



Oral health indicators for
OREGON

PAGE 17

PLUS

***ADA Research Brief:
Dental Care Utilization Rates***

63.4

57.3

68.9

60.5

39%
Oregon

42
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ADA's Health Policy Institute's interdisciplinary team of health economists, statisticians, health services researchers and data analysts provide policy knowledge related to critical issues in the dental care system.



Don't miss ODC 2016! April 7-9 in Portland. Read the last installment of our ODC preview, **31** by Dr. Psaltis: Conceive, Believe, Achieve!

Dr. Nicola: Introducing students to organized dentistry



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Membership Matters

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Membership Matters

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The “Festival Generation”

A generation that can change us for the better



By Barry J. Taylor,
DMD, FAGD,
FACD, CDE

Editor,
Membership Matters

barrytaylor1016@
gmail.com

THEY ARE A VERY DIVERSE, WELL-EDUCATED, AND TECHNOLOGY SAVVY GENERATION. we call them Millennials or Generation Y. More commonly they are dismissively referred to as the ‘Me Generation’ and a common refrain is that they grew up getting a ribbon for everything, so now they expect a ribbon for just participating. In a derogatory manner they are referred to as the ‘Entitlement Generation.’ These doctors who are in their late 20s and early 30s, however, are the doctors who are important to our membership right now. They are important because if we can’t get them to be members now, they almost certainly are not going to want to join when they are older. Older generations may find that they have more commonality with this younger generation than they realize.

I like to think of them as the “Festival Generation” as one Millennial researcher stated. It is a fallacy that they don’t joining groups; they will pay money to join all sorts of groups (or to go the music festivals). Two out of three still join the tripartite system. However they do want to see immediate value in their investment, much like when they go to a music festival, and expect to see the band play their hits. They are not going to join the American Dental Association just because it is the right thing to do; they will join if they see an immediate return on their investment. (We asked them to be critical thinkers, and look how they think now; they actually want a return on their investment.) They will join groups that they deem worthy of benefit for them. They don’t want to join a group unless it lines up with their values.

There is a phrase attributed to an English translation of the Talmud that states, “We don’t see things as they are. We see them as we are.” The collective “we” was able to go to dental school and pay off our loans within years and not decades. Those of us who didn’t go into specialties were in private practice within a few short years. There would only be a couple of students each year that would go into public health. We received most of our CE the same way we received the information in dental school: lectures with slideshows at conferences. The leadership of our associations was not very diverse, but that was just a reflection of our profession which lacked diversity.

So if that is how “we” are, what are “they” like? They have the same enthusiasm and intellectual capacity for dentistry as we did when we were 25 years old. They have a passion for dentistry and a

We asked them to be **CRITICAL THINKERS**, and look how they think now: they actually **WANT A RETURN ON THEIR INVESTMENT.**

desire to help their patients that is not unlike our own passion and desire. They do, however, get married later, they buy their houses later, but they still have the same aspirations of every generation of dentists. Because of their debt and late timeline, they do expect an immediate value in their investments of time and money.

The Festival Generation is technology savvy and busy. They need member benefits that are accessible 24/7, not 9 AM to 5 PM. This has driven associations to have more effective websites, apps, and other electronic media so that it is easier to enroll in programs according to ODA Membership Director, Kristen Andrews. Soon it will be easier to tailor content for individual members interests and they will be able to quickly see the savings when they enroll online. This is an element of membership that benefits all of us.

The Festival Generation also likes to be entertained; they are an event-driven generation. CE at conferences is still lecture based. To engage the Festival Generation, lecturers need to have more interactive lectures which involve technology. Who among us wouldn’t want to see “edu-tainment” versus another 6-hour PowerPoint presentation where we follow along with the printout of the exact same slides? Conferences are now competing with online CE, which can be more interactive, is often available 24/7, and can use video technology. It would benefit all of us to see these improvements in traditional conference lectures.

As our Executive Director, Conor McNulty summarized, “The population of Oregon dentists continues to evolve, as it has done for decades. We’re all conditioned to expect a more customized and personal experience with the organizations and communities we support and affiliate with. We’ll be a stronger and more engaged association as a result.” The changes the association makes to attract, engage, and retain the Festival Generation are changes that will benefit all of us. ●

The opinions expressed in this editorial are solely the author’s own, and do not reflect the views of the Oregon Dental Association or its affiliated organizations.

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Events & Education

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To add your component's continuing education event, please email bendsalari@gmail.com.
Please send all other events to Cassie, cleone@oregondental.org.

April 2016

DBIC Risk Management: Oregon Dental Conference. **Thur, April 7**, Oregon Convention Center, Portland. Info: www.oregondental.org.

Oregon Dental Conference: April 7-9, Oregon Convention Center, Portland. Info: www.oregondental.org.

DFO Motor Mouth Car Raffle: Sat, April 9, 12:45 pm, Oregon Convention Center, Portland. Info: www.smileonoregon.org.

ODA Board of Trustees Meeting: Sun, April 10, DoubleTree, Portland. Info: 503-218-2010.

May 2016

Continuing Ed., 1.5 Hrs: "Implants," Presented by Dr. Scott Dyer, **Tues, May 10**, Roth's, West Salem. Info: www.mpdentalce.com.

Continuing Ed., 1.5 Hrs: "HIV Overview for the Dental Healthcare Team," Presented by Geoffrey L'Heureux & Renee Yandel **Tues, May 10**, Lane County Community College. Info: www.lanedentalsociety.org.

Continuing Ed., 1.5 Hrs: "Treatment & Prevention of Peri-Implantitis," Dr. Harjit Sehgal, **Tues, May 10**, Stockpot Broiler, Beaverton. Info: www.wacountydental.org.

Continuing Ed., 2 Hrs: "Table Clinics," Presented by Multnomah Dental Society. **Thu, May 19**, Multnomah Athletic Club, Portland. Info: www.multnomahdental.org.

ODA Board of Trustees Meeting: Sat, May 21, Location TBA. Info: 503-218-2010.

June 2016

Continuing Ed., 1 Hr: "Oregon Board of Dentistry Update," Presented by Stephen Prisby, **Thu, June 2**, Lane County Community College, Eugene. Info: www.lanedentalsociety.org.

DFO Chip! for Teeth Golf Tournament: Fri, June 17, Langdon Farms Golf Club. Info: www.smileonoregon.org or 503-594-0880.

July 2016

ODA Board of Trustees Meeting: Fri, July 22, ODA Office, Wilsonville. Info: 503-218-2010.

September 2016

ODA Board of Trustees Meeting: Fri, Sept 30, ODA Office, Wilsonville. Info: 503-218-2010.

October 2016

ODA House of Delegates: Oct 7-8, DoubleTree By Hilton Hotel, Portland. Info: 503-218-2010.

November 2016

ODA Board of Trustees Meeting: Fri, Nov 4, ODA Office, Wilsonville. Info: 503-218-2010.

December 2016

Risk Management: Multnomah Dental Society. **Fri, Dec 2**, Portland. Info: Lora Mattsen, 503-513-5010

Risk Management: Washington County Dental Society. **Fri, Dec 9**, Redmond. Info: Dr. William Guy, 541-923-8678

The ODA House of Delegates is moving!

October 7-8

Double Tree by Hilton Hotel, Portland

*We'll be right here
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Thursday, May 12

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ODA Board of Trustees Nominations

Nominations are now open for the following offices, to be elected by the ODA House of Delegates, Oct. 7.

- **LDC**
(three positions, 3-year term)
- **BOT At-Large Member**
(three positions, 4-year term)
- **Speaker of the House** (3-year term)
DECLARED CANDIDATE: Jeff Stewart, DDS, MS
- **Editor** (3-year term)
DECLARED CANDIDATE: Barry Taylor, DMD, CDE

All ODA members are encouraged to participate in the leadership of this organization. For more information about any of these positions, call 503-218-2010 or email cleone@oregondental.org.

Interested applicants should submit a letter of interest and a one-page resume.

Email your materials to leadership@oregondental.org, or mail to:

*ODA Leadership Development Committee
Jim Smith, DMD, Chair
Nominating Sub-Committee
PO Box 3710, Wilsonville, OR 97070*



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Welcome New ODA Members!

Behnam Fakhravar DMD
Washington County
Dental Society

Cindy Q. Huynh DDS
Washington County
Dental Society

Ivan P. Paskalev DMD
Lane County Dental Society

Matthew J. Young DMD
Multnomah Dental Society

Reflections on Ethics...

*Membership
Matters is seeking
your assistance!*

In 2016 the ADA is celebrating the 150th anniversary of the ADA's Principles of Ethics and Code of Professional Conduct. **To recognize this milestone, the Oregon Dental Association would like to publish a collection of essays written by ADA members.**

This essay can be a reflection on the principles and code, how the principles and code affect your daily practice of dentistry, what the principles and code mean to you and our profession, or maybe a story about ethical or professional decisions you have had to make in our profession.

We hope that the issue will be a reminder to our members of the importance of ethics and professionalism in our profession. If you'd like to submit an essay, it should be between 600–1000 words in length and the deadline is April 15, 2016.

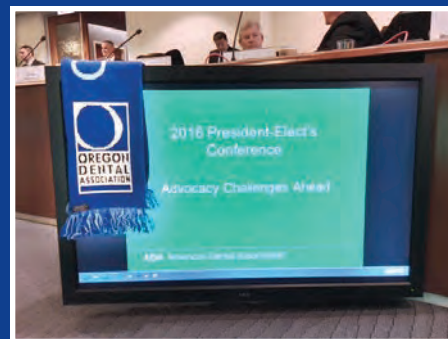
**To contribute, or
for more information,
please email editor
BarryTaylor1016@gmail.com.**

Join the Molar Movement #FightEnamelCruelty

Post your photos to Facebook or Twitter and tag the ODA, and you may be featured in a future Membership Matters!



For more information, or to email your photo to us, contact ODA Membership Specialist Kristen Andrews at 503-218-2010 x110 or kandrews@oregondental.org.



▲ **Gregg E. Jones, DMD, MAGD**, sporting the Molar Movement scarf at the ADA President Elect Conference at ADA Headquarters in Chicago.



11TH District Trustee Update



Rickland G. Asai, DMD

Trustee,
ADA 11th District

Past-president
of Oregon Dental
Association

asair@ada.org

WELL IT IS ONCE AGAIN TIME to report back to you. I hope that everyone is having a good year this year. I know that busyness issues persist in many areas, but I certainly hope that this year is the first to make a big turn in the economy for the profession as a whole.

One of the key roles of the ADA for those of us in the practicing world is to help protect us from the intrusions by third parties such as government and insurance carriers. I think that the ADA has had better success intervening in the government arena than the insurance area.

➤ Membership

Membership continues to be a major focus for the ADA at all levels. We continue to grow our numbers, but lose in market share. There were, however, 11 states that increased their market share this year, and Oregon was one of them. Congratulations to all involved in moving the needle upwards! Let's keep that trend going strong into next year.

To help in messaging to dentists, the ADA embarked on a strategic plan to develop personas this last year, and so you will start to hear more about this as the year progresses. The

the doctor-patient relationship through the denial of claims. And looking to the future, Res. 45 states policy on what should be involved in the practice of teledentistry.

Of course prevention is a big part of how we can get on top of this runaway rate of dental caries. Five resolutions, 49–53 were adopted that have to do with policies related to the over-consumption of sugar. Additionally, Res. 80 and 81 deal with policies of community water fluoridation, while Res. 44 funds \$150,000 in continuing our social media campaign on water fluoridation that was kicked off last year. The HOD also had some interest in exploring ideas on how to better provide products, services and salable materials to members with the adoption of Res. 94 and 95 with an eye towards retention and reward of membership.

➤ Access to care

Another big challenge to our profession is coming up with solutions for the access to care problem. We have seen mid-level legislation adopted in Minnesota and Maine. This, of course, is in addition to the DHATs working in the Alaska tribal clinics. There is too little information or documentation to demonstrate whether these programs in Alaska or Minnesota are working in a cost-effective manner, and whether they are impacting the incidence of disease.

The ongoing battles in many states is wearing down staff and volunteers alike, and consuming precious resources. One can only wonder if these are societal changes and trends larger than we can address. The question may then become: Do we have the resources to put towards this ongoing battle, or are there other strategies that we must consider? The 11th District championed Res. 92 which increased SPA (state public affairs) budgeted funds to help in addressing these types of mid-level challenges in states like Washington and Oregon. We are positioned and poised to support the states in their state legislative sessions, but as more states see this sort of activity, our finite resources are being stretched.

➤ Financial issues

The Board has decided to create a fresh approach to building the budget this year. Instead of having one lens to evaluate all that the ADA does, there will now be six areas of assessment. Each program will be evaluated on its impact to the success of our

Eleven states increased their market share this year, and OREGON WAS ONE OF THEM!

communications division is very excited to have this information and will develop a highly integrated communications strategy that is focused, targeted and innovative. There will be a new individual in charge of digital services as this area continues to grow in importance.

➤ ADA House of Delegates

Anti-trust issues prevent us from doing more than some very basic operational issues in regards to insurance. In fact, the 2015 HOD adopted Res. 12 to encourage states to work towards legislation of reporting loss ratios for dental insurance companies. Res. 13 sets out a definition of dentistry to protect our areas of practice for which we are trained. Res. 79 asks the Council on Dental Benefit Plans to look at whether insurance companies are interfering with

The opinions expressed in this column are solely the author's own, and do not reflect the views of the Oregon Dental Association or its affiliated organizations.

strategic plan, Members First 2020. The biggest change will be shifting from an activity-based budget to an outcomes-based budget. In this way we can more closely relate what we do through our budget that is directly tied to outcomes from our work. We believe this is the best way to build and refine the budget.

The ADA will also be focusing on three main objectives this year: focusing the message, targeting students and new dentists, and simplifying and standardizing interactions with our members across the whole enterprise.

The Health Policy Institute (HPI) led by Marko Vujicic, reviewed data to give us another year end glimpse of the dental marketplace. There is always a lag in obtaining this data. Dental spending continues to be flat. Dental care utilization is varied, with children's visits up again this year, seniors visits are flat, and for the first time in years, adult visits are flat instead of down; this may be good news, and the hope is that this may be the start of a new trend. Cost as a barrier seems to be receding. Dental incomes decreased from 2013 to 2014. Busyness seems to be flattening instead of decreasing, and hopefully this is the beginning of a long awaited turn around in the market.

The school loan consolidation and refinancing program being offered to members through Darien Rowayton Bank (DRB) is off to a strong start, with over \$100 million in loan applications in the first few months alone. This has been a very well-received member benefit since being implemented in September 2015. Average saving per loan has been in the \$30,000 range.

Well, these are the highlights from the 2015 HOD and January 2016 BOT meeting. Thank you again for your support of organized dentistry. A strong membership is important for us to stand together in addressing the ever changing challenges before us. Thank you for standing strong. Together we can make a difference! ●



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The Center for Evidence-Based Dentistry operates under the advisement of the ADA Council on Scientific Affairs to develop resources that help dentists integrate clinically relevant scientific evidence at the point of care. Evidence-based dentistry (EBD) integrates the dentist's clinical expertise, the patient's needs and preferences, and the most current, clinically relevant evidence. All three are part of the decision-making process for patient care.

EBD is a patient-centered approach to treatment decisions, which provides personalized dental care based on the most current scientific knowledge. The American Dental Association (ADA) defines Evidence-based Dentistry (EBD) as "an approach to oral healthcare that requires the judicious integration of systematic assessments of clinically relevant scientific evidence, relating to the patient's oral and medical condition and history, with the dentist's clinical expertise and the patient's treatment needs and preferences." 

>> **To learn more, visit <http://ebd.ADA.org>**



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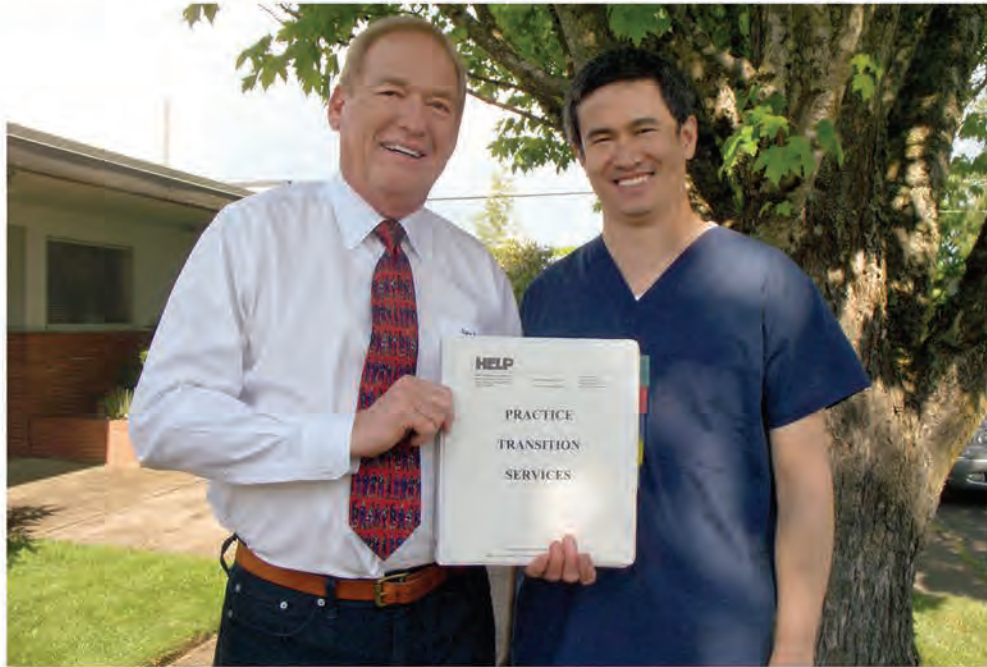
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Gary Schaub

"McMinnville, in the heart of wine country, is growing and is a perfect place to practice dentistry. Dr. Egan's staff was very helpful during the transition process, and they are really supportive of Dr. Wylie as he grows the practice. I really enjoyed working with both dentists, and the transition went very smoothly thanks to their flexibility."

Ken Wylie DMD

"Prior to my very successful transition with Dr. Egan, there was another practice that I wanted to buy that Gary represented. He was always available and got back to me. Even though that seller chose another buyer, Gary was still supportive of me. I could tell that he was sincere with his consolation and encouragement. He is very knowledgeable about the people and companies involved in the transition process. I would highly recommend him to both potential buyers and sellers."

Roger Egan DMD (McMinnville) Not Pictured

"Gary first appraised my practice 10 years ago and then again when I was finally ready to retire. The transition results were what Gary and I talked about. Since practice transition skills are not my strong suit, I really got what I paid for with Gary. His calm manner resulted in a perfect transition with Dr. Wylie."

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PICTURE, CALL THE TRANSITION EXPERT!**

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A light purple map of the state of Oregon is centered on a dark purple background. The map is semi-transparent, allowing the background color to show through.

Oral Health Care System: Oregon

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The ADA Health Policy Institute (HPI) aims to be a thought leader and trusted source for critical policy knowledge related to the U.S. dental care system.

Their mission is to provide, on an ongoing basis, policy knowledge related to critical issues in the dental care system in order to inform strategic decision making within and outside the ADA. Through innovative knowledge generation, synthesis, and dissemination, the Health Policy Institute aims to be a thought leader and the premier source for credible data and research on critical issues facing the dental care system.

HPI's interdisciplinary team of health economists, statisticians, health services researchers and data analysts has extensive expertise in policy research and has published extensively in top-caliber peer-reviewed journals. HPI staff regularly collaborate with external researchers in academia as well as think tanks and consulting firms.

continues

Research Brief

Dental Care Utilization Rate Continues to Increase among Children, Holds Steady among Working-Age Adults and the Elderly

By Kamyar Nasseh, PhD; Marko Vujicic, PhD

Key Messages

- In 2013, and for the first time since 2007, dental care utilization did not decline among working-age adults.
- Dental care utilization continued to increase among children in 2013 and is at its highest level since the Medical Expenditure Panel Survey began tracking dental care utilization in 1996.
- The Affordable Care Act has the potential to alter dental care utilization patterns. The establishment of health insurance marketplaces as well as Medicaid expansion could increase dental benefits coverage and demand for dental care.

The Health Policy Institute (HPI) is a thought leader and trusted source for policy knowledge on critical issues affecting the U.S. dental care system. HPI strives to generate, synthesize, and disseminate innovative research for policy makers, oral health advocates, and dental care providers.

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HPI's interdisciplinary team of health economists, statisticians, and analysts has extensive expertise in health systems policy research. HPI staff routinely collaborates with researchers in academia and policy think tanks.

Contact Us

Contact the Health Policy Institute for more information on products and services at hpi@ada.org or call 312.440.2928.

This Research Brief was published by the American Dental Association's Health Policy Institute and is reprinted here with permission. 211 E. Chicago Ave., Chicago, IL 60611. 312.440.2928. hpi@ada.org.

Since 2000, there have been significant changes in dental care utilization patterns among the U.S. population. As of 2012, dental care utilization was at its highest level among children and at its lowest level among working age adults.¹ The decline in dental care utilization among working age adults, which began in 2003 and persisted through 2012, has been driven in part by a decline in the percentage of individuals having private dental benefits.^{2,3} Conversely, dental care utilization among children, particularly those in lower-income groups, has increased over the past decade. The gap in dental care use between low-income and high-income children has narrowed dramatically while for adults it has widened.^{4,5} The American Dental Association's Health Policy Institute (HPI) has been tracking trends in dental care utilization for several years as well as studying the key drivers of recent trends.^{6,7}

In this research brief, we update previous research on dental care utilization patterns using newly released data for 2013.

➤ **Data & Methods**

We analyzed data from the Medical Expenditure Panel Survey (MEPS) that is managed by the Agency for Healthcare Research and Quality (AHRQ). We focused on the period 2000 to 2013, the most recent year for which data are available (data for 2013 were released in September 2015). The MEPS is recognized as the most reliable data source for dental care utilization at the national level.⁸

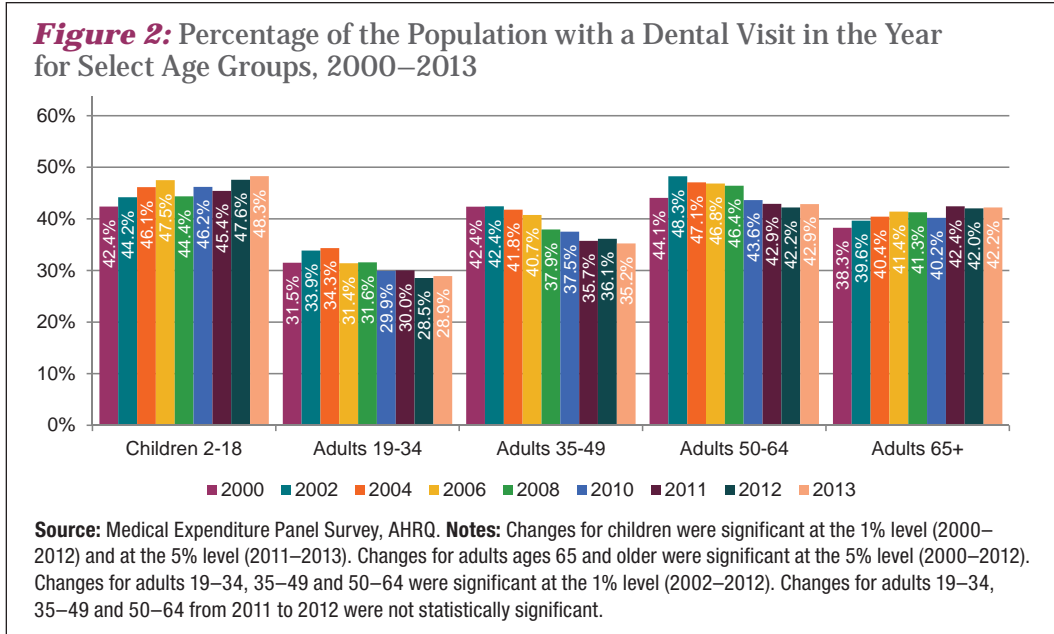
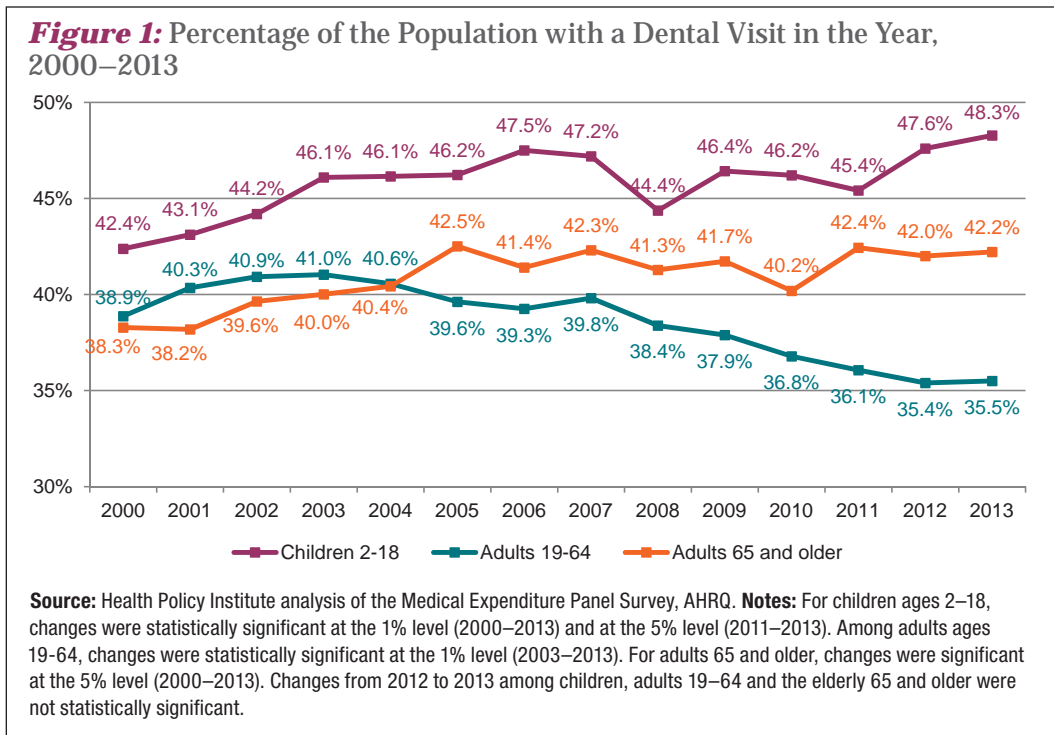
We measured dental care utilization as the proportion of the population who visited a general practice (GP) dentist in the year. This is the most basic indicator of dental care utilization. It does not capture any information on measures such as the type of care received, the total amount of care received, or whether a treatment plan was completed. Nevertheless, it is an informative measure of whether the population is seeing the dentist.

We examined trends in dental care utilization for children ages 2–18, working-age adults ages 19–64 and elderly adults ages 65 and older. For each age cohort, we analyzed trends in dental care utilization

by household income and dental benefits status. We classified dental benefits into three categories: public, private and uninsured. Public dental benefits include those provided through Medicaid or State Children's Health Insurance Programs (SCHIP). Because pediatric dental services are a mandated benefit, children enrolled in these programs were defined as having dental benefits. Medicaid coverage of dental benefits for adults is optional and varies considerably by state.⁹ MEPS does not allow us to identify the state of residence, however. Thus, we simply identify adults covered by Medicaid as publicly insured even though the majority will have either no dental benefits at all or very limited benefits. Because Medicare does not provide dental benefits,¹⁰ persons who only had Medicare coverage were considered uninsured for dental care. We test for statistical significance across time using a chi-squared test. Our point estimates and statistical inferences take into account the complex survey design of the MEPS.

➤ **Results**

Figure 1 shows trends in dental care utilization for children ages 2–18, working-age adults ages 19–64 and the elderly 65 and older from 2000 to 2013. The uptick in dental care utilization among children that occurred from 2011 to 2012 continued into 2013. From 2011 to 2013, children's dental care utilization increased from 45.4 percent to 48.3 percent, a change that was statistically significant at the 5 percent level. As of 2013, children's dental care utilization is at its highest level since the MEPS began tracking this



in 1996.¹¹ The overall increase in dental care utilization among children from 2000 through 2013 was statistically significant at the one percent level.

Dental care utilization among working age adults changed very little from 2012 (35.4 percent) to 2013 (35.5 percent). However, this is a break in the recent downward trend. For the first time since 2007, dental care utilization did not decline from the previous year. The overall

decline from 2003 through 2013 was statistically significant at the 1 percent level.

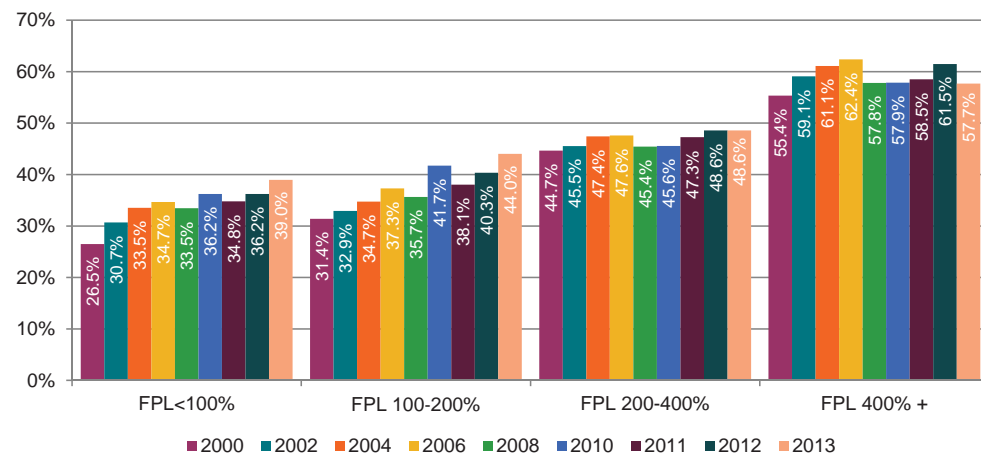
From 2012 to 2013, dental care utilization remained steady among the elderly. In 2013, 42.2 percent of elderly Americans saw a general practitioner dentist in the past year, up very little from 2012 (42.0 percent). Among the elderly, the overall increase in dental care utilization from 2000 (38.3 percent) to 2013 was statistically significant at the 5 percent level.

continues

Figure 2 shows dental care utilization rates for narrower age groups. Dental care utilization changed very little for adults ages 19-34 from 2012 (28.5 percent) to 2013 (28.9 percent). For adults ages 35-49, dental care utilization declined slightly from 2012 (36.1 percent) to 2013 (35.2 percent), a statistically insignificant change. Dental care utilization among adults ages 50-64 was also steady from 2012 (42.2 percent) to 2013 (42.9 percent). Looking at a longer timeframe, the overall changes in dental care utilization from 2002 to 2013 for adults ages 19-34, 35-49 and 50-64 were statistically significant at the 1 percent level.

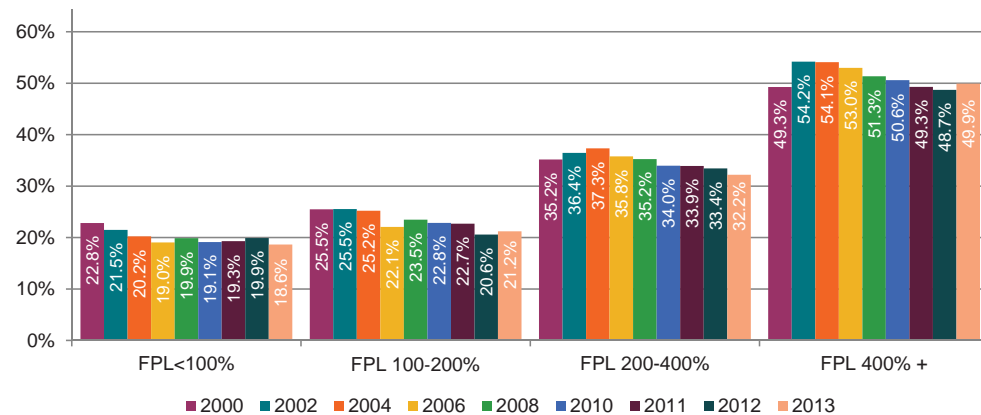
Figures 3 through 5 show dental care utilization rates for children, working-age adults and the elderly by household income. For poor children (FPL<100%), dental care utilization increased from 36.2 percent in 2012 to 39.0 percent in 2013. Among near-poor children (100-200% FPL), dental care utilization increased from 40.3 percent in 2012 to 44.0 percent in 2013. Dental care utilization did not change from 2012 to 2013 for children with household income between 200% and 400% of the FPL. The changes from 2012 to 2013 for these three income groups were not statistically significant. For high-income children (400% + FPL), dental care utilization fell from 61.5 percent in 2012 to 57.7 percent in 2013, a statistically insignificant change. Looking at a longer timeframe, the overall increase in dental care utilization from 2000 to 2013 among poor (FPL<100%) and near-poor (100-200% FPL) children was statistically significant at the 1 percent level (Figure 3).

Figure 3: Percentage of Children Ages 2-18 with a Dental Visit in the Year for Select Income Groups, 2000-2013



Source: Health Policy Institute analysis of the Medical Expenditure Panel Survey, AHRQ. **Notes:** Changes were significant at the 1% level for FPL<100% and FPL 100-200% (2000-2013). Changes from 2012 to 2013 were not statistically significant.

Figure 4: Percentage of Adults Ages 19-64 with a Dental Visit in the Year for Select Income Groups, 2000-2013



Source: Health Policy Institute analysis of the Medical Expenditure Panel Survey, AHRQ. **Notes:** Changes were significant at the 5% level for FPL < 100% and at the 1% level for FPL 100-200%, FPL 200-400% and FPL 400% + (2002-2013). Changes from 2012 to 2013 were not statistically significant.

For working-age adults, dental care utilization among the poor (FPL<100%) fell slightly from 2012 (19.9 percent) to 2013 (18.6 percent). Dental care utilization among adults with household income between 200% and 400% of the FPL also declined slightly from 2012 (33.4 percent) to 2013 (32.2 percent). Dental care utilization among near-poor (FPL 100-200%) and high-income (400% + FPL) adults increased slightly from 2012 to 2013. All changes from 2012 to 2013 were statistically insignificant. Looking at a longer timeframe, the decline in dental care utilization from 2002

through 2013 was statistically significant for all income groups (Figure 4).

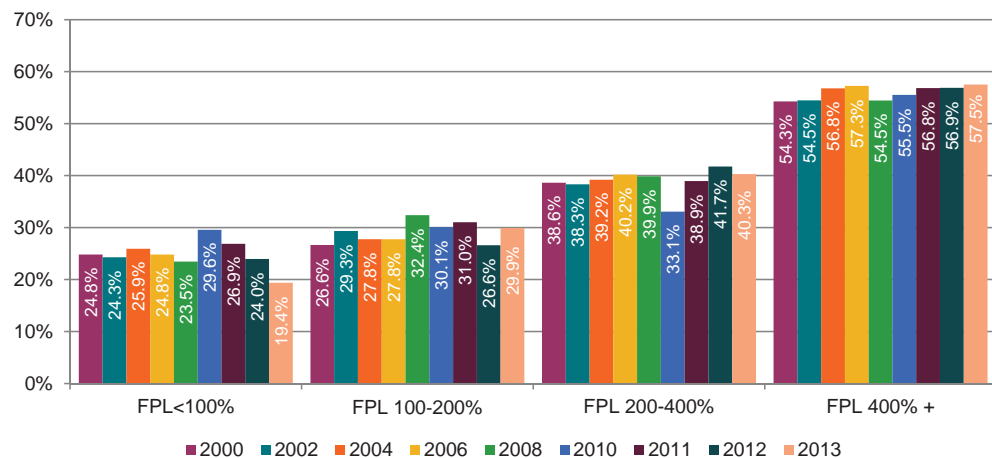
Among the poor elderly (FPL<100%), dental care utilization decreased from 24.0 percent in 2012 to 19.4 percent in 2013. This is a continuation of the downward trend in dental care utilization among the elderly poor that began in 2010, when utilization was at 29.6 percent. For the near-poor elderly (FPL 100-200%), dental care utilization increased from 26.6 percent in 2012 to 29.9 percent in 2013. The change in dental care utilization among the poor elderly from 2010 to 2013 was statistically significant at the one percent level. Dental

care utilization among the elderly with household income between 200% and 400% of the FPL also declined slightly from 2012 (41.7 percent) to 2013 (40.3 percent). For high-income elderly adults, dental care utilization increased slightly from 2012 (56.9 percent) to 2013 (57.5 percent). Changes for all income groups from 2012 to 2013 were not statistically significant (Figure 5).

Figures 6 through 8 show dental care utilization rates for children, working-age adults and the elderly, respectively, according to dental benefits status. Among children with private dental benefits, the percentage with a dental visit decreased from 59.3 percent in 2012 to 58.5 percent in 2013. For uninsured children, dental care utilization fell from 26.1 percent in 2012 to 24.9 percent in 2013. Both of these changes were statistically insignificant. Among children with public dental benefits, dental care utilization increased from 39.5 percent in 2012 to 42.4 percent in 2013, a change that was statistically significant at the 10 percent level. Looking at a longer timeframe, the overall change in dental care utilization from 2000 to 2013 for children with private dental benefits and public dental benefits was statistically significant at the 1 percent level (Figure 6).

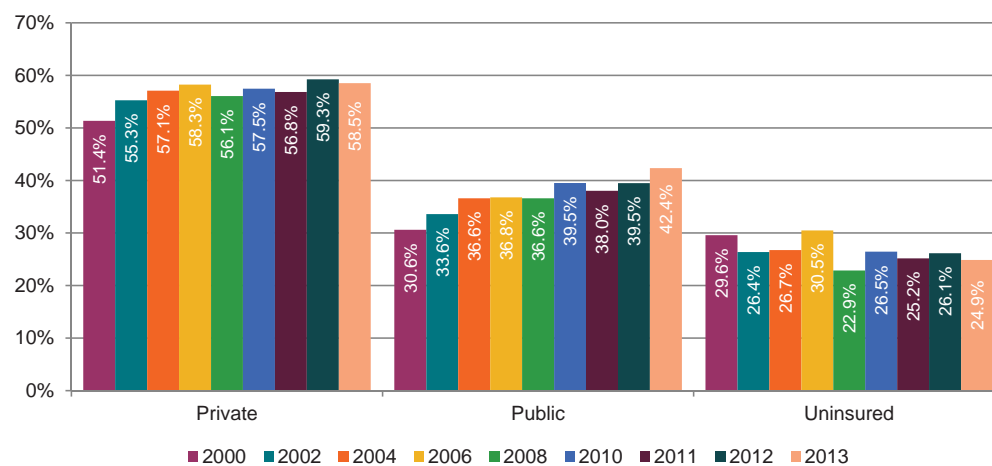
From 2012 through 2013, dental care utilization increased from 48.5 percent to 49.3 percent among working-age adults with private dental benefits. Among uninsured working-age adults, dental care utilization declined from 18.3 percent in 2012 to 17.1 percent in 2013. Dental care utilization among working age adults with public health insurance held steady from 2012 to 2013 (Figure 7). These changes were all statistically insignificant.

Figure 5: Percentage of Adults 65 and Older with a Dental Visit in the Year for Select Income Groups, 2000–2013



Source: Health Policy Institute analysis of the Medical Expenditure Panel Survey, AHRQ. **Notes:** Changes were significant at the 1% level for FPL<100% (2010–2013). Changes from 2012 to 2013 were not statistically significant for any income group.

Figure 6: Percentage of Children Ages 2–18 with a Dental Visit in the Year by Dental Benefits Status, 2000–2013



Source: Health Policy Institute analysis of the Medical Expenditure Panel Survey, AHRQ. **Notes:** Changes were significant at the 1% level for private and public (2000–2013). Changes were significant at the 10% level for public (2012–2013). Changes from 2012 to 2013 for the uninsured and privately insured children were not statistically significant.

Among the elderly with private dental benefits, dental care utilization increased from 66.9 percent in 2012 to 68.6 percent in 2013, a statistically insignificant change. Changes from 2012 to 2013 for elderly adults with public insurance or no dental benefits were not statistically significant (Figure 8).

➤ Discussion

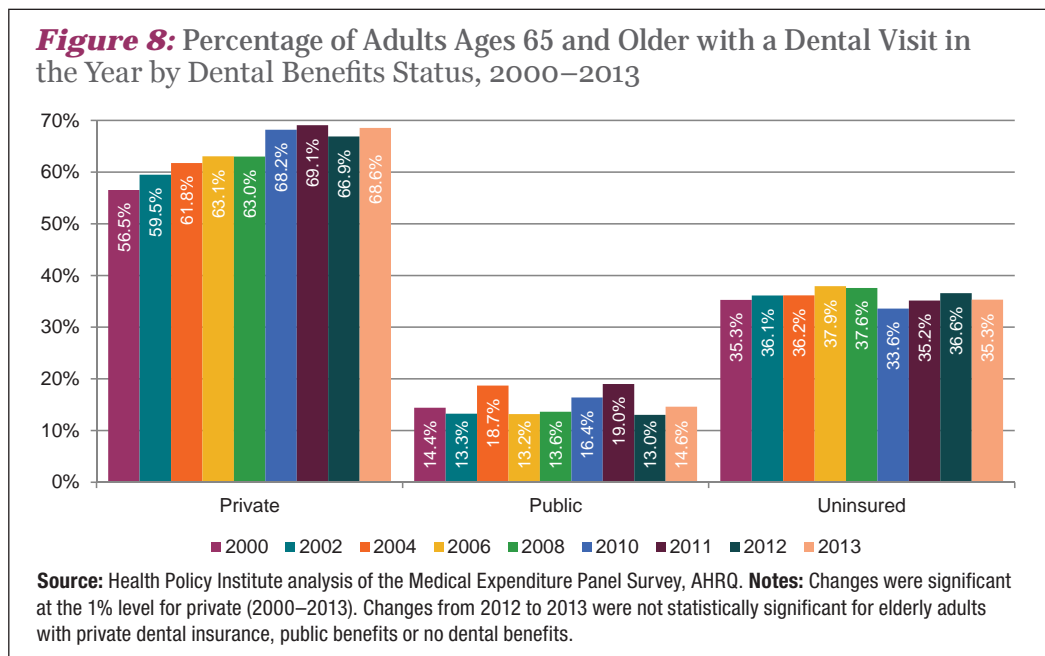
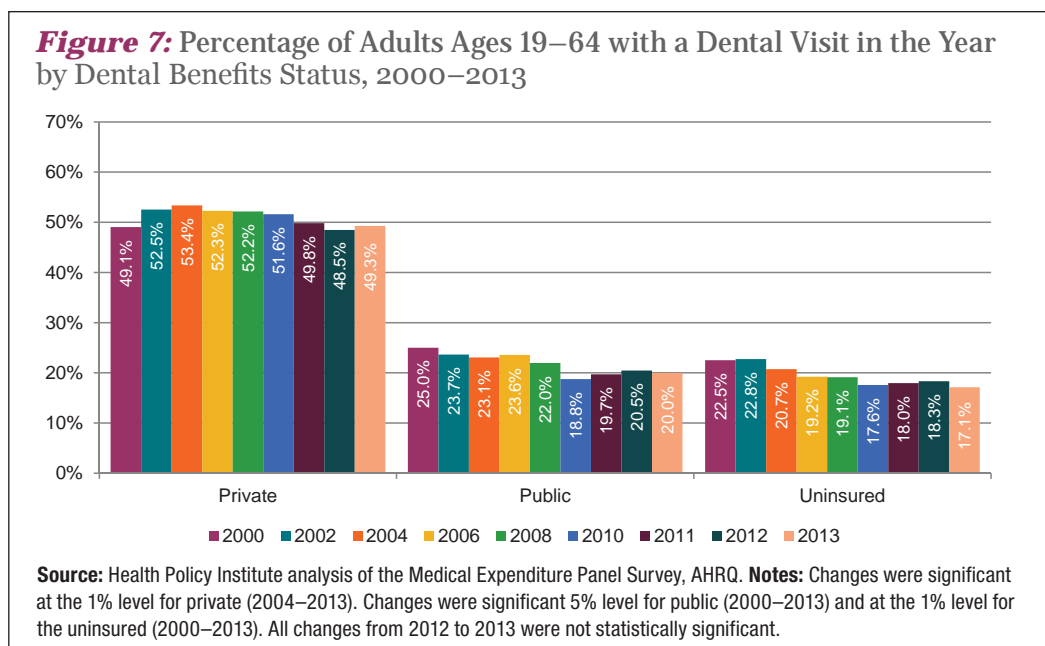
For the first time since 2007, dental care utilization did not decline among working-age adults, a potentially important finding given it

represents a break in recent trends. It remains to be seen if dental care utilization among this age group stabilizes, increases or declines again in the coming years. For children, dental care utilization continued to increase in 2013 and is at its highest level since the MEPS began measurement in 1996. The gains among poor children in particular have been large. Among the elderly, dental care utilization held steady from 2012 to 2013, although utilization is up significantly for this age group since 2000.

continues

The 2013 data from the MEPS provide us with a valuable benchmark on dental care utilization for all age and income groups prior to the implementation of most provisions of the Affordable Care Act. We will analyze 2014 data to try to understand the impact of the ACA. For example, beginning in 2014, many states expanded Medicaid eligibility. A number of these states provide limited or extensive dental benefits for adults in Medicaid. In fact, previous analysis estimates that up to 8.3 million adults gained dental benefits through Medicaid expansion.¹² Moreover, through April 2014, the take-up rate for stand-alone dental plans in the federally facilitated marketplaces was 15.8 percent for children and 18.8 percent for adults.¹³ Financial barriers to dental care are declining for working-age adults and the poor.¹⁴ It remains to be seen if these developments translate into increased dental care utilization among these groups.

To put dental care utilization trends into context, it is important to note that although overall dental care utilization is declining, the volume of dental visits in Federally Qualified Health Centers (FQHCs) and hospital emergency departments is actually increasing dramatically.¹⁵ It will be interesting to see if any increased demand for dental care resulting from Medicaid expansion and the rollout of health insurance marketplaces leads to increased dental care utilization in FQHCs, hospital emergency departments or private dental offices. New research strongly suggests that there is capacity in dental



offices to treat more patients, even after large Medicaid expansions.¹⁶

At the same time, increased dental benefits coverage does not necessarily equate to increased access to dental care. Proper enabling conditions need to be in place, such as sufficient Medicaid provider reimbursement and streamlined administrative processes in Medicaid, to attract dental providers to participate in Medicaid programs.^{17,18,19} The HPI will continue to monitor the impact of the ACA and other market developments on dental care utilization patterns in the United States.

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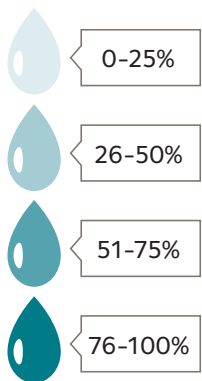
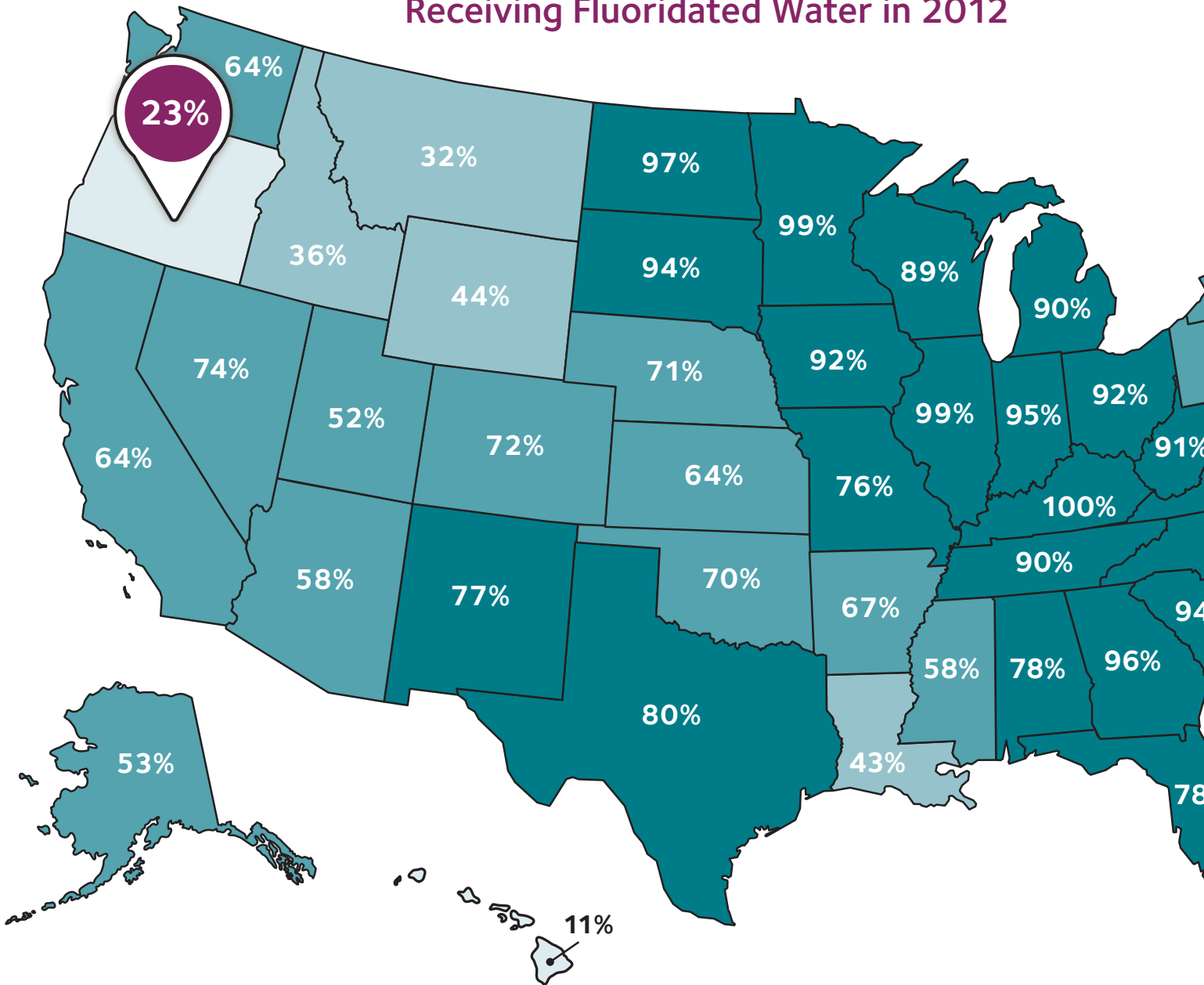
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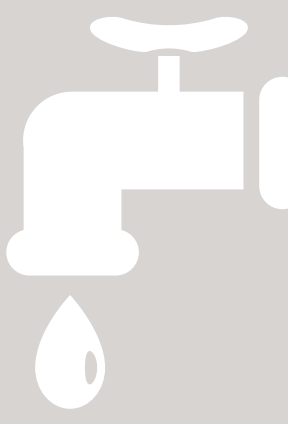
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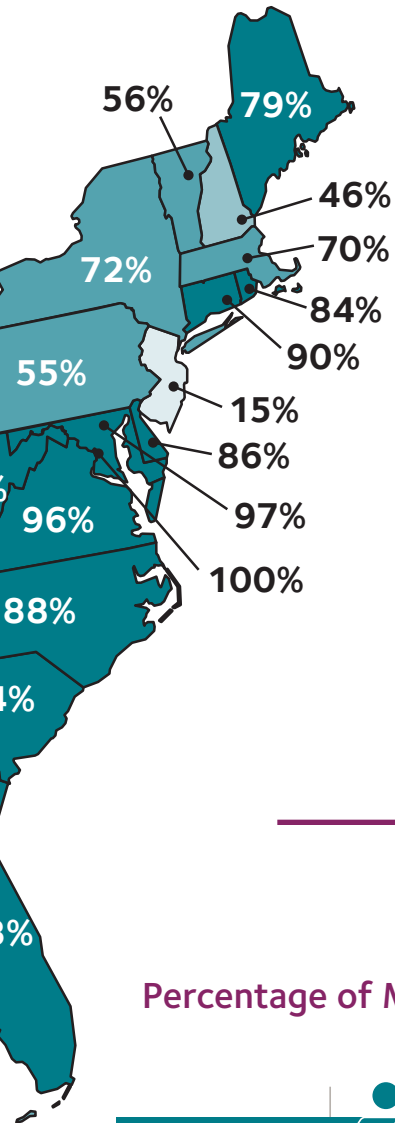


23%
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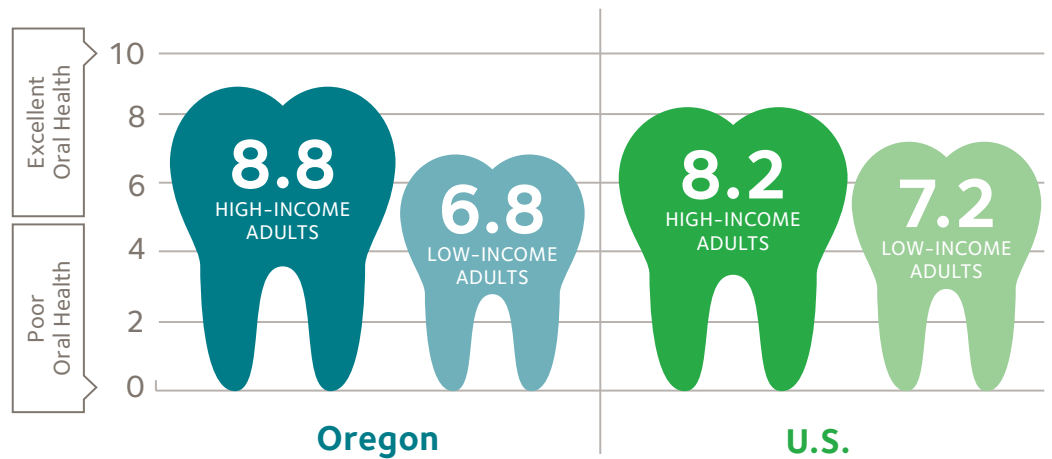


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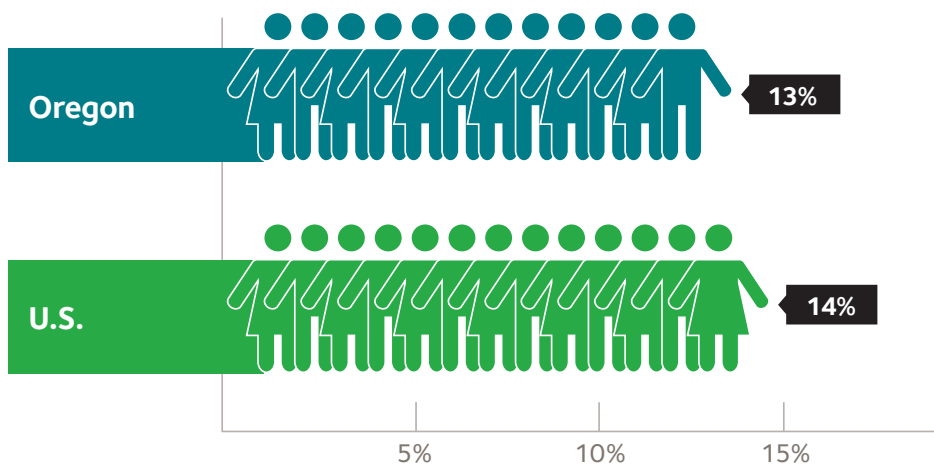
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Oral Health Status Index Among Adults in 2015

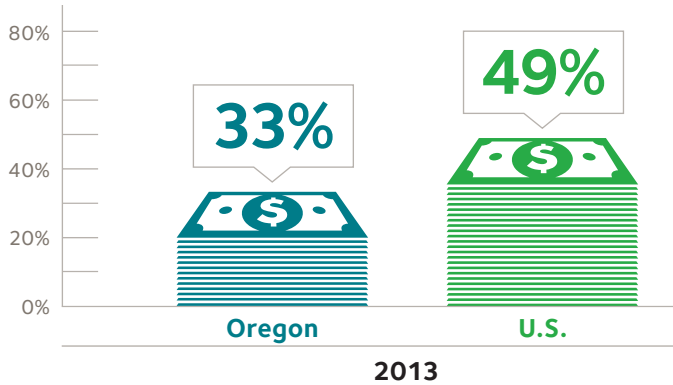


Percentage of Medicaid Children Who Received a Sealant on a Permanent Molar in 2013



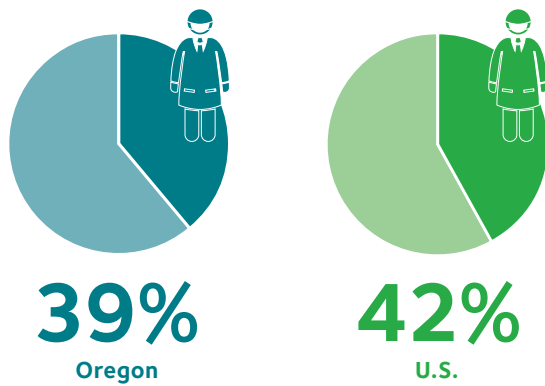
13%
OF OREGON MEDICAID CHILDREN 6 THROUGH 14 YEARS OLD RECEIVED A SEALANT ON A PERMANENT MOLAR IN 2013, COMPARED TO 14% NATIONALLY

Medicaid Fee-for-Service Reimbursement as a Percentage of Private Dental Benefit Plan Charges for Child Dental Services



BETWEEN 2003 AND 2013 REIMBURSEMENT RATES FOR CHILD DENTAL SERVICES IN MEDICAID **decreased 27.8% in Oregon**

Percentage of Dentists Participating in Medicaid for Child Dental Services in 2014

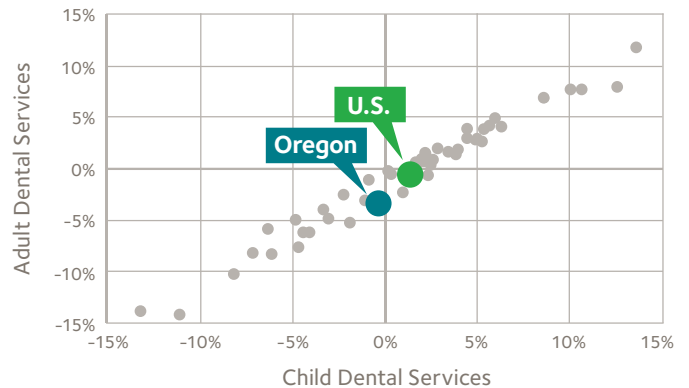
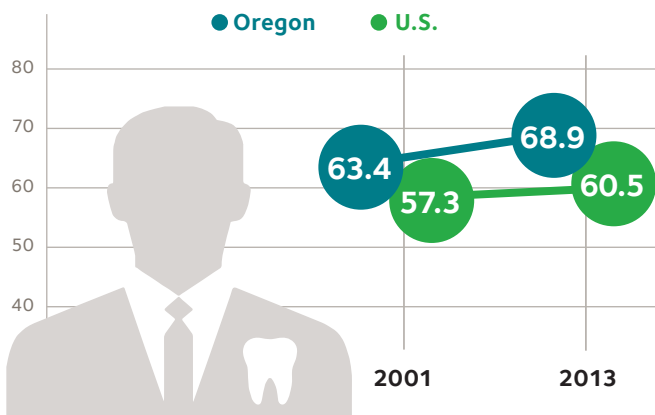


Change in Private Dental Benefit Plan Charges Between 2003 and 2013

CHANGE IN PRIVATE DENTAL BENEFIT PLAN CHARGES BETWEEN 2003 AND 2013

	CHILD	ADULT
OREGON	-0.4%	-3.3%
U.S.	1.2%	-0.6%

Number of Dentists per 100,000 Population



Oral Health Attitude Index Among Adults in 2015



Oral Health Knowledge Index Among Adults in 2015



ANSWERED ALL OF HPI'S ORAL HEALTH KNOWLEDGE SURVEY QUESTIONS CORRECTLY COMPARED TO 52% OF HIGH-INCOME AND 44% OF LOW-INCOME U.S. ADULTS

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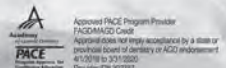
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Introducing students to organized dentistry

By Melody Finnemore

Dental student attendance at Multnomah Dental Society meetings has increased significantly over the last couple of years,

thanks to an outreach program that includes an open invitation to join the meetings free of charge and a designated faculty liaison who encourages the students and specialty residents to attend.

For several years, the Multnomah Dental Society has had a program in place in which students and residents from the OHSU School of Dentistry are invited to attend meetings, including the meal, at no cost. A key driver of the increased student attendance is that **Dennis Nicola, DDS, FAGD**, serves as the faculty liaison, actively promotes MDS meetings and encourages students to attend.

“It gives them the understanding that when they are done with dental school, they are not done with their education. Continuing education is an ongoing obligation,” he said, adding the dental society is developing a program to provide one-on-one mentoring for students to help them make the transition from school to practice.

A board member for MDS, and, since 2013, an assistant professor at the dental school, Dr. Nicola challenged other dental societies in the Portland metro area to invite students and residents to attend their meetings, too.

“We should give dental students reasons to want to join the Oregon Dental Association when they become practicing dentists,” he said, noting many new graduates are burdened with debt and membership dues may discourage them from joining organized dentistry. However, if they are introduced to the benefits of organized dentistry as students, they will more likely see the value they receive for their membership dues, including opportunities to learn from experienced providers, a support network, camaraderie and continuing education.

Dr. Nicola pointed out that some dental students spend two to six weeks in offsite clinic rotations in rural and underserved areas such as Baker City, Burns, Coos Bay and Klamath Falls, among others. He would like to see dental societies in those areas invite students to their local meetings as well.

“We need dental students in rural areas, and sometimes there is a fear of isolation in those areas, so an invitation to attend the meetings is a way to help them meet people, feel included and get involved,” he said.

Dr. Nicola, whose uncle was a dentist and whose father was a physician, graduated from Loma Linda

Melody Finnemore is a freelance writer for ODA and a partner in Precision Communications. She can be reached at precisionpdx@comcast.net.



“Good patient care means taking the time to get to know the patient, not just their obvious dental needs, but what is important to them.”

University School of Dentistry in 1973. He moved to Oregon in 1978, working in various clinics and practices in Portland for about 10 years before establishing his own practice in Newberg.

From the component in Loma Linda to the Multnomah and Marion Polk Yamhill dental societies, Dr. Nicola has participated in chapters of varying sizes, demographics and program focuses. Each offered some common benefits, he said, and a dental society does not have to be large to be valuable and effective.

“I’m very social, so I like the meetings and the collegiality that goes on. Also, the collectiveness of a group can provide benefits that individuals can’t on their own,” said Dr. Nicola, who was a charter member of the Yamhill County Dental Society.

“When I started, the traditional deal was one doctor/one office, and it was pretty much a solo thing, so many dentists were kind of isolated,” he added. “We’re the kind of people who, when things get tough, we put our head down and work harder. Sometimes you have to work smarter, not harder. And it’s good to know people who have the same concerns as you do.”

Among his goals as a mentor is to show students the meaning of patient care, not just from a technical standpoint but from an interpersonal aspect as well. Dr. Nicola noted: “I’ve been doing this for over 40 years, and not one single time have I had a tooth say, ‘Thank you.’”

“One of the keys is not to worry about convincing your patient that you are a big deal. Let them know that *they* are a big deal,” he said. “Good patient care means taking the time to get to know the patient, not just their obvious dental needs, but what is important to them. Because I was in private practice for a number of years, I had three families in Newberg where I had four generations as patients. That’s an honor.”

As a faculty member at the dental school, Dr. Nicola had the opportunity to do the hooding ceremony for his daughter, Stephanie Nicola Ness, DMD, when she graduated in 2013. In turn, Dr. Ness (who currently practices in North Dakota) honored her father when he received his lifetime membership from the Oregon Dental Association the following year. ●

Photo, above left: At a “Legacy” soccer tournament with (left to right) daughter Jennifer Nicola Bletscher, RN; son-in-law Jonathan Bletscher; spouse Lynda; Dr. Nicola; daughter Stephanie Nicola Ness, DMD; and son-in-law Alex Ness, DMD.

Photo, above right: 2013 OHSU School of Dentistry graduation with (now) son-in-law Alex Ness, daughter Stephanie, spouse Lynda, and Dr. Nicola.

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Greg Psaltis, DDS

FEW THINGS IN DENTISTRY AMUSE ME MORE than colleagues' confusion about my passion for pediatric dentistry. Many of the referring dentists apologize to me for the patients they send and are often quick to add some variation on the theme of "thank goodness for pediatric dentists." Non-dental people, when learning what I do, will invariably say that I must be "very patient" or a "very special person" to do my work. I am neither. In fact, I am rather compulsive and regular. So how is it that I cannot only find success, but also enormous satisfaction in working all day with children? The answer is as simple as C-B-A.

While there are doubtless many tricks to being successful with children, such as "blowing sugar bugs away with a whistle" instead of "drilling the decay out of your tooth," I believe the formula for success lies much deeper than that. I was inspired recently by a speaker who said that the secret to most successes in life depends on this formula: if you can Conceive it and then you Believe it, you will Achieve it. C-B-A. This simple formula is universally applicable and certainly so in pediatric dentistry. It never fails to amaze (and inspire) me that about one half of all our referrals (usually sent to us because the children "wouldn't cooperate") are ideal patients by the time they have taken their seats in our operator. How can this be? My talented and dedicated team has embraced the philosophy that is the hallmark of our practice. It is simply this: We believe that every child will have a perfect visit every time. Do we accomplish this? Of course we do not. If a child has a difficult experience with us do we abandon this belief? Again, we do not. After 35 years as a pediatric dentist, I am convinced that much of the success in the practice comes from nothing more than the belief by all members of my team that each child will do well. Children sense this immediately and respond accordingly.

Unlike most other specialties, pediatric dentistry is defined by our patient population, not by the procedures we do. This may account for the focus placed on relationship rather than technical care. It is not lost on me that much of the treatment we provide will ultimately fall out. The attitudes we engender in the minds of our patients, however, will

not exfoliate. My legacy as a pediatric dentist will be that the attitude my patients take to their next dentist will be a positive one lacking in the fears that many adults still carry toward our profession.

While it doesn't pay my mortgage or buy me groceries, a significant part of my "pay" in my practice comes in the form of gratitude. Children give me hugs and send me senior pictures; parents thank me with relief (if not disbelief) written all over their faces and at the end of my day, I take home thoughts of satisfied, grateful clients. As if that weren't enough, I also enjoy the fact that the government will not be taxing me 35% of this form of pay. I get to keep it all.

I am a Stanford University graduate and—quite frankly—I am one of the least likely candidates I know to be spending my day squirting "sleepy juice" and holding "raincoats" on teeth with a "button." If anything, I am more of an academic than a daycare provider. My career has taught me much. It is the lifelong education that I could never have gotten in college or even dental school. My private pediatric practice has taught me the power of positive thinking and the stunning results that come out of it. Dale Carnegie understood this years ago.

I smile at dental conferences when my behavior management course is in a room across the hall from the "How to make a bazillion dollars in dentistry" course. That room, of course, is packed with dentists. My room is filled with assistants and hygienists. Ironically, if dentists really wanted to be more successful, the information about relationships and positive thinking would get them much farther than learning how to "sell" a treatment plan or sending their patients computer-generated birthday cards.

Almost every day a parent will ask me, "Can I come here for treatment?" I doubt it is the cute vocabulary that attracts them. I believe the successful formula is as easy as C-B-A. 🍎

Like what you just read? Want to learn more? Dr. Psaltis is just one of the many great speakers at ODC 2016.

Please join us, April 7–9.

www.oregondentalconference.org

Dr. Psaltis has been a pediatric dentist for 41 years, primarily in private practice in Olympia, Washington. In addition to enjoying his practice, he lectures frequently on pediatric topics, as well as communication skills and practice management. He has published in several professional journals and often spends his vacations volunteering in Mexico and Bolivia to provide care for children without hope of access of care. His unique speaking style reflects his years of experience and keen observations, thus making his programs informative and entertaining. He was recently awarded the Gordon J. Christensen Lecturer Recognition Award for excellence in professional presentations.

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Enforcement news

By Paul Kleinstub, DDS, MS

Dental Director and Chief Investigator, Oregon Board of Dentistry

paul.kleinstub@state.or.us

www.oregon.gov/dentistry

ONE OF THE STATUTORY DUTIES of the Oregon Board of Dentistry is to conduct investigations, based “upon its own motion or any complaint... on all matters related to the practice of dentistry...” In fulfilling its duties, the Board relies upon the cooperation of licensees to provide information, (and often, patient records) to the Board. Details of disciplinary action taken against individual licensees are available on the Licensee Lookup menu on the Board’s website: www.oregon.gov/dentistry

Based on recurring issues noted in investigations that have resulted in discipline, the following reminders are provided to assist in your compliance with the Dental Practice Act.

Please also note that an underlying problem that generates many complaints is the area of patient communication. Clarity in communication by the dentist—before, during, and after providing services is essential. Also, a failure by the dentist to establish an in-office protocol to deal with patient complaints, and then personally deal with those complaints is a huge source of discontent by patients.

➤ Copies of patient records, radiographs, models

Under OAR 818-12-0030(9) a dentist must provide a patient—within 14 days of written request—legible copies of records, radiographs, and duplicates of study models, if the radiographs or study models have been paid for. The dentist may, however, require the patient to pay in advance for the cost of making copies or duplicates. The dentist must provide copies of radiographs, even if the patient still owes money for services provided subsequent to the appointment when the radiographs were taken. It is the Board’s position that any payment made on a bill are presumed to cover radiographs.

➤ Fees

Under OAR 818-12-0030(8) a dentist engages in unprofessional conduct if the dentist does or permits any person to misrepresent any facts to a patient concerning treatment or fees. When a patient requests fees for individual procedures, and these procedures would necessitate accompanying procedures such as the placements of implants (which would be accompanied by restorations), or cleanings (which would be accompanied by exams and radiographs), the dentist must indicate to the

patient the charges for the accompanying procedures.

The underlying cause for the greatest number of patient complaints appears to be centered around disagreements with, or misunderstanding of, the “front office staff” in dental offices, and the inability of the patient to communicate directly with the dentist. Other common complaints are misunderstandings about amounts which will be paid by insurance, or that a subsequent treatment will be required at additional cost.

➤ Infection control

Under OAR 818-12-0040 licensees must: wear disposable gloves whenever placing fingers in the mouth of a patient or when handling bloody or saliva-contaminated instruments; wear masks and protective eyewear or face shields when splattering of blood or other body fluids is likely; sterilize instruments or other equipment between each patient use; test heat sterilization equipment weekly; disinfect surfaces; and properly dispose of contaminated wastes.

The public is increasingly sensitive to infection control, and the Board has received complaints that masks or gloves were not worn, or instruments were not properly sterilized. Compliance with the Board’s infection control guidelines is required, and licensees are urged to comply with similar guidelines (i.e., CDC, Oregon OSHA, etc.).

Further, the Board has received a number of complaints about the cleanliness of dental offices. The complaints have centered around offices that gave the appearance of being dirty or run down. The investigation of these complaints revealed rust or staining that could have easily been resolved by normal housekeeping procedures.

➤ Informed consent

Under OAR 818-012-0010(10) licensees are required to obtain a patient’s or guardian’s informed consent prior to performing any procedure. Under OAR 818-012-0070(c) when informed consent has been obtained, licensees are required to document that informed consent has been obtained and the date the consent was obtained. This documentation



This article first appeared in the December 2015 issue of the newsletter of the Oregon Board of Dentistry. Reprinted here with permission.

continues on next page

Oregon Board of Dentistry Meeting Dates

(All meetings subject to change.)

- April 22, 2016
- June 17, 2016
- August 19, 2016
- October 21, 2016
- December 16, 2016

Meetings of the Board are open to the public. Most meetings are held at the office of the Board: 1500 SW 1st Ave., 7th Floor Conference Room, Portland, OR 97201. For specific information or agendas, call 971-673-3200.

continued

may be in the form of an acronym such as PARQ (Procedure, Alternatives, Risks, and Questions) or “SOAP” (Subjective, Objective, Assessment, and Plan).

The question then arises, does PARQ have to be documented at each appointment that treatment is provided. The answer would be “yes”, unless the licensee first has a consultation appointment at which time the licensee explains the planned Procedures, describes all of the Alternative treatments, mentions all of the Risks involved in the proposed treatment, and then answers any Questions the patient might have. At that time, if the licensee provides the patient with a final treatment plan that the patient agrees to, PARQ can be noted in the patient record, and as long as the treatment that is provided to the patient does not deviate from the treatment that was described in the final treatment plan agreed to by the patient,

PARQ does not have to be documented at each subsequent treatment appointment.

However, for example, if an inlay that was originally planned evolves into a crown because of an undermined cusp during the preparation appointment, informed consent needs to be obtained for the new procedure and PARQ needs to be documented in the patient records at that appointment.

➤ Documentation in patient records

Treatment notes must accurately document the treatment provided and the rationale for providing that treatment. The treatment notes should include documentation of past treatment provided, future planned treatment, and defensible documentation of your dealings with the patient.

Under OAR 818-012-0070(b) licensees are required to document the date and description of examination and diagnosis. The question then comes up on how could a dentist easily document in the records a diagnosis (dental justification) prior to providing a particular treatment to a patient. So, if the proposed treatment, for example, is to treat caries in tooth #4 – MO, you can make a note “Caries #4 – MO” either in the treatment plan or in the treatment note on the day the treatment is done

Under OAR 818-012-0070(f) licensees are required to document the date and description of all radiographs, study models, and periodontal charting. In reference to radiographs, the question has arisen that if there is caries evident on a radiograph, does the licensee also have to have written documentation of the presence of caries in the patient records. The Board has opined that the radiographs have no voice, they are only a tool to aid the dentist in diagnosing and documenting pathology and that the dentist must document the interpretation of what is evident on the radiographs. 📍

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Seventh annual poker tourney raises \$20,000 for DFO

Texas Hold 'em event helps improve oral health for Oregon children

When Bill Ludwig, founder of BnK Construction, came up with the idea of hosting a charity poker tournament to raise money for the Dental Foundation of Oregon (DFO), he had no idea of what it would one day become. From its modest beginnings seven years ago in a pole barn with a few dedicated players and small cash prizes gleaned from the proceeds, it has grown into a major fundraising event. This year, we hosted an astounding 84 players who competed for prize packages valued at over \$5,000.



Congratulations to this year's winners:

- 1st Place Rob Dixon (West Coast Finishers)
- 2nd Place Dr. David Renton
- 3rd Place Yoshio Kurosaki (Summit Properties)
- 4th Place Melissa Wheeler (Oregon educator)
- 5th Place Dr. Jason Bajuscak (2-time past winner)
- 6th Place Dr. Bill Scharwatt
- 7th Place Ray Yancey (Myhre Group Architects)
- 8th Place Dr. Weston Heringer, Jr.





The DFO Texas Hold 'em tournament, presented by BnK Construction, has raised more than \$97,000 over the seven years. This year alone, the event raised over \$20,000, due to the extreme generosity of the players and sponsors.

We are thankful to all the participants and sponsors who

made this event such a rousing success. Hundreds of children will greatly benefit from all the effort that was expended to make the poker tournament so much fun and so financially effective. All who partook in this event have made a difference in the life a child who they may never meet but who will be eternally grateful to their unknown benefactors. We can't wait until next year!

Along with **BnK Construction**, title sponsor since the tournament's inception, and **Moda Health** graciously providing their venue for three years running, there were a number of first time sponsors amid the many long term. Special thanks to:

Premier Table Sponsor:
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The craft beer was graciously donated by:
The Growler Guys, South Waterfront

Pizza was provided by: **Godfather's Pizza NW**. *An enormous shout out and thank you to Godfather's for providing the pizza each year; there is always plenty of food and drink for all who attend!*

There are many, many sponsors and volunteers who make this event such a success. Please, take the time to read the sponsor list to the right. Without these folks, the money would not be raised and far fewer children would be able to be served when there is so much need. The DFO thanks these sponsors and volunteers from the bottom of its heart for giving so generously over the past seven years.

This event could not take place without the time, efforts, and talents of the team from **BnK Construction, Inc.** A huge thank you to Bill Ludwig, Rick Shandy, Todd Rocha, Neal Linegar, Cristi



Shandy, David and Sheila Syzplinski, Michelle and Jared Shandy, Jon Scheile, Tyler Hall, Mark Roberts and George Quillen.

Thank you to our other volunteers, including: Steven Doane, Nancy Heringer, Darren and Heather Hippenstiel, Aaron Raasch, and Anna Velasco.

Thank you to all who participated, volunteered, sponsored, and donated. 🍀

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BUSY FAMILY PRACTICE IS CURRENTLY OPERATING WITH 1 DENTIST, but is in need of an associate dentist to join our team. We've been voted Roseburg's Reader's Choice #1 Favorite Dentist for the past 7 years. Our building was newly built as of Jan. 2008 and we're up to date with the latest dental equipment and procedures. We have a large patient database and we keep growing. Recent dental school graduates are encouraged to apply, as well as, those with a more substantial work history. Potential candidate must possess an excellent work ethic, friendly chair side manner and a team player attitude. Continuing Education is offered and encouraged. Guaranteed base pay with great incentive potential. Hours will begin as part-time, but could increase to Full-Time in the future. We handle the marketing and new patient generation. Contact us today! jody@drrandol.com

PERMANENTE DENTAL ASSOCIATES OREGON / WASHINGTON. OUR MISSION IS TO provide the best oral health care to every patient through evidence-based dentistry within a group practice setting. Excellent opportunities offered to skilled Dentists, including Specialists. For additional information, please visit: pda-dental.com, or for current practice opportunities: <https://pdacareers.silkroad.com/pdaext/employmentlistings.html>. Contact us, phone: 503-813-4915 or email: mpdajobs@kp.org.

DENTAL OPPORTUNITIES

GENERAL DENTISTRY

ASSOCIATE DENTIST WANTED: MODERN PRACTICE IN BRIDGEPORT area is seeking a general dentist for 2 days a week. This position has potential for growth and is great opportunity to work with a seasoned dentist and established clients. At least one year experience is preferred. We provide a full range of dental services including endodontics, oral surgery, and a wide range of restorative procedures. Our office has a great staff and 4 operatories with room to expand. Contact: davidstreiff@alderdentalgroup.com.

PRIVATE PRACTICE ASSOCIATE NEEDED, ALOHA, ORE. Beginning April/May, 2016, 4 days per week, \$600 min per day or 30% of collections (whichever is greater), General Dentistry (no specialties required), mentoring from experienced Dentists, contact Jon Schatz at jonschatz@att.net or (503) 349-1600.


PEDIATRIC DENTISTRY

PEDIATRIC DENTIST WANTED FOR EXCITING OPPORTUNITY! Pediatric Dentist associate wanted for an exciting opportunity in West Portland area. Beautiful, well equipped office is located in a highly desirable area with significant new growth and development. We have a passion for quality care for our patients and are committed to investing in our local community. Position would start as part-time and would expand to full-time quickly. We are looking for an individual who is invested in their career and strives to continually grow. E-mail CV to bskearbey@gmail.com.

PEDIATRIC DENTIST OPPORTUNITY IN GRESHAM AND SHERWOOD Excellent opportunity for a pediatric dentist to work part time or full time in Gresham and Sherwood. The offices are well established and accept nearly all insurance plans. Additionally, the offices are equipped with industry leading technology and safety equipment. Superior income potential, comprehensive benefits and a great work/life balance. Sign-on bonus and/or relocation fee is negotiable. Contact Ed at loona@pacden.com for more information.


PEDIATRIC DENTIST / GP FOR PEDO OFFICE: KLAMATH FALLS. Pediatric Dentist or GP who loves working with kids. up to \$250,000 salary. Contact Rex Gibson 541-408-1057 or rexandemily@gmail.com.


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LANE COUNTY & DENTAL SOCIETY

present





Overview for the Dental Healthcare Team

Tuesday, May 10, 2016
5:30 – 8:30 p.m.
2 CE credits

Geoffrey L'Heureux, PharmD, AAHVP
HIV Alliance Pharmacist

Renee Yandel
HIV Alliance Executive Director

Center for Meeting & Learning | Room 104
Lane Community College
Main Campus, Eugene

Participants will gain knowledge that is crucial to providing oral care to patients living with HIV. With this comes a new understanding of the stigma that some HIV positive clients encounter when attempting to receive oral care treatment and why it is important to decrease this to better serve the community.

details and registration at lanedentalsociety.org
Course content is appropriate for dentists and dental team members.



PROFESSIONAL PRACTICE SPECIALISTS

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Aaron Pershall - Randy Harrison



Specializing in the Sale, Transition and Appraisal of Dental Practices throughout the Pacific Northwest

WESTERN OREGON OMS – Dr. retiring from 30+ years serving the community. He is flexible to the transition needs of the new owner. High profit practice with average collections of \$1.3M for the last 5 years, on 170 days/year in office. Strong referral base serving a population of about 250k. Exceptional 5-year old, spacious 5-op office with state of the art equipment, including a Carestream 3DCTscan connected to all work stations.

EUGENE, OR – Excellent, high profit G/P in a very good area collecting \$700K+ for the last several years.

SALEM, OR – Wonderful 4+ op G/P collecting \$500K+. Excellent, high traffic location with good parking.

BEND, OR PEDO – Pedodontist retiring after 20+ wonderful years. Very nice office in a great location.

S. OREGON ORTHO – Wonderful, long established practice collecting \$600K+. Very nice office!

S. OREGON COAST – Excellent family G/P collecting \$500K+. Very nice office with newer equipment.

VANCOUVER, WA – Excellent, quality driven G/P collecting \$600K+, in a wonderful, high traffic location.

TACOMA, WA PROSTH – Well established practice collecting \$400K+ in 2014. 7 ops, digital x-rays and a full denture lab. Building also available!

BOISE AREA – Partner wanted for wonderful G/P. Collected \$500K in 2014. 5 ops, digital x-rays and more. Associate is working the practice; poised for growth!

KAILUA-KONA, HI – Fee-for-Service G/P collecting about \$400K. Come live, work and play on the Big Island! Motivated Seller!

FAIRBANKS, AK – Associate wanted for busy Endo practice!

MAT-SU VALLEY, AK – High volume G/P seeking a full-time associate with possibility to purchase. Position is 5 days per week; pays 35% of collections.

ANCHORAGE, AK – Well established G/P collecting \$500K annually. Possible merger opportunity.

KETCHIKAN, AK – 100% fee-for-service G/P collecting \$600K. 4 ops updated about 5 years ago.

NEW! ANCHORAGE AREA– Long-established G/P collecting around \$800K annually. Highly profitable, low overhead office has 7 ops (6 equipped) and runs Eaglesoft. Seller willing to work back for purchaser if desired. Call Today!

ANCHORAGE, AK – Excellent practice collecting over \$900K. 100% fee-for-service! Practice has Prosthodontic emphasis but the production mix is varied.

ANCHORAGE, AK – Excellent G/P collecting around \$950K. Seller is retiring and relocating. Great cash flow!

NEW! ALASKA OMS – Long-established, highly profitable, OMS practice collecting over \$2.8M. Beautiful, spacious, modern office and excellent staff. Seller is well respected and willing to transition.

NEW! KENAI PENINSULA, AK – Wonderful rural G/P collecting around \$1M. Low overhead practice is amazingly profitable! Digital x-rays, laser, pano and newer equipment throughout.

www.PracticeSales.com

Aaron@PracticeSales.com RandyH@PracticeSales.com

Please call for a Complimentary, Confidential Consultation

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SPACE AVAILABLE/WANTED

DENTAL OFFICE SPACE FOR LEASE DENTAL OFFICE space overlooking the Columbia River in Astoria, OR. Approx. 3,000 leasable sf. Plumbing & wiring in place. Patient parking available on dock. Restored Historic building with exposed wood structure. 503-880-4570 or donv@vcarch.com.

DENTAL OFFICE FOR LEASE. ESTABLISHED DENTAL PRACTICE in busy Clackamas area looking for a specialist to come in to take over the practice. 2500 sq feet with 6 plumbed operatory spaces. Call for details, KMO, Sue O'Halloran 503.661.8000.

MEDFORD OREGON DENTAL OFFICE FOR RENT. FOUR operatories, ideal location. Generous terms for starting dentist. Call 541-773-3592, or email lware@charter.net

PRACTICES FOR SALE

ENDODONTIC PRACTICE FOR SALE IN OREGON: ESTABLISHED endodontic practice in a small university town of about 12,000, drawing from surrounding population of about 58,000. Perfect town to raise a family. Over 2200 square feet building with 4 operatories; two operatories with G6 microscopes. A third operatory is for the occasional emergency to squeeze in; and the fourth is the CBCT room, equipped with a K9000. Plus basement storage and equipment space. Recreational opportunities abound for outdoor enthusiast. Building and equipment are priced to make an ideal starting package for the new grad or established practicing endodontist who wants to move. Please email: oregonpractice@gmail.com.

UNIQUE AND EXCEPTIONAL OPPORTUNITY IN THE NATION'S 5th fastest growing city. Practice is housed in the sole commercial space of a premier residential condo building, across the water with unobstructed views of downtown Seattle. Unique location that cannot be duplicated, with 15 years of existence, this practice offers tremendous growth and investment opportunities, ideal for two dentists who can capitalize on all the specialty work that otherwise is referred out. Commercial condos are no longer being made available in this city. Days and hours can be further expanded to leverage the value of the real estate investment in a doctor-owned and operated space. Referring out almost all specialty work. Growing hygiene department of 5 days/week and 4 days of single column restorative, the practice collected in 2015 just shy of \$1.3 million. During 2015 the doctor worked just 159 days, taking 8 weeks of vacation. The approximately 1,800 sq.-foot office was built 15 years ago and is also for sale by owner. The office is pristine; contemporaneous and plumbed for a potential 5th op. Adec chairs and digital radiography, Dentrix Software and computerized throughout. All heavy equipment including water-tank rest in a separate external storage unit, gases are located in an addition closet at the outside of the building. Opportunity not to be missed for the "right pair." Please contact Jennifer Paine at DG Transitions at (425) 216-1612 or jennifer@cpa4dds.com | www.alkidental.com.

PRACTICES FOR SALE

G/P PRACTICE FOR SALE ON THE NORTH-CENTRAL OREGON COAST Three operatories with digital X-rays Annual collections over \$585,000. This well established practice has been in the area for 34 years. Excellent collection policy in place. Well trained staff will continue with the practice and assist with the transition. Great opportunity for a young dentist as the selling dentist refers out most endo and oral surgery. Excellent hygiene program in place that produces 40% of the production. Building is in an excellent location with great visibility and would be available to the buyer to purchase. Contact: Buck Reasor, DMD. Reasor Professional Dental Services, info@reasorprofessional.com, 503-680-4366.

DENTAL PRACTICE FOR SALE: NEWBERG OWNER WILLING to carry the contract, no bank loan needed, great way to start and keep expenses low, 4 Opt.'s, last three year's production averaging over 1 million. Long term staff, Building for sale. Contact Jon Schatz at 503-349-1600 or jonschatz@att.net for a confidentiality agreement to obtain more information.

EQUIPMENT: SALE/SERVICE

BIOLASE W/HANDPIECES, ULTRASONIC CLEANERS, AND MORE. Search Dental equipment Morelli on: <https://portland.craigslist.org/wsc/hab/5471414039.html>

GENDEX & DEXIS INTRAORAL X-RAY SENSOR REPAIR We specialize in repairing Gendex & Dexis dental X-Ray sensors. Repair & save thousands over replacement cost. We purchase old/broken Sensors! www.RepairSensor.com / 919-924-8559.

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VOLUNTEER OPPORTUNITIES

DENTIST NEEDED FOR A METHODIST 10 DAY MISSION TRIP ON A MEDICAL/DENTAL BOAT IN THE BRAZILIAN AMAZON. May 27, 2016 to June 5, 2016. We will be providing basic medical and dental care to small villages along the Amazon River in the Manaus, Brazil area. Contact leader Elaine Jones RN at elainejones1213@hotmail.com, or 503-703-5932.

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