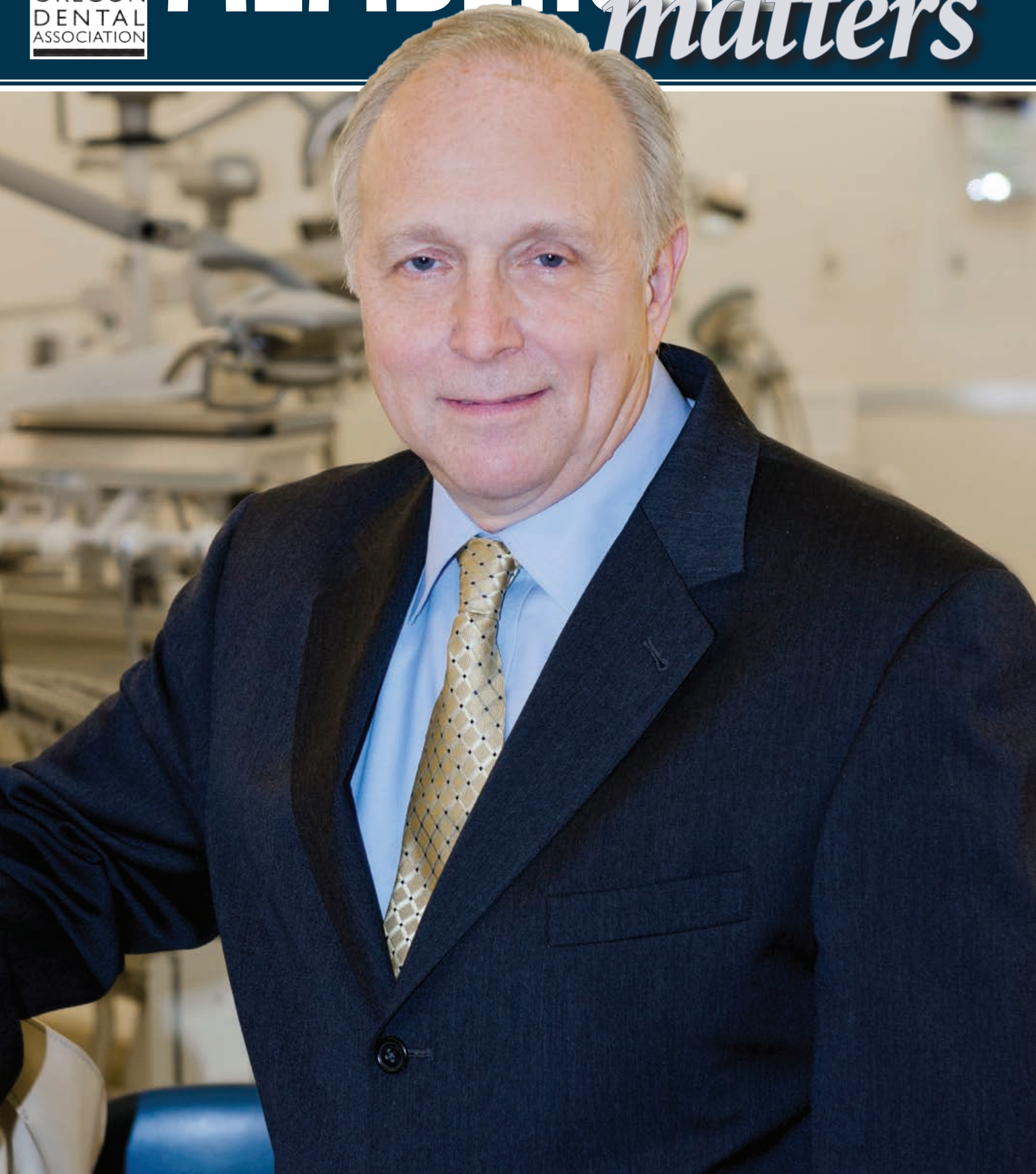




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September 2013



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Official publication of the Oregon Dental Association in support of its core purpose to advance the dental profession and promote the highest standard of oral health and oral health care.



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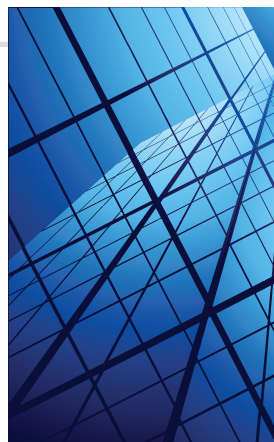
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Letters to the editor are welcomed.
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to this publication become the
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Blog www.TheToothOfTheMatter.org

- SEP 27** 10:00 AM **Board of Trustees meeting** (ODA)
NOV 16 8:00 AM **Board of Trustees meeting** (ODA)
NOV 24-27 **Oregon Mission of Mercy IV**
(Oregon Convention Center—Portland)
JAN 10 10:00 AM **Board of Trustees meeting** (ODA)
MAR 7 9:00 AM **Leadership Seminar** (ODA)
MAR 8 8:00 AM **Board of Trustees meeting** (ODA)
APR 3-5 **Oregon Dental Conference**
(Oregon Convention Center—Portland)
APR 6 8:00 AM **Board of Trustees meeting**
(DoubleTree Hotel Lloyd Center—Portland)

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www.oregondental.org, and
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of the page or call
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DBIC RISK MANAGEMENT COURSES

- DEC 6** 9:00 AM Multnomah (Portland) INFO: Lora Mattson, 503.513.5010
DEC 13 9:00 AM Central Oregon (Bend) INFO: www.centraloregondentalsociety.org



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COMPONENT CE CALENDAR

compiled by Mehdi Salari, DMD

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to bendsalari@yahoo.com.

FRI, SEP 20 Lane County **CE HRS: 6**
**Multidisciplinary Approach for Diagnosis,
Treatment & Prevention of Dental Trauma**
Nestor Cohenca, DDS

LOCATION: Eugene (Downtown Athletic Club)

INFO: www.lanedentalsociety.org

WED, OCT 2 Southern Oregon **CE HRS: 1.5**
Shade Taking & Dental Photography
O'Brien Dental Lab

LOCATION: TBA

INFO: Amanda Davenport at sodentalsociety@yahoo.com

TUES, OCT 8 Marion & Polk **CE HRS: 2**
**Ergonomics in the Office: How to Prevent
Back Pain and What to do When it Hits**
Jeff Blanchard, PT, MS, of Therapeutic Associates

LOCATION: West Salem (Roth's)

INFO: www.mpdentalce.com, mpdentalce@qwestoffice.net

TUES, OCT 8 Southwestern Oregon **CE HRS: 1.5**
**Update of Various Medications which
Contribute to Osteosclerosis**

Drs. Cook & Cherry (hematologist, oncologist)

LOCATION: Coos Bay (Red Lion Hotel)

INFO: Dr. Roger Sims at roger@rgsims.com

TUES, OCT 15 Washington County **CE HRS: 1.5**
**Part II: Dental Mgt. & Reconstruction of the
Head & Neck Cancer Patient**
Dr. Tuan G. Bui

LOCATION: Beaverton (Stockpot Broiler)

INFO: www.wacountydental.org, wcdskathy@comcast.net

WED, OCT 16 Multnomah **CE HRS: 1**
**How to Avoid Getting Bitten and Other Tips
from a Pediatric Dentist, Michelle Stafford, DDS**

LOCATION: Portland (McMenamins Kennedy School)

INFO: www.multnomahdental.org, lora@multnomahdental.org

THUR, NOV 7 Southern Oregon **CE HRS: 1.5**
Machu Picchu & Dentistry in Peru
Dave Allen, DDS

LOCATION: Medford (Sunrise Café)

INFO: www.sodsonline.org

TUES, NOV 12 Marion & Polk **CE HRS: 2**
Business Identity Theft, Warren Franklin

LOCATION: West Salem (Roth's)

INFO: www.mpdentalce.com, mpdentalce@qwestoffice.net

TUES, NOV 12 Washington County **CE HRS: 1.5**
**Options & Rationale for Managing Affected
Pulp of Primary Teeth, Dr. John E. Peterson**

LOCATION: Beaverton (Stockpot Broiler)

INFO: www.wacountydental.org, wcdskathy@comcast.net

TUES, NOV 12 Southwestern Oregon **CE HRS: 1.5**
Orthodontic Update
Dr. Craig Stevenson

LOCATION: Coos Bay (Red Lion Hotel)

INFO: Dr. Roger Sims at roger@rgsims.com

TUES, DEC 10 Marion & Polk **CE HRS: 2**
Oral Surgery for the Rest of Us
Mark Thomas, DDS, exodontist

LOCATION: West Salem (Roth's)

INFO: www.mpdentalce.com, mpdentalce@qwestoffice.net

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Barry J. Taylor,
DMD, CDE

Dental editor Summer editorial Time for some haiku

Spring graduation
Dental school debt begins
Manage budget well

Number 9 implant
Patient wants white as snow flakes
No, bleaching won't match

Uncomplicated
Why did I say no worries
Now must call surgeon

Know how to herd cats?
Executive Director
Position open

Root perforation
Endodontist now best friend
Can I buy you lunch?

First day of summer
Children get on bike first time
Too many chipped teeth

Patient wants first class
Dental insurance budget
Three unit bridge than

Must do spore testing
No excuse not to do it
Big fine otherwise

Gold colors of fall
More common than gold inlay
Now all porcelain

Temporary crown
Will fall off day of wedding
Should have prepped next month

Angry new patient
Too late for risk management
Board complaint on way

Patient calls Friday
Toothache started on Monday
Expects fix right now

Rubber base long gone
PVS is here today
Next is digital

Dentists salary
Icy slope downhill they say
Need spring thaw to stop

Brand new full denture
Perfect fit says the dentist
Patient says too loose

Common dental terms
Tough to relate to nature
Difficult haikus

Barry J. Taylor, DMD, CDE,
is editor of *Membership
Matters*. He can be
reached via email at
barrytaylor1016@gmail.com.

Allegations of overtreatment in dentistry: A perpetual issue?

The physician's professional responsibility for appropriate allocation of resources requires scrupulous avoidance of superfluous tests and procedures.

– *Charter on Medical Professionalism, 2002*



Phyllis
Beemsterboer,
Ed D, FACD



Gary T. Chiodo,
DMD, FACD

The American College of Dentists, of which both Drs. Beemsterboer and Chiodo are members, has a plethora of information on ethics on their website: www.DentalEthics.org.

Phyllis Beemsterboer is Associate Dean for Academic Affairs at the OHSU School of Dentistry and Associate Director at the OHSU Center for Ethics in Health Care. You can reach her at 503.494.8801.

Gary Chiodo, DMD, is Executive Vice Dean at the OHSU School of Dentistry. You can reach him at chiodoga@ohsu.edu.

In 1997, *Reader's Digest* published an article questioning the honesty of the dental profession. This story reported what it called, "disturbing news about the dental profession." After receiving a thorough examination and treatment plan at a dental school, with agreement among various faculty attendings, the author traveled 50,000 miles across America receiving 50 independent dental examinations from dentists in private practices. What he found was very disturbing and revealed incredible variation in recommended treatment from different dentists. He was told he needed minimal treatment by some, moderate treatment by others, and \$19,402 worth by yet another! While the article was embarrassing enough for the profession, the blog, generated by the online version of the story, was absolutely chilling.

While the *Reader's Digest* article drew major public attention to the allegation that some dentists may over-treat patients as a means to generate higher incomes, it was neither the first nor the last media storm about this issue. This labeling has, periodically, plagued dentistry, and has challenged the reputation of the profession for a very long time. So, is this a real problem? Do some dentists prescribe unneeded treatment to inflate cash flow? Was the variation in examination findings discovered in 1997 a fluke or a symptom of a real and on-going problem?

Our colleagues in medicine were also challenged in this regard by a 1985 article titled "When Doctors Disagree." This story explored some data analyses (supported, in part, by the Department of Health and Human Services) that demonstrated remarkable variations in the frequency with which various medical procedures were performed, even when such factors as patient age and

income were statistically controlled. Many of these allegations related to physicians who referred patients for tests to a facility in which the physician had a financial interest. It was because of these concerns that legislation such as the Stark law and anti-kickback rules were enacted.

Over-treatment and over-diagnosis are the application of unnecessary, excessive or ineffective medical procedures or drugs. So, what are the reasons for over-treatment? Certainly from the media and public perspective, the perception seems to be that the problem is greed. These sources tend to portray the over-treating dentist or physician as someone who is more interested in monetary rewards than patient health. This is the ugliest perception because it places the health care professional in the light of self-interest at any cost and patient interest as subordinate to income. While it is possible that there are some dentists who would fit that description, we suspect that they are few and far between, and certainly the exception.

Another potential reason for over-treatment by dentists and physicians relates to risk concerns. In an increasingly litigious society, health care professionals sometimes feel that they may incur substantial legal risk if anything is missed in a diagnosis. This can lead to running every test possible to document a thorough examination and, hopefully, rule-out every possible problem. Of course, in health care practice, it is impossible to rule-out every problem and, if a patient is truly litigious, he or she will find some reason to bring legal action regardless of the number and type of tests completed.

Also on the list of potential reasons for over-treatment are philosophical and training differences among professionals, insurance plan influences, community

standards, number of specialists available, age and gender of the patient, patient preferences, and—not to be forgotten—patient and provider convenience. Two dentists, one trained on the west coast and one on the east coast, may very well disagree on the first choice of treatment plan for a particular patient. That does not imply that one is wrong and the other right. There is art as well as science in any health care discipline, and variations in treatment plans is a natural outcome of that dynamic.

The ADA Principles of Ethics and Code of Professional Conduct does not directly address the issue of over-treatment, but it does discuss the applied principles of autonomy, justice, and beneficence. Respect for autonomy expresses the concept that dental professionals have a duty to treat the patient according to the patient's desires, within the bounds of accepted treatment, while justice fills in with the concept that professionals have a duty to be honest and trustworthy, communicating truthfully in their dealings with people. Recommending treatment that is clearly unneeded or excessive betrays the principle of autonomy because the patient would never have consented to such treatment. Indeed, in such a case, the informed consent process would have had to advise the patient that the proposed treatment is excessive and unnecessary and that the dentist really does not recommend it. Voluntary consent to such a thing is highly unlikely and would call into question the entire consent process.

The Code is more direct in addressing the possibility of a financial motive for over-treatment in its discussion of beneficence. This ethical principle requires the dentist to always act for the benefit of the patient. As the Code advises, this duty is required "...whether the dentist engages in fee-for-service, managed care or some other practice


arrangement. Dentists may choose to enter into contracts governing the provision of care to a group of patients; however, contract obligations do not excuse dentists from their ethical duty to put the patient's welfare first." This statement makes clear that any dentist, who places considerations of reimbursement or financial gain ahead of patient welfare, has acted unethically.

Even though the damage done by the "How honest are dentists," and similar articles and television programs is periodic and fleeting, the allegation of over-treatment driven by greed is one that the professions will continue to face and defend against in the future. Fortunately, dentistry, as a profession, enjoys a very high level of trust from the general public, and this, too, will likely continue. The most recent Gallop poll on honesty and ethical standards of people in

various fields rated dentists at the fifth highest among professions (physicians were at number three). Patients trust the dentist to recommend and deliver the best quality treatment. That trust must be assiduously protected. The best way to counter the unfortunate exposé articles about dentist and the inevitable blogs that follow is for each of us to prove to each of our patients that, while there will be outliers in every profession, they neither represent the majority of those professionals nor the profession itself. ●

References

- Bunker, John MD NYR April 25, 1985
- ADA Principles of Ethics and Code of Professional Conduct. www.ada.org/sections/about/pdfs/ada_code.pdf
- Update of perceived honesty and ethical standards of professions 2012, www.gallop.com/poll



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Volunteers NEEDED

The ODA councils and committees listed below currently have volunteer opportunities. **All ODA members are encouraged to participate in the leadership of this organization.**

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

ODA Leadership Development

Committee, Jim Smith, DMD

Chair, Nominating Sub-Committee

PO Box 3710, Wilsonville, OR 97070

or email: leadership@oregondental.org

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OSHA FactSheet

December 1st, 2013 Training Requirements for the Revised Hazard Communication Standard

OSHA revised its Hazard Communication Standard (HCS) to align with the United Nations' Globally Harmonized System of Classification and Labeling of Chemicals (GHS) and published it in the Federal Register in March 2012 (77 FR 5736). This significant change contributed to the revised standard requiring the use of new labeling elements and a standardized format for Safety Data Sheets (SDS), formerly known as Material Safety Data Sheets (MSDS). The new label elements and SDS requirements will improve worker understanding of the hazards associated with the chemicals in their workplace. To help companies comply with the revised standard, OSHA is publishing this specific requirements on several pages (December 1, 2013 to June 1, 2015).

The first compliance date of the revised HCS is December 1, 2013. By that time, employers must have revised their labels on the new label elements and the SDS format. This training is required for all employees who are likely to be exposed to hazardous chemicals in their workplace. To ensure employees have the information they need to better understand the hazards associated with the chemicals in their workplace, OSHA is publishing this specific requirements on several pages (December 1, 2013 to June 1, 2015).

Labels: The new label elements include:

- Hazard statement:** A statement that describes the nature and extent of the hazard associated with the chemical.
- Pictogram:** A symbol that represents a hazard.
- Signal word:** A word that indicates the level of hazard.
- Precautionary statement:** A statement that describes the measures that should be taken to minimize or prevent adverse effects resulting from exposure to a hazardous chemical or from release of a hazardous chemical into the environment.

SDS: The new SDS format includes:

- Section 1:** Identification.
- Section 2:** Hazard identification.
- Section 3:** Composition/information on ingredients.
- Section 4:** First aid.
- Section 5:** Fire fighting.
- Section 6:** Accidental release.
- Section 7:** Handling and storage.
- Section 8:** Exposure controls/personal protection.
- Section 9:** Physical and chemical properties.
- Section 10:** Stability and reactivity.
- Section 11:** Toxicological information.
- Section 12:** Ecological information.
- Section 13:** Disposal.
- Section 14:** Transport information.
- Section 15:** Regulatory information.
- Section 16:** Other information.

This is a series of informational text sheets highlighting OSHA programs, policies or standards. It does not contain any new compliance requirements. For more information on OSHA standards, visit www.osha-slc.gov.

For more information, visit www.osha-slc.gov or call 800-368-5888.

OSHA

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OSHA-DC-10-000

Training forms available at:

www.osha.gov/Publications/OSHA3642.pdf

OSHA3642.pdf

Train your staff on the

new formats by

December 1, 2013!

OSHA forms change: Safety Data Sheets (SDS) will replace Material Safety Data Sheets (MSDS)

Federal OSHA passed regulations changing the format of safety sheets for hazardous chemicals used in businesses. This change came not only with a forms change but a name change, and training requirements prior to the actual sheets being required for use. **Training for staff is required by December 1, 2013, even though the new SDS sheets do not have to be obtained until June 1, 2015.**

Specific information on what the training should include can be found at www.osha.gov/Publications/OSHA3642.pdf. Training is to help workers have a better understanding of the chemicals in the workplace.

OR-OSHA Resources offer clarification relating to the new SDSs: **If you don't have them will OR-OSHA cite you?**

OSHA states "that while distributors must comply with the 16-section format by June 1, 2015, OR OSHA will not cite employers who have requested, but not received, new safety data sheets for their hazardous chemicals by June 1, 2015. Because chemical manufacturers and distributors must comply with all requirements of the hazard communication standard by June 1, 2015, you should have no problem receiving new safety data sheets for currently produced chemicals.

"You are not required to obtain a new safety data sheet for chemicals you get before June 1, 2015. You should receive one, however, for orders placed after that date. If you request a safety data sheet, but the manufacturer or distributor can't (or won't) send you one, keep your documentation showing that you tried to get it in the new format; Oregon OSHA will not cite employers who have requested, but not received, new safety data sheets in these cases.

"Manufacturers are not required to create safety data sheets for their discontinued chemicals. Employers should keep their material safety data sheets—regardless of the format—for those products."

Affordable Care Act

Employers must notify employees by October 1

The Affordable Care Act (ACA) amends the Fair Labor Standards Act, creating a requirement that employers provide a notice to employees, informing them of the existence of the newly formed

Marketplaces under the ACA, along with information on how to contact the Marketplace to request assistance in purchasing coverage if the employees choose to do so.

Specifically, by October 1, all employers covered by the Fair Labor Standards Act (which includes all dental offices) will have to furnish each of their employees with a notice that informs the employees that there are new health insurance marketplace coverage options available.

Department of Labor has designed files for this notification purpose.

Download yours today.

For employers who offer a health plan to some or all employees, use:

www.dol.gov/ebsa/pdf/FLSAwithplans.pdf

For employers who do not offer a health plan to their employees, use:

www.dol.gov/ebsa/pdf/FLSAwithoutplans.pdf

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- Wanda E. Palena, DMD, PC, Vancouver, WA

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Peer Review

By John L. Fawcett, DMD

A review of peer review: ODA dispute-resolution process helps create win-win situation for dentists and patients.

MOST OFTEN OUR DIAGNOSIS AND TREATMENT are well accepted by our patients, and the outcome is satisfactory to all. But there are rare circumstances when treatment results are not what the patient anticipated. Professional rapport and patient confidence can usually override concerns, and some type of resolution can be developed in the office to solve these problems. However, at times, even the best of efforts by the best dentists and their staffs cannot resolve an escalating problem. The patient may feel the only course of action is to seek legal assistance. In the latter case, the complexity, expense, and emotions become daunting.

In the event that a dispute has gone beyond the point of in-office

resolution and help is needed, the dentist may offer the patient the option of ODA peer review. Many dentists who have gone through the peer review process have indicated it to be worth all their association dues. Accordingly, having some knowledge about the peer review system is prudent prior to becoming involved in a dispute.

ODA peer review is free of charge and is available only to member dentists and their patients (although third-party payers may sometimes be included), within a three-year period. If you become involved in a dispute, you may wish to recommend the patient contact Margaret Torgeson, ODA peer review director, prior to the initiation of legal action. She will evaluate the patient's complaint to determine if it is within the parameters of peer review. At times, she may be able to diffuse the patient's concerns and refer the patient back to the dentist for potential resolution.

If peer review appears to be in the best interests of all parties, ODA will mail appropriate forms to the patient to identify

the issues and detail what should be expected from those involved as the process moves forward. The dentist will have the opportunity to provide a written response to the issues presented in the complaint.

After acceptance, the peer review case will be referred to a committee of volunteer dentists in the local area to attempt mediation of the problem. Although the majority of cases are resolved in mediation, for those where no resolution can be developed, the case may need to be decided by a hearing. A hearing involves the local peer review committee

meeting with all parties to evaluate the problem (possibly including a clinical exam), listening to the issues, reviewing records, and making a

binding decision regarding the case. ODA will notify all parties of the decision along with the specifics of its implementation.

The dentist is bound by membership to agree to the results of the peer review process; by signing a form of similar content, the patient is similarly bound. Peer review allows the dispute to be resolved, avoids a report to the National Practitioners Data Bank, and excludes legal actions. The patient must sign a "Release and Satisfaction of All Claims" form indicating that peer review is the end of the dispute.

Offering peer review to patients when irresolvable problems occur demonstrates the dentist's good will and integrity in providing dental care. ODA maintains the program with the assistance of multiple volunteers, both generalists and specialists. ●

John L. Fawcett, DMD, is a former member and past chair of the ODA Peer Review Committee, as well as coauthor of the *Peer Review Manual*.

(Article reprinted from *Membership Matters*, April 2005, Volume 10, Number 11.)

This column is intended to acquaint you with the benefits that you receive as a member of the Tripartite (ODA, ADA, and your component dental society).

More information on member benefits can be found at <http://bit.ly/ODAbenefits>.

If you have any questions regarding Peer Review, please contact Margaret Torgeson, ODA peer review Director, at 503.218.2010 extension 108, or toll-free at 800.452.5628.

As an example of the types of cases they see, and what could have been done to prevent the complaint, the Oregon Board of Dentistry has provided the following case summary.

As a member dentist, remember to suggest the ODA's confidential Peer Review process to your patients as the best alternative to filing a complaint with the Board and/or taking legal action.

SUMMARY OF COMPLAINT The complaint alleges that a dentist provided unacceptable patient care to a patient, when the dentist only took 15 minutes to clean the patient's teeth and didn't "do a good job."

FINDINGS The investigation showed that during the course of treatment, on numerous occasions, the dentist failed to document that he had obtained informed consent prior to providing treatment. There was no periodontal probing done, and radiographs that were taken showed apparent caries on the mesial margin of a crown that was not diagnosed by the dentist when an exam was done. The patient was then seen in less than a year by several subsequent dentists who all diagnosed the presence of periodontal disease, but failed to also diagnose the caries not diagnosed by the original dentist. The patient ended up losing the cariously involved tooth after the carious lesion was found by a hygienist.

BOARD ACTION The Board closed the matter with a *strongly worded* Letter of Concern addressing the issue of ensuring that when informed consent is obtained prior to providing treatment, PARQ or its equivalent is documented in the patient records, and that when pathology is evident on radiographs, the pathology is diagnosed and documented in the patient records.

BOARD'S RATIONALE The dentist's chart documentation could have been better, but the issue of the diagnosis failure, because of the failure to diagnose by subsequent dentists, was too muddled to take down the path of disciplinary action. ●

What's your plan to attract new patients?

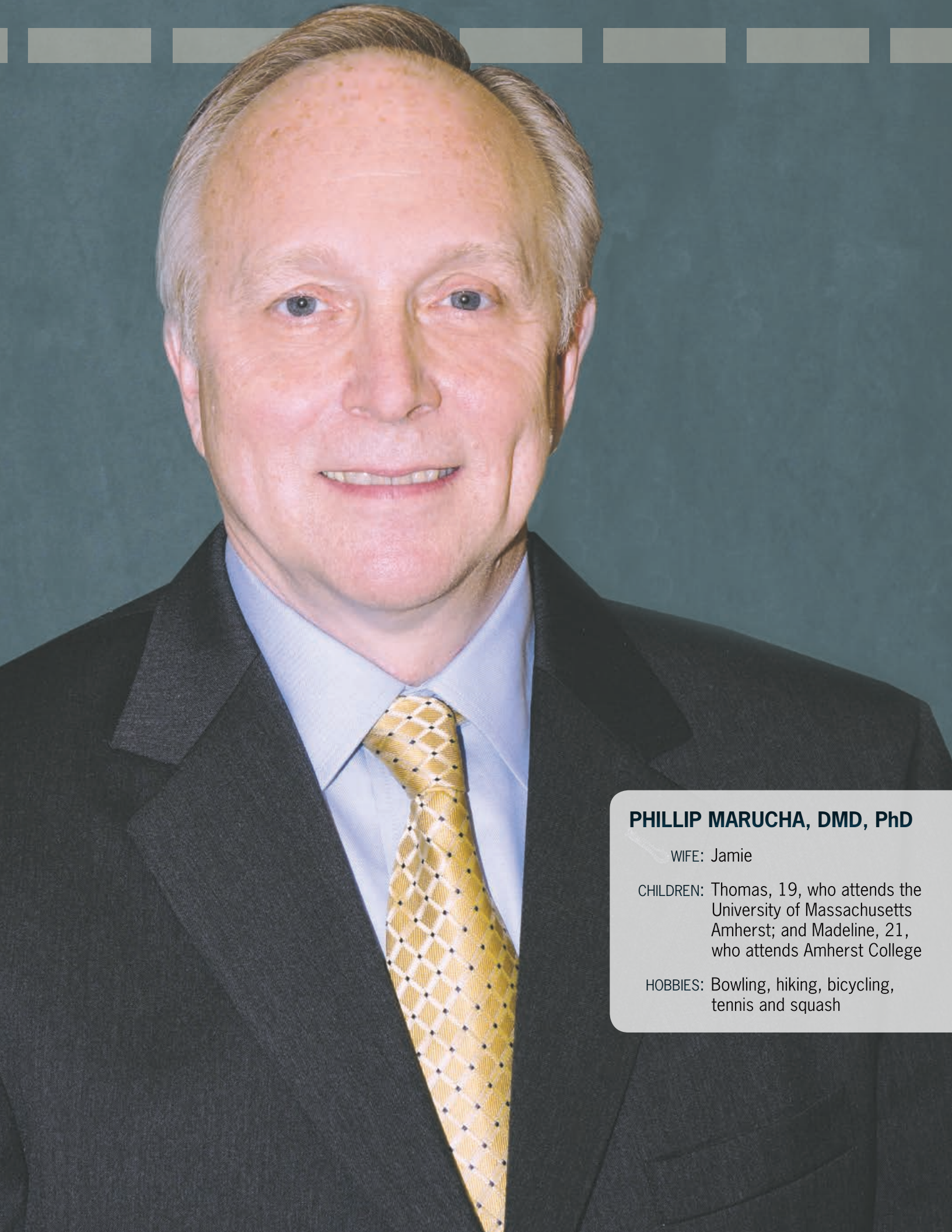
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HOBBIES: Bowling, hiking, bicycling, tennis and squash

Dr. Phillip Marucha

New dean of the OHSU School of Dentistry

By Barry Finnemore

As a youngster, selling newspapers on the street corners of Maryland, Phillip Marucha learned the value of hard work and developed the confidence that he could succeed at whatever he pursued.

Since then, Dr. Phillip Marucha, DMD, PhD, has become an accomplished dentist, immunologist, and researcher, with a focus on understanding how stress, gender, aging and other factors affect wound healing from the lab bench to clinical studies.

Dr. Marucha, the new dean of the OHSU School of Dentistry, comes to OHSU at what he describes as a very exciting time. A new home for the School is under construction on Portland's South Waterfront, and a focus on interprofessional education is enhancing the institution's collaborative culture and working to improve health outcomes.

Dr. Marucha took time recently to talk with Membership Matters about his background and experience (most recently, he served as associate dean for research, director of graduate studies, and head of periodontics at the University of Illinois at Chicago College of Dentistry); what attracted him to OHSU; and the future of dental education and health care delivery. He also shared a bit about his hobbies and the book he most recently finished.

How would you describe your leadership style?

I like to provide guidance, resources, and support to talented people and turn them loose to do innovative things. I'm really keen on mentoring. My job is to mentor without micromanaging, giving people opportunities to develop themselves in the context of the mission we're trying to achieve. I've always been a person who has appreciated the freedom to develop programs, so if I'm willing to do that for myself, I should be willing to allow others to do that. And I've had some really great mentors along the way.

What is the biggest lesson you've learned, and most significant accomplishment, as an academic leader?

The most significant lesson I've learned is to be patient. When you have ideas you want to explore them quickly, but you have to allow time for things to develop. That also means allowing time for people to develop and grow into a role.

What I've liked doing in my career is building things, particularly building programs. I built two DDS-PhD programs (a combined dental and research degree) at Ohio State University and UIC. I really like those programs because they develop future faculty and oral health researchers who will help shape the future of dentistry. They have a tendency to change the culture because they are excited, very inquisitive individuals who plant the seeds of curiosity among dental students, and they become leaders of the dental school community. I also was involved in the refurbishing of 23,000 square feet of research space at UIC through a \$9.9 million grant. Working with contractors, architects, faculty, and students through that process was exciting.

What drew you to dentistry and to research?

I'm a little bit of an "accidental dentist," in that I graduated from college with a BS in biochemistry and wasn't looking at dentistry or health care as a career path. I was interested in research. My first job out of college was at the National Institute of Dental Research. Dr. Paul Keyes, one of the founding fathers of the biological basis for oral disease, got me excited about exploring a dental career. I didn't decide to go to dental school until I was in a graduate program at UCLA and met Mike Newman, a periodontist who convinced me there was a role for me in dentistry that I couldn't play if I stayed in basic science research. I saw I was really made for it.

When I was a kid my dad repaired TVs in our basement. I grew up learning how to fix things, troubleshoot problems, and work with my hands. Once I got into dentistry I saw that it was natural for me to use those critical-thinking skills.

What attracted you to the OHSU opportunity?

A number of things attracted me. It has a great tradition of research and opportunities for growth, particularly in the area of interprofessional education. Having been part of a building project at UIC, the new space (for the dental school) is exciting and offers opportunities to interact with the nursing, medical, and pharmacy schools in ways that didn't exist before.

Interprofessional education is the right thing for patients. They deserve comprehensive, well-orchestrated health care where dentists are part of the team that provides coordinated care.

The other thing that interests me is that Oregon is a very progressive state at the cutting-edge of health care and health care reform. There's an opportunity to help mold that.

How will dental education change during the next 10 years? What roles will the School play in terms of serving the future needs of the profession and public?

We're seeing a dramatic transition from the way we used to practice, and it will require a whole new way of thinking for oral health professionals.

Dental education should change as dentistry changes and, in many ways, be a leader in how dentistry changes. A couple of forces will affect that. One is technology. For example, technology is moving toward milling rather than casting of crowns. There's the potential that 3-D printing will replace restoration. These things are not far-fetched anymore. There are also new ways to regenerate oral tissues.

The other factor is changes in our health care system. I see dentists triaging patients and helping detect things earlier, and interacting more with other members of the health care community.

Clearly there are health care funding issues. It's not clear where dentistry will fit into the process, but it seems that if, through reform, most everyone is going to receive health care, dentistry has an important place, because oral health is critical to systemic health.

The dental school is a place where we can help vision for that, with input from practicing dentists, to make sure students are at the cutting edge. It's a very exciting time, and I think OHSU is, and can continue to be, a leader.

We can also address the distribution of dentists around the state. The cost of dental education is way out of whack with our need to place dentists in areas where the economics won't support an income that will pay off \$300,000 or more in education debt. At UIC, students spend as much as 20 weeks during their senior year in community practice programs. We found that more students were likely to go into these types of practices after dental school if they had been exposed to them during their education. It allows them to be mentored as they transition into practice.

"The dental school is a place where ...with input from practicing dentists, ... [we can] make sure students are at the cutting edge.

It's a very exciting time, and I think OHSU is, and can continue to be, a leader."



How will you expand research at the dental school?

We should build on our strengths. We should be looking at interprofessional research in addition to interprofessional education. We also should look at areas where oral health technology will take us and target our research where there is future growth.

We also need to focus on the relationship between oral health and other systemic diseases, and how they impact each other, using health records to analyze health interactions statistically. OHSU is one of the premier places for health informatics research, taking a large volume of health information and developing personalized care that improves health outcomes.

Part of your research has focused on improving minority health. How do you see the dental school helping to meet that need specifically?

Health informatics is one of the ways. The studies we set up at UIC screened 10,000 patients for oral and systemic health in a very defined fashion. By understanding the parameters and susceptibility of patients, we could improve oral health for those populations. Diversity isn't just minority populations; it also includes those in rural communities with diverse backgrounds and lifestyles. Community practice programs can serve as sites for research to help us provide better care.

Do you plan to continue your research while acting as dean?

I'll be writing papers and wrapping up some projects, and we'll see how much time I have available to develop new research areas. It depends on how much time I have available to do all the things I need to do as dean and still maintain my research lab.

I still have lots of ideas I think are good ideas, and I also want to be a role model and mentor young scientists. It's important to have people dedicated to our missions of teaching and research.



Will the class size increase in the new school, and if so, how will those spots be filled (by in-state, out-of-state, international students)?

The landscape is very complicated right now. Several new dental schools are in development or have opened, and most are fairly large dental schools, so the questions are, what will the market bear and what are the needs of the country? I think we need to look carefully before expanding class size and come to a consensus on a direction. OHSU's primary goal is to train future dentists for the state of Oregon. That has to be the focus. We have collaborations with sister states like Montana, Idaho, and the Dakotas, and I think those are great relationships to continue pursuing. In the U.S., we have a distribution problem, possibly not a shortage of dentists, so our primary focus should be on solving that problem.



How do you see the relationship between organized dentistry (ODA) and the dental school?

It's critical, especially in Oregon where there is such a strong relationship already established. We need to be working and deciding together where dentistry is going and how we can serve each other. It also is a key component politically. We need to be working together to make sure there is the political will to do what is right for oral health care in the state.

What hobbies do you enjoy?

I'm an avid bowler. I started as a kid because we had two bowling alleys in town and not much else. I didn't bowl for 30 years, but started again five years ago. I decided one day I would pull out one of my old bowling balls and go to an alley. I started bowling once or twice a week. I was invited onto a team and started bowling in a couple of leagues. This last year I was able to carry a 203 average in one league.

I like to bike, hike, and play squash and tennis, but in Chicago you can't do much biking with all the snow and ice. We'll see how much I can do in Portland. It's a big biking town, but I also need to find time to do it.

What do you enjoy reading?

I read a combination of nonfiction and fiction. We just 'read' a book on tape called *Canada*. It's a novel about a person who is trying to understand how things work and sort of sees the worst of the world and how people make decisions that do them in. He's able to make decisions that don't take him down that track. I've also read all of Elmore Leonard's books. I like that they are murder mysteries with a historic sense to them. And I've reread classics like *The Sound and the Fury*. ●

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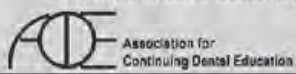
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Branding and Expanding

Corporate dentistry changing the oral healthcare landscape for patients, practitioners

By Melody Finnemore

A **DRIVE THROUGH SEVERAL OREGON CITIES** quickly illustrates the growth trend of corporate dental offices such as Aspen Dental, Pacific Dental Services, Gentle Dental, and similar chains that are rapidly opening for business throughout the state.

The expansion of corporate dental chains is occurring just as quickly across the nation. The number of such offices has grown by 25 percent over the last two years, according to the ADA's Health Policy Resources Center (HPRC).

The HPRC also found that the number of solo practitioners has fallen from 76 percent in 2006 to 69 percent in 2010. *Forbes* magazine, in a 2009 article, detailed the job growth corporate dentistry provides. Young dentists in particular find the corporate chain model attractive, and the ADA's New Dentist Committee has identified several reasons why. Among them, the increase in student debt puts owning a practice out of reach for many new graduates, and the recession forced many small practices to freeze hiring at the same time chains were filling positions.



In addition, the business support services provided by dental service organizations allows dentists practicing with large group practices to focus strictly on treating patients; chains provide more geographic mobility than owning a practice; and corporate dentistry may also offer better work/life balance than running one's own practice. The committee also found that most new dentists planned to eventually own their own practice, and working for a chain allowed them to gain valuable administrative experience they didn't learn in dental school.

"New dentists are seeking employment opportunities with flexibility, mobility, and practice management experience early in their careers, and this is a very fast-growing option," Danielle Ruskin, DDS, chair of the ADA's New Dentist Committee, said in an article published by the ADA.

As an example, Aspen Dental Management Inc. provides "back-office support" such as payroll and insurance services, property development, marketing and record-keeping for independently owned dental practices operating under the Aspen Dental brand, said Molly Salky, senior communications manager for ADML.

First established in Greece, New York, in 1999, Aspen Dental now has nearly 400 offices in 25 states. Last year,

Aspen Dental's practices recorded nearly 2.6 million patient visits and more than 550,000 new patients.

Aspen Dental's first Oregon practice opened in Keizer in 2009, and the opening of a Beaverton office in June marked its eighth practice. Aspen Dental also has locations in Roseburg, Hillsboro, McMinnville, Albany, Eugene, and Gresham, and it is considering future locations in Clackamas and Bend.

Since opening in the state, Aspen Dental-branded practices in Oregon have recorded nearly 80,632 patient visits and treated more than 21,495 new patients, according to Salky. She added that between August 12, 2012, and July 13, 2013, dentists and their teams from the eight Oregon practices saw 9,520 new patients and had 38,823 total patient visits.

When asked why Oregon is an attractive marketplace, Salky noted that access to care is a nationwide epidemic that is helping to fuel the chain's growth here and beyond.

"It's estimated that 47 million Americans have little or no access to affordable dental services, and many, regardless of whether or not they have dental insurance, live in areas of the country with few, if any, dentists," she said in an email interview. "Oregon is a state where 34 out of 36 counties have dental health professional shortage areas, as designated by the U.S. Department of Health and Human Services."

Salky said Aspen Dental typically hires its teams from the local community, though the practitioner who owns the practice may have come from elsewhere. Each office employs an average of 10 people, so the chain has about 80 employees in Oregon, she said.

Aspen Dental does not work with state-funded programs, such as Medicaid, and does not, therefore, accept Oregon Health Plan patients. It does provide a free new patient appointment, which includes an exam and X-rays, Salky said.

While the term "corporate dentistry" is commonly used to describe chain practices such as Aspen Dental, Salky called it a "bit of a misnomer."

"All Aspen Dental-branded practices are independently owned by dentists. As for the role of dental service organizations such as ADML, we believe that as our nation continues to address the complicated issues of health care, DSOs are among the sustainable solutions that significantly benefit both patients and doctors," she said.

Salky also referred to the following statement from the Federal Trade Commission: "Consumers benefit when health professionals can organize their practices in the way they find most efficient, consistent with quality care. Licensed dentists contract with DSOs to obtain a variety of back-office, non-clinical functions, allowing these dentists to focus primarily on the treatment of patients, and less on the business management aspects of running a dental practice."

Group practice organizations (GPO)

Typically, the group practice organization is a *de novo* or "starting from scratch" practice. There may be several offices or branch locations, each typically has one dentist. In this model, the dentist is an employee. GPOs grow through acquisitions of solo, small and large groups, and by starting new locations.

Dental service organizations (DSO)

(Also called dental management service organizations)

The DSO works with an existing practice rather than developing a new practice. In most cases the dentist retains ownership while contracting with the DSO to provide materials, human resources, marketing and information technology for a fee. DSOs grow by adding solo, small and large groups to the administrative arrangement.

Geographic or multispecialty model

This is the traditional multiple location practice. Some dentists may split time among locations. In most cases, the number of practices is limited by geographic reach. These practices grow by acquisitions of solo, small and large groups, and sometimes they are acquired, too.

continues on page 22 

What does the Oregon Board of Dentistry say about Dental Office Ownership?

679.020 Practice of dentistry or conducting dental office without license prohibited; exceptions.

1. A person may not practice dentistry without a license.
2. Only a person licensed as a dentist by the Oregon Board of Dentistry may own, operate, conduct or maintain a dental practice, office or clinic in this state.
3. The restrictions of subsection (2) of this section, as they relate to owning and operating a dental office or clinic, do not apply to a dental office or clinic owned or operated by any of the following:
 - a. A labor organization as defined in ORS 243.650 and 663.005 (6), or to any nonprofit organization formed by or on behalf of such labor organization for the purpose of providing dental services. Such labor organization must have had an active existence for at least three years, have a constitution and bylaws, and be maintained in good faith for purposes other than providing dental services.
 - b. The School of Dentistry of the Oregon Health and Science University.
 - c. Public universities listed in ORS 352.002.
 - d. Local governments.
 - e. Institutions or programs accredited by the Commission on Dental Accreditation of the American Dental Association to provide education and training.
 - f. Nonprofit corporations organized under Oregon law to provide dental services to rural areas and medically underserved populations of migrant, rural community or homeless individuals under 42 U.S.C. 254b or 254c or health centers qualified under 42 U.S.C. 1396d(l)(2)(B) operating in compliance with other applicable state and federal law.
 - g. Nonprofit charitable corporations as described in section 501(c)(3) of the Internal Revenue Code and determined by the Oregon Board of Dentistry as providing dental services by volunteer licensed dentists to populations with limited access to dental care at no charge or a substantially reduced charge.
4. For the purpose of owning or operating a dental office or clinic, an entity described in subsection (3) of this section must:
 - a. Name an actively licensed dentist as its dental director, who shall be subject to the provisions of ORS 679.140 in the capacity as dental director. The dental director, or an actively licensed dentist designated by the director, shall have responsibility for the clinical practice of dentistry, which includes, but is not limited to:
 - i. Diagnosis of conditions within the human oral cavity and its adjacent tissues and structures.
 - ii. Prescribing drugs that are administered to patients in the practice of dentistry.
 - iii. The treatment plan of any dental patient.
 - iv. Overall quality of patient care that is rendered or performed in the practice of dentistry.
 - v. Supervision of dental hygienists, dental assistants or other personnel involved in direct patient care and the authorization for procedures performed by them in accordance with the standards of supervision established by statute or by the rules of the board.
 - vi. Other specific services within the scope of clinical dental practice.
 - vii. Retention of patient dental records as required by statute or by rule of the board.
 - viii. Ensuring that each patient receiving services from the dental office or clinic has a dentist of record.
5. Subsections (1) and (2) of this section do not apply to an expanded practice dental hygienist who renders services authorized by a permit issued by the board pursuant to ORS 680.200.
6. Nothing in this chapter precludes a person or entity not licensed by the board from:
 - a. Ownership or leasehold of any tangible or intangible assets used in a dental office or clinic. These assets include real property, furnishings, equipment and inventory but do not include dental records of patients related to clinical care.
 - b. Employing or contracting for the services of personnel other than licensed dentists.
 - c. Management of the business aspects of a dental office or clinic that do not include the clinical practice of dentistry.
7. If all of the ownership interests of a dentist or dentists in a dental office or clinic are held by an administrator, executor, personal representative, guardian, conservator or receiver of the estate of a former shareholder, member or partner, the administrator, executor, personal representative, guardian, conservator or receiver may retain the ownership interest for a period of 12 months following the creation of the ownership interest. The board shall extend the ownership period for an additional 12 months upon 30 days' notice and may grant additional extensions upon reasonable request.

[Amended by 1977 c.192 §1; 1985 c.323 §3; 1995 c.286 §29; 1997 c.251 §6; 2003 c.322 §1; 2009 c.223 §1; 2011 c.637 §284; 2011 c.716 §4]

BRANDING AND EXPANDING

Aspen Dental operates within the Oregon Board of Dentistry's ownership guidelines since all of its offices are independently owned by dentists licensed in the state of Oregon, Salky noted.

Neither Gentle Dental's parent company, InterDent Inc., or Pacific Dental Services responded to interview requests for this article. According to Gentle Dental's website, it operates 105 practices in Oregon, Washington, Hawaii, California, Arizona, Nevada, Kansas, and Oklahoma. Based in Inglewood, Calif., InterDent Inc. provides management services to more than 450 dentists in about 125 affiliated dental offices.

Pacific Dental Services opened in 1993 and has 270 offices in eight states, including the Pacific Northwest. Joe Feldsien, senior vice president of professional partnerships, described Pacific Dental Services' business model in an interview with the ADA: "Our model is based on supporting

offices owned by dentists. That is one thing that distinguishes us—there is no corporate brand. We call ourselves 'private practice plus.' We are trying to bring a higher-end model and support the local dentist, with modern dentistry and the financing they need to be successful, hire staff, and do everything the private practice does."

Patrick Braatz, the Board's executive director, said Oregon's law states very clearly that dental offices must be owned by a dentist licensed to practice in the state. If the owner lives outside the state, they must appoint a dental director who is licensed to practice in Oregon.

The issue of ownership has ignited a call for the federal Department of Health and Human Services to ban dental clinics from participating in the Medicaid program if the clinics circumvent state laws like Oregon's.

In late July, Sen. Max Baucus, chair of the Finance Committee, and Sen. Chuck Grassley, ranking member of

the Judiciary Committee, made the request after a year-long investigation into allegations of abusive treatment of children in clinics controlled by corporate investors rather than dentists, according to a press release from Sen. Grassley's office.

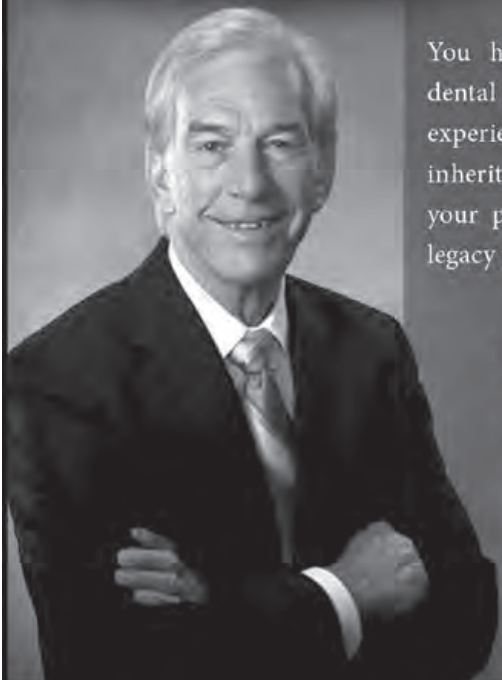
The "Joint Staff Report on the Corporate Practice of Dentistry in the Medicaid Program," released by Grassley and Baucus, focuses on dental management companies organized as a corporation or limited liability company that works with dentists in multiple states. The investigation found a failure to meet quality and compliance standards, including unnecessary treatment on children; improper administration of anesthesia; providing care without proper consent; and overcharging the Medicaid program, the release states.

Though corporate dentistry is banned in 22 states and Washington, D.C., the ADA is reaching out to dentists who work in chain practices and may not see the value of becoming a member of organized dentistry, because they already receive benefits such as insurance and business support services through their dental service organizations.

Earlier this year, the ADA's New Dentist Committee held a mega issue discussion about corporate dentistry, and some state dental societies are exploring how to increase their membership by targeting dentists working in chain practices.

As part of the mega issue discussion, a panel of speakers provided their perspectives about the pros and cons of practicing in a corporate chain. Along with the positive aspects mentioned above, the negatives included not having control over the number of insurance plans accepted by the chain. Also, some who practice with corporate chains said one of the cons is that they are compensated based on the amount the corporation collects rather than the services they provide. ●

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THE PATIENTS AT THE OHSU SCHOOL OF DENTISTRY are often a prime example of the term “patient” in all meanings of the word: they come in for three-hour appointments several times a month, and endure significant wait time as the overseeing instructors help students hone their skills. This time together creates a special bond between dental student and patient, which makes it that much more difficult when a student loses a patient due to financial hardship.

Many patients find the cost of dentistry prohibitive, and even with an average discount of 30% less than local private practice fees, expenses can still be staggering. Data from our surveys indicates that close to half of patients who choose to discontinue care at the school do so because of financial reasons. In 2012, a group of students recognized this issue and organized the OHSU School of Dentistry Patient Assistance Program (SPAP) as a way to help patients who are committed to addressing their dental care needs, but need a little extra financial help to complete their comprehensive dental treatment.

Fourth year student **Carly Peterschmidt** has had two patients selected as award recipients. She shares her thoughts on the program: “I have many patients who have shown me dedication to their dental care by showing up on time to their appointments, paying for their treatment without complaint, and making healthy changes to benefit their oral health. Many are on fixed incomes and are very honest about how much they can afford per month. SPAP has not only helped my patients, but has also helped me keep good patients who have a lot of needs, so that I can get the experience I need to become a dentist.”

Patients nominated by their student provider must meet criteria which include financial need and evident commitment to treatment. SPAP is not a handout but rather a partnership; qualifying patients may be awarded up to \$500 toward their phase 3 treatment needs, but no more than half of the expense of their treatment plan. In this way, we are helping patients who see the value of their dental treatment invest in their oral healthcare. In the seven months since the first award, the student-run committee has used donations totaling just over \$9,000 to help 27 patients reach their goals. Collaborating with patients to meet their needs allows the donations we have received from caring alumni, faculty, and community members to go a long way and help many people.

The SOD Patient Assistance Program helps patients finance the care they need, allows students to learn the skills to become excellent dentists, and helps the School of Dentistry thrive as an irreplaceable community resource. ●

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The deadline for submission is Monday, March 3, 2014.

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The Annual Meeting Council is holding the fourth annual Speaker Host Dinner & Training on Thursday, January 16, 2013, at 6:30 pm at the ODA building in Wilsonville.

Attendees will learn the responsibilities and benefits of hosting, receive a sneak peak at the 2014 Oregon Dental Conference speaker schedule and have the opportunity to select which speaker(s) they would like to host.

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Affordable Care Act and oral health *ADA analysis of impact*

First in a series of articles from the American Dental Association

Going forward, it is important that the ADA answer questions of most concern to members.

To facilitate this dialogue, the ADA invites ACA implementation questions at the dedicated healthreform@ada.org email address.

THE “PATIENT PROTECTION AND AFFORDABLE CARE ACT,” shorthand as the ACA and as this report will refer to it, has the potential to reshape health care in America. Expansion of medical insurance coverage, a move toward more integrated care delivery and significant changes in the financing of health care are among the expectations of ACA legislators and regulators. The Association’s primary focus has been the law’s potential effects on dentistry and the delivery of dental services to patients.

Introduced by ADA President Dr. Robert A. Faiella, this first in a continuing series of ADA News Q-and-A sessions is intended to update information on certain aspects of the ACA and its potential effects on dentistry and the oral health of the American public. This series begins with some preliminary questions regarding ACA implementation and a short retrospective look.

Additional Q-and-A reports will follow and will look ahead to potential effects of the ACA in 2014 and beyond. Going forward, it is important that the Association answer questions of most concern to members. To facilitate this dialogue, the Association invites ACA implementation questions at the dedicated healthreform@ada.org email address.

Preliminary questions regarding ACA implementation

What are some of the key provisions of the ACA?

“Of course, the primary focus of policymakers was on the medical/hospital delivery system but a number of provisions will directly impact dentistry and it is very likely that changes in the larger delivery and payment systems will have ripple effects on dentistry in the future,” Dr. Faiella said in a statement introducing this series. For example, many of the systemic changes, such as paying for outcomes and not procedures and adopting health information technology (such as electronic health records), are

directed at medicine but may affect dentistry at some point.

A primary goal of the ACA is to increase health insurance coverage by expanding Medicaid and establishing health benefit exchanges, which are intended to facilitate the purchase of private sector coverage by small businesses and individuals who lack coverage. An estimated 3 million children will gain private sector dental benefits through the health insurance exchanges by 2018. The ACA provides for expanding Medicaid to “newly eligible” adults with incomes up to 133 percent (138 percent, net of income disregards) of the federal poverty level: \$15,282 for an individual, \$31,322 for a family of four. The federal government is obligated to pick up 100 percent of the cost of covering this additional population initially and 90 percent long term.

The expansion of Medicaid coverage will vary significantly depending on how states respond to the Supreme Court ruling that the federal government cannot withhold all federal Medicaid funds from states that refuse to expand their programs. There is no requirement to provide dental services to newly eligible adults but states have the option to add those services at their discretion. If all the states expand their Medicaid programs along lines called for by the ACA, up to 3.2 million more children and 4.5 million adults could have access to extensive dental benefits, according to an Association-contracted study. At publication, 23 states and the District of Columbia have indicated they will participate in the expansion with several others leaning toward participation or looking for alternative ways of participating.

ACA provisions that authorize increased funding for public health infrastructure and prevention programs are consistent with Association policy. But many of these new programs had not been funded as this report was written.

This article is from the ADA News, Volume 44, Number 14. August 5, 2013.

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What are health benefit exchanges?

Health benefit exchanges, or health insurance marketplaces as they are described by regulators, will be available in each state, the District of Columbia and the territories to help individuals and small businesses (up to 100 employees) buy private sector coverage. The marketplaces will be accessible online, and consumers should have access to navigators to help them make informed plan selections. Exchanges must begin enrolling beneficiaries by Oct. 1 and be fully operational by Jan. 1, 2014. Initially, the exchange will be available only to individuals and small businesses. Plan designs and premiums will vary by state. People with incomes from 100–400 percent of the federal poverty level are eligible to receive tax credits to subsidize their coverage through the exchange.

As of Jan. 1, 2014, all plans participating in the exchange (and in the individual and small group markets outside the exchange) must meet ACA and state-established standards to become qualified health plans (QHPs) except for standalone dental plans. In general, all QHPs must offer an essential health benefit (EHB) package defined by the ACA to include pediatric dental coverage among 10 service categories. However, a QHP in the exchange does not have to offer the pediatric dental EHB if there is a standalone dental plan in the exchange offering the benefit. This and future ACA reports will have more to say about the effects of this coverage dichotomy.

What is the status of the formation of health benefit exchanges or marketplaces?

In an effort to meet the October deadline of having exchanges open to accept applications, the Obama administration launched a consumer-focused website, *HealthCare.gov*, to help consumers understand their coverage choices. The administration's goal is to ensure that consumers will be able to create

accounts, complete online applications and shop for qualified health plans through this website. As of July, 16 states and the District of Columbia planned to operate their own state-based exchanges; seven will partner with the federal government; 27 will rely on the federal government to run federally facilitated exchanges.

What exchange issues most concern the ADA?

The ADA believes exchanges must maximize competition among plans with dental benefits. Plans must offer real value and provide consumers with an adequate network of providers. "Although federal regulators have been receptive to our message, only after the exchanges have been operational for some time will we know the true nature of the plan offerings and the adequacy of their networks," said Dr. Faiella.

The Association also is concerned with the way federal regulators have interpreted the law. On the one hand, regulators say consumers, including those with children, do not have to purchase the pediatric dental benefit if the purchase is made inside the exchange. Yet, outside the exchange (in the individual and small group markets), everyone, including families without children, must purchase a pediatric dental benefit. This may cause a great deal of confusion for purchasers. "The ADA disagrees with the federal government's interpretation and believes it is inconsistent with congressional intent and that it is also bad public policy," said Dr. Faiella. It is bad public policy because it treats dental coverage inside the exchange differently from coverage outside the exchange in the individual and small group markets.

How are dentist employers affected?

The ACA does not require small businesses with less than 50 full-time equivalent employees to provide health insurance. More than 99 percent of dental practices have less

than 50 employees. Small business employers who pay at least 50 percent of the premium for employee coverage may qualify for a small business tax credit. To qualify, an employer must have less than 25 full-time equivalent employees whose average annual per-employee wage does not exceed \$50,000. The tax credits, which disappear after 2016, will be available on a sliding scale to assist with the purchase of health insurance. For example, a business with 10 or less employees and \$25,000 or less in average wages will receive a credit of 50 percent. Adding to controversy around this issue, the administration recently announced that it will delay until 2015 a requirement that employers with 50 or more full-time employees offer insurance.

How are dentists as health care consumers affected?

Plans in the individual and small group market are prohibited from imposing pre-existing condition limitations, excessive waiting periods and co-payments or deductibles for certain preventive services. Coverage must be guaranteed issue and provide for guaranteed renewability and plans are prohibited from rescinding coverage. Plans may use age, tobacco use, where someone lives and family composition to calculate premiums and must offer coverage for dependents up to age 26.

What are some of the key "revenue raisers" in the ACA that might affect dentistry?

There are a number of new taxes and ACA tax code changes intended by Congress to help pay for implementation including several with dental relevance.

- The ADA continues to support repeal of ACA provisions that are inconsistent with Association policy. This includes the 2.3 percent medical device excise tax that took effect Jan. 1. Association advocacy includes support for

HEALTH CARE REFORM

congressional repeal efforts and, on the regulatory side, communications with Internal Revenue Service officials and comments on IRS regulations implementing the new tax. In *ADA News* articles and other communications, the Association has pointed out that manufacturers, not dentists, will be responsible for paying the tax but that dentists will likely see tax-related cost increases. See for example “One Step Closer to Medical Device Tax Repeal (But Miles to Go)” at the ADA advocacy website, ADA.org/advocacy.

- Flexible spending accounts allow employees to set aside tax-free money to pay medical and dental bills. The FSA set-aside was limited to \$2,500 a year in 2013 to increase annually by a cost-of-living adjustment;

- In 2013, there is 0.9 percent payroll surtax on wage and salary income over \$200,000 for single filers or \$250,000 for joint filers. The 2012 Medicare Hospital Insurance (Part A) tax for the Medicare Hospital Insurance Trust Fund is 1.45 percent of all salary income with an equal 1.45 percent paid by employers. Starting in January, the tax is 2.35 percent on all earnings above \$200,000 and \$250,000 respectively. The rate for the self-employed increased from 2.9 to 3.8 percent;

- There is also a 3.8 percent tax in 2013 on some investment income of taxpayers whose modified adjusted gross income exceeds \$200,000 for single and \$250,000 for joint filers. Investment income includes rents, dividends, interest, royalties and capital gains on property sales (with a partial exclusion for primary residence sales).

A Retrospective Look

Where was the ADA when health reform legislation was first being discussed?

Very early in 2009, the ADA communicated to all members of Congress and the Obama

administration the ADA's belief that a relatively small government investment in meeting three goals can contribute to significant improvement in the oral health of Americans.

- mend the tattered Medicaid safety net by improving the dental Medicaid program;
- adequately fund proven oral disease prevention programs;
- rebuild the dental public health infrastructure, which includes recruitment and retention of dentists competent in public health practice.

How did the ADA respond as legislation developed?

As various House and Senate committees assembled the legislative parts within their jurisdictions, it became apparent the ultimate legislative package would be far reaching. “We made a decision very early to be engaged in the process to ensure we had a voice in the debate, and it's a good thing that we did because some of the early proposals could have been especially problematic,” Dr. Faiella said.

The ADA used its grassroots network and lobbying staff to address a multitude of issues. For example, during the August 2009 congressional recess the ADA asked members to meet with lawmakers and attend town hall meetings. In talking points the Association developed for participants, we said the ADA opposed a proposed government-run insurance plan that would compete with private insurers. We also said that:

- additional funding is needed for Medicaid dental services;
- consumers deserve insurance protections that ensure health care value and transparency;
- the McCarran-Ferguson antitrust exemption for the business of insurance should be repealed;

- more needs to be done on prevention and public health investment;
- the ADA opposes the revenue raisers in the legislation.

As an employer mandate was proposed, we emphasized the need for a small business exemption and a stronger medical liability reform. We also objected to the \$2,500 cap on Health Flexible Spending Arrangements and the 2.3 percent medical device tax. In short, the ADA's focus at the time was on improving access to dental care for those most in need as the appropriate goal of oral health provisions in any health care reform bill. We supported provisions that moved us toward that goal and opposed provisions that conflicted with ADA policy and were inconsistent with our stated goals.

Did the ADA endorse the ACA?

The ADA did not endorse the ACA, passed in March 2010, because it did not include provisions to improve access to dental care for millions of Americans by properly funding Medicaid dental services. It is by that measure that we assessed all major health care reform proposals under consideration as to whether they would have a major, positive impact on the oral health of Americans.

What has the ADA done to represent the profession and our patients as ACA implementation began in earnest?


Despite the fact that the ACA fell short of the ADA's goal of properly funded Medicaid dental services, the Association worked hard to ensure members' interests are addressed as the law takes effect in stages. “The federal agencies responsible for ACA implementation did not engage in any significant rule making immediately but once the process began we made sure we were at the table meeting with the key decision makers,” Dr. Faiella said. “Even though the Association's seasoned staff has excellent contacts,

we took the extra precaution of hiring outside consultants to specifically help us deal with key regulators so that we had ongoing intelligence on the process.”


In early 2011, the Association had an initial opportunity to comment on the implementation process, and we continue to offer advice and comments as the ACA regulations and agency guidance are released. An overarching goal of ADA advocacy with federal officials is to ensure a consumer friendly oral health benefits market in each state. The Association’s message to the regulators is this: Dental experts should provide recommendations on dental issues. The ADA supports an environment where dental benefits, whether offered as stand-alone plans or dental riders to medical plans, can adequately compete and offer consumers options for accessing oral health care. Consumers should be able to easily understand their choices based on price, quality, provider network adequacy and other factors. What has the ADA done to help constituent dental societies advocate on behalf of their members with regard to the state’s role in ACA implementation?

Understanding that many decisions about health benefit exchanges will be decided at the state level, the ADA in November 2011 contracted with the consulting firm Leavitt Partners, LLC to help develop materials for use by constituent dental societies. The ADA and Leavitt continue to host conference calls with state dental society staff and dental leaders to address ACA implementation at the state level. Extensive materials, including tool kits with general and state-specific information, were developed. ●

Look for the next part of this series in an upcoming issue of *Membership Matters*.




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A busy summer for the Tooth Taxi

THE TOOTH TAXI SPENDS THE SCHOOL YEAR

visiting public schools across Oregon, but during the summer months, we serve children in special summer programs, including students of migrant and seasonal workers.

The summer officially kicked off in June with a two-week visit to the De Paul Alternative High School in Northeast Portland where 91% of children screened needed treatment. We saw 51 students and provided \$21,406 in donated dental care for some very grateful students.

The Tooth Taxi team worked evenings at Hillsboro's Glencoe High School on two visits, so they could provide treatment to migrant workers from the camps that spent their day harvesting blackberries. The team screened 35 people and provided \$10,403 in donated dental services to 17 young workers.

In July, the Tooth Taxi visited Canby's Trost Elementary School where they helped primary students, middle and high school students, and provided screenings for 53 students, treated 27 children on the van, and delivered classroom oral health education to 205 students. At the Townsend Labor Camp in Fairview, we served migrant workers, and were joined by the Medical Teams International (MTI) dental van on Wednesday evening. They focused on adults, while the Tooth Taxi focused on children. The demand was overwhelming.

In August, the Tooth Taxi will be visiting additional schools and programs in the greater Portland area including Friends of the Children, Molalla Elementary School, the School Based Health Center at Tigard High School, run by Virginia Garcia, and the Salem Boys & Girls Club.

Tooth Taxi stays late at the Glencoe HS evening program



Patient ready for radiographs aboard the Tooth Taxi in pretty pink shoes

In the fall, its "back to school" for the Tooth Taxi with visits planned for schools in Tillamook, Umatilla, Union, Jefferson, Lane, Marion and Multnomah counties.

Our sincere thanks to all of the volunteers who helped us during the summer program. You can see their names and photos on the DFO website under Tooth Taxi Adventures at www.SmileOnOregon.org. ●

Position Available

Oregon Dentist for Mobile Dental Van

We have a unique opportunity for a caring and energetic dentist who enjoys working with children to join our highly successful mobile dental clinic program. The mobile clinic travels throughout the state of Oregon each week providing comprehensive dental care in order to improve oral health for Oregon school children (K–12). Based out of Portland, the “Tooth Taxi,” a fully equipped, state-of-the-art mobile dental van travels the rural areas of the state spending up to a week at a time at schools fulfilling the mission of the Dental Foundation of Oregon (DFO): “Improving Oral Health for Oregon’s Children”.

For more about the Tooth Taxi, visit the Dental Foundation of Oregon website: www.SmileOnOregon.org

The successful candidate will possess strong leadership and communication skills, has the ability to prioritize and treatment plan patient’s needs and educate children on the importance of oral health.

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