MONTEREY BAY

SmileLine

The Newsletter of The Monterey Bay Dental Society

Summer 2010

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MONTEREY BAY
SMILELINE

NOTES FROM OUR PRESIDENT...

It is hard to believe that half of 2010 has gone by. It has been a challenging six months as we have all experienced the effects of our troubled economy to some degree. We talk to our colleagues, and discuss ideas about how to keep our numbers up, and how to implement a lean budget. Still, we can take solace in the fact that we chose a wonderful profession that affords us independence and a great living. This is not the case for the good majority of people, and it is to our benefit to take a few minutes to acknowledge our good fortune.

Thinking back about why we choose dentistry as a career is a good start. Most of us knew someone in the field who inspired us. Others had family members who recommended going to dental school because we could be our own boss and have a respectable income. All of us hopefully chose it because we wanted to help people. We are living in times that are testing our dedication to help people. Now more than ever we are encountering uninsured patients in this community we call home. Some have lost their insurance, some have reduced benefits with high deductibles, and others no longer have the Denti-Cal program coverage since its closure. Our dental society office gets daily calls from people inquiring about low cost and emergency services. Some make it to a clinic, but some have been in such despair, that their only recourse has been to go to the hospital emergency room. Children of low income families still have Denti-Cal and Healthy Families coverage, so they can use their benefits for care with enrolled providers. However, their coverage is subject to the State budget cuts, and we will know in the next month how the new budget will affect these programs.

In late April I attended the State Launch of the Head Start Dental Home Initiative in Sacramento. Head Start, in collaboration with the American Academy of Pediatric Dentistry, started a nationwide project to ensure that all Head Start students have a dental home. The project will take five years, and in April it was California's turn to begin the campaign. The idea is that utilizing the local dental societies as an organizing hub, members will take these children as new patients. It is a very ambitious project, and we are at the midpoint of the five years. The greatest obstacle is not that there are not enough providers, but that most of the students have a government subsidized program with very low reimbursement. Low reimbursement blocks access to care. A one doctor practice could not afford to see a high number of children under government assisted programs, but what if the practice could see a handful? What if all other practices did the same? The success of this program will vary from region to region in the State, because it will depend on having providers willing to accept the low reimbursement. Only with the volunteer effort of many, if not all, general practitioners and pediatric dentists in the State, a dental home will be a reality for Head Start students.

We are fortunate in our tri-county area to have health care centers taking care of the uninsured. The dental clinics of Dientes, Salud Para La Gente, San Benito Health Foundation, Community Oral Health Foundation, and Clinica de Salud del Valle de Salinas do an outstanding service in our community, but even with these clinics, the need for dental care in the indigent population keeps growing. We have already a great number of members giving financial breaks to their existing patients to continue their care, and we also have the Affinity program and the Rotary matching volunteer doctors with deserving patients. I would like to thank all the above organizations, doctors, and staff for their dedication. I would like to invite all of our members to enjoy the satisfaction of doing what we love for someone in need. I encourage you to consider giving a hand up by volunteering in your community. If you would like to volunteer in any way directly with patient care or on the dental board, call us. It all goes back to taking care of our home.

Marielena Murillo, D.D.S., President

Save That Date!

Carole Hart, our MBDS Executive Director is retiring! But not without a chance for us to say what we really think of her!

Please mark your calendars for Friday, January 28th 2011, 6 pm. Hyatt Regency Monterey.

You will receive your invitation shortly by separate mailing. Seating will be limited. Don't miss this!!

MBDS Members: We would like to publish a special edition of the MBDS SmileLine in honor of Carole Hart. To do that, we ask that you submit stories & comments about Carole and/or photos to David Shin, the Monterey County MBDS Director. Please do this by October 30th! David's e-mail address is smylmkr@juno.com

Thank you!!

Your MBDS Board of Directors

Monterey Bay Dental Society

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In This Issue

The Smileline is published by the Monterey Bay Dental Society, 8 Harris Court, #A2, Monterey, CA 93940 (831) 658-0168. This newsletter solicits and will publish, space permitting, signed articles relating to dentistry but will assume no responsibility for the opinions or validity of the theories contained therein.

Subscription rate for non-MBDS members is $15.00 per year. Acceptance of advertisements in no way constitutes professional endorsement by the MBDS.
This publication is printed by Sir Speedy, Monterey, CA 93940.

Cover photo by Dr. Bruce Donald DDS
Design by Robert Packard

From The Editor

Lloyd Nattkemper, DDS, Editor

Transitions in our lives and in our practices can be exciting and can bring wonderful, positive change. Eventually. They can also be pretty darn traumatic. They also almost always demand a measure of courage and resilience, and often just plain hard work, to bring about. Stuff like going to college. Starting a practice. Phasing out amalgam and learning to use resins, glass ionomers, compomers, and porcelains. Getting married. Deciding you are going to invest in digital impression technology, cone-beam CT and update the skills and level of care you are providing your patients. Taking on an associate. Retiring.

Every one of us who are members of the Monterey Bay Dental Society will be part of a transition early this next year. Carole Hart will be retiring. She has plans to move to a beautiful place hopefully free of people contacting her in search of dentists who can provide dental treatment for less than we can afford to provide, away from dental auxiliaries who need jobs in a tough economy, a place where the Peer Review Committee just wouldn't think of looking.

For me, this transition is, well, going to be in the pretty darn traumatic category. Before I moved to the Peninsula in 1988 to start my practice, Carole was already supporting me. Invited me to attend an MBDS Officer Installation Dinner, that year at Quail Lodge. Carole introduced me to a tremendous number of Monterey Bay area dentists—months before I moved. She was there helping to sift through job applications for staff, put me in touch with other specialists to help serve as mentors during my first years, listened to concerns and triumphs, provided solid but gentle no-nonsense guidance. Still does.

Over the years, Carole has answered our MBDS phone, responded to e-mails, done all the tasks an organized and highly self-motivated secretary would do. She has also attended a multitude of CDA House of Delegates meetings and a blur of other meetings, often in Sacramento, has been involved with hundreds of Peer Review cases, important ethical decisions, and who-knows-how-many sometimes unpleasant situations—patients unhappy with their dentist, dentists unhappy with other dentists, dentists unhappy with staff, patients frustrated with "access to care" issues, communities or individuals unhappy about fluoride or mercury or radiation. She has provided a viewpoint based on experience and sound judgment to all who all who have sought to ask.

Through all of this—and I am quite certain there is a lot more I don't know about that Carole gracefully keeps to herself—Carole has maintained this amazing attitude and integrity. If you know her, you know what I'm talking about. She jokes now about how she has "short timer's disease" and is way past being ready to retire. But there is still this incredibly positive energy coming from somewhere inside her, unwavering common sense and a 24/7 sense of humor that somehow has not faded one little bit. I was humbled to witness at a CDA Leadership Conference earlier this year in San Luis Obispo something we all can be very proud of. Other component executive directors attending the event as well as CDA staff who were present spoke of Carole as being one of the finest, most highly regarded, most approachable and most liked component executive directors in California. Impressive, huh? No big surprise to anyone who has served on your MBDS Board. Pretty tough act to follow in my book.

But, no worries. We have a search committee actively pursuing and screening, there is a process in place, and someone, some capable, personable, knowledgeable, responsible, energetic, positive individual will take the helm sometime after the new year dawns.

This is a good time to take a minute and let Carole know she has made a positive difference in your practice and in the way dentists around the Monterey Bay are perceived by the public and by other dentists. Even if you don't think she has made a difference, trust me. She has. In ways you may never realize. And mark you calendar so you can attend her retirement party. She would like that.

Lloyd P. Nattkemper, DDS
Editor

Just thought our members might be interested in what happened to me.
I recently had a very bad experience with the Department of Justice, State of California.
I started my practice in 1992 and treated Medi-Cal/Denti-Cal patients from the onset until 2004.

I have had numerous problems with the administrators of Denti-Cal resulting in over 75 formal letters of complaint to various agencies in the state.

Between 2000 and 2002, I took Denti-Cal to small claims court on 8 separate occasions for under payment disputes and won all 8 times.
In 2004, more than 10 but less than 15 DOJ agents showed up at my office with a search warrant. They were wearing windbreaker jackets with "POLICE" on the back, bulletproof vests and had their guns out. They went from room to room yelling who they were and loudly stating, "CLEAR".

I was charged and arrested for a felony. The DOJ said I treated 19 Denti-Cal patients in 2004 and overcharged for the surgery. They felt the extractions of teeth in these 19 patients should have been billed as "simple" versus "surgical". The difference in billable amount was about three thousand dollars.
Six days prior to the scheduled trial on 24 May 2010, all charges were dismissed with prejudice which neans there is zero chance of reopening the case.

The last six years of my life have been difficult at best. This "incident"really took its toll on me mentally and financially.

Thanks sincerely,
Ben F Tarsitano, DDS, MD

Letters To The Editor - Follow Up

10 June 2010

JOHN DOWER ESQ
SUPERVISING DEPUTY ATTORNEY GENERAL
BUREAU OF MEDI-CAL FRAUD & ELDER ABUSE
STATE OF CALIFORNIA DEPARTMENT OF JUSTICE
455 GOLDEN STATE AVENUE SUITE 11000
SAN FRANCISCO CA 94102

RE: Ben F Tarsitano, DDS, MD, Lt.Col. USAF Reserve
AG #FR2003104375

Mr. Dower:

I received copies of the letters you sent to the dental board and the medical board and really take exception to your explanation of why the charges were dropped.

As you well know, the core of the complaint revolved around the treatment of 19 Denti-Cal patients in 2004. All 19 patients were referred to my office for surgery by their primary care providers (family dentists). These dentists had the opportunity to fully examine the patients, form diagnoses and recommend appropriate treatment. All 19 patients were surgically treated in my office in a timely fashion. The care provided these patients easily met the standard of care. Statements were submitted in an appropriate manner reflecting the treatment provided. Denti-Cal had the opportunity to decline payment, reduce payment, request further information or pay the claim. Denti-Cal paid the claims based on the forms submitted and a copy of the x-ray depicting the tooth/teeth in question.

You and your investigators have made incredible accusations against me! You accused me of swapping x-rays from one patient to another, performing unnecessary surgery, holding patients down against their will (children?), paying "kickbacks" to referring dentists, hiding charts in a colleague's garage, etc.

One week prior to the trial of 24 May 2010, you contacted your witnesses and realized you did not have a case. The reason you had no case is because there was never any crime committed (at least by me and my office)! You know as well as I that this whole endeavor was a result of my adversarial relationship with Denti-Cal. I took them to court on 8 separate occasions between 2000 and 2002 because they underpaid or refused to pay entirely for the treatment I provided their patients. Denti-Cal was ordered by the Superior Court, Santa Cruz County to pay full restitution along with court costs.

Shame on you Mr. Dower. I want you to reimburse me for my expenses. My legal fees were $366,906.71 and because of your actions, I was not able to participate in the Denti-Cal program from Oct 2004 to present. Lost wages for the 5 years comes to $1,500,000 for a total of $1,866,906.71.

Sincerely,

Ben F Tarsitano, DDS, MD

Letters to the Editor reflect the opinion and experiences of those submitting the material. The Editor encourages replies and will publish these so long as they are appropriate and respectful.

HITECH Act - Provisions Took Effect In February

The Health Information Technology for Economic and Clinical Health Act, known as the HITECH Act, was enacted as part of the American Recovery and Reinvestment Act of 2009, signed by President Barack Obama on Feb. 17 of last year.
The HITECH Act amends the federal HIPAA Act and its implementing regulations, the HIPAA privacy rule and the HIPAA security rule, and adds requirements related to the privacy and security of health information.
Several provisions of the HITECH Act go into effect in February, including requirements affecting business associates, access to patient records, and restrictions on the use and disclosure of protected health information.
Although the HITECH Act's breach notification provisions went into effect on Sept. 23, 2009, the U.S Department of Health and Human Services stated that it would exercise its "enforcement discretion" and not impose sanctions for failure to comply with the required notifications for breaches discovered until February 2010.
Jan Katerkamp, paralegal, CDA legal department, has prepared an article for you to use in your publications, which outlines the provisions of the HITECH act. You can access the article at HITECH Act or if you have any questions contact Jan Katerkamp.

Info box

*For further guidance, please visit the U.S. Department of Health and Human Services Web site at hhs.gov/ocr/privacy. More information on HIPAA and the HITECH Act is also available on the CDA Compass at cdacomp*ass.com.

New HIPAA amendments to take effect in February

By Jan Katerkamp

The Health Information Technology for Economic and Clinical Health Act, known as the HITECH Act, was enacted as part of the American Recovery and Reinvestment Act of 2009, signed by President Barack Obama on Feb. 17 of last year.

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Required provisions for HITECH compliance:

Breach notification: The HITECH Act and related regulations require dentists to notify affected individuals of a data breach promptly. The media must also be notified if the breach affects more than 500 people in any one state. In addition, Health and Human Services must be notified at the same time individuals are notified if the breach affects more than 500 people in total. Breaches affecting fewer than 500 people must be reported annually to the secretary of Health and Human Services. Business associates of dentists (e.g., malpractice insurers, third-party vendors, etc.) also are required to notify the dentist if they experience a data breach.

The breach notification obligations only apply to breaches of "unsecured protected health information." Health and Human Services defines that term as any protected health information "that is not rendered unusable, unreadable or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the secretary in guidance." Health and Human Services issued guidance that the only mechanisms to render the protected health information unusable, unreadable or indecipherable are encryption or destruction. Health and Human Services further states that "encryption" must be an algorithmic process with a confidential process or encryption key. "Destruction" means that paper copies of protected health information must be shredded or destroyed; and electronic media copies must be cleared, purged or destroyed. In short, if a data breach is experienced, but the information in question was encrypted or destroyed consistent with the guidance, there is no obligation to notify the affected individuals.

Business associates: Prior to the HITECH Act, business associates of a covered entity were only contractually obligated to comply with HIPAA through their business associate agreements. After Feb. 17, 2010, business associates will be required to comply with the HIPAA security rule. That is, they will need to implement the administrative, physical and technical safeguards of the HIPAA security rule. In addition, if a business associate violates the terms of its business associate agreement or fails to comply with the security rule, the business associate will be subject to the same civil and criminal penalties as covered entities. It is important that current business associate agreements are revised, if necessary, to reflect these changes. It is the obligation of the covered entity to put an agreement in place with any business associate to whom they disclose protected health information.

Minimum necessary standard, limited data sets: Current HIPAA privacy rule provisions require covered entities to use, disclose or request only the "minimum necessary" amount of protected health information to accomplish the intended purpose, but the HIPAA privacy rule does not define the term "minimum necessary."
The HITECH Act requires Health and Human Service to issue guidance on the minimum necessary standard within 18 months

HITECH Act, continued

of the HITECH Act's enactment (i.e., by Aug. 17, 2010). For now, the HITECH Act defines compliance with the minimum necessary standard as using or disclosing a limited data set, which is a subset of protected health information from which the majority of identifiers (e.g., name, address, phone number, etc.) have been removed. Existing exceptions to the minimum necessary requirement continue to apply, including disclosures for treatment and payment purposes.

Access to electronic health records: Currently, covered entities are only required to provide individuals with a copy of their protected health information in the form or format requested if it is "readily producible in such form." The HITECH Act now requires covered entities to provide individuals with electronic copies of their electronic protected health information. Individuals can now also designate another person or entity to be the recipient of the electronic protected health information. This provision becomes effective Feb. 17.

California law: In addition, state law requires that dentists allow patients to inspect their records within five working days from receipt of a written request. Reasonable clerical costs for locating the records and making them available may be charged. Copies of records must also be provided to the patient or patient's representative within 15 days of receiving a written request detailing specifically which records are to be copied (CA Health and Safety Code §123100). Dentists must comply with current state law and the upcoming HITECH provisions.

Restrictions on disclosures of protected health information: The HIPAA privacy rule currently provides individuals with a right to request a restriction on the use or disclosure of protected health information for purposes of treatment, payment or health care operations purposes. Until now, dentists had no corresponding obligation to agree to that request. However, effective in February 2010, if a patient has paid out of pocket for services rendered and requested that the dentist not send their health information (or portions thereof) to their dental plan, the dentist must comply with this request.

HITECH provisions already in effect:

Heightened enforcement and increased penalties: The HITECH Act calls for heightened enforcement of HIPAA compliance. Prior to the act, penalties for noncompliance could be waived if the covered entity did not know, and through reasonable diligence would not have known, of the violation. This is no longer the case. All HIPAA violations may incur penalties, based on the level of intent or neglect behind the violation. Penalties range from $100 to $1.5 million per violation.

The heightened enforcement and increase in penalties provisions became effective on Feb. 17, 2009.

Sharpening Your Business Skills

By Judy Goldman

You awake one morning to realize that the changing dental industry has left you behind. Your monthly new patient numbers are way down along with your production; you're bookkeeping system leaves a lot to be desired using only about 50% of your computer program capability; your recall system leaves a lot to be desired; and you have just had a visit from your local OSHA office. Welcome to the business of dentistry.

Consider another scenario. You have recently graduated from dental school. As a new dentist, you are faced with the exciting decision of how and where to start practicing your new career. Whether you decide to be an associate in an established office, or enroll as a provider in a health care clinic, or set up your own new practice, this will be one of the most important decisions you will make in your dental career.

Starting a new dental office or reorganizing an old one can be more than just exciting and rewarding. It can also be expensive and frightening. A multitude of critical decisions will need to be made and the task may seem insurmountable. This is not the time for the weak spirited.

A doctor who decides to start from scratch will most definitely be one with courage, vision and a lot of faith. There will be many sleepless nights planning and thinking about contracts, lease agreements, equipment, staff, charts, systems and where the new patients will come from. The entire project may take more than a year from the birth of the decision to an actual operating dental practice. It will take even loner for the black ink to flow.

Established doctors who realize they have been left behind, and new doctors who decide to purchase an established practice will also be undertaking an exciting and risky project. You may find it necessary to completely restructure the practice to bring it up to date and become competitive in today's market. This too will be a major endeavor and may come in the form of both physical structure (décor and equipment) and the policies and politics of running the dental practice. A clinical minded practitioner may be uncomfortable venturing into these unknown realms of dental practice management.

There are a multitude of systems to be established in the clinical and administrative areas of a dental office. Although it may seem overwhelming at first, a host of questions must be addressed thoughtfully and carefully. Questions must address computer management, insurance relationships, marketing, overhead, OSHA compliance, hiring & firing, and staff management.

Since these are only a few of the concerns to be addresd, in addition to your clinical talents, sharpening your business skills

will become imperative. Dentists should seek professional help in setting up systems in areas where they are not experienced.

Dental organizations abound with continuing education which includes all areas of practice management. Consultants and trainers can be a resource for individualized custom guidance. Like the dental industry itself, practice management consulting has been growing and changing and consultants are specializing in defined areas of the dental business, making it possible to target a single area of concern.

You will find specialists in office administration, accounting, soft tissue/hygiene programs, patient communication, OSHA compliance systems, practice marketing, implant programs, insurance and collection systems. There are also a multitude of general practice management consultants who will provide a complete office administration package. With this variety, you now have the option to target a problem area with an expert, or cover all bases with a general practice administrator. Regardless of the resource, information received from these experts is invaluable.

Great opportunities lie ahead for the dental profession. It is exciting to consider the future, especially with a carefully laid plan for success. Either revitalizing your current practice, opening a new dental office or buying into an established practice, a dentist can look forward to a long productive career with professional and financial rewards. The key is to stay excited, but plan, and don't be afraid to ask for help if you need it. You have worked hard for your chance at success. Plan well now and enjoy the success for years to come.

Reviews available at www.PDA-JudyGoldman.com

Judy Goldman started her dental career at the age of 16 working as an assistant for her father (Dr. Speedy Nutz) and has, since then, worked in every corner of the dental practice. As the wife of a dentist, she brings over 35 years of practical experience to the field of Dental Consulting with understanding from both the team's and the business owner's perspective. She has added to this solid foundation an education in Business Administration and Marketing. This combination of practical hands-on experience, education, and business acumen has given Judy a unique perspective on the professional challenges of building a solid business and marketing program for the successful dental practice. This has made her a much sought-after educator, lecturer and author on the subject of practice administration and the start-up and organization of dental practices. It is Judy's privilege to be listed, for the past three years, in Dentistry Today as one of the industry's "Leaders in Dental Consulting". Whether your need is to build a solid foundation or revitalize an existing practice, Judy Goldman and Practice Development Associates understands your dream.

Dentists: Don't Let That Dispute Fester

Allan Kass and Jim Atkins are commercial and small business mediators and co-founders of Santa Cruz Mediation Group and would like to share with dentists the information they learned through their observations of patient disputes that have come before small claims and civil court.

We both have long relationships with our dentists and were pleased with our experience—so we were surprised to see a dentist being sued—and then more surprised when other dentists came before the courts. We started to see patterns. Based on our experience we'll venture that there will be an increase in small claims court disputes by patients with counter-suits by dentists. Compared to other health professions, dentists seem to be more visible and vulnerable by working in solo or small practices; as patient's co-payments or full payments increase there will be more disputes.

The observations and suggestions we share, we are sure will not be applicable to all dentists but some may find informative while others will say, "of course I do that."

I. Issues Related to Treatment

Patients view the dental experience as similar to going to a physician. Patients are used to having a dialogue with physicians during a visit and gaining information through that process and then going forward with that information for treatment. The dialogue might include diagnosis, treatment outcomes, alternative treatments, recuperation and if a treatment is lengthy/and or painful, follow up by the physician's staff about patient's concerns. Generally speaking, dental patients did not feel they experienced a similar process, as rarely is there a pre-treatment discussion about treatment results (to their satisfaction) nor follow-up post-treatment.

Disputes in court cases that we have observed related to treatment included but not limited to: purpose for treatment, "color matching, size and durability of crowns", and continuing pain.

II. Issues Related to Payment

There were many complaints regarding the "billing"/ payment process with a universal dissatisfaction with lack of information about patient's financial responsibility before treatment. Patients generally have an idea of what their health insurance plans cover but not their dental plans. Issues observed were: a) insurance eligibility, b) drug coverage or lack thereof, c) out-of-pocket cost to patient not being identified before treatment; d) dentist's billing not aligned with the insurance co-payment policy; and the most prevalent e) patient's not understanding their own policy.

Dentists: Don't Let That Dispute Fester, continued

III. Why Address These Issues

Our experience as commercial and business mediators has taught us that those businesses that identify small disputes early in the conflict process will result in the best solutions for everyone. With small claims court, the "best case scenario" is anxiety, loss of time in preparation for court and court time and worst case is up to a $7500 judgment, court fees, a " legal record" of the judgment and the negative publicity.

IV. Suggestions

a. Prior to "non-routine" lengthy, painful or expensive treatments and when obtaining "informed consent", be sure to discuss treatment outcomes and patients projected expense.
b. Following lengthy or painful treatment, have office staff follow-up with your patient so that staff will convey to you (the dentist) any concerns that need to be addressed by the dentist.
c. Align the billing process with patient's specific insurance co-pay policy but also include on form: "If you think there is a mistake in the billing, please call immediately."
d. Any questions that patient has about coverage, encourage patient to check with their insurance prior to treatment.

It is our experience that small disputes lead to large disputes and that although there is nothing earth shattering about these suggestions, implementation will reduce almost all the disputes that we observed.

GOT X-RAY STUFF?

If you are converting to digital radiography and have analog equipment or supplies no longer being used, Cabrillo College Dental Hygiene is looking to help you. Please consider donating functional equipment, film, developer, fixer etc.! Any such items are eligible as charitable donation income tax write-offs.

Contact Aud Kennedy at (831) 477-5269 or aukenned@cabrillo.edu

My Patient Filed Bankruptcy-Will I Be Paid?

According to creditcards.com, "California continued to lead the nation in 2010, with more than 59,000 (bankruptcy) filings for the first quarter of the year, followed by Florida, with nearly 26,000 filings. Illinois also topped the 20,000 mark. In California, filings soared by more than 40 percent over the previous year, while in Florida the number jumped by more than one-quarter." With such staggering data, it is no wonder dental practices are reporting an increase in the number of patients filing bankruptcy.

Even when a patient has a large outstanding balance, many practices are unaware of the severity of their financial situation until a notice of bankruptcy filing arrives. This filing will most likely come in the form of a notice to you by the bankruptcy court. Individuals file bankruptcy to discharge all or as much of their debt as possible; sadly, this often includes dental bills.

There are three different bankruptcy proceedings ("chapters") to be aware of 7, 11, & 13.

Chapter 7- This proceeding is the most common and is known as a straight or liquidation bankruptcy. The only money available towards a debtor comes from assets that can be seized and sold, but a primary residence and car are often exempted. Since there are often little assets to sale, your chances of seeing any payments from your patient are slim to none.

Chapter 11- This is the least common filing you will encounter. This is a reorganization proceeding where debtors try to keep their property and use it in the reorganization. It can be a long and drawn out process. Similar to Chapter 7, the chances of a debt being paid are slim to none.

Chapter 13- Also known as a repayment bankruptcy, and your most likely chance of receiving payments towards the patient's account. Chapter 13 allows individuals with a regular income to develop a plan to repay all or part of their debts usually over three to five years. Payments are made to a trustee, who then distributes them to identified creditors.

Dentists, who wish to be included in the repayment distribution for a chapter 13 filing, must contact the trustee or court and ask to be included in the initial meeting of creditors. A claim must then be filed with the court, within 90 days after the meeting, according to U.S. Bankruptcy Court. After the meeting, the debtor, the trustee, and those creditors who wish to attend, will come to court for a hearing to establish the debtor's repayment plan.

It can be upsetting when a notice of bankruptcy arrives from a patient that already has an outstanding balance. The initial reaction is to immediately discontinue treatment and attempt to pursue the balance. However, both of these actions could have possible negative results. Once a notice of bankruptcy arrives,

My Patient Filed Bankrupty, continued

discontinue all collection attempts against the patient or the patient's property. If a collection agency is involved, they must be notified of the bankruptcy and informed that collection efforts must discontinue.

If the patient is in the midst of treatment or in a provisional state, such as a crown, treatment must be completed before the patient can be dismissed from the practice. After treatment is completed, the patient can be sent a formal withdraw from care letter.

If you receive notice of a bankruptcy filing from a patient of record, consider the following:

- Do not discontinue treatment without giving the patient adequate notice to secure the services of a new treating dentist. You must complete any treatment that is in a provisional state before formally withdrawing from care.
- Stop all collection efforts towards the patient's account. This includes phone calls and statements. If the account is currently being handled by a collection agency, inform them that collection attempts must stop. You may still pursue pending insurance payments.
- Depending on the type of bankruptcy proceeding, determine whether you are listed on the debtor's schedule of creditors. If you are not, request to be added. You may have to write off the patients account if you are not included on the schedule of creditors.
- Download and complete the official proof of claim form. Document the specifics of the debt and attach supporting information.
    - http://www.uscourts.gov/uscourts/RulesAndPolicies/rules/BK_Forms_Official_2010/B_010_0410.pdf
- File your claim with the court where the patient filed bankruptcy as soon as possible.

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A pessimist sees the difficulty in every opportunity; an optimist sees the opportunity in every difficulty.

Winston Churchill

Make A Presence On The Web

By Garrett Guess, DDS, Technology Editor

Part 1: Domain Name Selection

The information available on the internet continually grows at an incredible rate covering just about every subject one could be interested in. One of the most valuable resources the internet provides to a dental practice is the ability for the practice to have a "presence," or a set of web pages that provide information to someone looking to research what the practice is all about. More and more, patients are using the information available on the internet to find a dentist, and learn about the doctor, the staff, and even the facilities. Internet web pages contain a far greater amount of information compared to a phone book advertisement, or mailed brochure. Having a web presence is becoming a necessity for any dental practice looking to inform current as well as prospective patients and colleagues about their office. If you currently do not have a web page that establishes your web presence, what are your options to get with the times? This article in this and subsequent issues will elaborate on the specific options available and the steps involved when a dental practice wants to create a web presence on the internet.

In their simplest form, web pages consist of a set of specifically formatted computer data files that reside on a computer that is specially configured to be visible to other computers on the internet. This special computer has a name that is established and individualized that permits computers on the internet to be able to find the computer when requested.

For example, when someone on the internet uses their web browser, and types in the web address "www.drguess.com," their computer will send out a request over the internet and receive web page files from the server computer that resides at my dental office, which is just sitting around waiting to share its pages. This process involves many networked computers that communicate over the internet, not just the person's computer and my server computer: domain name server (DNS) computers are computers on the internet that translate addresses like drguess.com into numbered addresses which correspond to specific computers on the internet. In my case, drguess.com corresponds to an address called an IP (internet protocol) address which is a series of numbers and periods (69.229.176.62, for example) that permits proper routing of information between the person's computer, and my computer. The IP address can be likened to a compressed list of driving directions with freeway numbers that lead to one another until the final destination is obtained.

In order to establish a web page that people can actually remember and discover, having a translated address is a necessity. Anyone would have a hard time remembering or even typing in the 4 sets of numbers every time they wanted to look up

my web site - it is a lot easier to type in "drguess.com" instead. Therefore, in order for a dental practice to have a web presence, one of the first decisions to make in this process, regardless of the specific method used to host web pages, involves deciding on a domain name. This name is utilized as the web address, for example www.drguess.com and is also used as the domain for email addresses, such as endo@drguess.com, so it is important to come up with a domain name that is easy to remember, clear to understand, and easy to type without making mistakes.

Once you decide on a name, there are numerous web sites on the internet available that permit you register or reserve the name so someone else can not use it. A quick search on the internet will reveal numerous web sites that provide such a domain name registration service; I have used Network Solutions since the beginning of the commercialized internet in the 1990's as they were the original domain registrar prior to the registration service also becoming a competitive business in and of itself. Their process is easy - just search for a name to see if it's available on their website, and if it is available, you can register it for a small fee. Once you have a name picked out, the next step is to decide which option works best for your practice to actually implement the web server itself. The decision making process to help determine the best method of web site serving will be discussed in the upcoming article in next month's Facets.

Part 2: Serving the Site

Creating a web presence involves multiple steps with various options to consider. In the last issue, the first step of obtaining a domain name that will represent your practice's website on the internet was discussed. Once a domain name is determined and registered, the next step is to decide how the web pages will be delivered to the internet. Web pages consist of numerous files that enable content to be viewed or interacted with by users browsing the internet. In order for a web site to exist on the internet, these special web page files need to be placed on a web server computer whose function is to respond to requests from internet computers so the content can be shared. A web server computer is an essential part to having a web presence, and there are several options available to a dental practice that vary based on initial and long-term costs, control and responsibility.

A web server computer from a hardware standpoint is not really a special computer. You don't necessarily go to the computer store and tell them "I'd like to buy your web server, please." A computer that provides web pages on the internet can be a simple machine that is connected to the internet, but has two specific differences over a normal home or office computer. First, web server computer needs to have an internet address that does not change. Most DSL or cable internet providers provide an internet address to your computer that is dynamic, meaning if you disconnect from the internet then reconnect, you will often end up with a different address. If your actual computer address changes, then that means the domain name server computers on the internet will not know how to route traffic when someone looks for your website. To prevent this dynamic address change, having a static address is necessary for a web server that has to remain accessible at all times. Obtaining a static IP address is as simple as calling your internet service provider and adding static IP address functionality to your service for a small fee. Once you have a static address, the computer becomes a web server by having special web server software enabled. This software is usually open-source software that is free, and as a result is often included in the computer's operating system architecture. For example, every Mac OS X-based computer has web server functionality built into it. Therefore, I can take an old Apple computer, give it a static IP address, enable the web server software, and presto: I have a functional web server. After the particular web page files are placed on the computer, it will become a working web server.

The Domain Name System which routes internet traffic that requests your web site's name to your actual machine, enables a web server computer to reside anywhere. That means a dental practice has three options to have web server functionality: to have their own web server computer on their premises, to have their own computer off the premises (like at their home), or to have their web site completely hosted by someone else using their servers (website hosting services). It is evident from these three options that the level of involvement and responsibility varies significantly. Owning and maintaining your own web server computer provides the most control of not only the files themselves, but control of the site availability, as well as bandwidth. If you have your own server, that computer and internet connection is only serving a single site, versus an internet hosting company that may server thousands of sites increasing their risk of a server going down due to significant traffic load or increasing exposure to hacking attempts. On the other hand, paying a company to host your web site means you depend on their systems to be functional at all times, and your also are bound by their restrictions on bandwidth usage and storage space. With the internet popularity and the ease of publishing web sites due to software improvements, there are many companies that now provide web hosting services for a very low fee, like $5.00 per month - google "web hosting" and you will see there are plenty of options available. Paying someone else to serve your website is cheaper in the short term but more restrictive, whereas running your own web server requires more knowledge of the process, but gives you greater flexibility overall. If you do not have the knowledge to set up and run your own server, have a computer consultant set up a

machine in your office, so you can get the benefits of having your own server without having to learn a new trade. Once a web server computer is set up and running it requires minimal to no involvement: just an active internet connection, and power, and it will take care of the rest. In the next issue, options involved with the content and capabilities of web pages will be discussed.

Part 3: What do you want your web site to do?

The past two technology articles have outlined the first steps to obtaining a web presence for a dental practice: choosing and reserving a domain name for your web site so people will know how to find you, then the options of how to provide web pages to viewers by either hosting pages on your own server, or by hiring a service provider. Regardless of the method of serving your web pages on the internet, the next step to consider in the process is deciding what content and capabilities you want the web site to possess.

The simplest of dental practice web pages are those which serve solely as informational pages aimed primarily to inform patients (like my own practice site http://www.drguess.com). These sites provide practice contact information like address and phone number, doctor and staff information, services provided, as well as information about the physical facilities. These simple web pages are useful to introduce a practice to a prospective patient, or help a patient find directions to the office if they don't feel like picking up the phone to call. Most patients are anxious about dental care, especially new patients, so having a way for them to see where they are going, and what to expect can help familiarize them with the practice and minimize the anxiety of going somewhere totally foreign. Web pages can also serve to advertise work results with case images that provide the scope and quality of your work, something that is helpful for esthetic services aimed at prospective patients (not very useful for endodontics!).

Beyond the advertising capabilities of a web site, there are other functions a web site can perform by becoming more interactive. If your office utilizes electronic patient records, a web site can be used to permit patients to register their information, permitting them to complete the required registration "forms" prior to their visit to the office. This allows a patient to arrive at their appointment, and all of the necessary personal information, medical history, medications, etc., can be already entered into the practice management database saving the front desk staff the work. This is extremely useful from an efficiency standpoint in a practice that sees many new patients, like a specialty practice, as the time used by patients filling out forms can be completed in their own time outside of the allotted appointment time, prior to coming to the office. While the convenience of online patient registration seems like a no-brainer, there are a couple important issues to consider before employing such a system. First of all, depending on your patient demographic, some people may not have internet access, or those that do may not trust sending their medical and personal information online. Additionally, having users directly able to create records in your practice management software can have negative consequences if abused. For example, a hacker could create a routine that will register an endless number of patients as fast as possible, which can overload a server computer and possibly crash it or corrupt it. For this reason, most dental practices that utilize online patient registration, do so by an indirect method: patients fill out a form online that is not directly tied into the main practice software. Instead, a separate database is used to retain that info, and when needed it the information is imported into the main practice management software database. This insulates the server from online hackers and malicious software routines that can bring down a server computer. A safer and still useful alternative to having online registration is to provide registration forms online for download and printing, so patients can bring the filled out forms to their appointment.

In the near future, patients may be able to access their full chart records online, which would be an extremely useful tool when patients are referred for specialist care, for example: they won't need to remember to bring xrays or a referral slip, or request an office to send information. By simply logging in their dentist's electronic chart over the internet through their web pages, treatment information and images could be instantly viewed to obtain the best and most detailed history possible to provide the best care feasible. This capability exists today, but unfortunately the potential security and liability risks far outweigh the potential benefit. So for now, the most common use of a web site for a dental practice is firmly set as an advertising medium for prospective patients. As security measures and familiarity amongst the doctor and patient population increases, greater functionality from dental practice websites will become the standard. With the content of your practice web site in mind, in next month's article the methods of creating the actual files that make web pages will be described.

Part 4: Creating the content

Reaching out to the world, or more practically to your patients and colleagues, via the internet most commonly involves the use of web page-based media that anyone anywhere can view on their computer. If you have made the decision to have a presence on the web, creating the content to appear on your web site can be done in many different ways, with varying involvement and varying expense.

If you do not have an interest in learning the process of web page creation, there are many businesses out there that provide full service one-stop packages to get you online. These businesses

will ask you for particular content input, mostly to create the textual information displayed on the pages, as well as get photos and video from you that you want to include on the pages, as well as the colors and overall layout design you prefer. Often these web designers utilize a template web site where you can fill in your personalized information and images and they will create the pages, and even host them for you for a monthly fee. The drawbacks of this type of service starts with the higher cost compared to the alternatives, and also that many of these website creation businesses tend to create web pages that all look the same from a layout standpoint, and use the same stock images throughout the pages. It is not uncommon to see the same grey haired man smiling with his super white teeth on different dentists' web pages. Original content and original design is attainable, but usually comes at a premium when you're paying for someone to create original designs for you.

For the do-it-yourselfer, the old days of coding HTML files as the sole means to create custom web pages have been eclipsed thanks to the numerous available commercial software packages that can build web pages from a more familiar word processing interface, and have minimal cost from free to several hundred dollars. Most computer users these days have the ability to use software applications to create documents, for example using Microsoft Word. In addition to standard text documents, these applications like Word permit the simple addition and manipulation of graphics and images to make professional quality printed works. Web page creation software use the same easy methods as used by word processing programs to create completely customized web pages that can incorporate videos, music, images, text, and various layout designs. By creating your own pages, the originality and flexibility to display what you want is not constrained. Additionally, by having the ability to change the content yourself, you can update it as frequently as you want without significant cost versus paying someone every time you change your site.

Another option to create pages to be displayed on the internet is to use someone else's templates and layouts, on someone else's server - this is similar to the methods incorporated by FaceBook, or LinkedIn, where you add content to a site that is owned and served by those respective companies. You have less freedom of design, but you can simply get your practice's information out there on the web.

When deciding on the type of content to have in your site, it used to be that a website was designed in different forms: one that didn't include high resolution images for those users who browsed the internet with a lower speed telephone modem, and then one version for those with high speed internet. These days, creating special content for slower connections has been eliminated, with web sites now detecting the type of web browser to tailor content to based on formatting instead of speed - for example, if a computer is accessing the site, its normal configuration is displayed with videos and animations; on the other hand if a cell phone is accessing the site, a stripped down, smaller interface version is displayed. While most dental practices are not making web sites that are dynamic in their layout designs, this may change as the popularity of internet browsing phones and devices continues and patients seek more interaction and utility from their dentist's web sites. The creation of the web page content in general has a varying cost, flexibility with regards to originality, and ease of content editing depending on the amount of involvement you are interested in having and the amount of money you want to save.

Editor's Note: Dr. Guess is a Diplomate of the American Board of Endodontics, and maintains a private endodontic practice in the La Jolla/ UTC area. He also developed an endodontic practice management software program called EndoTrac. Dr. Guess serves as the Technology Editor for FACETS, the newsletter for the San Diego County Dental Society. This series of four articles appeared in FACETS earlier this year. They are reprinted here with the kind permission of Dr. Guess, Dr. Brian Shue (FACETS Senior Editor) and the SDCDS.

Monterey Bay Dental Society
Component Profile—May 2010
Demographics

Total Number of Members (approx): 409

Age of Membership
20-29……5
30-39……58
40-49……75
50-59……..113
60+……158

Gender of Membership
Female……67
Male……..342
Undisclosed……..0

Number of CDA Delegates……4
Number of CDA Trustees……..1

Sedation Dentistry and Sleep Apnea

By Dr. Todd Morgan

The pharynx manages some of the most complex functions of the human body, changing tone and shape with every breath, swallowing effort, and vowel we pronounce. Unlike other animals that have rigid and strutted airways, ours is flexible and supported only by muscle tone. Indeed, it is precisely the floppiness and length of our airway that sets us apart from other animals: not only do we possess the physical prerequisites for speech; we also have the cortical equipment needed for expression of abstract thought through language. But at night we are bound to the same physiologic principles as other mammals when sleep commands muscles to rest.., but leaving us uniquely vulnerable to airway collapse. Snoring and obstructive sleep apnea (OSA) is a measure of this collapse when airflow is diminished through changes either muscle tonus or altered caliber.

THE PROBLEM

We understand now that both the muscular (tissue compliance) and neurologic (reflexive) components that help the airway respond to closing pressures during sleep are altered in OSA patients. For patients with sleep apnea that undergo sedation, pharyngeal muscle tone is diminished further, risking exacerbation and dangerous hypoxia. Anesthesiologists are keenly aware to follow tailored protocols for patients with a diagnosis of sleep apnea in the outpatient surgery and hospital setting, as set forth by the American Society of Anesthesiology. (1) However, it is the undetected apneic that is at particular risk and this is why any healthcare provider administering sedation or narcotics should use precautions to identify and protect these patients.

SOLUTIONS

Identification of at-risk patients can most easily be accomplished thru the intake health history, plus adding two or three additional questions once co-morbidities to OSA are found. For example, given that a patient presents with hypertension and is also obese, one may consider asking about snoring or repeated arousal and un-refreshing sleep. A level of suspicion about OSA can quickly be developed and referral for evaluation recommended. Taking it one step further, a short questionnaire designed specifically to identify OSA risk is preferred.

In a study conducted last year, two dental offices in San Diego were asked to administer the "Apnea Risk Evaluation System" (ARES) questionnaire to consecutive patients in order to assess prevalence of undiagnosed OSA in those patient populations, as part of a larger NIH funded grant designed to study the effects of oral appliances. (2) Both offices demonstrated very similar prevalence, showing that 67% of men and 24% of women were in need of a sleep study. A random subset of those queried were given sleep studies that showed the questionnaire correctly correlated sleep disordered breathing with 98% sensitivity. Further, the questionnaire also correctly predicted that 70% of those surveyed would have moderate or severe OSA. Given these results, one might expect statistically to find considerable numbers of patients with untreated OSA in their practices. Physical inspection of the oral cavity and oropharynx can also be quite telling. The classic "tongue to big for the mouth" patient that has your assistant complaining quickly about their forearm muscles may also have apneic tendencies. Many of these patients will show signs of bruxism and/or clenching, understood now to be compensatory maneuvers to thwart pharyngeal collapse. Some of these signs are: scalloping of the lateral borders of the tongue, linea alba, as well as tooth wear and headache. They may also be those folks who have the most disdain for your dentistry: would you complain if you already have a crowded pharynx and then someone wanted you to open wide (closes airway), stuff cotton rolls in your mouth (closes airway), and then pushes your tongue back and sprays water (chokes you)? Sounds like that could cause anxiety.., aren't those the same patients we're sedating??

Sedation dentistry is a wonderful opportunity to make our patients comfortable during care and has a proven track record of safety. Understanding the added risks of sedating patients who are predisposed to airway collapse in the post-operative period is our responsibility. Simple questioning to uncover covert OSA, as well as guiding the patient toward evaluation and taking the proper precautions during the recovery and pain management phase of care is not only prudent, but may also be a life saving service to our patients.

Dr. Todd Morgan maintains a general practice in Encinitas at Scripps Memorial Hospital. He has been treating OSA in his practice since 1990, and is a charter member of the American Academy of Dental Sleep Medicine. He has authored a book chapter and published several articles in peer-reviewed medical journals. Recently, his group completed one of the largest NIH funded studies on the effects of oral appliances for sleep apnea. *1. A Report by the American Society of Anesthesiologists Task Force, Practice Guidelines for the Perioperative Management of Patients with OSA. Anesthesiology, 2006. 2. Morgan TD,Levendowski DJ, Montague J, Metzler V, Westbrook PR. Prevalence of Probable Obstructive Sleep Apnea Risk and Severity in a Population of Dental Patients, Sleep Breath 2008*

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STEM CELL RESEARCH AND DENTISTRY
BY DEBORAH ELAM MS, CAE

What is the title of the research activity?
Utilization of autologous adult mesenchymal stem cells for repair and regeneration of oral and maxillofacial tissues. Autologous means that the donor and the recipient of cells is the same person. Therefore, no immunological reaction to the implanted cells will occur.

Who are the investigators?
Mirek Tolar, Robert Boyd (Dept of Orthodontics), Thomas Indresano, Anders Nattestad, Bahram Javid (Dept of Oral and Maxillofacial Surgery), Robert Ahlstrom (Implant Clinic), Ove Peters, Alan Gluskin (Dept of Endodontics)

What are you trying to find out?
Our main projects are:

1. To determine the optimal cultivation conditions for bone marrow-derived adult stem cells that can then be used for building new bone tissue and cartilage
2. To use platelet-rich fibrin or platelet-rich plasma for enhancement of adult stem cell growth and differentiation. Autologous platelet-rich plasma has already been used clinically to enhance healing and regeneration of injured tissues after surgery. We are interested in its supportive effects on adult stem cells in vitro and want to look into mechanisms of its action on the cellular level.
3. To analyze the host response during healing of a periradicular lesion and to mobilize dental pulp-derived adult stem cells for pulp and dentin regeneration. We are interested in the role of adult pulp stem cells in the regenerative process.

Why is this research important?
Autologous skin, skeletal muscle, bone, even teeth have been successfully transplanted to different sites of the same person for decades. Adult stem cells have the advantage that they can be induced to form different tissues. Dental pulp-derived stem cells can differentiate not only into odontoblasts, but also into osteoblasts and other connective tissue cell types. They can be obtained from deciduous teeth of a child, preserved frozen and used when the individual needs them later. Similarly, stem cells can be isolated from extracted wisdom teeth.

Embryonic stem cells (derived from embryos) and induced pluripotent stem cells (adult cells that have been genetically manipulated to proliferate and differentiate) also possess proliferative and developmental potential that we are still learning to control. By contrast, autologous adult stem cells have already been shown by numerous autologous bone and bone marrow transplantations performed during last decades to be safe for patients. This is why laboratories are pursuing this line of bench-to-clinic research for various types of adult stem cells.

How are you doing this research?
We will use mainly laboratory in vitro models for studies on growth, differentiation and expression of specific markers of adult stem cells. We are developing a rodent model of dental pulpitis, in which treatments utilizing dental pulp stem cells can be tested.

When will this research be finished?
We plan a time frame of 2-3 years for the projects outlined above. Based on the results of one phase, the next phase will be planned and implemented.

How will the results of this research eventually translate into clinical dental practice?
Regenerative dentistry using stem cells offers a new realm of dental treatment that will become more and more important in the future.

Mao JJ wrote (Stem cells and the future of dental care, NYSDJ, March 2008, pp. 20-24): "Stem cell research and development will, over time, transform dental practice in a magnitude far greater than did amalgam or dental implants….stem cell technology will generate native tissue analogs that are compatible with the patient's own."

Mirek Tolar, MD, PhD, is Associate Professor in the Department of Orthodontics, Dugoni School of Dentistry UOP. He is Head of the Pacific Regenerative Dentistry Laboratory.

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Focusing your life solely on making a buck shows a certain poverty of ambition. It asks too little of yourself. Because it's only when you hitch your wagon to something larger than yourself that you realize your true potential.

Barack Obama

Compounding Corner

by David Smith

Lichen Planus

Lichen planus is an inflammatory disorder of an unknown cause. Oral manifestations represent the most common dermatologic disease of the mouth. Lichen planus is usually seen in middle-aged adults and is commonly associated with stress, anxiety, and a variety of drugs. The oral form of this disease typically presents in two forms; reticular and erosive lichen planus. Reticular lesions have white, lacelike lines or striae on the lateral borders of the tongue, buccal mucosa and gingival tissue. Most patients are unaware of the intra-oral form of the disease as it is often asymptomatic. However, the erosive, atrophic or ulcerative form of lichen planus may display ulcerated areas with mucosal atrophy; these can be quite painful and may require long-term pharmacologic therapy.

Treatment of Lichen Planus

The immunologic complexity of lichen planus makes this disease state a challenge to treat. A & O Compounding Pharmacy has a formula for a Troche which contains, Tretinoin 0.1% and Clobetasol 0.05%. Tretinoin stimulates mitotic activity and increases turnover of follicular epithelial cells causing revitilization of the top layer of tissue. Clobetasol is a potent corticosteroid which decreases inflammation.
We were involved in treatment of a 58 year old male patient who had reticular lesions on his tongue. His physician prescribed Stanford Mouthwash (Tetracycline/Nystatin/ Hydrocortisone/ Chlorpheniramine) for 2 rounds of treatment. Although the patient experienced symptomatic relief from using the Stanford Mouthwash, the lichenoid lesions did not heal. On our recommendation, the patient was then prescribed the Tretinoin/ Clobetasol Troche which he allowed to dissolve on his tongue three times daily. The lichen planus cleared up within 5 days of treatment. As a note, we have used Tretinoin/ Clobetasol Mouthwash but it may cause excessive irritation to the mouth. The troche dosage form is more localized and can be pressed against an affected area. Dosage forms such as the Polyox mucosal bandage for singular or a small number of lesions can be utilized to coat and deliver active ingredients to the site of action. Polyox mucosal bandage made with Tretinoin and Clobetasol may be applied to erosive or ulcerative forms of Lichen Planus.

Local Anesthetics

We have recently been working with several of your colleagues on topical anesthetics.
This form of anesthesia has become increasingly popular due to its ease of application which provides the necessary action needed for a procedure. We have formulations that require a small amount of medication to be used topically, good flavor and at a savings to your practice. Please call on us if you have any questions or if there is a product that is unavailable or no longer made. We would be interested in working with you.

Editor's note:
David Smith is a compounding pharmacist and owner of A & O Pharmacy in Salinas. He regularly contributes original articles detailing pharmaceutical compounds which can be of benefit to dental patients. David can be reached at 758-0976 or via e-mail at aopharmcy@yahoo.com

RM Matters - Prescription Liability

By Carla Christensen
Risk Management Analyst, TDIC

Many dentists treat their dental teams like an extension of their families; so when an office manager has a sinus infection or a hygienist has trouble sleeping, the dentist may feel compelled to help them. Unfortunately, attempts to assist staff, relatives or friends with non-dental ailments may result in discipline with the dental licensing board and may even cost the dentist his or her dental license, as well as, place the person taking the medication at risk. Practicing medicine without a license is a presumption of negligent care.
For example, a dental assistant's husband strains his back while repairing his car. The assistant asks the dentist to prescribe her husband a few prescription painkiller tablets until he can see his physician. This is a valued employee so the dentist decides to write the prescription. Two days later, her husband is involved in a work-related accident. Drug testing by his employer reveals the presence of the painkiller, which is in violation of the company's vehicle operation policy. He admits he failed to contact his doctor after he obtained the medication from his wife's employer. The dentist is charged with practicing medicine without a license and the dental board and Drug Enforcement Agency (DEA) initiate investigations. State licensing boards give particular scrutiny to prescribing narcotic pain medications such as VICODIN® because of the potential for misuse.

Even if the treatment involves a condition of dental origin, a dentist is at risk if he or she writes a prescription without first performing a dental exam, obtaining a health history and documenting indications for prescribing the medication. Asking if the employee, relative or friend has any known allergies prior to prescribing is not sufficient. The individual may be taking another medication that could result in a serious drug interaction. Be aware of staff that have access to your DEA number. It is illegal for an employee to use your DEA number to call in a prescription or to order additional medication through an established vendor without your authorization. Access to your DEA number does not entitle a member of your staff to prescribe or obtain prescription medications without your knowledge and approval.

To avoid potential exposure for prescription liability follow these guidelines:

- Do not write a prescription for anyone who is not a patient of record.
- Do not provide medication or prescriptions for non-dental issues.
- Examine the patient, obtain a health history and document the diagnosis related to treatment recommendations and prescriptions.
- Keep all narcotics in a locked location; you should maintain possession of the only key.
- Perform frequent, random stock checks and audits.
- Secure prescription pads and closely monitor quantity.
- When possible do not delegate pharmacy prescription calls to staff.

Prescribing medication for an employee, friend or family member who is not a patient of record places a dentist's reputation and license at risk. The best of intentions may result in the worst outcome for you. The best practice is to treat family members and friends the same as all other patients, without exception. Avoid liability exposure by refusing to write prescriptions for non-patients and for non-dental reasons. If you have any questions regarding the information presented in this article or you need to discuss another risk management issue affecting your practice, please call the TDIC Risk Management Advice Line at 800.733.0634.

TDIC

Dental Assisting 2010

What the Future Holds for the Santa Cruz County Dental Assisting Program!

Some may say the future of Dental Assisting Programs looks grim based on the number of graduates versus actual employment opportunities in the surrounding dental communities. What does the employment market look like for vocational training within our local dental community? You'd be surprised, but the opportunities are out there!

Last year, of the 26 students at graduation, 50% of those students held part-time and/or full-time positions. Approximately, 70% of those graduates are now working in the dental field!

Our current graduating class of 23 students has nearly met the same employment status of 50% employed part-time/full-time with one student hired as a temporary employee over the summer. The majority of our graduates have been hired locally. Several students are continuing their education by pursuing their RDA licensure upon completion of their work experience requirements, and there are several students pursuing dental hygiene.

We have been very fortunate to have a tremendously supportive dental community in providing our dental assisting students internship opportunities with direct hands-on-training as well as local dentists providing leadership, guidance, and lecture/power point presentations supporting our revised curriculum.

As part of our revised curriculum, our students begin their initial pre-clinical internships early in October and continue through spring as they advance in their clinical training. Our students are required to complete a minimum of 240 clinical internship hours. Several of our students completed well over 320 hours in pursuit of additional clinical experience opportunities at a variety of dental office settings (private and clinics).

Our goal is simple, to provide our dental communities with educationally-qualified dental assisting professionals. We are a constant "work-in-progress," as we look to the changes in dental assisting duties and technology including teaching methodologies to accommodate the learning styles of our students.

As instructors, we are staying abreast of teaching methodologies via our membership through the California Dental Assisting Teachers Association (CADAT). This year, Minerva Zepeda and I are honored to have been asked to serve on CADAT's Board of Directors. We have also encouraged membership for all of our teaching staff including instructional aides.

CADAT is also providing a student textbook resource to prepare students/employees for the upcoming Dental Ethics and Law examination. CADAT is also looking to add a "student page" to their website as a resource for students in assisting students and exam candidates in providing information regarding RDA examination applications, RDA schedule and filing dates, listing of resources for review classes, kit rentals and study guides!

There has also been a significant change in the application process to our program to include a reading assessment test, mandatory

orientation, and a panel interview with administration and teaching staff. In addition to these changes, high school students are encouraged to take the "Dental Occupations Program" taught by Minerva Zepeda, RDA prior to their application/enrollment to the Dental Assisting Program.

As with many other programs within in the state, we are limited by our budgets, but fortunate to have facilities such as the Cabrillo College Hygiene Department to assist us in providing our student facility use for our Dental Radiology Certification course and other needs! We are very excited about the transition to the new facility at the Cabrillo Hygiene Department which will allow us the use of six dental x-ray operatories! We should mention that our program is fee-based which includes textbooks, materials fees, CPR training, OSHA training, etc.

To meet the needs of our students, two of our instructors have also obtained their CPR instructor's certification! During the past two years we have incorporated "interview workshops" in preparing our students for employment opportunities by having "mock" interviews with local dentists and office managers. Yes, "we are definitely a work-in-progress!"

On a final note, we are in desperate need of an electric dental chair! One of our units "died" this past semester, and we would appreciate anyone who may be in the process of remodeling an opportunity to "donate" a chair to our program

On behalf of our graduates, administration, and teaching staff, we sincerely wish to thank our local dentists and dental community for your continued support and most of all, an opportunity to serve you!

Best regards,
Debbie Reynon, CDA RDA AA

Santa Cruz County ROP

Dental Assisting Program

Email: alliemae1956@aol.com

Hair is the first thing. And teeth the second. Hair and teeth. A man got those two things he's got it all.

James Brown

Future of Dental Laboratory Technology

Carol Pilmer owns R Dental Ceramics in San Diego, and is an active member of the Dental Lab Owners Association of California. She represents this association at CDA, and regularly speaks and writes on behalf of dental laboratories for state and national organizations. This article is reprinted with kind permission of the San Diego Dental Society and Ms. Pilmer.

The 2008 CDA HOD Resolution 37RC-2008 sponsored by the San Diego County Dental Society directed the Policy Development Council to "study the issues affecting dental laboratory technicians including the workforce capacity, and outsourcing and quality of materials" and to "report to the 2009 CDA House of Delegates their findings and recommendations".

In response to this resolution a Dental Lab Work Group was created by the PDC. Members included Dr. Lawrence Radcliffe, Dr. Wai Ming Chan, Dr. Ed Graham, Dr. Karin Irani and Ms. Pilmer with CDA Staff members Bill Lewis and Gayle Mathe.

As a CDA Allied Dental Health Professional, guest member of the CDA Board of Trustees and member of the Dental Lab Work Group and at the suggestion of Dr. Russell Webb, Carol Pilmer attended the ADA FUTURE OF DENTAL LABORATORY TECHNOLOGY CONFERENCE representing the California Dental Association on August 7, 2009

This Chicago ADA meeting was mandated by a 2008 ADA HOD Resolution for the ADA Council on Dental Practice to examine the State of Affairs for Dental Laboratories.

Background information presented at this Conference came from Drs. Gordon Christensen and William Yancy who have convened annual Dental Lab Summit Council Meetings since 2005 during the Chicago Mid Winter Meetings.

The objectives of their meetings included identifying the challenges facing the dental labs and the impact on the delivery of dental care; recommend actions to meet these challenges; publish findings to stimulate, facilitate and motivate action by those organizations able to meet and resolve the identified challenges.

Four Major Areas of Discussion for the Summit Included:
1. Dental Lab Educational Programs, Student Recruitment & Retirement
2. Regulation: Dental Lab Certification Issues; Off Shore Dental Labs; Grey Market
3. Dentist Lab Interaction
4. CAD/CAM Technology

The Conference combined the Certification & Off Shore categories and renamed it Regulation.

This ADA Conference had 58 listed attendees representing all areas of dentistry and dental lab technology. (General Dentistry, Dental Education, Student Dental Association, National Association of Dental Laboratories, Prosthodontic Forum, ADA Board of Trustees, ADA Council on Dental Practice, ADA Council on Scientific Affairs, Commission on Dental Accreditation, Members at Large, Dental Publications, American Academy of Cosmetic Dentistry, CDA, several dental manufacturers, and individual dental laboratories)

Dr. Kathleen O'Loughlin, ADA Executive Director, was introduced to the group and brought greetings from the ADA.

The first presenter was Bennett Napier, Co-Executive Director of NADL. His presentation focused on lab statistics, regulations and off shore statistics.

Mr. David Owsiany, Ex Director of the Ohio Dental Association shared an update regarding the 2008 TV coverage regarding "Lead in a Crown". He cited a letter dated April 17, 2008, from the CDC to the ADA stating that such small amounts of lead in the crowns tested are unlikely to cause adverse health effects. Following the results of tests conducted by outside sources for the ADA, released in March 2009. Since the release of these findings there has been no further stories on lead in dental crowns.

Dr. William Yancy, shared greetings, thoughts and opinions from Dr. Gordon Christensen to the group and presented the following recommendations for the group to consider during the day's discussion:

- The ADA should assist in the development, funding and student recruitment for these schools.
- States should be encouraged to develop laboratory certification programs, with mandatory CDT supervision in the labs.
- Dental school administrators and CE directors should be encouraged to combine dental and DLT students together in common educational programs.
- The ADA should include more dental laboratory technology programs in its sponsored programs.
- The ADA should be encouraged to work with the FDA to provide adequate observation of offshore lab products and make a statement supporting the disclosure of offshore lab use to dentists and the dentists disclosing to patients.
- Developing more Accredited Dental Tech Schools

Dr. Burney Croll, Ex. Director of the Lab Summit, presented information about the adequacy of undergraduate dental school training and examination in prosthetic dental laboratory techniques, as well as workforce concerns, the education and alternative training models used for dental lab technicians.

Presentations continued with Dr. Damon Adams, editor-in-chief of Dentistry Today, sharing his insights regarding Doctor-Technician Relationships and Mr. Warren Rogers of Knight Dental Group gave an overview of the Complex Challenges Within Contemporary Dental Labs.

Dentist/Technician Relationship breakout session examined the following issues:

- Creating relationships with high schools to develop and promote dental lab technology as a career choice.
- Local dental societies should be encouraged to create a partnership with DLT schools to introduce dental technology education/training to high school students.
- The need to create policies to support Dental Lab Tech standards and certification.
- The relationship between dentists and dental lab techs should be promoted and CE courses at meetings that feature both dentists and dental lab tech speakers should be promoted.

The Dental Educational Group's discussion included:

- Promoting the value of dental lab technicians through interdisciplinary education.
- Encouraging dental schools to use local dental labs so that dental students can interface with dental lab technicians.
- ADA is encouraged to include sessions to provide interaction between New Dentists and dental lab technicians.
- ADA is encouraged to support increasing the number of dental lab techs in the workforce and that dental schools use Certified Dental Labs to support their programs.
- The possibility of having Dental Lab Technology programs established in dental schools, thereby giving both parties the opportunity to learn together and begin forging working relationships early in their careers.
- For those schools where this is not possible, create at the very least some type of interaction between technicians and dentists, whether an internship or visitation.
- ADA should discourage the overseas outsourcing of student cases as a cost effective way of having the restorations fabricated. (This is a common practice in some of the Dental Schools throughout the United States)

Future of Dental Laboratory Technology - continued

Regulatory/Offshore Breakout Session discussions included:

- Dentists should document all materials used for patients in the patient record.
- Creating uniform state regulations and a national curriculum for dental lab technicians.
- Strive to create market based, not government based solutions to the problems dental labs currently face.
- Support full disclosure of point of origin from lab to dentist and encourage the same from the dentist to the patient.

CAD/CAM Technology observation report contained:

- The realization that this new technology will impact the profession significantly in the future.
- Digital impressions have a steep learning curve and have the promise to eliminate steps, improve accuracy and result in fewer remakes.
- Manufactures appear to use dentists as beta testers and encourage them to invest in new technology that may not have a positive return on investment.
- Technology alone cannot change behavior; a dentist can still take a bad digital impression.
- CAD/CAM technology is complex and costly.
- This technology will not eliminate the dental lab.
- Digital communication tools such as shade matching may increase and improve the dentist/lab relationship and reduce remakes/reshades.
- Trends toward off shore outsourcing and in-office CAD/CAM puts pressure on labs to stay competitive and CAD/CAM may make dental labs attractive to investors….

Ms. Pilmer was asked to share her lab's CAD/CAM experiences and was assured by other participants this was the type of information that interested the group's participants.

As a follow-up to this conference the ADA Council on Dental Practice will review the report and make its recommendations to the ADA Board of Trustees.

Carol J. Pilmer

Allow the president to invade a neighboring nation, whenever he shall deem it necessary to repel an invasion, and you allow him to do so whenever he may choose to say he deems it necessary for such a purpose - and you allow him to make war at pleasure.

Abraham Lincoln

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Email:minervaloveslife@gmail.com.

Minerva Zepeda, RDA, is an instructor for Mission Trails ROP teaching dental x-ray and for Santa Cruz ROP at Watsonville High teaching Dental Occupations.
She has this to say in regards to her work as a teacher: during my twenty eight years of experience working in the dental field I have learned listening, interpersonal skills and much more.

Teaching provides me the opportunity to share my experiences, challenges, skills and abilities with aspiring dental assistants in the program.
I also teach workshops twice a year for Santa Cruz ROP for Dental Assistants introducing students to digital x-ray, software, and equipment management.
I too am an ROP graduate many moons ago so I know the challenges that may come up! So sharing my stories, obstacles and challenges can motivate and set the example to students in a supportive way. I traveled the journey of a Registered Dental Assistant, walked the path and now I am excited to be an instructor. There are no limits to one's personal and professional growth working in the dental field—so reach high!
Many smiles, Minerva

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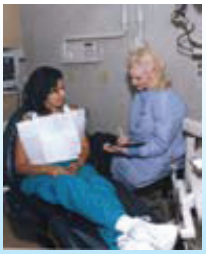

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Suzie Dault, C.D.A., R.D.A.E.F. is the President/Founder of Dental Specialties Institute, Inc. In addition, she is a Certified instructor for both the American Red Cross and the American Heart Association and has been serving the dental profession for over 20 years. Member C.D.A.A., N.D.A.A. and C.D.A.T.

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We are sponsoring a drive to collect items for care packages that will be shipped to service men and women in Iraq and Afghanistan. The next shipment will be:

Wednesday, November 17, 2010

Deadline drop off at the Monterey Bay Dental Society Office is Wednesday, November 10. The following items are needed for care packages:

Food/snacks: chewing gum, mints, individually wrapped hard candy, lunch box sized packages of seeds, pretzels, cookies, etc. Granola bars, instant oatmeal, sweetened drink mixes (crystal light, Kool-Aid), ground or instant coffee, cocoa, tea. Sugar and sweetener packets. Small pop up tins of tuna or chicken (NO PORK PRODUCTS). Lunch packets of tuna or chicken with crackers, fruit, non-refrigerated microwaveable meals, dried fruit (NO APRICOTS –"bad luck"), Slim Jims.

Personal/ Hygiene: Hotel/travel size deodorant, shampoo, lotion, conditioner, toothpaste, mouthwash. NO SOAP. Toothbrushes, floss, brush-ups, breath strips, disposable razors, eye drops, saline nose drops. Small had sanitizers, small Kleenex packs, Q-tips, anti-fungal creams, band-aids, medicated foot powder, moleskin cushions for feet, non-aerosol air freshener, new or used DVDs or CDs, AA and AAA batteries, disposable cameras, current paperback books and magazines, pens, cards for the troops to send home.

We can also accept checks to purchase items. Kindly make check payable to "Operation Yellow Ribbon-Monterey". Your donation is tax deductible. For more information contact Barbara Johnson at (831) 622-7630 for OYR. If you need a pickup of items please call Drs. Marielena Murillo (831) 521-6745 for Salinas, Monterey, and South County, and Dr. Alison Jackson (831) 662-2900 for Aptos, Santa Cruz, and North County.

Thank you for your donation!

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