental auxiliaries to the full extent of their capabilities, with appropriate training and supervision.

My point of taking this trip down memory lane is to remind you that dentistry has changed dramatically over the last 147 years. No one could have imagined back then the changes that would occur. One hundred and fifty years ago, dental care often just meant "tooth pulling" services offered by a barber or blacksmith. The tools were primitive and the science related to oral health was yet undiscovered. But dentistry changed when organized dentistry was born. Organized dentistry was the vehicle that made dentistry into a true profession, consistently pushing to modernize and advance both the art and science of dentistry. And organized dentistry continues those efforts today.

For nearly 150 years, from the provision of valuable information and services and the promotion of professional ethics and dental education to advocating for changes to ensure dental laws and regulations reflect the latest science and marketplace changes, the dentist-leaders of the ODA and organized dentistry at all levels have worked for the best interests of dentists and their patients. And regardless of what the future holds, that will never change.

Nominations sought for ODA vice speaker position

A call for nominations is now extended for the position of the Ohio Dental Association vice speaker of the House of Delegates. According to the ODA's bylaws, candidates for this appointed position must be an Active, Retired or Life member in good standing of the ODA. The term of office for the vice speaker is one year.

Candidates for the position should be a registered and/or certified parliamentarian or working to obtain his/her parliamentarian certification and should also possess a knowledge and familiarity with the ODA's bylaws. Additionally, candidates should have an understanding of, or be willing to develop an understanding of, the ODA's parliamentary authority, which is the "American Institute of Parliamentarians Standard Code of Parliamentary Procedure."

The vice speaker of the House of Delegates assists the speaker of the House of Delegates and parliamentarian during the ODA House of Delegates meetings, including presiding over the ODA House of Delegates meetings if needed.

Candidates should submit their curriculum vitae and a brief cover letter explaining why they are appropriate to hold the vice speaker position – for example association experience, leadership competencies, etc., to the ODA Executive Director, 1370 Dublin Road, Columbus, Ohio 43215 or at david@oda.org by Dec. 31, 2013.

ADA, from page 1

create awareness locally and statewide, to finding additional sources of product donations, Woodard works to make each event successful.

"Knowing that this program is about helping children in need — and that Ohio dentists care so much — is what matters," Woodard said. "It is because of each dentist who has participated in Give Kids A Smile Ohio since 2003 that I am receiving this honor, and I thank them all."

More than 194,000 children have participated in a GKAS Ohio program since 2003, averaging 17,000 children treated each year. More than $10,000,000 in volunteer dental services has been provided to Ohio's children since 2003, with an average of 2,355 volunteers participating annually.

For more information about participating in the 2014 Give Kids A Smile program, contact Woodard at (800) 282-1526.

In other business, the ODA had 16 delegates, 16 alternate delegates, plus ODA secretary Dr. David Waldman, 7th District Trustee Dr. Joe Crowley, and ADA Treasurer Dr. Ron Lemmo attend the ADA House of Delegates meetings held during the ADA Annual Session.

These delegates and alternate delegates, who were selected by their Ohio peers at the local level, participated in discussions regarding various resolutions governing the internal operations of the ADA and setting ADA policy.

The delegates approved the 2014 ADA operating budget, which does not include a dues increase. The Board of Trustees anticipates positive gains in revenues in 2014.

The ADA Annual Session also included opportunities to receive Continuing Education, an exhibit hall, several speakers and forums, and special events including a new dentist reception.

ODA Meeting & Event Calendar

Dec.

6 Subcouncil on Dentists Concerned for Dentists
24-25 ODA office closed for Christmas holiday
31 ODA office closed for New Year's holiday

Jan.

1 ODA Office Closed for New Year's Holiday
10 Council on Access to Care and Public Service (call)
15 Council on Dental Care Programs and Dental Practice
16-17 Executive Committee
17 Leadership Development Committee

Call for nominations extended for OSDB member

A call for nominations is now extended for the position of dentist board member for the Ohio State Dental Board.

The Ohio Dental Association has the opportunity to recommend nominees to the Governor of Ohio for three possible dentist board member openings on the Ohio State Dental Board (OSDB), which may be vacant in April 2014. Two of these board member positions are for general dentists and the third board member position is for a dental specialist (other than a periodontist, which is already represented on the OSDB).

The ODA Executive Committee is seeking potential candidates who are interested in serving in this capacity on the Ohio State Dental Board. The term of office for Ohio State Dental Board members is four years. The OSDB meets on average eight to nine times per year.

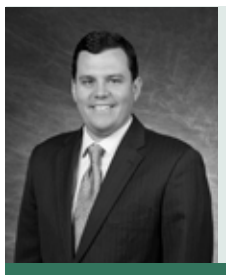
Criteria that the ODA Executive Committee is seeking in candidates includes:

- being in practice at least five years
- being familiar with Ohio's Dental Practice Act
- having knowledge about regulatory issues related to dentistry
- having a history of support/involvement with ODA governmental affairs and activities such as Ohio Dental Political Action Committee (ODPAC) membership, grassroots efforts, etc.

Please send a nomination letter along with the nominee's curriculum vitae to the ODA Executive Director, 1370 Dublin Road, Columbus, OH 43215 by Dec. 31, 2013.

Have a question? Contact the Ohio Dental Association!

dentist@oda.org | (800) 282-1526 | (614) 486-2700



Legal Briefs

Keith Kerns, Esq. ODA Director of Legal & Legislative Services

Dental license renewal due by end of year

This fall, dentists and dental hygienists should have received licensure renewal information from the Ohio State Dental Board. As was the case during the last several renewal periods, the board will direct licensees to renew licenses and report continuing education requirements online. The information and payment of the renewal fee is due by Dec. 31.

The basic requirements of licensure renewal are unchanged from prior years.

Dentists must complete 40 hours of continuing education by the end of the biennium. If the board believes that the dentist has failed to complete the requirement, the board must pursue disciplinary action against the dentist as a matter separate from a renewal violation. Separation of these two issues provides the dentist accused of a deficiency with due process protections and a forum to submit proof of their compliance with the CE requirement rather than face automatic license discipline.

Dentists who have obtained CE credits through the Ohio Dental Association Annual Session can download and print their CE slips by visiting www.oda.org.

Dentists who fail to file the renewal paperwork and/or submit the fee by Dec. 31 no longer are automatically suspended from practice and will be sent a notice from the dental board. The dental board must send this notice via certified mail no later than Jan. 31, 2014.

This grace period allows the dental license to be renewed with the submission of the paperwork, the payment of the biennial registration fee of $245 and the payment of a late fee in the amount of $100 at any point until April 1. The dentist's license remains valid and in good standing during the grace period as long as the dentist remains in compliance with all other aspects of the dental practice act.

If a dentist fails to submit the necessary paperwork, renewal fee and/or the late fee by April 1, then the board may initiate disciplinary action against the dentist in order to suspend the dentist's license. A license that has been suspended as a result of this disciplinary action can be reinstated with the payment of the biennial registration fee and an additional fee of $300.

Dentists are wise to be proactive on licensure renewal. Any dentists or dental hygienists who have not yet received renewal information from the board should contact the board immediately in order to obtain the information.

For more information on the license renewal process, please contact the ODA department of government affairs at (800) 282-1526.

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CHICAGO DENTAL SOCIETY
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Registration is just around the corner. Avoid lines, guarantee the courses you want and save money by registering early. Registration begins Nov. 1. Find more information at **http://on.cds.org/MWMod14**.

Members get in for free!

The Chicago Dental Society offers **FREE REGISTRATION to the MIDWINTER MEETING*** to member dentists.

Even if you do not live in the Chicago area, you can still join as an associate member. Learn more at **http://on.cds.org/MBRod14**.

**Does not include fees for courses or special events tickets.*

Dental Insurance Corner

In-office dental plans

Christopher A. Moore, MA
ODA Director of Dental Services

The Ohio Dental Association has recently fielded questions related to dentists offering their own in-office dental plans. These in-office dental plans have many different permutations off of the same general principle: for a fee, the consumer gets a membership in a plan that affords him or her access to various free and/or discounted dental services in the dental practice that is selling the plan.

Some dentists utilize the services of a third-party that has already developed a turn-key in-office dental plan operation, including marketing and enrollment services. Other dentists go the do-it-yourself route and develop their own plan and everything that goes along with it.

The dentist selling the plan typically markets it to his or her current patients who do not have dental benefits from another source, though some dentists have sent marketing materials to the general public and not confined their marketing to only their patients.

For a fee the consumer receives a membership in the dentist's in-office dental plan. Some dentists charge a monthly membership fee and others charge an annual fee. Oftentimes the consumer's membership is automatically renewed unless it is cancelled in writing. It is unclear which party, consumer and/or dentist, has the authority to issue the written cancelation.

In return for the membership fee, the consumer may receive certain dental services at no charge and fee discounts on others that are provided by the dentist who sold them the plan. The discounts range from a defined fee schedule to a percentage off the dentist's fee for the covered service.

The benefits are not typically transferrable to another dental practice.

> Have your attorney review your in-office dental plan before making it available.

Some plans have waiting periods and/or a minimum length of time that the consumer must be enrolled before receiving dental services while others do not. Some have riders enabling consumers to purchase coverage of additional dental services. Most plans have co-payments for certain services and defined benefit limitations and exclusions.

Regulatory issues

There is no single in-office dental plan on the market. The regulatory status of their many variations is somewhat uncertain. The Ohio Dental Practice Act governs the practice of dentistry in Ohio, not the selling of dental benefit plans. The statutes and regulations governing insurance in Ohio are enforced by the Ohio Department of Insurance (ODI).

While much of the language that is used has a connotation of dental insurance, marketing materials that are produced by third party services and dentists are careful to state their in-office dental plans are not insurance.

"The ODA is unaware that ODI has reviewed any of these plans to either verify or refute these claims," said Dr. Manny Chopra, chairman of the Council on Dental Care Programs and Dental Practice. "Simply saying an in-office dental plan isn't insurance or regulated does not mean that the regulatory authorities will necessarily agree. It is imperative that dentists who want to create these types of plans only do so with a complete and thorough understanding of the laws that may regulate them."

Discount medical plans are regulated by ODI. They are defined as "a business arrangement or contract in which a person, in exchange for fees, dues, charges, or other consideration, offers access to members to providers of medical services and the right to receive discounted medical services from those providers." Dental care services are included within the law's definition of what is considered to be "medical services."

Services offered through a discount medical plan may only be provided pursuant to an agreement between the discount medical plan organization (i.e., the "person who does business in this state; offers to members access to providers of medical services and the right to receive discounted medical services from those providers; contracts with providers, provider networks, or other discount medical plan organizations to offer discounted medical services to members; and determines the fee members pay to participate in the plan") and the health care provider. Some of the points that must be addressed in this agreement include: "a list of medical services and products offered at a discount, the discounted rates for medical services or a fee schedule that reflects the provider's discounted rates and a statement that the provider will not charge members more than the discounted rates."

Discount medical plan organizations that utilize third parties to "market, promote, sell or distribute a discount medical plan" must have a written agreement with the marketer. The discount medical plan organization is bound by and responsible for a marketer's activities that are within the scope of the marketer's relationship with the organization.

Discount medical plan information that is supplied to the public must include numerous disclosures. Some of these include: a statement that the plan is not insurance; benefits provided under the plan; any waiting periods for certain medical services under the plan; cancellation and refund rights; membership renewal, termination and cancellation terms and conditions; and procedures for filing complaints with the

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ODA members who would like to submit a dental insurance related question, problem or concern may do so by sending the appropriate information to the ODA Dental Insurance Working Group, 1370 Dublin Road, Columbus, OH 43215, or 614-486-0381 FAX, or chrism@oda.org.

Clinic connects volunteers with kids in need of oral health care

By Jackie Best
Managing Editor

KidSMILES Pediatric Dental Clinic in Columbus brings together volunteer dental professionals with children in need of care, plus provides oral health education to students at area schools.

The clinic treats children up to age 18 who do not qualify for Medicaid or have private insurance and whose families have a household income of less than 250 percent of the federal poverty level. Patients pay $10 per visit, no matter what kind of treatment is needed or how many times they've been to the clinic, and all care is provided on a volunteer basis.

Dr. Jim Homon, president and founder of KidSMILES, first got the idea to start the clinic several years ago when reading an article about access to care in the "Journal of the American Dental Association." An Ohio Dental Association member, Homon thought one solution to help provide care to more patients would be to create a non-profit clinic where dentists, hygienists, assistants and staff could volunteer their time without having to do it in their office, and patients could receive continuous care for a nominal fee.

Submitted photo
A volunteer sees a patient at the KidSMILES Pediatric Dental Clinic in Columbus.

"With a coordinated effort, we can have several volunteers work on the same patient and have coordinated care," Homon said. "It's a win for everyone."

Volunteers are only required to spend one day a year at the clinic, and dentists are encouraged to bring their entire staff to volunteer for a day.

"We encourage offices to do it as an office as a team building experience. It's fun for them and is good team building,

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discount medical plan organization and ODI.

Among other restrictions, a discount medical plan organization is prohibited from using in its "advertisements, marketing material, brochures, or discount medical plan cards the terms 'health plan,' 'coverage,' 'benefits,' 'copay,' 'copayments,' 'deductible,' 'preexisting conditions,' 'guaranteed issue,' 'premium,' 'PPO,' 'preferred provider organization,' or any other terms in a manner that could mislead a person into believing that the discount medical plan is health insurance."

Consumers must be permitted to cancel their membership in a discount medical plan at any time.

If a discount medical plan organization cancels a consumer's membership for any reason other than the consumer's failure to pay fees, then it must provide the consumer with a pro-rated reimbursement of all periodic fees charged, less nominal fees associated with enrollment.

Violations of the laws governing discount medical plans can be subject to ODI disciplinary action. These actions may include civil penalties of up to $25,000 per violation, assessment of administrative costs to cover the expenses ODI incurred in pursuing the violation, restitution to consumers and other correction actions.

Other considerations

In addition to the regulatory concerns, the ODA's Council on Dental Care Programs and Dental Practice identified the following issues for dentists to consider before putting their name on an in-office dental plan that is sold to the public:

- Have your attorney review your in-office dental plan before making it available.
- How do you handle situations involving consumers who purchase your in-office dental plan but do not disclose that they already have dental benefits?
- How do you handle situations involving consumers who obtain dental benefits after they have purchased your in-office dental plan?
- Are your in-office dental plan's benefits transferrable to another dentist, consumer or patient?
- If you have participating provider agreements with other third-party payers, like preferred provider organizations (PPOs), that contain "most favored nation" provisions, then you may be contractually obligated to extend your in-office plan's discounts to consumers who are covered by your other participating provider agreements.
- If your in-office dental plan is sold to consumers who have dental benefits from another source, then ensure the free and discounted fee care you provide is properly reflected to other involved third-party payers.
- What are the costs associated with the plan beyond the free and discounted fee care that is provided through it, e.g., membership data base sign-ups, tracking and renewals?
- Does your in-office dental plan make financial sense from the patient's perspective, e.g., how much free or discount fee dentistry does the consumer need to receive in order to financially justify the cost of their membership fee?
- Be prepared to respond to questions like: Why do I have to pay a fee in order to get a discount off of a fee that you the dentist control and can discount whenever you want?
- Does the consumer receive any other benefits for their membership fee?
- Understand the terms and words you use to describe in-office dental plan may have regulatory and/or marketing ramifications.
- Are there any tax ramifications associated with your in-office dental plan, e.g., are taxes owed on these types of membership fees and who is responsible for paying them?
- Are there any unclaimed funds ramifications associated with your in-office dental plan?
- Are patients who have dental benefits being "penalized" because they cannot access your in-office dental plan?
- What regulatory or legal impact does health care reform have on your in-office dental plan?

"I urge dentists who are considering selling an in-office dental plan to their patients to consult with their attorney before rolling it out to the public," Chopra said. "I also encourage dentists who have questions or concerns about these plans or have direct experience with them to provide the feedback to the ODA so we may continue to study this issue for the membership's benefit."

ADA Library available to assist members

By ODA Staff

The American Dental Association Library and Archives (http://www.ada.org/294.aspx) experienced some major changes to its operations in 2013 in order to save dues dollars and keep the library relevant in a technologic society.

Ohio Dental Association member dentists should know that they may still make use of the valuable resources of the library. ADA Library staff is available to aid dentists with their information searches by providing reference assistance with PubMed (http://www.ncbi.nlm.nih.gov/pubmed/) searches, access to ADA archives and historical information, assistance with Internet searches

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and that's how they work most efficiently as a team," Homon said. "Rather than us hodgepodging something together, even though they're in a different surrounding with different equipment, they're used to working with each other. We've been very successful with that, and offices enjoy coming in."

The clinic is currently open two days a week, and about 400 volunteers are signed up to help. It opened in December 2012, and for the first six months the KidSMILES Board of Directors staffed the clinic to work out any kinks that might come up. Volunteers then began working at the clinic in May, and since then they've had about 200 patient visits. The clinic's goal is to expand to five days a week and have 7,500 patient visits a year.

The clinic provides comprehensive dental treatment, including cleanings, extractions, endodontic treatment, minor periodontal surgery and orthodontics.

Before the clinic was built, KidSMILES achieved non-profit status in 2010. The process was somewhat complicated because a professional office is considered a for-profit operation. However, Homon said he worked closely with the IRS for about two years in order to achieve non-profit status. Then the KidSMILES team began fundraising to be able to build the clinic. The first major grant came from the Columbus Blue Jackets Foundation for $50,000. Since then, KidSMILES has received several other grants.

In the meantime, KidSMILES started an educational outreach program in 2011 where volunteers go into schools along with the Blue Jackets mascot Stinger to educate students about oral health.

"Education is a big component of our mission. You can't just treat the problem, you need to also educate," Homon said.

So far, they have seen over 8,000 students. The education program is ongoing, and their goal is to see 5,000 students a year.

Homon said his favorite part of KidSMILES is "to see that we're actually solving the problem and creating access to care and educating kids. Long-term it's to see statistics change right here locally. It's done one patient at a time, and we're starting to turn that tide. It's a long battle. It's exciting to see how many people are getting excited about donating and are willing to donate their time."

The KidSMILES Board of Directors is made up of Homon, Dr. Jeff Milton, Dr. Tim Edwards, Dr. Jennifer Livermore and Dr. Fred Sakamoto. Homon's wife, Julie Homon, is the executive director. In 2013, the Ohio Dental Association Foundation awarded KidSMILES a $5,000 grant. For more information about KidSMILES, visit www.kidsmilesclinic.com.

Ohio Dental Association membership retention holds steady in 2013

ODA staff

The Ohio Dental Association has retained 96.15 percent of its 2012 membership, a slight decline from its 96.92 percent rate last year. Moreover, 20 of its 25 local component dental societies have retained 95 percent or more of their 2012 membership. Following is a list of those societies:

- Maumee Valley Dental Society (100 percent)
- Northwest Ohio Dental Society (99.32 percent)
- Lorain County Dental Society (99.15 percent)
- Northeast Ohio Dental Society (98.86 percent)
- WD Miller Dental Society (98.67 percent)
- Western Ohio Dental Society (98.39 percent)
- Stark County Dental Society (98.08 percent)
- Tuscarawas Dental Society (97.92 percent)
- Eastern Ohio Dental Society (97.78 percent)
- North Central Ohio Dental Society (97.32 percent)
- Central Ohio Dental Society (97.06 percent)
- Cincinnati Dental Society (96.71 percent)
- Akron Dental Society (96.23 percent)
- Keely Dental Society (96.13 percent)
- Dayton Dental Society (96.08 percent)
- Muskingum Valley Dental Society (96.04 percent)
- Mad River Valley Dental Society (95.77 percent)
- Greater Cleveland Dental Society (95.57 percent)
- Toledo Dental Society (95.16 percent)
- Corydon Palmer Dental Society (95.09 percent)

In 2009, the ODA's Council on Membership Services (CMS) decided to publish the list of component dental societies reaching or passing the 95 percent retention threshold as a way of recognizing the accomplishment and providing an incentive for local societies to make a strong effort to renew their members.

"The council feels that achievements in membership retention ought to be recognized and appreciated by the full membership, not just by its members who monitor the data," said CMS chair Dr. Martin Fitz. "We also wanted to see if we could capitalize on the motivating power of friendly competition to help improve our membership numbers."

Year-to-year eight component societies have so-far improved their renewal percentage in 2013 against 15 where rates have declined. 2013 marked the fourth consecutive year in which the Maumee Valley Dental Society retained 100 percent of its members.

Membership renewal invitations, an electronic email notice and 2014 tripartite membership dues statements were sent to 2013 members in mid-November. Members wishing to report a change of address, retirement, or submit an inquiry about their membership status should contact the ODA Membership Department at: (800) 282-1526, or via email at: membership@oda.org.

SAVINGS, from page 1

The ODA also provides members many different services. Members can save approximately $1,083 by taking advantage of all the services offered by the ODA. In addition to the services listed in the chart, the ODA also offers a peer review process, which allows dentists and patients to resolve disputes. Depending on the situation, savings can vary greatly, however, dentists could potentially save thousands of dollars from avoiding the court system.

The Ohio Dental Association Services Corporation (ODASC) offers products that dentists can purchase at a discounted rate. By taking advantage of some of these products, dentists could save approximately $4,230.

For a cost breakdown of ODA products, services and initiatives that save dentists money, see the chart on page 1.

And these savings don't even take into account many of the invaluable opportunities available through the ODA. Member dentists have opportunities to volunteer and improve access to care, receive expert guidance on regulatory compliance and have 24-hour access to the members-only section of www.oda.org. For more information about how the ODA serves its members, visit www.oda.org.

Tripartite membership renewal now available

ODA dues renewal statements were mailed out in mid-November. ODA membership dues are due Jan. 1, 2014, for the 2014 membership year.

Members can renew online at www.oda.org/renew, by phone at (800) 282-1526, by fax at (614) 486-0381 or by mail to Ohio Dental Association, 1370 Dublin Rd. Columbus, OH 43215.

Any members who have moved, changed their email address or changed any other contact information should contact the ODA by calling (800) 282-1526 or emailing membership@oda.org to ensure they receive their dues statements. To verify the information the ODA has on file, sign onto www.oda.org and click on "my account" in the black bar along the top and then click on "my profile" along the left hand side.

ODA Staff

Attending CE courses at the ODA Annual Session is just one of the ways members can save money.

Opinion & Editorial

The Explorer

Matthew J. Messina, DDS
Executive Editor

Dentistry 2050

For this special Nostradamus Issue of the "ODA Today," we have asked all of our regular columnists to answer a series of questions concerning their vision of the state of dentistry in 2050. Had I posed these questions as recently as 2007, I suspect that the answers, or at least the tone of the piece, would be quite different.

In 2007, I would expect that most of us would have envisioned the future of dentistry as some sort of Star Trek-based world, where dental decay had been eradicated by a vaccine or an oral rinse that targeted the suspect bacteria. Periodontal disease was on the decline due to the ability to deliver targeted, site-specific antibiotics. Systemic diseases have been controlled with the advances in pharmaco-genomics, where drugs are developed for the patient's individual genetic make-up and disease profile.

Dentistry still had plenty of work to do, since even in 2050, people just don't get the fact that they have to brush their teeth. Advances in implant technology have made it so that even teeth lost to trauma can be routinely replaced with predictable results.

Ahh, what a happy world that would be!

Sadly, the recession of 2008 and the passage of the Affordable Care Act (ACA) have squashed the boundless optimism of the turn of the century and left many of us with a vision of the future that is somewhere between George Orwell's "1984" and Aldous Huxley's "Brave New World."

Reality will probably end up somewhere in between. Like anything, the truth will be what we make it. And we have a lot of work to do to avoid that Orwellian end.

As I prepared this issue, I was struck by the fact that the tipping point for the future of dentistry, and in a broader sense medicine as well, was the passage of the ACA in 2010. Ignoring the more than 20,000 pages of specifics for a bit, the overall impact of the legislation was to enshrine into law the concept that people have the right to health care. This irrevocably changed the practice of dentistry, since if a patient has the right to dental care, then we have the obligation to provide that care, regardless of whether the patient can pay for that care.

We can whine about what the right to health care has done to the business of dentistry, but that ship has sailed, even if the ACA is repealed or altered. Our task going forward rests in education and legislative advocacy.

On one hand, the profession of dentistry has always felt the professional, ethical and moral obligation to try to help people. We have never before and will not now leave people in pain or medically threatened with infections. We also feel a special desire to protect children from dental disease. As a profession, we can and will provide the needed emergency and basic dental care required by all Americans.

The challenges occur when the right to basic dental care expands to an expectation for the same level of dental care for all people, regardless of the ability to pay for it. As a society, we do not have the resources to guarantee optimal dental (and medical) care to everyone. If the right to health care morphs into a goal of equal outcomes for all Americans, by necessity, that equal result will be a lower level of care for all. In this future, dentistry in 2050 more closely resembles dentistry in 1950.

In order to alter the perceived downward trajectory of the practice of dentistry, our profession has an important role to play. We have to band together and work with a unified voice to seek to change the course before us.

As dentists, it is incumbent on us to find ways to provide care in as efficient and clinically effective manner as possible, so that all of us do some part of taking care of the number of people who need help and feel that they can't receive care. Every dentist needs to grab the rope and pull together. But we can't be expected to solve the problem alone.

As a profession, we must advocate for legislators and the government to do their part to help, by providing adequate funding for the safety net as well as financial incentives, especially student loan forgiveness, for dentists who choose to practice in underserved communities.

We also must stress that patients have a part to play as well. If you have the right to dental care, then you have the obligation to take care of yourself as best you can. We're not asking much. The prevention refrain that we have sung for years is still the best answer: Brush twice a day, Floss once a day, See your dentist on a regular basis, and Eat a healthy diet. It's not sexy, but it works. For minutes and pennies a day, you can prevent serious dental problems before they occur, which takes stress off the safety net.

This isn't new. The ADA's Action for Dental Health Initiative represents these principles. If we all get behind it, we can begin to take some control of our future and make it bright again. If not, it's easy to write the script for this movie . . . and I'm not thrilled with how it ends.

Dr. Messina may be reached at docmessina@cox.net.

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What will the profession of dentistry look like in the year 2050?

President's Message

Paul S. Casamassimo, DDS, MS, FAAPD, FRCSEd, ODA President

The Explorer

Matthew J. Messina, DDS
Executive Editor

Between the Lines

Ken Jones, DDS, JD
Guest Columnist

It's Your Choice

Robert Buchholz, DDS
Guest Columnist

Taking the Next Step

Ryan Walton, DDS
Guest Columnist

This month, the "ODA Today" columnists are taking a look at what they think the profession of dentistry will look like in 2050. Continue reading to see their answers to six questions about the profession's future.

Dr. Casamassimo: The chance to crystal ball dentistry a generation hence is challenging! The world at large will, of course, determine what happens to us. Clouds block a clear view of where we will be in 2050, but let's make these perhaps naïve, but optimistic assumptions:

- We will avoid nuclear conflagration and the brushfire wars in the third world will have abated,
- The G-7 nations, the American people, and a unity of responsible state governors will have had their way with the federal government, and as a country, we will have controlled spending,
- Oil from shale, natural gas, continued high crop yields, and plentiful fresh water, all under a watchful eye of environmental safeguards, will position the U.S. well, and
- Unabated population growth in third world nations, like Iran and Egypt, which have no stable economic or agricultural infrastructure, and which have had doubling populations in recent decades, will force them to depend on the industrialized world for survival.

What will the role of organized dentistry be?

Dr. Messina: Organized dentistry must stand as the primary authority for the public when they look for information about oral health. The ADA, ODA and local dental societies are closely involved with the social media of the day, making sure that accurate information is available to the public. They support members of the profession with information and education as needed. Organized dentistry provides the central lobbying force for the protection of dentists and their patients in Washington, D.C., and in the State House. Most of the dental meetings are done online by virtual conferencing, though occasionally, groups find solace in getting together to talk things out face to face, usually over adult beverages.

Dr. Jones: Organized dentistry will have little or no role. Already, it is no longer expected of us to join and, more essentially, to actually participate. As older dentists retire and leave dentistry, finding young dentists to serve the profession is a growing chore. Many decline to continue once their initial, reduced-dues period is over. This attitude is frequently due to the excessive costs of their education and, sometimes, due to the influence of some of their dental educators, but more often, it's due to their employment status and resulting lack of independence.

Dentists who feel they have no stake in a better profession no longer want to pay the price for autonomy and professional improvement. To them, it's often "just a job." As these issues of dependence have grown within the profession, I see a decreasing number of experienced dentists who are willing to work from within the organization to make things better, either for the profession or, more importantly, for the public.

Dr. Buchholz: The trend of new dental graduates participating in organized dentistry has been steadily decreasing, for several years. Ohio Dental Association member numbers have very slightly decreased, which is a tribute to current members conveying why there are more pros than cons of belonging. However, camaraderie has vanished in our profession. I believe the only common denominator binding us together is the fear of a change in the way we as individuals render our services. Every member recognizes that through the ODA's lobbying efforts, any changes in the Dental Practice Act have and will continue to be thwarted. Progressives and their respective organizations will continue to press for reform concerning how dental services are delivered. If their agenda is successful in changing the current model, then expect organized dentistry's influence in health care decisions to quickly wane.

Dr. Walton: I believe that organized dentistry's most important role is to help educate the government officials responsible for making decisions on the details of dentistry. This will not change. In fact, I believe as our world becomes more complicated, this role will become increasingly important. Elected officials are bombarded with issues involving every aspect of their constituents' lives. We are but a small segment. There is no way these officials can be fluent in the details necessary to make good decisions. Our profession is one that involves different types of practice and encompasses young and old. We are a group of students, practicing dentists and retirees. These advocacy efforts are and will continue to be crucial to ensure that the future of all members of our profession is protected.

Dr. Casamassimo: We need to accept that forces beyond our control will shape oral health care in 2050. We will likely see organized dentistry transform into a federation of dental professions with a clear union complexion. Why is that? We cannot deny the growth of corporate dentistry. We cannot deny that pressure to decrease costs will dominate change in dental and medical care leading to fewer dentists and more auxiliaries. As increasing numbers of graduates choose corporate practice, and as newly defined expanded function auxiliaries emerge, we will see the role of organized dentistry become one of supporting not just dentists, but all dental professionals as the system tries to continually reduce cost and thus erode income and the doctor-patient relationship. ODA will likely become the ODAHAEFDACDA and cover all team members and new ones! It will become the dental professions against the government-insurance complex. It is already moving there, but we don't appreciate the magnitude of it.

What will the dental team look like?

Dr. Jones: Dentists and hygienists will be gone. Dental care will be overseen by non-dental corporate or government public health administrators, and provided by two-year tech-school grads. Specialty care will be done, if at all, by physician-surgeons. Today's graduates will be out of work or retired and gone. Graduates of the next few decades will find their roles gradually reduced to observation and administration until even that role is gone. Perhaps, the team will only be mom, doing it all. (See www.dentidrill.com It's unbelievable!)

Dr. Buchholz: The current dental team has remained constant, with only a slight variance, for over a half century.

The dentist, dental assistant, hygienist model has been complemented by the addition of EFDAs. This health care model works and has stood the test of time!

Over the next half century, society's social engineers will try to disrupt this model and attempt to force the profession to adopt mid-level providers (MLP). The social engineers, in the quest for solutions to a perceived "access" to care problem, believe MLPs should perform duties that are comparable to what our physician counterparts, known as physician assistants, perform.

The next state to adopt MLPs will be California, followed by the remaining left coast states. The New England states will be next, followed by Florida. This process could take close to a decade or two. I suspect the MLPs will be hybrids of dental hygienists and EFDAs, and will be trained to remove decay and restore teeth, under the direct supervision of a dentist.

Remember more than a quarter century ago, hygienists in Colorado became the first team members to practice independently, and we all know how unsuccessful those endeavors have been.

Dr. Walton: Even with the changes being implemented allowing for more responsibility to auxiliary dental team members, I still cannot imagine a dental model that does not allow for the dentist to be the primary decision-maker and have sole responsibility for the matters of the dental practice. We can discuss all the changes that can (and surely will) come our way, but removing the dentist from the lead position within the dental team would signal a collapse in our profession. I simply cannot imagine that.

I think the general office trend will be towards larger group practices, taking advantage of sharing office space, staff and costs. Having dental offices open more hours of the day and more days of the week just makes sense, and sharing space and costs within one building is the best way to accomplish this.

Dr. Casamassimo: The dentist will remain the captain of the ship, but at a functional level, most care will be provided by some form of DDS-DHAT combo. Ironically, the DHATs (Dental Health Aid Therapist), like registered nurses, will try to make themselves doctors in the health care system, Dr. DHAT if you like, and any cost saving benefit derived from lower-paid professionals will vaporize! We will be back where we started!

Dr. Messina: With the pressure to provide care at increased levels of efficiency, the majority of dental care is provided in larger group practice settings, with a smaller number of dentists leading larger, more complex teams of professionals. There is an expansion of assistants with duties performed under the direct supervision of dentists. The push for mid-level providers that was popular in the early part of the 21st century flopped, as the programs were created but no one entered them. The advocates of mid-level providers failed to realize that in addition to the fact that most people don't want to go to the dentist, almost no one wants to be the dentist, especially with less training and lower wages. The critical problem in 2050 is hiring and retaining committed professional assistants and laboratory technicians. The number of hygienists is stable and adequate to meet the needs of the profession.

What will be the biggest roadblock to access to care?

Dr. Buchholz: There is NO roadblock to access when anyone seeks dental care. There are financial impediments for individuals. There are priorities in life that trump seeking any health care services.

There is dental health ignorance and folklore that carries over from one generation ad infinitum.

In the last century, the Hershey company experimented with dental health benefits. They offered 100 percent coverage with no deductibles and no annual dollar maximums. Guess what, there was very little utilization cost creep over what traditional indemnity plans normally deliver, in corporate American dental plans. I'll grant you, this was before the "Ten over Ten" esthetic dentistry boom occurred. But your common middle income American and their respective family members will visit a dentist regularly 50 percent of the time, and of that 50 percent, 35 percent will visit semi-annually for routine check-ups.

The norm is, roughly 50 percent of the populous only seeks dental care when

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dentistry in 2050

Continued from page 13

they're in pain. Once the pain is relieved they vanish until the next episode of discomfort occurs.

In short, human nature only changes with education!

Dr. Walton: I really don't believe we have an access to care issue in our country at this point, save for a few remote geographic locations that are not in close proximity to a physical dental office. Personal responsibility, or lack thereof, is now and will continue to be the biggest roadblock to obtaining dental care. I would call this "access to care" issue what I really believe it is ... lack of desire to pay for care. I routinely hear safety net clinic stories about patients who cannot afford the dental care they need, yet have made the decision to buy expensive phones and designer clothes. Our medical health care delivery system has made free care increasingly available. Until this culture of expectancy is diminished, we are doomed to continue down this road with dentistry as well.

Dr. Casamassimo: There will be no obstacles to care! Look at the Affordable Care Act! Right now, we have decided that non-participation in Obamacare is a punishable offense! Employers are also incentivizing participants to be healthy. Penn State tried to penalize employees unsuccessfully to engage in healthy activities. The time has come when inattention to health will cost you and failure to comply will mean penalties, financial and otherwise. Use childhood immunizations and flu vaccination as examples. Currently, these are elective, but pressure mounts to force parents to immunize their children to gain access to school and health care workers to take the flu vaccine. In Europe, decades ago, leaders determined that a carrot approach would not work to get people to seek dental care, so they demanded participation of those receiving other government services. The public, with few exceptions, will acquiesce to participation, because other government-provided benefits will be withheld without participation, and folks, that is about half of Americans! I expect that in the intervening years before 2050, we will see a vaccine or other safe, effective, and preventive way to prevent decay and evidence will strongly support its universal application. Maybe in places like rural Idaho, we may see resistance, but in the inner cities, among those most susceptible, we will see acquiescence. There will be declining early childhood caries, and a universal acceptance of some form of prevention in early childhood.

Dr. Messina: The biggest roadblock to access to care continues to be fear. As it has always been, even with the expansion of the Affordable Care Act to provide for basic dental care for all Americans, fewer than 50 percent of people see the dentist on an annual basis, even though the care is free.

Dr. Jones: The continuous and growing procession of teenaged single-parent families, most often supported by government welfare programs, (i.e. our tax dollars) where home dental care, proper nutrition and parental responsibility are not priorities, and typically results in a "society owes it to me" attitude of entitlement ingrained by a whole line of similar parents and grandparents. Political correctness decries teaching them to care. Couple those attitudes with one that already doesn't even take advantage of the help that is available right now and you have a recipe for disaster.

Will dental education still be an entity unto itself or will dentists become a sub specialty of medicine?

Dr. Casamassimo: We will see a dichotomizing of dentistry. Dental education will have to adapt to a different role. We cannot continue to add dental schools and increase class sizes. To see the future, one has only to look at legal education, the lack of jobs, and the consequent decline in law school applications. The legal profession is a vision of what will happen to dentistry as we overproduce highly indebted dentists who then join corporate ranks and succumb to data-driven treatment decisions. Some dental schools will fold, some will fall under medical education, training a new "uber-dentist" in smaller numbers with advanced diagnostic skills, overseeing less trained professionals' application of reparative and other needs of patients. We will see some melding of the "doctor" with the advanced "fixer." This phenomenon is already in play in some non-socialized first-world countries in other professions.

Dr. Messina: Dentistry remains a separate profession, since it is a highly specialized area of knowledge and training. Physicians don't want to work in the mouth and are quite happy to allow us to have complete control of that area. Strain continues to exist between oral surgery and medical specialties (ENT, plastic surgery) for elective procedures. The trend for large hospital systems to employ physicians has resulted in the situation where there are no longer private physicians working in the U.S. Hospitals had experimented with acquiring dentists, but abandoned it since there was no money in it for them. A small number of dental practices have partnered with some medical groups to provide concierge medicine that includes dental care for a select group of patients.

Dr. Jones: The current educational direction predicts that dental education will, mostly, be a two year vocational school course, taught by other course graduates who have a few years' experience. Specialty care will be done by physician/surgeons with, perhaps, six to 10 months training in extractions and weekend courses in implants. Actual perio treatment will be non-existent due to repeated pocket infusion with antibiotics and, ultimately, implants. Ortho might be a sub-specialty of orthopedic surgery.

Dr. Buchholz: I'm certain our older members remember Dean Martin as an airliner captain in "Airplane." On the plane's P.A. system he asks, "Is there a doctor on board" and then mutters to a flight attendant, "I hope it's not a dentist ...."

I anticipate our profession will still be an entity unto itself. Variables include future economics, technology, the evolution of the Affordable Care Act and government environment (regulations).

The return on investment for anyone considering applying for dental school admission is drastically going down. Dental schools are pricing schooling out of middle class American's financial reach. And the debt burden of obtaining a dental degree is enslaving its graduates into corporate dentistry servitude for years.

In Ohio, Case Western's dental school will cease operation or become a "foreign exchange" dental school.

OSU's dental school will see class size diminish over the next half century as a result of technology (a cure for dental caries ... finally) and because of additional auxiliary utilization.

Will dentists still make treatment decisions, or will another entity/factor have a say?

Dr. Walton: My hope and belief is that patient decision will always guide treatment decisions for dental care. This is a fundamental tenant of the dental care system as I see it. I can understand that changes in law and government mandated insurance may have a large impact on the future of dental care. Insurance companies now play a major role in treatment decisions for some patients, but should not now or never in the future guide decisions for treatment. Our role as dentists is to provide treatment options and recommendations to our patients. No matter what the year, my belief is that relationship will never change.

Dr. Casamassimo: Unless I am living on another planet, the erosion of the doctor-patient relationship is well underway, particularly in medicine! We still hold onto the ability to determine what is best for our individual patients, but think about the growth of insurance, regulations, the impact of systemic health issues on dental care, competition from corporates, and the often cold and uncaring specter of evidence-based dentistry driven by big data and government! I doubt that dental treatment planning will ever be totally formulaic but by 2050, much more so.

> "Our role as dentists is to provide treatment options and recommendations to our patients. No matter what the year, my belief is that relationship will never change."
>
> – *Dr. Ryan Walton*

Dr. Messina: The dentist remains the primary contact for his/her patients and decisions concerning treatment remain based chairside and individualized for each patient. That being said, pressure is constantly being exerted for treatment planning to conform to standards established by government entities and insurance companies. The dentist remains in control of treatment decisions, but other entities may determine whether the care will be reimbursed.

Dr. Jones: Individual, private dental practices will have gone the way of today's private medical practices, and will have disappeared, leaving health care professionals as little more than non-influential employees, dependent on the whims of their employers for all facets of treatment decisions, worker compensation, and any sense of professionalism.

Dr. Buchholz: There can only be one reply to this question. When a dentist stops informing his or her patients of all possible treatment options, regardless of their social standing, insurance benefits, education level, or other standards employed in measuring one's capabilities in decision making, 50 years from now ... then he or she should cease to claim to be a member of the profession. The patient should always be afforded the necessary information to make a decision!

What effect will cost/insurance have on dental treatment?

Dr. Messina: A basic level of preventative and emergency care will be provided for all Americans. Above that, insurance as we know it today no longer exists. As a benefit to employment, some corporations will negotiate for reduced fees with larger dental groups to provide care for their employees. The majority of restorative care will be provided fee-for-service. The dentist will be ultimately required to make the case with the patient that the value of the care recommended exceeds the cost. We will have come full circle to the pre-insurance dental world of the 1950s.

Dr. Jones: Cost will be the sole determining factor for care for most of the population. Those who may be able to afford a higher level of treatment options will find them by paying their physician-surgeons, possibly under the table, for special care. If it is available in other countries at a lower cost, many will, as now, travel for their dental care. There will be no dental insurance, since, by that time, the government will have decided that dentistry is a covered "benefit" for the increasing numbers who receive government assistance.

Dr. Buchholz: Facts:

1. By 2035 most of the (78 million) Baby Boomers (two phases 1946-54 and 1954-64) will be dead.
2. Half of the last Boomers (1964) will be dead by 2045.
3. Right now Boomers control 80 percent of all personal financial assets.
4. Boomers are responsible for 50 percent of all consumer spending and 80 percent of all leisure travel spending ... THESE FOLKS DRIVE our ECONOMY!

Prediction(s):

A. Entitlement society rules ...

B. Single payer (medical) government insurance that covers child dental and basic adult dental services ...

C. No other dental insurance ...

D. Dentist's pay will derive from government pay and "underground" dental services ...

Dr. Walton: I believe that dental insurance will soon fall under the umbrella of medical insurance as an all-encompassing mandate by our government, requiring that all Americans be covered. That being said, insurance will exist there in some form, but will clearly not be something that gets better with time. Coverage levels have not changed much over time as it is now with private insurance. More patients may be covered by some basic level of insurance, but this coverage will likely be minimal. Perhaps it will cover two cleanings per calendar year (maybe one), maybe a base level of radiographs for a reasonable examination.

Dr. Casamassimo: The jury is still out on that one. Because, as requested by then-House Speaker Nancy Pelosi, we passed the bill before we read it, Obamacare will continue to be tweaked for a decade at least and significant conflicts between oral and systemic health in terms of financing will surface. Families will be challenged to cover insurance premiums, cover out-of-pocket expenses, choose between systemic and oral health, and be forced to buy coverage they do not want or need. Ironically, by 2050, we may have a generation of adults whose health choices forced by Obamacare will have resulted in deteriorated oral health!

In summary, who the heck knows what will happen in 2050. If I am still coherent, someone let me know if I was close!

Agree? Disagree? Contact us!

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- Submit a letter to the editor to jackie@oda.org.

Where is dentistry going?

By Stephanie Sisk
Chicago Dental Society

Surveys, reports and forecasts all hint at a shifting, sometimes confusing, landscape for dentistry:

- The outlook for dentists is strong, so say forecasts including that from the U.S. Bureau of Statistics. Between 2010 and 2020, dentistry is expected to grow by some 32,200 jobs, a 21 percent increase.
- Retirements will be on the rise during that time; the average dentist's age today is almost 54, up from 47 in 1990, according to surveys by the American Dental Association (ADA). Though economic uncertainty plays a big role, forecasts show that the number of retirees could exceed the number of graduates entering the profession by nearly 700 each year.
- Enrollment in dental schools is at 20,352, down from a peak of 22,842 in 1981. But the number of schools, both public and private, has grown to 66 from 55 since 2000. There are 2.6 applicants for every opening at dental schools.
- Women in dentistry have increased substantially, to nearly 46 percent for the 2010-11 school year from nearly 37 percent in 1995.
- Education debt load has hit a staggering average of $180,557 in 2011, up from $164,000 in 2009 and $54,550 in 1990, ADA surveys show. Using 2011 constant dollars, that dental school education in 1990 would have cost $93,882 when average homes cost $122,000, average U.S. cars were $14,489 and gas was about $1.20 a gallon.
- The portion of dentists out of school 10 years or less and in solo practice in 2009 was nearly 46 percent, dramatically down from 67 percent in 1990. The numbers for employee dentists: nearly 28 percent in 2009, more than doubling since 1990 when the number was 13 percent.

What's next?

With an unsettling gumbo of educational debt load, inexperience and weighty career decisions to make, who can blame new dental school graduates for their apprehension?

Most juggle short- and longer-term plans as associates or even as employees in various flavors of corporate-run businesses before eventually launching their career as solo practitioners.

And yet. . .

Dental operations with different models — large group practices and for-profit, corporate-owned dental service operations like Aspen Dental, Pacific Dental and Heartland Dental Care — continue to notch dramatic growth, though the overall share is still small.

Overwhelmingly, the face of dentistry today is still the solo practitioner. Dental school graduates surveyed by the American Dental Education Association (ADEA) continue to indicate a strong entrepreneurial drive and desire to be self-employed, but academic leaders and others point to a subtle and growing shift among younger dentists interested in choice and lifestyle.

Among students he talks to today, "the gold standard is not their own solo practice," said Frank Licari, associate dean of academic affairs at Midwestern University's College of Dental Medicine in Downers Grove.

"I'd agree with that," seconded Richard Valachovic, president and CEO of Washington, DC-based ADEA, who studies trends among dental students and educators. "People are thinking of options other than the solo practice."

Both Drs. Licari and Valachovic point to burdens new grads face, like student loan repayment and economic uncertainty and their desire for a stable paycheck and work flexibility as big factors in choosing a direction after school. Other grads feel unprepared to juggle business responsibilities like hiring, billing and scheduling along with the tasks of financing and building a new practice.

Rather than stress the solo practice as the go-to model, "we tell students that you have to find out yourself what you want to do," Dr. Licari said. "We say that you shouldn't let other people make you feel like a second-class citizen for the practice decision you choose."

"The reality is, some grads, given their experience as care providers, are not necessarily also small business owners," Dr. Valachovic said. Working as an employee seems a more tenable path, at least for the short term, in this generation of dental students, he said.

Still, only 5-10 percent of students choose to be employees. "Yes, it's a trend," Dr. Valachovic said, "but nothing substantial."

And so, what to make of it? As a profession, where is dentistry headed?

Large group practices, some with and without outside investment, and other provider models are the future, at least according to a 2012 report from global dental product giant Straumann.

There will be a "steady" decrease in the number of solo practices by 2020, Straumann reported, as well as "efforts to boost efficiency and capacity.

"As the cost of equipping and running surgeries increases, single-dentist practices will become less common as practitioners join group practices and chains," reads its Vision 2020 report released in May 2012.

Straumann also sees the rise of women in the field, as females overtake males in enrollment. "As this trend continues it is also expected that a growing proportion of female dentists will work part-time, for family reasons — which in turn will accelerate the trend toward group practices."

Similarly Deloitte, the U.S. consulting company, has gotten in the act, forecasting dental workforce trends in a report last year that predicted the rise of practice "variations," "non-traditional health providers," and a reboot of "traditional work roles and responsibilities" in dentistry.

To be sure, economic pressures, government policy on health care and education funding changes affect dentistry's outlook. Add to the debate who can and should be trained to provide dental care (dental therapists), the cost of increasingly expensive digitized dental equipment, and a shift in the attitudes and lifestyle choices of dental students, and the question over dentistry's future is wide open.

One area that is sure to stay and grow is dental service operations, owned by corporate entities that serve their investors. So-called corporate dentistry has grown dramatically in the last 10 years, to growing scrutiny and criticism.

These companies often tout their ability

See DENTISTRY, page 16

Opinion & Editorial

Letter to the Editor

Involvement in ODA provides members great opportunities

To the editor:

I wanted to share how great my experience on the Ohio Dental Association Committee on Access to Care and Public Service (CACPS) has been.

The opportunity to meet and work with one of the finest state level organizations in organized dentistry has just been a tremendous experience. The staff at the ODA is top notch and really set the stage for dentists to be successful. The ODA government affairs team is so attuned to the needs of dentists and has had so many successes working with congress and the regulatory agencies. I hate to think of where we would be without their constant monitoring and intervention with these institutions on behalf of dentists and their patients.

Before I became involved in the CACPS, I really didn't appreciate the level of activity for less fortunate citizens of Ohio. It's easy to get tunnel vision working chair-side with patients all day. The ODA access to care program management and interaction with other state agencies has truly made a difference to the underserved in the state of Ohio. And so many dentists across the state have done a world of good for these patients, but it just wouldn't happen as effectively without the staff at the ODA as the organizational hub at the center of the big wheel of access to care in Ohio. I'm grateful for the opportunity to work with ODA staff.

I have also had a great opportunity to work with many of our leaders at the state level in dentistry. What a wonderful opportunity to interact with them as well as representatives of some of the state and professional regulatory agencies. And through the ODA Day at the State House I have had the wonderful opportunity to meet with my state representative on behalf of my profession.

I would highly recommend dentists become involved in some aspect of organized dentistry. Pick an area of interest and find a committee or council to get involved in. You'll find it to be rewarding.

— Dr. Geoff Bauman
Newark, OH

DENTISTRY, from page 15

to ensure standardized procedures as well as reduce costs through efficiencies.

However, they've also suffered black eyes from federal and congressional investigations spotlighting pressure tactics used by a minority of these companies, aimed at patients and doctors to provide unneeded treatment, overbilling schemes, and heated questions over whether licensed dentists are owners and managers of the operations as required by most states.

Some worry the future of dentistry will follow the footsteps of physicians, who have consolidated into group practices particularly in urban areas, and pharmacists, who have largely disappeared in favor of a retail presence at giants like Target, Walgreens and CVS Pharmacy, where they also sometimes stock store shelves.

"I don't think dentists are heading down that road," said Darryl Pendleton, associate dean for student and diversity affairs at the University of Illinois at Chicago College of Dentistry. "Patients are looking for a personal relationship" with their dentist, he said.

"We've always had (patients') respect and expectation" for prevention and wellness care that just isn't shared in the same way by the revolving door that is a visit to a physician today, added Dr. Valachovic.

Dr. Pendleton agrees that the corporate entities continue to take market share and that some grads choose that route. "We're seeing more and more (students) willing to go the corporate route than four or five years ago." Those grads work hard, increase their speed, improve their hand skills and pay down their debt with a steady salary for a few years in a safer transition.

"But then they move on," he said.

For many, the interest in calling their own shots in a solo practice is the irresistible aspiration.

Whatever the eventual goal, said Dr. Valachovic, dental schools should prepare their students to cope with an explosion of information, technology and experiences ahead of them.

Dr. Licari has a similar goal of stressing critical assessment and analytical skills as the foundation for Midwestern students. As business demands and cultural forces evolve, schools and staffs can't "accurately predict the future over a 30-year career to make traditional instruction useful," he said. With change inevitable, students are told, "we can't give you all the answers."

"Instead of memorizing facts and techniques," said Dr. Valachovic, "we need to create students who are critical thinkers and life-long learners."

"If you're going to be a contemporary practitioner, and you want efficiencies and technology, you have to bring people together," he said, citing a growing movement toward collaborative practice.

An example of the dentist-focused collaborative approach is the Minneapolis-area based Park Dental. Starting with two dentists and an idea in 1972, Park Dental has grown to a group of 26 offices. Of the group's 95 dentists, 60 are owners, with the remaining staff working as associates on an eventual path to ownership. There are no outside investors.

"We are one of the few practices doctor-owned and managed," explained John Gulon, who has worked at Park Dental for 26 years and currently serves as president.

Park Dental dentists concentrate on patients while the group hires accountants and other personnel to handle business duties, Dr. Gulon explained. The group practice offers professional development, a collaborative spirit, and a laser focus on patient care rather than business issues. He describes Park Dental's goal of offering a dental home not only for patients but also for its dentists.

"We don't want swinging doors at our office," he said.

The script for dentistry's future is still being written, and the forces that mold it will continue to evolve. A useful game plan for today's dentist? Flexibility, dedication and careful deliberation.

Stephanie Sisk is a veteran reporter and editor who brings two decades of experience in journalism. Read Front Desk, her monthly online column addressing problems dentists and staff members experience in the office, at CDS.org.

This article is reprinted with permission from the September/October 2013 issue of "CDS Review."

Taking restoration to the next level: equipment maintenance

Editor's Note: This article first appeared in "generationD," the ODA's online publication for dental students and dentists in practice for 10 years or less. To access current and past issues of "generationD," visit www.oda.org/generationD.

By Dr. Andrew Zucker
Subcouncil on New Dentists

We all apply different definitions to the term "restoration." Some people restore classic automobiles and classic boats. Others restore old houses and antique furniture. Dentists restore teeth, proper occlusion and even broken jaws. We are experts at completely dismantling a human being's ability to chew and then restoring it to complete function within tolerances of sheer microns.

But when our autoclave leaks, or a handpiece hose breaks, or our compressor dies, what do we do? Most dentists immediately call their supply rep. We have the confidence to irreversibly drill into a patient's hard tissue, but we won't grab an allen wrench and learn how our expensive equipment operates. Why? Trust me, many of those items are far less complicated than the things we restore every day!

One of the most expensive costs a dental office can incur, especially those of us practicing in rural areas, are travel costs for repair personnel. I never truly appreciated this fact until my father was on a vacation and our suction pump started leaking all over our mechanical room. What did I do? I called our rep! The repairman spent two hours driving to our office, 30 minutes replacing a faulty check valve, and two hours driving back. That's four and a half hours of labor and $40 in parts. When my father returned to the office, he laughed at me. Then he proceeded to show me where I could have bought that check valve at a local marine discount store for $13, and taught me how to replace it in 15 minutes. I suddenly realized that my father wasn't just absurdly cheap; some of these repairs really are simple!

We also had a suction pump die a few years ago. I started researching new pumps and decided I liked a certain model for around $2,000. Again, my father just shook his head and laughed. In less than 5 minutes he had the electric motor removed from the unit, and a local shop completely rebuilt it for something like $70. Three years later, that pump is still running as if it was brand new. Now that's my kind of restoration.

Since graduating from dental school, I learned to appreciate the value of keeping an inventory of commonly replaced items: assorted O-rings, metric and standard allen wrench sets, various tubes and hoses for dental units, light bulbs for overhead lights, and every gasket used in our autoclaves and dental units. And in a pinch, I learned that many "dental" parts are readily available in marine stores, pool/spa stores, and even the irrigation department at your local hardware store. I can strip and rebuild a leaky air/water syringe in 15 minutes; quick enough to get it done over a lunch break.

Sure, there are more fun ways to spend a weekend than rebuilding a compressor. No one wants to spend a Saturday morning replumbing a dental unit. But let's say you average $150/month in repair or replacement costs for your equipment. And let's say you plan to practice for 35 years. That's $63,000 over the course of your career! So roll up your sleeves, don't be afraid to get your hands dirty, and learn to repair some of your equipment when it breaks down. Just be sure you wash the grease off your hands before you drive away in the car my advice just bought you.

The views expressed in the monthly columns of the "ODA Today" are solely those of the author(s) and do not necessarily represent the view of the Ohio Dental Association (ODA). The columns are intended to offer opinions, information and general guidance and should not be construed as legal advice or as an endorsement by the ODA. Dentists should always seek the advice of their own legal counsel regarding specific circumstances.

Which Brokerage Firm is Truly Looking Out for YOUR Interests When Selling Your Practice?

Dual-Representation Brokerage Firms?

Dental Supply Companies Who Also Act As Brokers?

Your Accounting Firm Who Offers Brokerage Services?

Is it a dual-rep brokerage firm? *NO*.

You cannot serve two masters. Dual-rep firms charge buyers hefty fees, and as a result, their strategies usually negatively affect the final selling price and/or terms the owners agree to when selling. In addition, if a buyer has to choose between two similar practices- where one requires a substantial fee to a dual-rep firm, and the other does not- which practice and brokerage firm will they choose?

Is it the equipment/supply companies who are also brokering practices? *NO*.

In most cases, the owner is selling and retiring. The supply companies want to please the buyer in order to gain or retain their business post-closing. Whatever the terms, their priority is to get the deal done in order to pick up the buyer as a new client, at whatever cost to the seller.

Is it your accounting firm that also owns a practice brokerage company? *NO*.

This could be the biggest conflict of interest that exists. Sellers look to their accountants for advice asking, "Is the price or tax structure acceptable?" Will the accountant advise their client against a "bad" deal if a large commission is on the line to their firm, or to a brokerage company they are partners with or are profiting from?

Is it the firm that has successfully represented sellers for over a decade? *YES*!

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Advertisers Index

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PARAGON Dental Practice Transitions currently has in Ohio (17) practices for sale as well as (2) associate to ownership opportunities, (2) co-ownership opportunities and (3) perio and (1) oral surgery practices. Please visit us at www.paragon.us.com for details of all current listings or contact Jennifer Bruner at (614) 588-3519 and jbruner@paragon.us.com.

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Miscellaneous

Continuing Education Opportunity. 7 CE Credits (6 Clinical, 1 Pain Management). Sponsor: Michigan Academy of Pediatric Dentistry. Date: February 8, 2014. Location: MGM Grand Detroit, Michigan. Course Title: Pain Control for the Pediatric Patient and Emergency Medicine in Pediatric Dentistry. Presenter: Dr. Stanley Malamed. Part one of this course will review current local anesthetics (LA); their safety and efficacy in children. Dr. Malamed will discuss differences in children's anatomy and techniques for achieving effective and safe pain control. Current research into new drugs and techniques will be presented. Part two will focus on preparation for medical emergencies for the dental office and staff, specific management of the pediatric patient and how to manage emergencies for both adults and children. Bronchospasm, seizures, drug over dose (eg, LA and sedatives) as well as respiratory and cardiac arrest will be reviewed. MAPD members $295; AAPD members $350; non-member dentists $425; hygienists $150; staff $100. $25 discount if registered by December 31, 2013. Cost includes course fees, handouts, and lunch. Contact Dr. Michelle Tiberia (586) 216-3593 or mojopedo@yahoo.com. For more details visit http://www.Michiganapd.org. Registration begins December 1, 2013 and closes on January 31, 2014.

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and recommendations or referrals to other information sources. ADA staff also conducts research and shares listings of currently available articles and abstracts.

Electronic databases and resources that dentists may find helpful include:

- The National Library of Medicine's PubMed/MEDLINE database and its Loansome Doc (https://docline.gov/loansome/login.cfm) full-text journal article ordering system.
- The ADA's EBSCO A-to-Z List (https://www.ada.org/ada/login/loginv2.aspx?ReturnUrl=%2fmembers%2f8961.aspx) to access full text journal articles.
- http://webopac.ada.org/ELIBS-QL14_A60005_Documents/journals-current-external.pdf to request, for a fee, any of the over 600 journal titles that are available in print only and are not in circulation.

To access the ADA Library and its services, dentists may call (800) 621-8099, ext. 2653 or (312) 440-2653 between 10 a.m. and 5 p.m. EST or email library@ada.org or make an appointment to visit in person.

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