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FROM THE EDITOR

Learning From Our History

By Alayna Schoblaske, DMD
Editor of *Membership Matters*

FEBRUARY IS BLACK HISTORY MONTH. During these 29 days (Happy Leap Year!), we recognize the generations of African Americans who faced adversity to shape our country's history. As such, I want share the stories of two black physicians: Dr. Rebecca Lee Crumpler and Dr. Montague Cobb. While they are not dentists, their stories highlight the complex ways that race, health care, and professional organizations intersect. I heard much of this information in the *New York Times'* 1619 Project, which has been one tool in my personal learning about the history of racism in the United States. More information about this source will be cited at the end of the article if you want to learn more.

Dr. Rebecca Lee Crumpler was the first black female physician. She graduated from the New England Female Medical College in 1864, and when the Civil War ended in 1865, she moved to Richmond, Virginia, to serve as a physician in one of the Freedmen's Bureau hospitals. The Bureau was created to support over 3.5 million people who were released from slavery into freedom without resources to support their newfound freedom. Many of these people struggled with housing and found shelter in places such as abandoned prisons, former barracks, empty churches, and more. Between cramped quarters and poor hygiene, many people living there became sick and died. Medical care was primarily delivered via house calls, and most white physicians refused to treat newly emancipated black patients. It was at this point that the Freedmen's Bureau Medical Division was created. The hospitals at which Dr. Crumpler and other physicians arrived were incredibly under-resourced, employing only 120 physicians for over 3.5 million patients, and lacking in beds, sheets, and proper quarantine facilities.

The Medical Division, Jeneen Interlandi argues, was created with a problematic balance in mind. The post-Civil War government wanted to provide just enough health care to prevent the spread of disease to white communities, but did not believe that the recently emancipated people deserved enough free health care to thrive. This was based on the false underlying belief that "black people aren't dying for want of basic necessities, they are actually dying because they are biologically inferior to whites and ill-suited to freedom."[1] What was the point, the government thought, in funding health care for people whose death was inevitable?

Sixty-five years after Dr. Crumpler graduated, in 1929, William Montague Cobb graduated from the Howard University Medical School. He returned to Howard to teach anatomy and physiology and, in 1963, became president of the National Medical Association. The NMA was founded in 1895 as an organization for black physicians at a time when American Medical Association membership was restricted to whites only.[2] (What would become the National Dental Association, an analogous organization, was founded in 1901 at Howard University.[3] Some components of the American Dental Association continued following discriminatory membership practices until 1965.[4])

As Dr. Cobb stepped into leadership at the NMA, President John F. Kennedy was also promoting legislation that would create Medicare. The idea of government-sponsored health care was first proposed by President Truman in 1947, but was defeated in part because of AMA opposition. President Kennedy hoped that targeting his plan at a smaller and more vulnerable population — senior citizens — would improve acceptance. The AMA intervened again, staunchly opposing Medicare by claiming that it would "put the government smack into your hospital."[5] The NMA, however, supported Medicare as an opportunity to make health care more equitable, and Dr. Cobb saw it as a tool to help end hospital segregation, which had persisted into the 1960s.

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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He continued to see substandard care provided to patients in black hospitals and black wards of white hospitals, and was determined to end these "separate but equal" policies. With the passage of the Civil Rights Act in 1964, hospitals risked losing government funding if they discriminated on the basis of race. Medicare could provide a great deal of money to hospitals, but they would have to desegregate first. Dr. Cobb and the NMA testified in support of Medicare before its passage in 1965. Within four months of Medicare being signed into law by President Lyndon B. Johnson, over 3,000 hospitals desegregated.

Dr. Cobb's accomplishments are significant, to be sure, and the desegregation of health care was an important step toward equity. The story doesn't end there, of course. Our health care system still retains fragments of its racist past. Black women are more likely than white women to die of pregnancy-related complications.[6] Black patients are less likely to receive analgesia for acute pain than white patients.[7] And black children are more likely to develop cavities than white children.[8] We have a long way to go.

It is our own individual work to reflect on what these stories mean for our lives and practices. This is what I believe. By understanding our history, I am more deeply committed to the work of justice and health care equity. I am responsible for being lovingly critical of myself and my profession so that growth continues. This work is not easy. In fact, it is uncomfortable, unrelenting, and uncharted. I also believe it is critically important.

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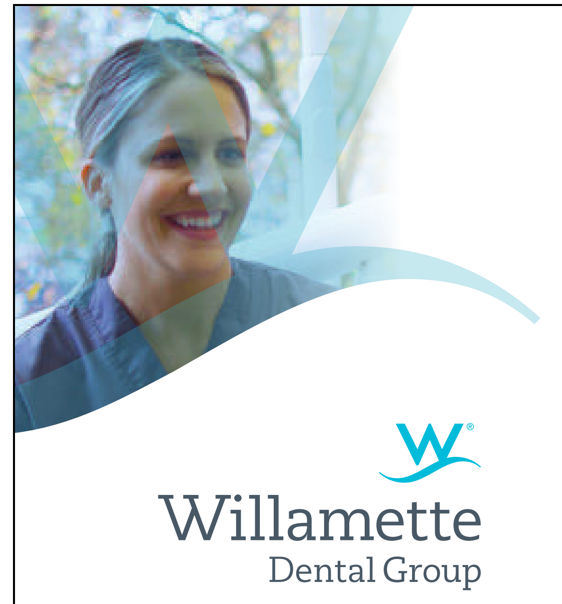

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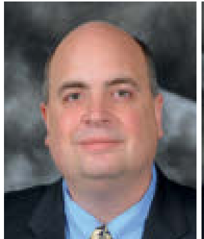
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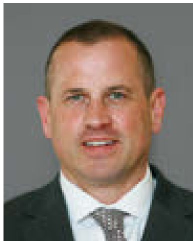
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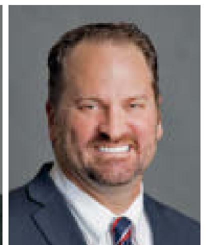
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CONTINUING EDUCATION

Events & Education Component CE Calendar

Calendar provided by Mehdi Salari, DMD

Date	Host Dental Society	Course title	Speaker	Hours CE	Location	More Information
02/07/20	Southern Willamette	5 Steps to Solving Work-Related Pain in Dentistry	Bethany Valachi, PT, DPT, MS	2	Corvallis (The Clubhouse at Adair)	swdsoregon@gmail.com
02/07/20	Southern Willamette	Current Composite and Light Curing Techniques	Jack Ferracane, PhD	2	Corvallis (The Clubhouse at Adair)	swdsoregon@gmail.com
02/11/20	Marion & Polk	Marijuana & Oral Health	Barry Taylor, DMD, FAGD, FACD, CDE	1.5	West Salem (Roth's)	www.mpdentalce.com or marionpolkdentalsociety@ gmail.com
02/18/20	Lane	Infection Control	Dr. Monica Monsantofils	2	Eugene (LCC Main Campus)	www.lanedentalsociety.org or office@lanedentalsociety.org
02/25/20	Clackamas	ODA Ambassador Program	TBA	2	Oregon City (Providence Willamette Falls Comm. Center)	www.clackamasdental.com or executivedirector@ clackamasdental.com
02/27/20	Southern Oregon	Implant Seminar	Dr. Riley Clark	1.5	TBD	www.sodsonline.org or sodentalsociety@gmail.com
03/10/20	Marion & Polk	Individual and Household Preparedness	Gregory Walsh	1.5	West Salem (Roth's)	www.mpdentalce.com or marionpolkdentalsociety@ gmail.com
03/10/20	Washington Co.	Practice Management - Finding and Keeping an Outstanding Team	Candice Martin	1.5	Beaverton (Stockpot Restaurant)	www.wacountydental.org or contact@wacountydental.org
03/12/20	Southern Oregon	Conservative Treatment of TMJ	Dr. MaryAnn Geness	1.5	Medford (Patterson Dental)	www.sodsonline.org or sodentalsociety@gmail.com
03/17/20	Clackamas	Dental Team Ergonomics	Sarah Stuhr	2	Oregon City (Providence Willamette Falls Comm. Center)	www.clackamasdental.com or executivedirector@ clackamasdental.com
03/18/20	Multnomah	3D Bioprinting/ Biomaterials and Tissue Engineering	Luiz Bertassoini, DDS, PhD	2	Portland (OHSU School of Dentistry)	multdental@aol.com or lora@multnomahdental.org
04/28/20	Clackamas	Functional Approach to Medicine & Dentistry	Casey Means, MD	2	Oregon City (Providence Willamette Falls Comm. Center)	www.clackamasdental.com or executivedirector@ clackamasdental.com
05/08/20	Southern Oregon	Functional Aesthetics	Dr. David Hornbrook	8	Medford (Hilton Garden Inn)	www.sodsonline.org or sodentalsociety@gmail.com
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05/12/20	Washington Co.	HIPAA Training - Staff Invited	Terre Harris	1.5	Beaverton (Stockpot Restaurant)	www.wacountydental.org or contact@wacountydental.org
05/21/20	Multnomah	Table Clinics	TBA	2	Portland (MAC Club)	multdental@aol.com or lora@multnomahdental.org
05/26/20	Clackamas	Perio	Drs. Tran/Nguyen	2	Oregon City (Providence Willamette Falls Comm. Center)	www.clackamasdental.com or executivedirector@ clackamasdental.com
10/27/20	Clackamas	Risk Management	Chris Verbiest	3	Oregon City (Providence Willamette Falls Comm. Center)	www.clackamasdental.com or executivedirector@ clackamasdental.com

Find this calendar online at **www.oregondental.org**. Click “Meetings & Events” > “Calendar of Events”.

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Friday, April 3: 7:00 AM – 3:00 PM
Saturday, April 4: 7:00 AM – 1:00 PM

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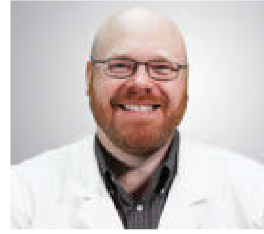
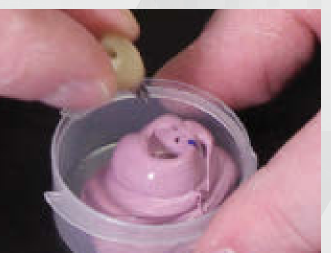


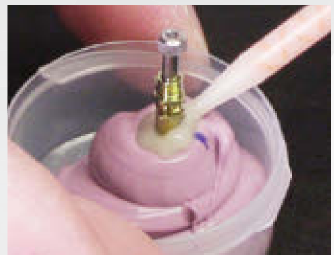
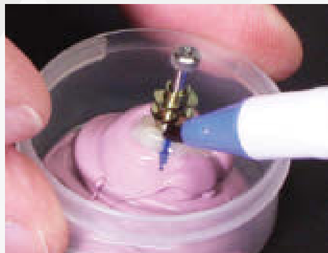
Things You'll Need:

- A completed temporary with the desired emergence profile
- An impression coping, preferably open tray
- An implant replica
- A mixing cup or similar small vessel
- VPS bite registration material
- Fast-set temporary or resin material
- Sharp blade

Start out by attaching the temporary to an implant replica. Next, fill a mixing cup about 2/3 full with vinyl polysiloxane. Add the VPS to the abutment/analog junction and embed the analog in to the mixing cup. Add additional VPS to extend the material to the contact points. Once the VPS has set up, mark the buccal side for future reference.



Unscrew the temporary crown, and remove it from the analog. Next, you may need to trim back some of the bite reg material with a blade. Then take your impression coping and screw it on to the analog.

Fill the space around the impression coping with resin or temporary material. Once it has cured, extend your buccal mark on to the resin. Unscrew the impression coping. Trim off any excess material, fill in any voids and polish.

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COMPLIANCE CORNER

Oregon Board of Dentistry Approves New Rules Changes

AT THEIR OCTOBER 25, 2019, MEETING, the Oregon Board of Dentistry approved rules changes that took effect January 1, 2020. Below is an overview of the 34 rules changes; to view the full changes, please visit their website at **Oregon.gov/dentistry**. If you have any questions about the changes, please reach out to Board of Dentistry staff at 971-673-3200.

- With the passage of HB 2220, the rules for the prescription and administration of vaccines were adopted.
- Dental anesthesiology was added as a new dental specialty area.
- The rules regarding the standard for BLS for the healthcare provider were amended and clarified.
- The requirement for certain dentists to register with the Prescription Drug Monitoring Program (PDMP) was added.
- The rules regarding patient records and documentation of dental implants were adopted.
- With the passage of SB 824, the rules for the recognition of testing agencies for meeting requirements of licensure were amended and expanded.
- Continuing education requirements and standards were amended and clarified.
- Anesthesia monitoring rules and standards were amended and clarified.
- The rules regarding dental assisting scope and certification were amended and clarified.

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OREGON DENTAL CONFERENCE

Welcome to the 2020 Oregon Dental Conference®, an Event for the Entire Dental Team!

OUR 128TH ANNUAL MEETING WILL BE HELD at the Oregon Convention Center in Portland, OR, April 2-4, 2020. We are pleased to welcome back our partner groups: the Oregon Association of Dental Laboratories (OADL), the Oregon Dental Assistants Association (ODAA), the Oregon Dental Executives' Association (ODEA), the Oregon Dental Hygienists' Association (ODHA), the Oregon Society of Oral and Maxillofacial Surgeons (OSOMS), the Oregon Society of Periodontists (OSP), and the Oregon State Association of Endodontists (OSAE).

Central to the success of your practice are the people who bring their individual talents to work every day. To build that success, your team members need to build on their skills and knowledge. With over 100 courses and 66 speakers, the 2020 Oregon Dental Conference offers an opportunity for the whole dental team to connect, learn, and grow!

Follow us for sneak peeks and real time updates!

Share your conference experience:

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PORTLAND PHOTOGRAPHY

OREGON DENTAL CONFERENCE

Join Us for These ODC Signature Events

FIRE UP SO YOU DON'T BURNOUT

PREVENT, BREAK THROUGH, and EXTINGUISH BURNOUT (once and for all)

Presented by Jessica Rector, MBA

Join us for the ODC General Session!

THURSDAY, APRIL 2:
10:30-11:30 AM

RECOMMENDED FOR: Entire Dental Team

COURSE NUMBER: 4127

CE CREDITS: 1*

*This course appears to meet the Oregon Board of Dentistry's requirements for CE related to practice management and patient relations.

Burnout is like a wildfire—spreading quickly and affecting everything in its path. Ms. Rector's research shows that 79% of the workforce is burned out. The World Health Organization now recognizes burnout as a medical diagnosis, yet most don't know how to identify it. When burnout is unresolved, you experience a decrease in productivity, communication, health and morale.

In this powerful presentation, Ms. Rector shares key strategies to prevent and extinguish burnout by better handling stress to improve focus, performance, and dental care.

Participants will:

- ✓ Examine three key factors that are almost always the underlying cause of burnout
- ✓ Apply proven burnout strategies to enhance time management, focus, and patient relationships
- ✓ Identify and pinpoint your biggest "burnout moments" to prevent future stress and improve your health

Don't Miss These Exciting Offerings!

NEW DENTIST REGISTRATION CATEGORY

ODA member dentists who graduated between 2016 and 2019 save $100 on registration!

GENERAL SESSION!

Thursday, April 2, 10:30 AM — 11:30 AM

Featuring Keynote Address by Jessica Rector, MBA

ODA MEMBER LOUNGE!

Recharge in the exclusive ODA Member Lounge, located in the Skyview Terrace! ODA members can enjoy refreshments, snacks, complimentary massages, and mingle with colleagues in this members-only private space.

Thursday: 7:00 AM — 3:00 PM
Friday: 7:00 AM — 3:00 PM
Saturday: 7:00 AM — 1:00 PM

*Due to limited space and amenities the lounge is not able to accommodate non-ODA member guests.

EXPANDED SOLUTIONS MARKETPLACE HOURS!

Come take advantage of one-stop shopping for all things dental!

Thursday: 11:30 AM — 6:30 PM
Friday: 8:00 AM — 5:30 PM

SNACKS AND SOLUTIONS

Visit the Solutions Marketplace to network with exhibitors while enjoying coffee and pastries in the morning and Happy Hour snacks in the afternoon!

Friday: 8:00 AM — 10:00 PM and 3:30 PM — 5:30 PM

SOLUTION CIRCLES

Thursday: 11:45 AM — 1:00 PM
Friday: 11:30 AM — 12:45 PM

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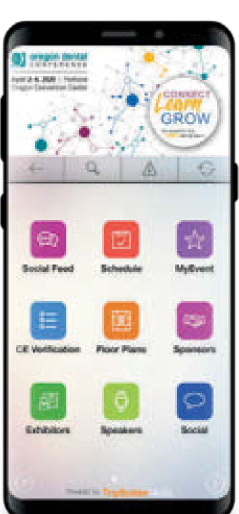

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*Course handouts will be available March 19, 2020.

NEW HEADQUARTER HOTEL!

We are proud to announce our partnership with the Hyatt Regency Portland at the Convention Center. This newly built hotel is just steps from the Oregon Convention Center for easy access. Reserve your room by March 10 and use group code: G-ORDA to receive the special ODC rate! For other lodging options please visit **www.oregondentalconference.org**.

PHOTO COURTESY OF HYATT REGENCY PORTLAND

Important Dates & Deadlines

February 21 **PREREGISTRATION DEADLINE**
Register by February 21 to receive a tuition discount and conference materials prior to ODC.

March 10 **HOTEL/LODGING CUT-OFF**
Special ODC rates are available at multiple hotels through March 10. See page 7 for details.

March 19 **COURSE HANDOUTS ONLINE**
Course handouts will be available online at ***www.OregonDentalConference.org*** and through the ODC Mobile App, starting two weeks prior to the conference. ***Handouts will not be printed for distribution on-site.*** If you wish to have ODC handouts available for reference during courses, please be sure to download them in advance.

March 19 **REFUND, TRANSFER, AND CANCELLATION DEADLINE** All refund, transfer and cancellation requests must be submitted in writing. If cancellation or transfer occurs after preregistration materials have been mailed, badge(s) must be returned with the written request. A $25 handling fee will be charged for all tuition refunds. ***Workshop, and additional course fees are non-refundable. Refund requests will not be granted, for any reason, after 11:59 pm on March 19, 2020.*** Registration transfers will be accepted for the same year and event without penalty.

March 19 **MAIL/FAX REGISTRATION CLOSED**
Anyone registering after March 19 must register online or on-site in Pre-Function A of the Oregon Convention Center.

April 2–4 **ON-SITE REGISTRATION**
Registration will be available in Pre-Function A of the Oregon Convention Center during the hours listed below. **NOTE:** *Photo ID is required for both on-site registration and badge reprinting. Dentists who are not members of ODA will need to show their ADA card to receive the ADA member rate.*

ON-SITE REGISTRATION HOURS

Thursday, April 2: 7 AM – 6 PM
Friday, April 3: 7 AM – 5:30 PM
Saturday, April 4: 7 AM – 1 PM

CONFERENCE SCHEDULE

THURSDAY, APRIL 2	
7 AM – 6 PM	Registration Open
7 – 9 AM	Pierre Fauchard Academy Breakfast
8 AM – 5 PM	Scientific Sessions
10:30 – 11:30 AM	General Session with Keynote Speaker, Jessica Rector, MBA
11:30 AM – 6:30 PM	Solutions Marketplace open
11:45 AM – 1 PM	Solution Circles in the Solutions Marketplace NEW!
12:15 – 1:15 PM	American College of Dentists Luncheon (off-site)
3:30 – 6:30 PM	Grand Opening Reception, Solutions Marketplace

FRIDAY, APRIL 3	
7 AM – 5:30 PM	Registration open
8 AM – 5:30 PM	Solutions Marketplace open
8 – 10 AM	Snacks & Solutions in the Solutions Marketplace
8 AM – 5 PM	Scientific Sessions
11:30 AM – 12:45 PM	Solution Circles in the Solutions Marketplace NEW!
12 – 2 PM	Oregon Association of Dental Laboratories (OADL) Board Meeting
12 – 1:30 PM	Oregon State Association of Endodontists (OSAE) Luncheon
3:30 – 5:30 PM	Snacks & Solutions in the Solutions Marketplace
6 – 10 PM	All-In for Fun Game Night at the Hyatt Regency Portland

SATURDAY, APRIL 4	
7 AM – 1 PM	Registration Open
7 AM	International College of Dentists Breakfast (now located at the OCC)
8 AM – 4 PM	Scientific Sessions
9 AM – 12 PM	OHSU Student Research Competition
11 AM – 12:30 PM	Oregon Dental Hygienists' Association (ODHA) "All RDH" Event
11:45 AM – 12:45 PM	OHSU School of Dentistry Alumni Association Awards Presentation and Lunch
2 – 4 PM	Oregon Society of Oral and Maxillofacial Surgeons (OSOMS) PAC Update

OREGON DENTAL CONFERENCE

HOW TO REGISTER

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1. ONLINE AT: **OregonDentalConference.org**

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Register online anytime through March 31. Register before Feb. 21 to receive your conference materials before the ODC, and to receive the early bird discount.

2. IN PRINT: **By Mail or Fax**

Download the registration form at OregonDentalConference.org.

Print the form, complete it, and return via fax or mail with your payment. Please be advised that there is a **$25 PROCESSING FEE** for faxed or mailed registrations.

Mail and fax registrations close on March 19. After this date, you must register online or in person at the ODC.

3. IN PERSON: **On-site at ODC**

Registration will be available on-site starting at 7 AM on Thursday, Friday and Saturday, April 2–4, in Pre-Function A of the Oregon Convention Center.

Photo ID is required for both on-site registration and badge reprinting.

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REGISTRATION CATEGORIES AND FEES

		Full Conference Badge		Solutions Marketplace-Only Badge	
		BEFORE FEB. 21	*AFTER* FEB. 21	*BEFORE* FEB. 21	*AFTER* FEB. 21
DENTIST CATEGORIES	**ODA Member**	$300	$420	$25	$50
	ODA New Dentist Member (graduated 2016–2019)	$200	$320	$25	$50
	ADA 11th District Member (AK, ID, MT, WA)	$300	$420	$25	$50
	ADA Retired or Life-Retired	$300	$420	$0	$0
	ADA Direct Member	$300	$420	$25	$50
	Retired Volunteer Dentist in Oregon (with DV license)	$0	$0	$0	$0
	ADA Member Dentist outside 11th District (not from OR, AK, ID, MT, WA)	$330	$475	$25	$50
	Non-ADA Member	$865	$1,010	$200	$400
	International Dentist	$330	$475	$25	$50
NON-DENTIST CATEGORIES	**Hygienist; Assistant; Administrative Staff; Laboratory Tech**	$105	$205	$25	$50
	Student* (dental student; dentist resident; pre-dental student; hygiene student; assisting student; lab tech student)	$0	$0	$0	$0
	Retired Volunteer Hygienist in Oregon (with HV license)	$0	$0	$0	$0
	Non-Dental Guest** (family, children 18+, friends)	$105	$205	$25	$50

*PLEASE NOTE: Complimentary student badges for pre-dental students, hygiene students, assisting students, and lab tech students will not be able to access the CE system. If you require CE, please register in a paid category.

**See "Non-dental guest" policy on page 42.

REGISTRATION MATERIALS Confirmation of registration will be sent to individual registrants after processing. A packet containing name badges for all participants will be mailed to all primary registrants who register by Friday, February 21, 2020. Those registering after February 21 may pick up their name badge at the Oregon Convention Center during on-site registration hours with photo ID.

COURSE HANDOUTS will be available online at OregonDentalConference.org and on the ODC Mobile App, starting on March 19, 2020.

REFUNDS, TRANSFERS, AND CANCELLATIONS All refund, transfer and cancellation requests must be submitted in writing. If cancellation or transfer occurs after preregistration materials have been mailed, badge(s) must be returned with the written request. A $25 handling fee will be charged for all tuition refunds. **Workshop, and additional course fees are non-refundable. Refund requests will not be granted, for any reason, after 11:59 PM on March 19, 2020.** Registration transfers will be accepted for the same year and event without penalty.

Inside Dentistry Opinion Perspective

Dental Caries in the 21st Century: How P4 Medicine Is Changing the Face of Dentistry

By V. Kim Kutsch, DMD

DENTAL CARIES IS THE MOST COMMON DISEASE tracked by the WHO. It is basically number one in every country and every demographic worldwide. Tooth decay seems ubiquitous with our modern condition. Historically, dental caries was a less common disease, and disease rates can certainly be tied to increased dietary consumption of refined sugars. However, there are also other risk factors that contribute to the progression of this disease, including saliva or hyposalivation, genetic susceptibility and the biofilm itself. Early disease models focused on identifying a single pathogen responsible for the disease. And at one time the dental profession focused on *Mutans streptococci* as the pathologic agent. However, we now know that dental caries is much more complex than that; it is truly a multifactorial disease resulting from biofilm dysfunction. We have identified the known risk factors that drive this disease, with the end result being net mineral loss from the teeth due to prolonged periods of low pH in the mouth.

The primary treatment for dental caries has been the surgical removal of the diseased portion of the tooth and repair to esthetics and function with an assortment of restorative materials. The dental professional may have offered a suggestion to limit dietary sugar, improve brushing and flossing habits, and throw in some fluoride for good measure. Community water fluoridation was also introduced to optimize the access to the fluoride exposure benefits. And to some measure this approach has been effective in repairing the damage from this disease, but it neglected to examine and mitigate the cause of the disease in the first place, and patients continue to develop new decay after treatment. Consequently, decay rates have remained constant or increased. This is a frustration to patients and professionals alike.

Enter the 21st century and P4 Medicine. This new approach includes a model that is predictive, preventive, personalized, and participatory. The surgical dental model fails on each point. The best practice of care for dental caries today is a risk management-based philosophy. Caries risk assessment had been demonstrated to be predictive in clinical trials. It also focuses on preventive strategies, identifying risk factors and developing a regimen to prevent future disease. This prevention approach has a long history in dentistry. Today's preventive dentistry includes not only primary, secondary, and tertiary prevention, but also quarternary prevention. Primary prevention is the health promotion strategies designed to help people avoid the onset of disease and reduce the incidence. These strategies include community water fluoridation and homecare instructions. Secondary prevention is the prevention of recurrence or exacerbation of a disease that has been diagnosed. Tertiary prevention focuses on reducing disease progression and suffering. Quarternary prevention is a new important concept that strives to mitigate unnecessary or excessive intervention of the health care system. New technology developments in diagnostic instruments also carry the risk of increased surgical intervention that may not be appropriate, while guidelines for non-surgical approaches are improving.

Caries risk management is also personalized, as it identifies the specific risk factors contributing to an individual's disease. This leads to a new conversation. Damaged teeth still need to be restored, but now professionals can discuss what's causing the patient's disease. The process then becomes participatory as the professional utilizes wellness coaching techniques to help the patient create personalized strategies for behavioral change to decrease specific caries risk factors.

Caries risk management also fits well in the Evidence Based Dentistry

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Originally published in: Kutsch K. Caries prevention in the 21st century. Inside Dentistry. *2019;15(10).* *Copyright © 2019 to AEGIS Publications, LLC. All rights reserved. Used with permission of the publishers.*

model as dental professionals translate current dental research into clinical practice methods. The challenge for today's professional is to take the results from population cross-sectional studies and applying the data to clinical practice on an individual patient, for whom they have the longitudinal responsibility for care. Another challenge exists in research study design to isolate and identify specific risk factors and then test them in clinical trials with targeted strategies.

The new models of P4 Medicine and the Quarternary Prevention create new challenges but also new opportunities for the dental profession. As we continue to grow and change, new systems like Caries Risk Management allow us to create predictable and better outcomes for our patients in the 21st century, which has always been our goal.

Want to Learn More?

Dr. Kutsch is presenting on
Friday, April 3
at the 2020 Oregon Dental Conference!

Mark your calendar and plan to attend!

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ODC SPOTLIGHT

Diabetes Detection in the Dental Office?

By Susan Maples, DDS, MSBA

TYPE 2 DIABETES MELLITUS (DM) IS CONSIDERED a chronic *preventable* disease, but sadly, it is one of the top five killers in America today. DM is the leading cause of new cases of blindness and of kidney failure, and 60+% of lower limbs amputated in non-trauma cases. But did you know that adults with diabetes have death rates from heart disease and stroke that are two to four times that of people without DM?

There's one more statistic that you may not be aware of: After analyzing data from the National Health and Nutrition Examination Survey for 2009/2010, researchers found that a startling 60% of those with DM had moderate to severe periodontal disease (PD). There is, in fact a *bidirectional* relationship between active PD and uncontrolled DM, meaning each makes the other worse!

Meanwhile, a dual epidemic is upon us! Sixty to seventy percent of adults have active PD. Similarly, diabetes and its precursor, prediabetes (PDM), together affect 103 million people, *one-third of the U.S. population*!

How can dental professionals help? First, with early diabetes detection. Unfortunately, about 28% of patients with DM and 86% with PDM *don't know it!* Evidence suggests that periodontal changes are the first clinical manifestation of disease. Here are some minimum action steps:

First, let's each learn to recognize the risk factor criteria, as well as oral signs of DM such as: gingivitis, periodontitis, salivary dysfunction (dry mouth), dental caries, oral infections, Candidiasis, taste interference, neurosensory disorders (taste, smell, swallowing, etc.).

Second, let's begin to recognize the bidirectional effects of DM on periodontal disease, and realize our critical role in helping a diabetic patient gain both glycemic control *and* periodontal stability…simultaneously.

When you start to find unidentified (or uncontrolled) DM in patients, you'll realize that managing their active periodontal disease is like trying to wrestle a gorilla with one hand tied behind your back. It's hard enough with two hands.

The Bi-Directional Relationship of Unstable Diabetes Mellitus and Periodontitis

When we think about unstable diabetics losing a leg from infection that began with a scratch on the foot, it makes sense that these patients can also develop periodontal changes. Compromised vasculature is one obvious reason, but we also have valid evidence that diabetes is believed to promote periodontitis through an exaggerated inflammatory response to periodontal micro flora.

Now flip it around. There is ample evidence indicating that "active periodontitis is a risk factor for poor glycemic control. Thus, for our patients who have PD *and* DM, we must individualize our approach to stabilize both, concurrently.

Criteria for Diabetes Screening

To identify patients with unknown (and thus uncontrolled) diabetes *before* periodontal therapy, consider the known risk factors.

- overweight/obese
- family history of DM
- over age 45
- African American, Alaskan native, American Indian, Hispanic, Native Hawaiian or Pacific Islander or of Arabic descent
- Hypertension (medicated or not)
- Hypercholesterolemia: low HDL, high triglycerides, high LDL
- Not physically active

Some *symptoms* of unstable DM are:

- Tingling, pain or numbness in hands or feet
- Unexplainable hunger, thirst, or frequent urination
- Blurred vision, cataracts or glaucoma
- Bleeding gums or tooth loss

If your patient is overweight/obese and has at least one other risk factor or symptom, consider an HbA1C test.

A1C Testing in the Dental Office:

Hemoglobin A1C is a simple blood test that measures circulating blood sugar over an average of the past two to three months. The FDA still doesn't recognize point-of-care testing for A1C as "diagnostic," so elevated A1C levels, indicative of PDM and DM, should be shared with the patients' medical team, along with

your risk factor criteria. We must collaborate with the patients' medical professionals for definitive diagnosis and any necessary pharmacologic treatment. Note the A1C levels are as follows:

Normal: 5-4 and below
Borderline PreDiabetes: 5.5 and 5.6
PreDiabetes: 5.7 to 6.5
Diabetes: 6.5 and above

You may have noticed that the American Dental Association along with major dental insurance carriers now have an established a code for A1C testing in the dental office.

Although PD may prove to be an independent risk factor for type 2 diabetes, further research is underway to determine if treating PD will reduce the onset or progression of DM and the burden of disease complications.

What Can We Do Right Now?

- We can address root cause, helping patients make better decisions around diet and body movement.
- We can get comfortable completing a quick finger stick A1C blood test for pre-diagnostic data.
- We can routinely monitor A1C on periodontal diseased *and* high-risk-for-diabetes patients. (Conveniently, periodontal maintenance prophys are often every 3 months — that's the same time interval recommended for A1C monitoring).
- We can work collaboratively with our medical colleagues for pharmacologic assistance in gaining glycemic control.
- We can develop a current and evidence-based protocol for full mouth periodontal disinfection for the unstable diabetic.

Meanwhile, enjoy the personal and professional rewards. While you are saving lives and saving teeth, you will soon be recognized as a practice of distinction around *Total Health Dentistry* and begin to draw the very best health-seeking patients from far and wide.

References

1. The Relationship Between Oral Health and Diabetes Mellitus. Ira B. Lamster, DDS, MMSc; Evanthia Lalla, DDS, MS; Wenche S. Borgnakke, DDS, PhD; George W. Taylor, DMD, DrPH, Oct 2008.
2. Standards of medical care in diabetes — 2018 Diabetes Care. 2018; 41 (Suppl.1) S13-S27American.
3. CATEGORIES OF INCREASED RISK FOR DIABETES (PREDIABETES): Diabetes Care. 2016; 39(Supple 1): S14 (January, 2016).
4. Dental Parameters Coupled with Elevated A1c Lalla, E, et al. 7/2011 J Dent Res 90(7); 855-860.

Want to Learn More?

Dr. Maples is presenting on **Saturday, April 4** at the 2020 Oregon Dental Conference!

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ODC SPOTLIGHT

5 Social Media Challenges and How to Overcome Them

By Rita Zamora

THE SOCIAL MEDIA MARKETING LANDSCAPE CONTINUES TO evolve and shift. Some practices are incredibly active on Facebook, Instagram, and even Snapchat — they enjoy being social and are rewarded with visibility, likes, follows, reviews, and word of mouth. On the other hand, there are those not familiar with or disinterested in social media who are just now realizing it's important to get started or up-level their social media efforts.

Whether you are well-established on social media or just getting started, there are a number of challenges I continue to hear practices voice. Here are the most common issues and tips to help overcome them.

1) How can we get people to like our Facebook page or follow us on Instagram?

A few years ago, it was easy to grow your page likes. You could put a sign up in your office, or simply ask people to like you, and they were happy to oblige. Today, the marketplace is crowded and people are more protective of their newsfeed real estate. The good news is there are still several effective techniques to grow quality likes and followers. Here is one of my favorites:

Offer patients a special goodie, like an organic personalized lip balm, reusable eco-friendly grocery bag with your practice information printed on it, or teeth whitening strips, when they check-in, tag or follow your practice on Facebook or Instagram. Posts tagged with a location get 79% more engagement on Instagram (SproutSocial 2018), so you get the added benefit of visibility as well.

2) Why doesn't anyone see or pay attention to our posts?

There could be a number of reasons for this. One reason is that not many people even see your posts. Social@Ogilvy has reported that organic Facebook reach may have declined to reach as few as 1-2% of your followers. One solution to this reduction in visibility is to boost your posts. Using the paid "Boost" option for your posts will significantly expand the number of people who see your content on both Facebook and Instagram.

A second possible reason no one is paying attention to your posts is that your content may be generic or filler content — or maybe it's just not that interesting (yikes!). If this is a problem, know you can easily correct it by posting some creative, personalized, and engaging photos or videos. Fun giveaways and patient appreciation campaigns are also popular.

3) Where can we find good images to use for our content?

We are in an Instagram economy. Images represent your brand, and people are drawn to personalized, attractive and unique visuals. The most popular posts I continue to see are those with photos of the doctor and team. Clever practices snap a variety of pics in one day and then spread out posting them in the future.

You have a powerful tool in your purse or pocket: your smartphone camera. Snap some photos of your team and practice (Note if you are including your team in your social media photos and video to get a signed consent from them). You can use a variety of apps and filters or stickers to add some pizzaz to your photos or videos. If you must use the occasional stock photo, use them sparingly.

4) We have trouble posting consistently — what can we do?

Understand that it's more important to be communicative on social media, rather than consistent. Yes, it may look like you've fallen off the face of the earth if you don't post anything for two years. However, people understand you have a business to run, and they don't expect you to be on social media constantly. Patients will understand if you post that you will be out of the office for the holiday season or vacation — just say something about it rather than disappearing.

One of the most important tools you can use for social media is an editorial calendar. The only way you can be strategic about what you are posting on social media is to plan for it. An editorial calendar is essentially a content plan for the month ahead, which helps with consistency as well. What types of treatments do you want to do more of or be known for? Include those topics in your plan. You can take your planning one step further by scheduling your content in advance, using

Facebook's free scheduling tool or by using a tool like Hootsuite to schedule content for multiple social media sites.

5) We've run out of ideas on what to post!

Another benefit of using an editorial calendar (as mentioned above) is you can plan your content strategy. A social media strategy isn't something you execute for one month and then it's done — it's an ongoing strategy for long-term benefit. What are the themes you are posting about on a consistent basis? Perhaps it's a philanthropic effort your practice is involved with. Or you may have set a goal to increase the amount of dental implant treatment or sleep dentistry you perform and that will require that you promote those procedures every month.

In some cases, you may just need some outside energy, ideas, or creativity. There are a multitude of online courses, webinars, and coaching available. Another option is to take a coffee break and peruse other practices' social media to gain some motivation and inspiration.

Want to Learn More?

Ms. Zamora is presenting on
Thursday, April 2
at the 2020 Oregon Dental Conference!

Mark your calendar and plan to attend!

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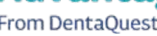

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The DFO encourages you, along with your family and friends, to participate in these upcoming fun runs during the month of March. Funds raised are used to support the Tooth Taxi in Crook County and Marion County.

Salem Paddy Pint
Saturday, March 14, 2020
Go here for details and to register:
https://runsignup.com/Race/OR/Salem/SalemPaddyPint5K

Prineville Paddy Pint
Sunday, March 15, 2020
Go here for details and to register:
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PHOTOGRAPHY BY AMY NICOLE

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tooth taxi

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- Choose from our Wine Wall and support the DFO
- Register for the 2020 Chip! For Teeth Golf Tournament
- Tour the enhanced Tooth Taxi

And much more on April 2-4

16th Annual Chip! for Teeth Golf Tournament at Langdon Farms Golf Course

PHOTOGRAPHY BY AMY NICOLE

For 16 years, Dental Foundation of Oregon supporters have traveled from all parts of Oregon for a delicious breakfast buffet and morning on the greens, followed by a luncheon awards banquet. Your involvement this year will help us achieve our goal to raise $50,000 to help Oregon's children and vulnerable communities receive important dental and oral health care.

Please join us on Friday, June 12th, when the day begins at 6:30 a.m. with a hot breakfast buffet followed by a 7:45 a.m. scramble format, shotgun start. A southern barbeque buffet lunch will be served soon after players come back from the course, and attendees are encouraged to purchase raffle tickets for a bevy of prizes.

We have something for everyone and encourage golfers of all levels to take part in the festivities. Organized as a four-person scramble, golfers are allowed to form their own foursomes, and with the assistance of Langdon Farms staff, we can even help match up golfers in order to help them get to know fellow players.

We are incredibly proud that the Chip! For Teeth Golf Tournament and raffle proceeds go toward helping us fulfill our mission to advance oral health education, provide charitable care, and coordinate resources for Oregon's children and vulnerable communities. Registration is now open on the DFO website **www.SmileOnOregon.org**.

Tooth Taxi Statistics (September 2008 – December 13, 2019)

23,865 students screened	**13,503** appointments in the van
24,926 students received oral hygiene education in the classroom	**$7,839,375** value of free dental care provided

The Dental Foundation of Oregon is grateful to our business and community partners, donors, and volunteers who annually help us achieve our mission to advance oral health education, provide charitable care, and coordinate resources for Oregon's children and vulnerable communities.

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GROUP PRACTICES

The Future of Independent Practice?

WSDA, ODA Join Forces to Explore Group Practice Formation

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BIG IDEAS ARE OFTEN SPARKED BY SHORT conversations among peers.

On a dreary morning in Seattle last January, organized dentistry leaders from the states comprising the American Dental Association's 11th District (Alaska, Idaho, Montana, Oregon, and Washington) converged on the WSDA office for their annual summit to discuss pressing issues. Oregon Dental Association (ODA) President Dr. Barry Taylor requested that "Group Practice Formation" be added to the agenda, and shared details about an exciting group practice he had heard about from a colleague in Virginia.

"The Virginia practice, as it was described to me, seemed like the perfect balance between the clinical independence enjoyed by solo practitioners and the economies of scale in purchasing equipment, supplies, and supportive services afforded to large practices often owned by one person or a small group," said Taylor.

This idea piqued attendees' interest. Many expressed interest in learning more about group practice and believed dentists across the Pacific Northwest would consider joining groups.

"Dr. Taylor's enthusiasm for group practice was contagious. Having WSDA and ODA join forces to learn more about how dental group practices can work in the Pacific Northwest was an opportunity that I did not want to miss," said WSDA President Dr. Denny Bradshaw. "There is immense benefit to having two forward-thinking associations collaborate on an issue that is front-of-mind for all of our members. We are stronger when we work together."

Discussions about group practice formation continued between ODA and WSDA, expanding to include those with experience forming and working within group dental and medical practices. The result of these discussions was a "Group Practice Summit" held in SeaTac this past October.

The Group Practice Summit, attended by leaders from WSDA, ODA, and the Idaho State Dental Association (ISDA), featured two speakers familiar with group practice, Dr. Ralph Howell and Ms. Kara Dowdall. Howell, a practicing dentist in Suffolk, Virginia, is a founding member of Atlantic Dental Care. Dowdall is the vice president of operations for Proliance Surgeons, a group medical practice in Washington state.

Group Practice Defined

Group practice is not a new idea. Medical and dental group practices have existed for decades across the country.

The phrase "group practice," however, is widely misunderstood or misused in the dental community. One overgeneralized definition is "any dental practice other than a 'traditional' solo practice." This definition fails to appreciate the immense diversity of practice models outside of solo practice.

For example, many dentists are employed by government, academic, and public health institutions, which are not owned by dentists. These institutions are afforded public policy exceptions in state dental practice ownership laws due to their respective missions, such as training future workforce or providing health care to those enlisted in the military. Though large numbers of dentists often work for these institutions, they are not considered group practices.

Many also use the terms "dental support organization" (DSO) and "group practice" interchangeably, but these concepts are distinct from one another. Conceptually, DSOs are not dental practices, but rather companies that provide non-clinical supportive services to dental practices. DSOs are typically owned by non-dentist corporations or private equity firms.

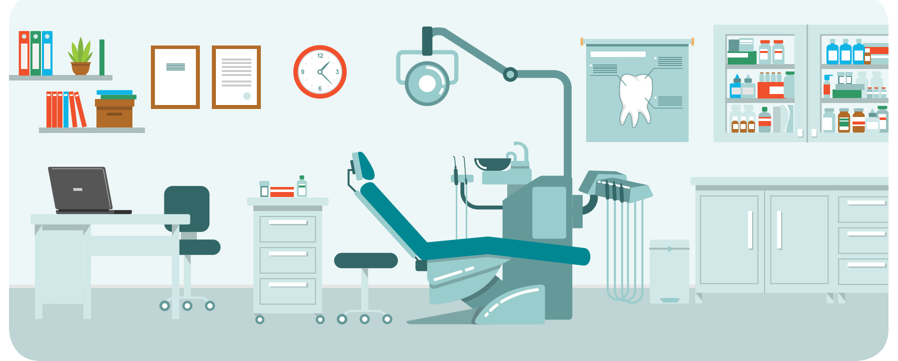
Some states permit non-dentists or DSOs to own and operate dental practices. In those states, DSOs may be permitted to own dental practices outright and employ dentists to work for them. A DSO engaging in this type of activity is said to be engaged in the corporate practice of dentistry, which is allowed in some states but strictly prohibited in many others, including Washington.

So, what is a group practice? A group practice is a practice with multiple dentist-owners operating under one legal entity (typically a professional corporation or professional limited liability company) with a single tax identification number. A dental group practice can operate in one office or across multiple offices.

A group practice has distinctive characteristics, which may be

viewed as benefits or drawbacks by different dentists. A group practice typically maintains some degree of centralization, resulting in economies of scale related to operational costs (e.g., administrative services, equipment, supplies) and the ability to better negotiate reimbursement contracts in certain circumstances.

Not all group practices are the same. A spectrum exists, with decentralized groups that afford individual owners more autonomy on one end and groups with highly centralized structures on the other. Atlantic Dental Care and Proliance Surgeons represent different positions on this spectrum.



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Atlantic Dental Care

At first glance, Dr. Ralph Howell seems to be what many would call a "typical" dentist.

Howell works in private practice with his father, Dr. Leroy Howell, who, in his eighties, still practices dentistry a few days a week. Howell's daughter, Dr. Dani Howell, joined the practice a few years ago. Howell has also been active in organized dentistry, serving as president of the Virginia Dental Association and as a longtime delegate to the ADA's House of Delegates.

For many years, Howell operated one dental office in downtown Suffolk, in the Hampton Roads region of Southeast Virginia. Hampton Roads is home to several military bases including Naval Station Norfolk and Langley Air Force Base. Howell's downtown Suffolk practice has a strong base of patients built over two generations, many of whom have come to him or his father for routine care for decades.

Howell had been aware of the significant trends impacting small group and solo dental practices but gained a deeper appreciation for these trends after opening a second location in a growing area of Suffolk.

"Patient expectations were very different in our second office," Howell explained. "In more instances, patient treatment decisions were driven by out-of-pocket costs and what a dental benefits provider chose to cover, which, as we all know, can run contrary to standard of care. In the new office, we didn't have the same relationships built on time and trust."

Other trends, including rising student debt, growing numbers of dental school graduates, and increasing costs of providing care also caused Howell to reflect on the future of the type of practice he had built over many years. He also saw a growing number of dental support organizations moving into the area and the advantages they realized in negotiating with supply companies and dental benefits carriers.

"The idea that became Atlantic Dental Care started with three like-minded dentists in Hampton Roads who wanted to preserve patient relationships and remain competitive in the changing practice environment," Howell said.

The idea of forming a group quickly grew beyond those three founders.

On January 1, 2013, 32 independent dental practices became 32 divisions of a single company, Atlantic Dental Care (ADC). The company employed 52 dentists spread out across 38 locations in the Hampton Roads area.

"Organizing the group took a lot of leg work early on," Howell said. "Each division had to handle several important administrative matters including changing official practice names, tax identification numbers, NPI numbers, business licenses, marketing materials, and contracts with benefits carriers. We also did a lot of communicating with our patients to explain what ADC was and how it would help us provide them with better care."

How ADC Works

Atlantic Dental Care operates as a professional limited liability company (PLLC). Howell describes how his organization uses the legal entity as an "Operational Umbrella," with ADC serving as a "unifying body" and each member retaining some operational independence in their own dental practice.

Operating under a "unifying body" means that all employees across the 32 divisions are direct employees of ADC. The company has a common pension plan, medical benefits plan, and payroll system. Each dental office's assets are controlled by the company, meaning that risk is similarly shared. Atlantic Dental Care is a single financial entity with a common tax identification number, and the general ledgers and balance sheets for each division roll up into one consolidated set of financial statements.

"Many issues are determined at the PLLC level either because it is required by law or because of economic benefit," Howell explained. "All other decisions are left to each division. We want each division to remain somewhat autonomous so it can keep most day-to-day operations

similar to what made that practice successful prior to joining Atlantic Dental Care."

Examples of day-to-day operational decisions retained at the division level include delegation of duties, patient scheduling, billing, and determination of what supplies, materials, and equipment will be used at the practice.

Personnel decisions provide a good example of how business decisions are made at various levels within ADC. Direct management of staff, including associates, hygienists, assistants, and front office staff, remains at the division level, as are decisions regarding whom to hire and, if necessary, when to terminate an employee.

While these personnel decisions are made at the division level, they must comport with a common set of personnel policies and employment contracting requirements set at the PLLC level through its own governance process. Decisions about base employee benefits are also made at the PLLC level, though each division can offer additional or enhanced benefits at its discretion.

"There are many advantages to employing through an organization larger than a single dental practice," Howell said. "We are able to provide better benefits at a lower cost per capita, which is very helpful with both recruiting new employees and retaining existing ones. Also, since all divisions are under one tax identification number, we can talk amongst the owner-doctors to discuss compensation and benefit philosophies as well as other personnel matters."

All work at the PLLC level is handled by the Board of Managers, which is made up of a representative from each division. The Board of Managers elects officers, executive committee members, and contracts with external consultants to handle day-to-day operations of the organization. ADC does not have any paid staff at the PLLC level.

Economies of Scale

Perhaps the most obvious benefit to forming a group practice is the ability to use the group's size to negotiate better prices for practice expenses and more favorable reimbursement rates with benefit carriers.

"After a few months of operations, we were able to begin negotiations with dental supply companies," Howell said. "Prior to joining ADC, each of us had no idea what other members of the group were paying for supplies. All of us thought we were getting a great deal, but when we were able to compare costs with each other, we were quite surprised to learn the variance in prices we were each being charged for the same supplies from the same companies and, at times, even by the same sales representatives."

"Purchasing at a larger volume allows us to obtain supply prices unavailable to us prior to forming ADC," Howell said.

ADC has been able to negotiate more favorable reimbursement rates with some dental benefits carriers. Contact negotiations occur at the PLLC level. Divisions cannot enroll with plans outside of ADC. In some instances, ADC has chosen not to join the networks of some plans after engaging in negotiations.

Seven Years Later

Seven years into the venture, ADC has continued to grow and is learning how to best support its divisions in providing optimal oral health care.

"Since 2013, ADC has more than doubled to include 132 dentists across 77 divisions," Howell stated. "We are now the largest dental practice in Virginia with over 500 employees. About a quarter of all dental practices in Hampton Roads are a part of Atlantic Dental Care."

Howell believes the endeavor has been successful because of ADC's core values and strong, inclusive governance.

"We don't just let any interested dental office in our group," Howell explained. "ADC has a committee of member dentists thoughtfully review those who are interested in joining. From the outset, we have strived to make the organization easier to leave than it is to join."

"The greatest benefit we provide to our members is the preservation of the independent private practice model with the clout of a much larger organization," Howell continued. "Though it is pretty easy to leave ADC, few have, because the practice philosophies of our member dentists are in strong alignment with the group practice. It also helps that we provide a greater level of flexibility in a rapidly changing practice environment."

ADC is currently focused on internal growth of its existing divisions and improving organizational efficiencies. The company has several member committees looking into developing best practices and streamlining operations.

One area where increased efficiencies can be achieved is in practice management software. Before ADC formed, several practice management software programs were used across the different practices. When ADC formed, the group decided to allow each division to keep the practice management software it had previously used, and several different programs are used across the divisions to this day.

"We currently have inefficiencies due to multiple systems doing the same thing. This matter is being discussed within our governance but, like in any democratic organization, decisions of significance take time," Howell said.

The Atlantic Dental Care model is being replicated elsewhere in the Commonwealth of Virginia. A group of dentists in the Richmond area have formed Central Virginia Dental Care. That group currently has 101 dentists across 69 offices.

Currently, both Atlantic Dental Care and Central Virginia Dental Care do some joint marketing and recruitment activities. In the future, these entities may join together with other similar groups to have even greater economies of scale.

Next Steps for WSDA, ODA

Attendees of the October 2019 Group Practice Summit left the meeting with increased interest in group practice formation. They agreed that WSDA and ODA should articulate a role to help members learn how to form groups and, potentially, provide recommendations for consultants to aid members in group practice formation.

"Driving innovation to reduce our members' costs in providing optimal oral health care has emerged as a priority in WSDA's next three-year strategic plan," said WSDA executive director Bracken Killpack. "Members should expect more from us on how to form a group practice and efforts to reduce barriers to forming dentist-owned groups in the years ahead."

"The ODA is also very interested in supporting the development of group dental practices in the Pacific Northwest," explained ODA executive director Conor McNulty. "We routinely get inquiries from our members about how ODA can support them in finding or starting a group practice. ODA is committed to helping our members succeed in the practice modality that is right for them."

Since the summit, leaders from the two associations have continued to move this dialogue forward. A joint task force is being formed to create in-depth educational materials on forming groups as well as develop recommendations on additional support WSDA and ODA can offer their members. Look for more information from WSDA on these efforts in the months ahead.

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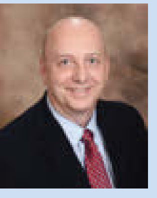

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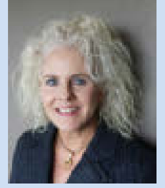

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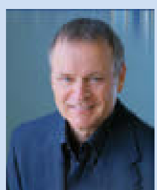

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