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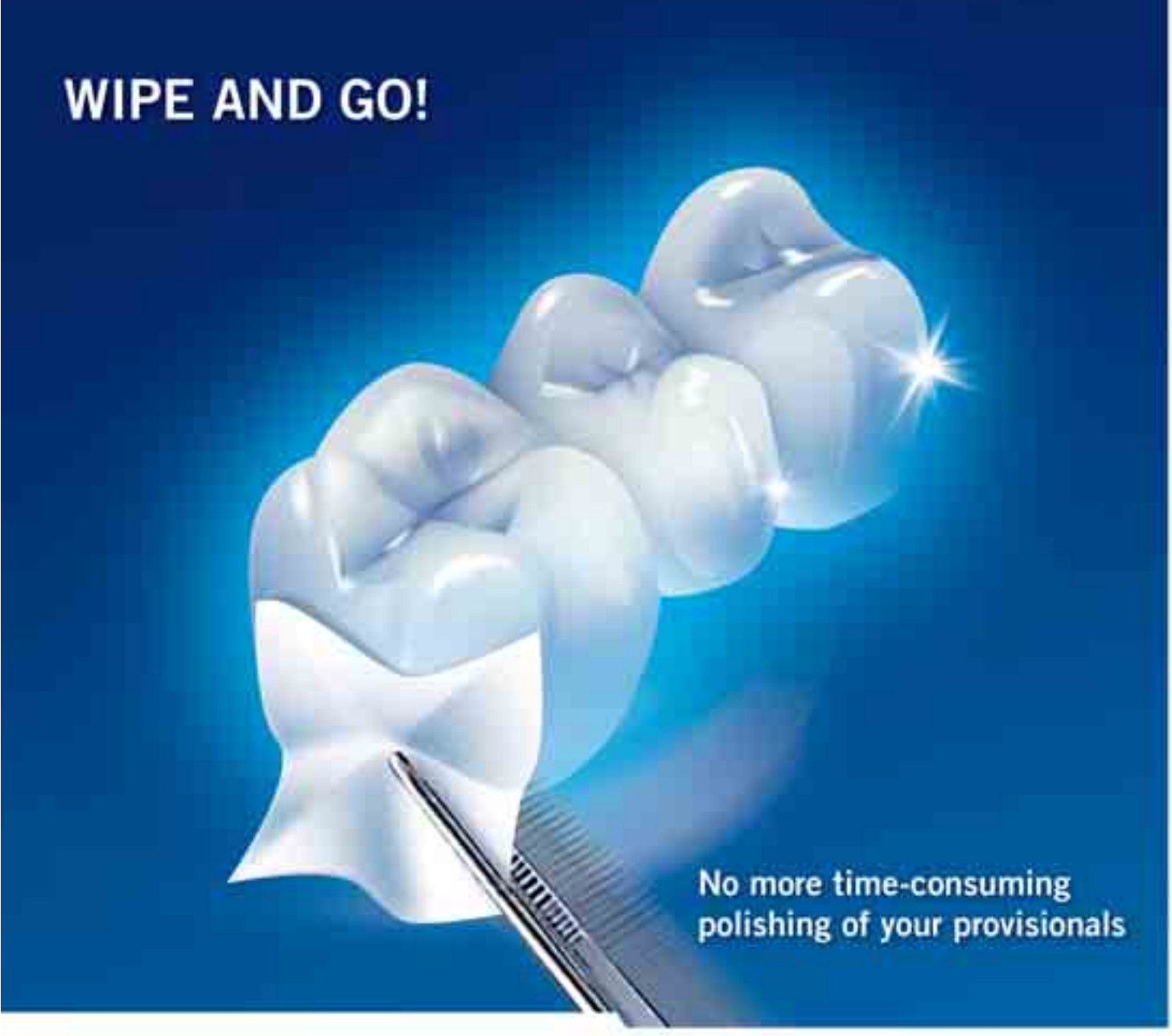

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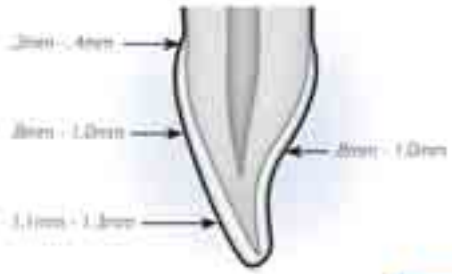

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Endodontics

Do you think a CBCT image of a tooth would significantly improve endodontic outcomes?

A. Yes **B.** No

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–Deborah Levin-Goldstein, RDH, MS

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Message from the Online Community Manager

A New Face to Help Post Your Case

For more than two years as Dentaltown.com's online community manager, I have had the distinct privilege of helping Townies find answers to their questions and aid them in navigating Dentaltown.com. Though e-mail and the message boards have always been a great resource, a lot of Townies still aren't aware that our help line on the Dentaltown.com homepage was my direct line, which often led to many conversations that began with, "Oh! You're a real person!" This always brought smile to my face because I know the deflated feeling you get when you hear the automated "Press one to reach…" – especially when you're frustrated with your computer.

Since my time at Dentaltown I've helped hundreds of Townies with their questions and concerns, which has always been the highlight of my day. Recently my duties have changed since I took over as Dentaltown's marketing director, and because of this new transition, I am pleased to announce that I'm passing the torch – or telephone in this case – to Dentaltown's brand new Online Community Manager Ashley Harris. Ashley will be available to help Townies by e-mail or phone. So whether you need a reminder of your login information, want to learn how to post a case, or just feel like talking about Dentaltown, you can give her a call. I will miss my daily phone chats with all of you, but I'm not going anywhere so you can still get in touch with me, plus I guarantee you're going to love working with Ashley!

(I'll still) See you on the message boards,
Kerrie Kruse, Marketing Director

Hello Townies, and thank you for the introduction, Kerrie! I'm Ashley Harris and I am very excited to take the reins as online community manager. I was first introduced to Dentaltown last July, which is, without a doubt, the best resource for dental professionals in the world! I absolutely love this close-knit, family-like community. I am eager to get to know many of you, and learn how I might be able to serve your needs as a Dentaltown.com user. I am here for you to voice your questions, concerns and general message board chatter. I'm only a private message, e-mail or phone call away!

Looking forward to meeting you all on the boards,
Ashley Harris, Online Community Manager

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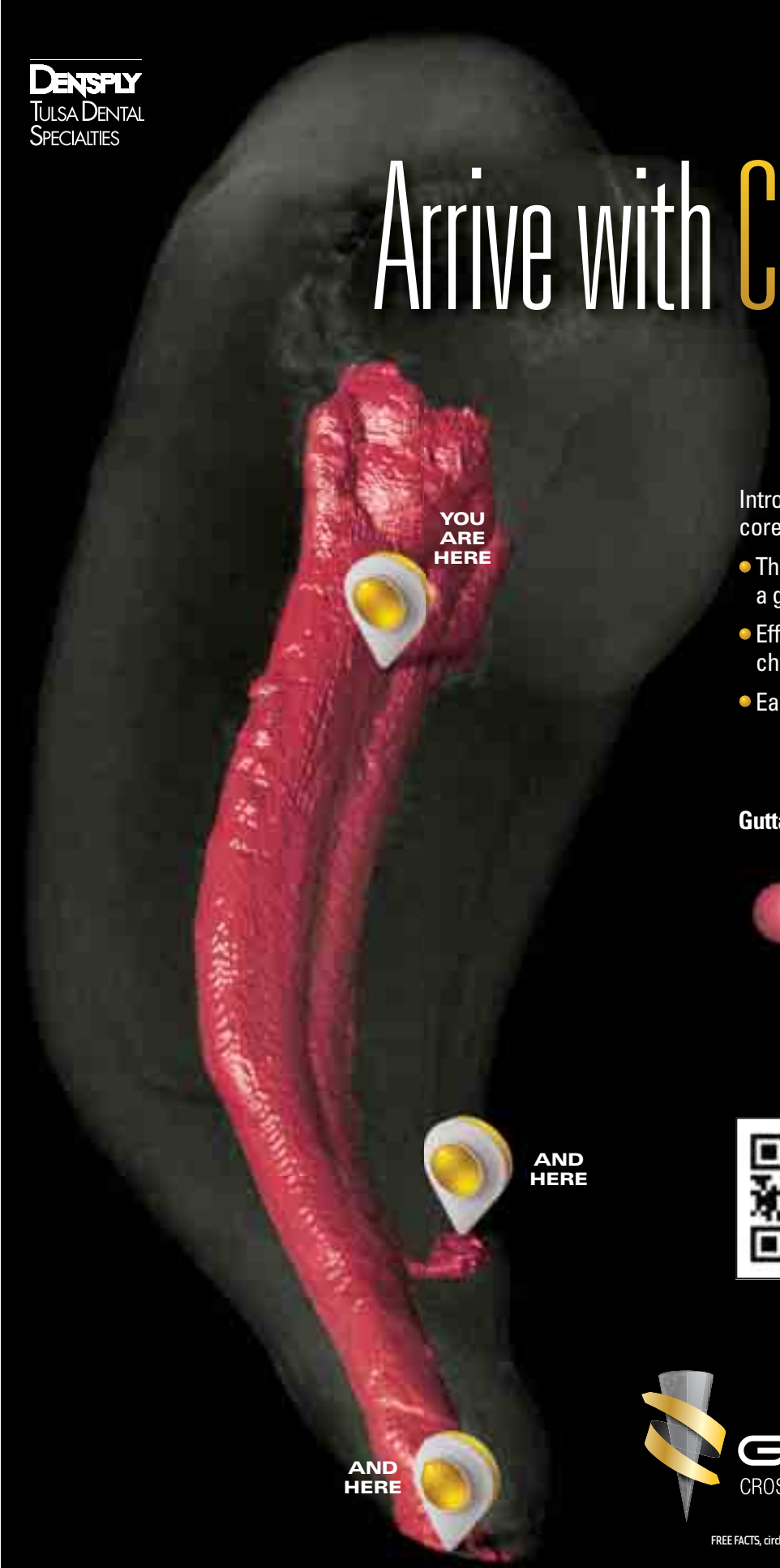

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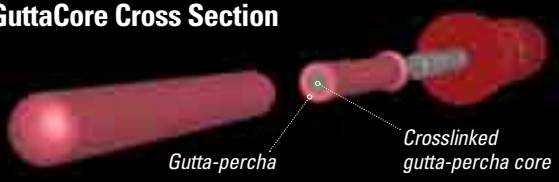

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My name is Dr. Mark Costes and I'm far from the typical dentist and dental business coach. In my first seven years of dental practice, I was able to build a six practice, multi-million dollar dental empire. **BUT**, please don't get the impression that I'm saying this to brag. In fact, I probably made more mistakes in my first year of dental practice ownership than most dentists make in an entire career!

The difference though, is that I viewed each failure and challenge as a learning experience and an opportunity to improve and grow my business. This philosophy, and my decision to study and model the most successful marketers and dentists on the planet, has led me to where I am today.

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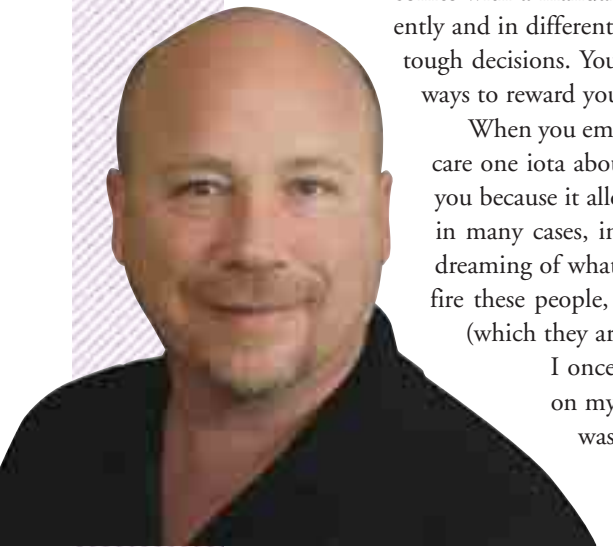
You're Fired, You're Welcome

by Howard Farran, DDS, MBA, Publisher, *Dentaltown Magazine*

We've all witnessed the extreme sides of management either first hand, through stories of others or even on TV. We've watched Donald Trump put eager contestants through grueling hell on *The Apprentice* for years. Even if you never watched the show, you're likely aware of his scathing catch phrase, "You're fired." If you didn't step up to the plate and knock one out of the park, you heard the catch phrase. If you didn't work well with the rest of your group, you heard the catch phrase. Trump has a reputation for being a pretty brutal guy on TV and off. Another pretty brutal guy, who I was pretty fond of, was New York Yankees owner George Steinbrenner. After Steinbrenner passed away in 2010, I wrote a column about him and the way he managed his team. If his people weren't the best, he shipped them off to the farm league and got the best. If you weren't cutting the mustard, you were gone. You're the big bat and you haven't hit one into the stands in weeks? Adios. Can't pitch? Sayonara, tiger.

The reason why I wrote a column about Steinbrenner and encouraged you to *"win like George"* is because I see the other management extreme in dental practices far too often. I'm talking about the soft-spoken, sweet doctor who keeps to himself, is afraid of confrontation and whose employees either rule the roost or are all looking to work at another practice. I'm talking about the doc who hears complaints about Amy from his entire staff all day. Amy never shows up to staff meetings, she's rude to her co-workers in front of patients, she never sticks around for lunch-and-learns, she leaves early and she never helps prep for the next day's patients… and the doc never does anything about her. Sure there's probably a good reason why. Maybe she's a really good assistant when she's around the doc. Maybe she's worked at the practice since before the drywall was put up. Maybe she's the best friend of the doctor's wife. The other employees absolutely love the practice, they dive for the ball every time and they'd love the place a thousand times more if the doctor would just get rid of Amy the bad apple. But the doctor can't pull the trigger. What more damage does Amy have to do for the doctor to see she needs to go?

Being the owner and/or manager of a dental practice requires a skill set that you never learned in dental school. Dentistry is hard, but managing people can be much harder. People are infinitely more complex than a crown placement or even a trifurcated root canal. Nobody comes with a manual. Every person responds to positive and negative reinforcement differently and in different ways. You need to build up the courage to be a leader and make some tough decisions. You need to find ways to evaluate your teams properly. You need to find ways to reward your superstars and to weed out your non-performers.



When you employ a C, D or F player, they're trading their time for money. They don't care one iota about your business, your services or your customers. They're working for you because it allows them to earn a living to do what they truly want to do, or perhaps, in many cases, in lieu of what they want to do. It's likely they sit around all day just dreaming of what it is they're going to do the second they get out of work. You need to fire these people, not just because they're bringing your business and your team down (which they are), but because these people need to learn what their *true* calling is.

I once hired a dental assistant who was decent on paper, but she only lasted on my team for about three months. I was fresh out of dental school and she was about 10 years older than me and had been a dental assistant for about 15 years. She had all the credentials needed to do the job. She was fairly proficient, and I had very little concern with her ability to do the job. The main problem was she wasn't a people person.

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You've likely been in the presence of an assistant who pokes around in the patient's mouth asking them questions to which they can't possibly answer because their mouth is open and jammed with 80lbs of gauze, but she keeps talking, telling the patient what she sees in his mouth, what problem areas he needs to focus on, etc. *That's* the kind of assistant you want. Someone who's so concerned about the current state of your patients' teeth she won't shut up about it.

Well, this particular assistant of mine didn't talk. She didn't talk to the patient, or the rest of the staff. I'd watch her, puzzled. I couldn't believe, when she actually did talk to people, *how* she talked to them. I couldn't believe how she reacted to people. She had very little empathy for others. We got along pretty well and I genuinely liked her as a person, but I knew I had to let her go. When the big day came, I first said, "You're being fired right now." (And by the way, if you have to fire someone, "You're being fired right now" really needs to be the first thing out of your mouth. No story. No hemming and hawing. None of this, "You've been a valued employee here for X amount of months and I'm really sorry to blah blah blah." You need to lay it all out from the get-go, be like the Donald and say, "You're fired."). When she asked why, I told her I needed to give her some advice. I said, "You don't like people. You don't work well with people. In fact, I think you might actually hate working with people. You've been a dental assistant for 15 years and I bet you're miserable doing it. You know what you need to do? You need to get out of dentistry! It's not for you! I really think you need to find a job where you're not working with people at all."

"When staff in your office are not involved, when staff are detached, give them the freedom they need and fire them!"

(Yes, I was pretty blunt, and sure, this sounds cruel, but stay with me here.)

As I said this to her, I recalled the numerous conversations she and I had about her garden and her plants. She was really into it, man! She could list off what was in her garden and what it took to care for certain things and which plants needed more sunlight than others. Whenever she spoke to me about plants, it's like the light turned on in her eyes.

I told her, point blank, "You seriously need to get a job at a plant nursery. It's the only thing you ever talk about with any passion whatsoever, and I really think plants are the only thing on the planet that would actually get along with you!"

We settled everything pretty soon after that. She collected her belongings and I walked her to her car. Yes, she was shocked that she was getting fired, but I reinforced the plant thing.

Six months later, guess who shows up at my practice for her bi-annual cleaning? You got it. I was very surprised to see my old assistant. In fact she came in with her husband and her kids. She sought me out right away. I didn't know if I was going to get punched or what. She shook my hand vigorously as she told me getting fired from my dental practice was the best thing that ever happened to her.

Seriously!

She told me she was completely trapped in thinking that she had to keep doing what she was doing because dental assistants made pretty decent money and that she had gone to school and spent all this time becoming a dental assistant that she never stopped to ask herself if she actually enjoyed it or not. She went to go work for a nursery and she *loved* it! She thanked me up and down for breaking her unfortunate momentum.

When staff in your office are not involved, when staff are detached, give them the freedom they need and fire them! Most people, when they're being fired, think the person doing the firing is a total jerk. No! Not true! If this person loved their job, if this job gave them purpose, if it was the first thing they thought about when they woke up and the last thing they thought

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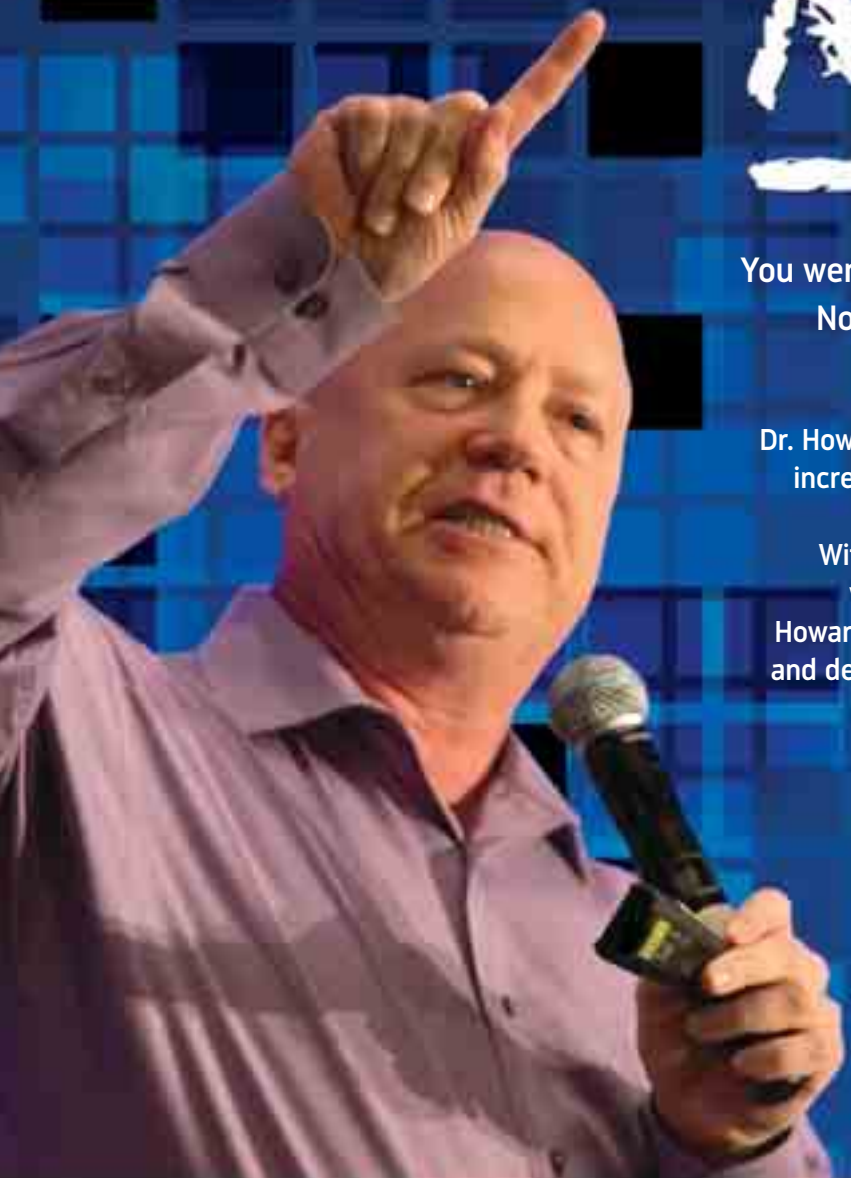

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thought about when they went to bed, you wouldn't *have* to fire them. They'd be doing a good job! Humans are too complex to offer up any blanket statement on anything, but from my experience, if you have to fire a C player, it's because they really don't like what they're doing – which means they're probably in the wrong career! It's almost like a divorce. There can be fighting going on and total dysfunction, but it finally takes one person to take the high road and decide, "It can't go on like this for 20 years. It's time to end this for both our sakes."

When you fire a C, D or F player, it's not because you don't like the person, it's because they're just not right for the job they're currently doing. As crazy as it sounds, you might be doing many of these people a favor.

Employers too often settle for marginal employees. You have to aim high with your standards. You are allowed to be picky! The number-one mental error in practice management today is that managers think they are responsible for their team's performance. This is completely backward. Management is responsible for finding teammates who perform exceptionally well. It's not your job to motivate your team. They need to come to the office already motivated. I have never regretted letting someone go who wasn't meeting expectations; and usually when we find a replacement, we find that the person works out so much better than the last person. The only regret I have is for not making the change sooner.

You don't always have to fire someone, though. Sometimes there are other options. Let's say your dental assistant is a really nice person. She's great with people, she's outgoing, she enjoys her interactions with you and your patients, but she just doesn't like assisting. Then perhaps instead of keeping a miserable assistant around, and instead of letting her go, why don't you move her up front where she can be around people and schedule appointments and thrive and not have to worry about prepping operatories or taking digital X-rays? I can't tell you how many times I have been pleasantly surprised by how an employee who struggled in one position really excelled and thrived in a different position.

You constantly need to evaluate your team. Letting an employee know how he or she is performing in their job is still important to do on an annual basis, but if someone is really struggling and their performance is a major issue, you can't wait until their annual review – that's too damn long. If Amy is shirking her responsibilities or being a jerk, you need to nip that behavior in the bud and let her know what happens if she keeps it up right then and there. You can't wait a year to tell someone they're not doing what they're supposed to be doing. Yes, letting someone go can be a traumatic experience for the person getting fired and the person doing the firing, but even more traumatic than not making this kind of tough decision is allowing someone with no passion for what he or she does to continue draining the life, spirit and (eventually) profits out of your practice. ■

Howard Live

Howard Farran, DDS, MBA, is an international speaker who has written dozens of published articles. To schedule Howard to speak to your next national, state or local dental meeting, e-mail colleen@farranmedia.com.

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The Era of Feedback

by Thomas Giacobbi, DDS, FAGD, Editorial Director, *Dentaltown Magazine*

No Contest: The Case Against Competition is a book that was first published in 1986. The author, Alfie Kohn, is credited as one of the pioneers in the anti-competition movement. Briefly stated, this is the time when we stopped keeping score for children under the age of nine and we gave everyone a trophy at the end of the season. I am not here to debate the wisdom of this movement, only to point out the fact that this generation is all grown up and they are writing reviews on everything. Amazon.com, Yelp.com and many other Web sites are filled with user-generated reviews – reviews of products and services, restaurants and hotels and anything else you can imagine. Welcome to the era of feedback. Is it really possible that the least criticized children have grown up to be the most critical of everything they encounter?

A recent headline from *The Onion* proclaimed: "Brave Woman Enters Restaurant Without First Looking It Up Online." [As an aside, if you do not get your "news" on TheOnion.com, you are missing some great stories.] I will be the first to admit I could relate to this fictional woman, because I frequently use Yelp when I travel. I find it is a great way to discover popular restaurants in my vicinity. Why not let scores of diners point me in the right direction? When I am interested in seeing a new movie, I look it up on RottenTomatoes.com. For many years, Zagat was the go-to resource for restaurant reviews even prior to the proliferation of the Internet.

Nobody wants to be criticized but everyone needs feedback. Dental companies often seek out your feedback in a very direct way by asking you to sample a new product. The smart companies also pay very close attention to your comments on Dentlatown.com. Dental practices are also faced with the prospect of being reviewed on any one of hundreds of different Web sites, some specific to dentists, others simply a listing of businesses. This trend has spawned a new business support function: reputation management. 1-800-DENTIST has recently launched ReputationMonitor, which you can read about on page 118.

In the world of print magazines, feedback has always been shared through letters to the editor. *Dentaltown Magazine* does not publish this feedback in our print edition for two reasons: 1) comments could be two to three months old before they reach a print edition, 2) the contents of our magazine are available on Dentaltown.com 24/7/365. If you read an article in this issue and you want to make a comment, log on to Dentaltown.com and post your comments directly on the article. You might soon discover other dentists who agree with your point of view. Have a question for the author? Share it in the comments section of the article and everyone will benefit from the answer. I have provided some basic instructions at the end of the article to accomplish this task.

We invite you to read and participate in the articles, message boards, clinical cases and CE articles we publish every month. This is much more than feedback, it is an opportunity to engage in a conversation with your colleagues. Each issue of our magazine contains information to improve your clinical dentistry and expand your understanding of our profession.

continued on page 22

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"Is it really possible that the least criticized children have grown up to be the most critical of everything they encounter?"

I'm excited to share the fact that we are in the process of developing an improved digital version of our magazine that will streamline the process of interacting directly with our content and also allow for offline viewing. Our current digital version can be viewed on Dentaltown.com in both HTML and PDF formats.

Fig. 1

In addition to interacting with the content we select every month, there are opportunities to provide content for future issues of the magazine. Over the years we have found many talented dentists willing to share information with their colleagues. Your first option is to post a case or start a thread online at Dentaltown.com. The conversation can begin immediately. However, if you would like to submit an article, we now have a "submit an article" button on our site (Fig. 1). I look forward to your additional involvement in the conversations. In the meantime, I can be reached via e-mail: tom@dentaltown.com. ■

How to Leave a Comment at the End of an Article

- Click on the cover of the most recent edition of *Dentaltown Magazine* on the Dentaltown.com homepage to get to the content of the current issue.
- Click on an article.
- Read it.
- Scroll down to the bottom of the article and click the "Add Comment" button (if there aren't currently any comments posted after the article) or the "View Comments in the Message Board" button, which will take you to a thread about this article, where you can post your two cents.

Things on My Desk

How To Open a New Dental Office or Relocate Your Current One

A Journey Through the Dark Side of Dentistry

By Gordon F Osterhaus Jr., DDS
Edited by Eric Curtis, DDS
Cost: $295
Pages: 244

Dr. Osterhaus is a rare breed: a dentist with 20 years of private practice experience who decided to change careers and become a dental equipment and start-up consultant. His new book is a detailed explanation of the right way to build a new office or relocate an existing practice. Throughout the book, he uses real-life stories to illustrate his messages. This book is certain to save you money and prevent premature aging as you will have an opportunity to consider all the appropriate details before you start your project. You might think that you will leave your project to the experts; this book will teach you to trust, but verify.

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What's New in Continuing Education?

by Howard M. Goldstein, DMD, Director of Continuing Education

There are great beers being released right now for Octoberfest. There are great CE courses being released on Dentaltown also. Watch a course, take the test, then drink a celebratory beer! Sounds like a plan, right? Here are a few CE courses that have been released in the last few weeks:

EMO Scale Your Practice for 20+ Percent Growth by Dr. Bill Rossi

In this one-hour course, Dr. Rossi shows how many doctors have experienced more than 20 percent growth in their practices by simply clarifying clinical protocols, intent and language.

In every practice, a gap exists between what dentists and staff can do for their patients and what the patients choose to do. This gap can lead to frustration, compromised patient care and cost thousands of dollars in lost practice income.

Countless articles have been written about case acceptance: how to set up and plan consults, sales techniques to use and even scripted dialogue. Without the right foundation, these techniques can actually harm the doctor-patient relationship and the practice. None of these things work as well as creating a strong ethical foundation. This seemingly philosophical approach has very real and practical benefits that will add significantly to your bottom line and peace of mind.

Oral Cancer: Screening, Diagnosis and Dental Management by Dr. Fayette Williams

Yes, noted Townie poster, "toofache32," has shed his cloak of anonymity to give a course on this important topic. Join Dr. Williams as he discusses how oral cancer patients face significant challenges during treatment and for the rest of their lives. Although dentists encounter these patients commonly, many are unsure of their role in the

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Dental Marketing Summit Series
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The Tutorial for the New CEREC 4.0 Software
by Dr. Todd Ehrlich
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diagnosis and management of oral cancer and its related treatment sequelae. While early detection is most easily performed in the general dentist's office, much of the U.S. population unfortunately does not seek routine dental care. This course is designed to educate the dental practitioner on the various etiological factors of oral cancer, the possible role of commercially available adjunctive aids in detection, and the dental management of common oral side effects of oral cancer treatment.

A couple of months ago we released what has become the most popular course on dental marketing: ***Dental Marketing Summit Series*** **by Howie Horrocks and Mark Dilatush.** This series is designed and delivered to assist any dentist with the total understanding necessary to promote dentistry properly, effectively and efficiently. Participants will receive personalized marketing plans and new patients.

The Tutorial for the New CEREC 4.0 Software by Dr. Todd Ehrlich

The CEREC software has been updated and greatly changed for a better user interface. This interface has made the flow for CEREC much easier, however attributes like the tools and parameters, have greatly changed. This course will walk you through the CEREC 4.0 program and give you key features to know so that your CEREC 4.0 experience will be successful.

As always, enjoy learning from the comfort of your home! ■

To search for a course:

1. Go to the Dentaltown.com CE page at: http://dentaltown.com/onlinece
2. Enter your keywords in the box at the left
3. Click the "Search Courses" button (Do not press "Enter" or "Return")

New Clear-View UNC 12/23 Probex

Dentists and hygienists now have a new style of Clear-View Probex to choose: The UNC 12 Probex contains a UNC 12 Clear-View probe tip on one end and a 23 explorer tip on the other, allowing diagnostic screening to be accomplished quickly and efficiently with one instrument. The metal handle is textured and lightweight for better control and comfort, and the black markings contrasted against the surgical-grade stainless steel offers high readability. For more information, call 888-670-6100 or visit www.premusa.com.

New Products

If you would like to submit a new product for consideration to appear in this section, please send your press releases to Assistant Editor Krista Houstoun at krista@farranmedia.com.

www.dentaltown.com

Halloween Toothbrush

Keeping child patients' teeth clean during Halloween can be a trick, so Plak Smacker has created a treat they will enjoy using. The small handle of this holiday-inspired, black and orange toothbrush is a comfortable fit for younger children to use while keeping up with their oral hygiene after celebrating with their trick-or-treating stash. To order the Halloween toothbrushes for your office, call 800-558-6684 or visit www.plaksmacker.com.

SimPlant GO

Materialise Dental launched SimPlant GO, a new user-friendly implant-planning solution. With SimPlant GO, there are no surprises during surgery because you have optimally planned the implants in the bone – and with SurgiGuide, this planning is then transferred into a fully predictable surgery. SimPlant GO's intuitive navigation, sleek 3D images and simple four-step process are so straightforward you can learn it between appointments. For more information, visit www.simplantgo.com.

Shield Force Plus

Tokuyama Dental America, Inc., introduces Shield Force Plus, a new desensitizing agent. Shield Force Plus is a one-component, single-application, light-cured protective sealant designed for the treatment of hypersensitive dentin. It applies in 30 seconds and offers a unique green color that enables dental professionals to accurately place the solution on the sensitive area. For more information, visit www.tokuyama-us.com.

The New Tetric EvoFlow

Ivoclar Vivadent has made Tetric EvoFlow even better, improving the material by introducing additional shades and new translucencies, adding an extra fine application tip and creating a more ergonomic design. The viscosity of Tetric EvoFlow is "flowable when desired and stable as required" meaning it can be used effectively as a liner, but is also non-slumping in Class III and Class V restorations. The shade range now offers three levels of translucency and the cannula tips have been redesigned to provide more precise placement. For more information, visit www.ivoclarvivadent.com.

PermaCem 2.0

DMG America introduces new PermaCem 2.0, a permanent cement that provides one of the strongest bonds to zirconium restorations. Utilizing both chemical and mechanical adhesion, the dual-curing properties offer an exceptional bond across all substrates, including zirconia. And as a single-step cement, it provides clinicians with the added benefit of not requiring an etching step. For more information, visit www.dmg-america.com or call 800-662-6383.

GC FujiCEM 2

GC America, Inc., launches the second-generation, resin-modified glass ionomer luting cement, GC FujiCEM 2. The new luting cement incorporates high-elastic crosslinking monomers with a modified filler-surface treatment to increase strength properties all around. Indicated for a broad array of indirect restorations including all types of metal-, resin-, alumina- and zirconia-based inlays, onlays, crowns and bridges, GC FujiCEM 2's other benefits include high fluoride release, low film thickness and excellent marginal integrity. For more information, visit www.gcamerica.com or call 800-323-3386.

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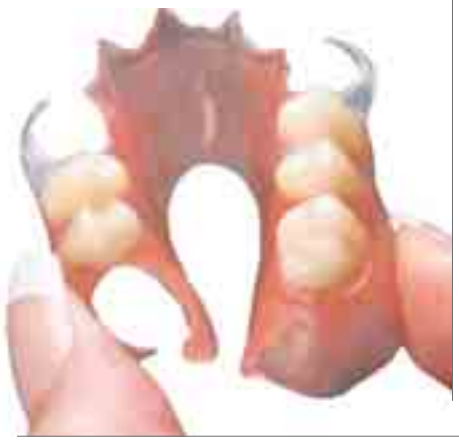
Duraflex Partial Denture

Duraflex Partial Denture is an advanced thermoplastic material – lightweight and flexible – that delivers patient satisfaction. Duraflex offers natural-looking aesthetics, a comfortable fit, and is easy to adjust, and even easier to polish. Duraflex won't absorb moisture and is stain and odor resistant. Contact Assured Dental Laboratory for more information at 877-283-5351 or www.assureddentallab.com.



Schick 33

Sirona Dental Systems, Inc., is proud to announce the launch of Schick 33, a new intra-oral digital sensor and image management system. Schick 33 delivers a combination of high-resolution images, dynamic image management and integration with existing Schick systems. For an in-office demonstration or more information, contact your local Patterson representative, or call 1-800-873-7683 today.

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Shake the Dust Off Your Retraction Procedure

by Gary Alex, DMD

Most dentists have a preferred "go-to" protocol when it comes to tissue retraction. Techniques include the use of single or double retraction cord, use of chemical astringents such as aluminum chloride, tissue ablation by laser or electrosurgery, and the use of expanding foams and pastes that are injected around the preparation. Ideal tissue retraction does not just expose the preparation margin but some of the unprepared tooth structure apical to the margin (Fig. 1). Depending on the specific clinical situation, some techniques might work better than others and I believe it is an advantage for dentists to understand and be proficient in a number of different tissue retraction techniques.

Fig. 1

Fig. 1: An example of a good impression where tooth structure apical to the preparation margin has been clearly recorded (material used was 3M ESPE Impregum/Permadyne).

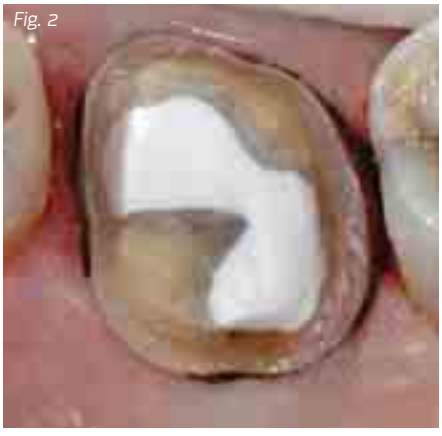

Fig. 2

Fig. 2: Excellent tissue retraction is possible with retraction cord. In this case, the cord was soaked with an aluminum chloride solution prior to placement.

The Classic Option: Retraction Cord

When used correctly, and in the appropriate clinical situation, both single and double retraction cord techniques can be very successful (Fig. 2). I usually soak the cord in an aluminum chloride solution prior to placement. The cord is soaked and then wiped dry with cotton gauze (so it is not too wet), then placed with a serrated cord-packing instrument (Ultradent). As a general rule, I use cord for all-ceramic crown restorations such as Lava Zirconia crowns (sometimes a single-cord and sometimes a double-cord technique). In a typical preparation, I place a distinct chamfer margin at or slightly below the free gingival margin on the buccal and interproximal, while the chamfer margin on the lingual is typically at or above the free gingival margin. Preparation margins placed above the free gingival margin usually do not require any retraction, which is a huge clinical advantage – one I take advantage of whenever possible – when aesthetics and/or retention are not an issue. In this scenario, retraction might be needed only on the buccal and interproximal of the preparation. In some cases I will use aluminum chloride retraction paste in addition to the retraction cord. This can be helpful in the event of spot bleeding as the paste can be applied only to the areas that need extra hemostasis. Disadvantages of cord include placement time, especially with multiple preparations, patient discomfort, and the possibility of gingival recession and marginal exposure if the connective tissue attachment is damaged.[1]

Advantages of Retraction Paste

Just as there are preparations that are well suited for use with retraction cord, there are also cases where an aluminum chloride astringent retraction paste has advantages. For example, I find aluminum chloride paste very useful for preparations with shoulder-bevel margins. I prefer these preparations in posterior teeth when retention is an issue (ferrule effect afforded by bevels) and sometimes when placing cast gold and PFM crowns. With shoulder/bevel preparations, the bevel is typically placed below the free gingival margin and bleeding is sometimes an issue.

1. S. Phatale, P.P. Marwar, G. Byakod, S. B. Lagdive, J. V. Kalburge, *Effect of retraction on gingival health: A histopathological study, J Ind Soc Periodontology 2011 14(1): 35-39*

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Fig. 3


Fig. 4

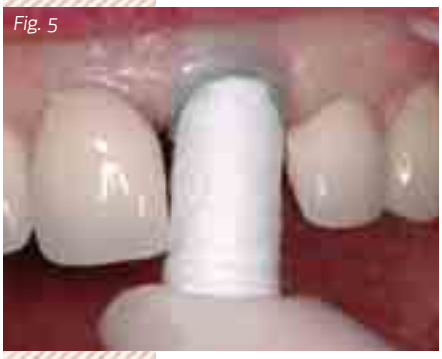
Fig. 5


Fig. 6

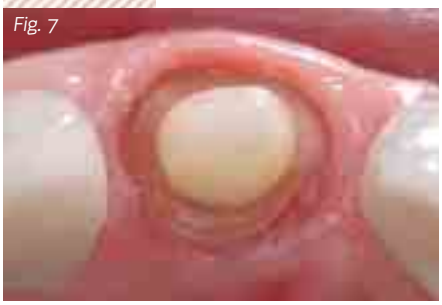
Fig. 7

Figs. 3-7: The use of the 3M ESPE Retraction Capsule in conjunction with a Comprecap for excellent tissue management and retraction for single unit anterior all-ceramic crown.

The use of aluminum chloride, especially in conjunction with ROEKO Comprecap compression caps, can be very effective in controlling bleeding and providing tissue retraction. The compression caps are available in a number of sizes to fit over the prep and help force the aluminum chloride paste into the sulcus. They also give patients something to gently bite down on while the retraction paste takes effect.

An additional advantage of retraction paste is that it requires less technical skill to properly apply than retraction cord and can be taught and delegated easily to dental assistants. On the downside, aluminum chloride interferes with the chemical setting process of both polyether and vinyl-polysiloxane impression materials. It is *very* important for dentists to *thoroughly* wash off residual retraction paste prior to placing impression materials.

Customizing the Retraction Paste Technique

Perhaps the best-known aluminum chloride paste material for tissue retraction is Expasyl (Kerr Dental). One drawback of this product is that it is designed to be used with a rather expensive specific dispensing syringe. Some dentists also find that the material has a thicker viscosity than they would prefer. A new aluminum chloride paste from 3M ESPE (Retraction Capsule) has recently been introduced. This product employs a 15 percent aluminum chloride paste that is dispensed from single-use compules making it very practical in terms of asepsis (use one compule and throw it out). Unlike competitive products, the capsules fit easily into most composite dispensing guns eliminating the need to purchase a separate dedicated dispenser. The compules are designed with a unique, long, thin, plastic dispensing tip that allows it to be inserted directly into the sulcus and a very fine bead of material to be placed (Figs. 3-7). Although not recommended by the manufacturer, I find that the length of the dispensing tip can also be adjusted by simply cutting the nozzle to the desired length. This also enlarges the inner diameter of the dispensing tip increasing flow of material (somewhat analogous to cutting back on a caulking gun dispensing tip), which may be desirable in some clinical situations. The viscosity of the material can also be altered to some degree by refrigeration prior to use (thicker viscosity) or by placing the compule in a cup of warm water for a few minutes prior to use (thinner viscosity).

Review Your Options to Improve Your Results

The bottom line is that many viable options for tissue retraction exist. It is up to dentists to familiarize themselves with these options, become proficient with the materials and techniques, and then select the one that is most appropriate for the specific clinical situation. ■

Author's Bio

Dr. Gary Alex graduated from Tufts University Dental School in 1981 and continues to enhance his dental education by completing numerous hours of continuing education with an emphasis on occlusion, adhesion, comprehensive dentistry, materials and aesthetics. An international researcher and lecturer, Dr. Alex is an accredited member of the American Academy of Cosmetic Dentistry, International Association of Dental Research, American Equilibration Society and is co-director of the Long Island Center for Dental Esthetic and Occlusion. Dr. Alex maintains a practice in Huntington, New York that is geared toward comprehensive prosthetic and cosmetic dentistry.

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What Numbers to Track, Am I Crazy?

Metrics are vital to the success of your practice. Here, Townies discuss which metrics they track and why.

drhepp
Member Since: 12/11/03
Post: 1 of 27

I think I'm different than most dentists. Maybe I'm not, you guys tell me. I care a great deal about the metrics we look at. I have spent many years developing and refining what metrics we look at every month. Some have proven to be very helpful and some, not so much. I am in a unique position in an organization where it is relatively easy to change what numbers we look at if we need to. For the past five years I have tracked these numbers on an Excel spreadsheet so it is easy for us to see the trends in my business. As I talk to my dental friends and colleagues, I realize that I am the exception to the rule as far as tracking numbers go.

Last night I went to a Clark County Dental Society meeting. The guest speaker was an expert on dental practice management and her lecture focused on the numbers dentists should be tracking. I was shocked. This was stuff I made a point to learn 14 years ago before I even bought my own office. This was dental management 101 stuff and I was nearly the youngest person in the room. I guess I was a bit perplexed that there were so many dentists in the room that still didn't know this stuff. No wonder these guys are going broke. So many of these small business owners just work "in" their practices and don't work "on" them. I know many guys do get it and manage things properly, but I am always surprised at the number of owners who don't. OK, rant over.

The following numbers we track monthly and I have a monthly staff meeting where we cover the numbers and talk about the good, the bad and the trends. I have a staff bonus system in place that is tied to our monthly production, collections and expenses. Therefore the staff is very interested in the numbers. On another note, I have had several different evolutions of bonus systems over the years in an effort to build the right type of motivation. I have been using my current one for four years and it seems to be working very well.

- Monthly production: This dollar amount tracks the value of every dental procedure and service that has been provided in the last month. We set a bonus level at the beginning of the month to shoot for.
- Monthly collections: This dollar amount tracks every dollar that we have received in the last month whether it is from a patient at the time of service, a patient payment or an insurance company payment.
- Monthly expenses: Using QuickBooks and a bookkeeper, I track where every dollar has been spent during the month. Staff and personal payroll, dental supplies, office sup plies, marketing, office services, depreciation, amortization, etc. The bonus is tied to this number as well, but I keep this number private and out of the numbers meeting. I don't want to flaunt to my staff how much money I make. I know they are smart and know, but I don't want to rub it in their faces.
- Write-offs: The dollar amount we have written off as uncollectable for the month. This is pro bono work, family discounts, staff discounts and write-offs I have agreed to take by signing up with certain insurance plans. When this number gets too high, it's time to look at the contracts I have with insurance plans, or sever some family ties.
- Actual production: Monthly production minus write-offs.

Visit the following message boards for more number-tracking talk.

What Numbers Do You Track?
Search: Track Numbers

Dental Metrics
Search: Metrics

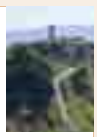
continued on page 38

- Collection percentage for the year: This is production/collections x 100 for the year in total. I want to know what percentage of the work I am doing I'm actually collecting money and getting paid for. The bonus is tied to this number as well.
- Number of new patients: How many new patients we saw during the month.
- New patients scheduled: This is not what it sounds like. This number is how many of the new patients who came in and were diagnosed with treatment, made an appoint ment for that treatment. I track this number to be able to follow my case acceptance percentage. During the meeting, we discuss, by name, each patient who did not schedule and why. I set it up this way so the employees knew I was going to be asking about patient acceptance. It has more gravity if something has to be reported and not just recorded. It also allows me to see if there is a developing problem with our treatment planning system.
- Number of patient referrals: How many of our new patients have been referred to us by an existing patient. This tells me if our patients feel they are being treated well.
- New patient sources: How many came from naturopathic doctor referrals? How many came from the Internet? Was it a Google search for Vancouver dentist? Was it a Google search for mercury-free dentist? Was it from the Yellow Pages (not anymore)? Did someone drive by and see our awesome sign and come in? These numbers are critical to me so I can see the sources of our new patients. If I am going to plan how to best use my marketing dollars, I need to know where to spend that money. I don't use Yellow Pages ads in Vancouver anymore because numbers of new patients from it dried up. With our practice management software, it is easy to track how much actual production was generated from our Yellow Pages ads. This was great ammunition when the Yellow Pages salesmen tried to up-sell me.

I am not sure there are three more metrics I should be using. I worked with a very capable consultant several years ago that helped me develop this list. Over the years it has been tweaked and added to. Some things have been removed. I could track a hundred more things, but this list tends to be the lifeblood of my business. ■

APR 6 2012

Long Span Bridge
Member Since: 03/10/03
Post: 2 of 27



I also feel that we must keep an eye on *trends* in our practice. I have found it somewhat frustrating to compare my practice to other practices, since every practice is different and we might all measure our data differently. But I do think that it is critical to verify that *trends* in *my* practice are moving in the direction that I want them to be moving.

I was recently surprised by a new analysis that I just did. I have been tracking my total practice production dating back to 1976 and it has shown a nice steady growth curve. But just recently the ADA has released new data at www.ada.org/freereports.

This gives some great data, but the one that I found most interesting was 1970-2011 Dental CPI changes. Anyway, the result that I got when I adjusted my yearly production by these dental CPI figures showed my practice production was actually quite flat. The healthy growth curve that I thought I had was virtually wiped out when CPI was factored in.

So in spite of our best efforts, sometimes the numbers can fool us. I guess the old saying "liars figure and figures lie" is still true today. So my advice is to definitely track your practice data, but keep an open eye toward what the charts are actually saying. ■

APR 6 2012

blue
Member Since: 05/17/04
Post: 5 of 27

I am the same way; a numbers guy. I track all the same things: production, collection, new patients. I use data from Dentrix and QuickBooks. My wife pays all the bills and even prints the checks in QuickBooks.

One thing I have started keeping track of is my hygiene department. I have two hygienists and live in a state where coronal polishing (after training) is legal. My goal is for each hygienist to see 11 patients a day and my assistants to do 10 kid prophies a day. That is a total of 32 hygiene patients a day. My goal is to average 85 percent for the month.

The past year we averaged 77 percent and I consider us to have a very productive hygiene department. If we hit 85 percent, that's knocking it out of the park. Every day that we have hit 100 percent, we easily exceed our daily practice production without me doing any big production. I love those days.

Keeping track of the numbers is key if you have goals and want to achieve them. By the way, my hygienists are in charge of these numbers and I use these when discussing their salaries. ■

APR 7 2012

Kevin Tighe
Member Since: 12/27/10
Post: 9 of 27

Most dentists and staff I have interacted with all keep some kind of statistics but don't now how to use statistics. Usually the statistics that are kept are production, collections and new patients. These are important statistics to keep, but don't serve a lot of use in managing a practice on a day-to-day or week-to-week basis. Those stats are typically looked over at the end of the month, and if they're going up everyone's happy. If they are going down few know what to do about it other than to "work harder."It is, in fact, far more important to monitor what are called "sub-statistics." For example, a receptionist or appointment book secretary or scheduling coordnator could keep the following sub-statistics:

- The number of patients who called in
- The number of patients who scheduled
- The number of patients who kept their appointments

These sub-statistics help make up the number of new patients. It is much easier for the receptionist or appointment book secretary or scheduling coordinator to control and monitor these than concentrate on total number of new patients.

Sub-statistics should be developed for each postion in your dental practice and monitored.

The most fundamental use of statistics is when a number is going down since you can't keep doing the same things. Everyone has probably heard the old saying, "The definition of insanity is doing the same things over and over again and expecting different results." Typically, when numbers are going down, bad habits have developed and good habits have been dropped or changed. The trick is to be able to quickly recognize what has changed by examining the sub-statistics. Once you narrow down the area where there's been a change, you need to figure out what changed and get the successful actions back in. As an example, there could've been a change of personnel coincident with the numbers declining. However, it is not necessarily true that the new person on the job can't do the job, but more likely is not replicating the successful

continued on page 40

actions and habits of the last person to hold the job. Assuming the new employee is willing and trainable then it is fairly easy to get him or her doing what the previous successful employee did.

Anyway, I find that the use of statistics is rarely understood by most dentists and staff and they usually consider them more paperwork than of use in managing a practice. Hopefully, the above info brings to light how statistics can be helpful in managing a practice. ■

APR 7 2012

Long Span Bridge
Member Since: 03/10/03
Post: 10 of 27

Blue, thirty-two prophies per day is impressive. A couple of things about this puzzle me. During an eight-hour day, that works out to four mouth exams every hour. At five minutes per exam each, that is 20 minutes out of every hour that takes you away from your chair. So it would seem difficult to accomplish much in the way of restorative work on your patients at this pace. Obviously you work at a faster pace than I am able to do.

Secondly, if each of these 32 prophies per day comes in twice per year and you work 200 days per year, then you need an active patient population of 3,200 patients to justify this level of intensity. Things are obviously going well in your practice if this is your goal, but most of us can run a decent hygiene program at a much less frenetic pace.

Now, if you have an associate to help with the exams and you work significantly less than 200 days per year, then your strategy would make much more sense to me. Just some thoughts… ■

APR 7 2012

blue
Member Since: 05/17/04
Post: 12 of 27

Thirty-two a day very rarely happens, like I said, we average about 77 percent, so that means about 23 patients a day. But 32, as far as production goes, is a home run.

Here is how we do it: I have six ops, each with a Parkell Cavitron, three ops are dedicated to hygiene, two for me, and one that is shared but mostly for hygiene.

Hygiene number one only sees adult patients (11), hygiene number two sees about six adult patients and the rest are child prophies. We try to see 15 child prophies a day split between my assistants, and hygiene number two (I will scale or Cavitron, if need be). The hardest number to reach is the child prophies, especially during school hours.

I know the first question you ask is: How good is our care?

We give great care. We all wear loupes, try to remove every morsel of tarter. We have digital X-rays, and use Casey intra-oral cameras on each patient. Exams can be tough at times, especially new adult patients. Child prophies are usually a breeze. I can have a family of three kids (bring back to ops all at once), review all X-rays in my office and check all three at once. We are extremely efficient, have a tremendous recall system and a well-oiled staff. We work hard and know no other way. My staff gets bored on down days. I am very demanding. We use headphones, computers in ops and I constantly calculate when it is time to break away from my work and do checks.

I refer full-mouth rehabs, endo and perio. I do a ton of extractions (no impactions) and things that are very predictable and that I am good at.

We never turn an emergency away and have a huge number of active patients. ■

APR 7 2012

Find it online at: www.dentaltown.com
search Number Crazy ▶

Advanced Tips for Improved Shade Matching

- It is important that color selection is done when the patient is first seated in the dental chair as Chroma and Value can change due to minor dehydration after the patient's mouth has been open for a period of time. Studies show that teeth can take more than 24 hours to return to their natural state. Additionally, there is less chance for optical fatigue.
- Use a room with some natural light if possible and avoid pointing any light directly toward the patient.
- The amount of reduction is the most important factor in creating esthetic restorations. 1.5 mm - 2.0 mm is recommended in order to have adequate porcelain thickness for proper shade matching.
- Limit viewing to 5 seconds, as eye fatigue will set in. Your initial decision is usually the most accurate.
- Diagrams should be used. A facial view of the clinical crown is used to indicate the position of the various shades, while a proximal view shows the technician how the body and enamel porcelains should be layered.
- The patient should be reclined at a 45% angle with the patient's mouth level with the dentist's eyes. Shade guide tabs should be applied parallel to the tooth, never in front or back.
- If your camera doesn't have a ring flash, have the patient sit up with their chin slightly tucked in. This will help keep the flash from reflecting in the picture.

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My First Practice: A Retrospective Blog

A Townie is buying an existing practice and documenting his experience for people to learn from and contribute to.

NileDDS
Member Since: 04/11/10
Posts: 1 & 2 of 227

Alright young dentists, eager, tired and underpaid associates everywhere, let's try and make something positive of this experience.

I am in the middle of buying a dental practice (Steve Kuzmak got me jealous), and thought I would share my ups and downs with everyone in a similar boat here. This will be in the form of a blog.

My hopes are to document the thought process leading up to my decision of departing my current excellent – but far from perfect – associateship position to purchase my first dental practice. I am also counting on your support, and am absolutely counting on learning from others who have done this before. I don't have anything to preach here. I'm just learning all this as I go. This whole process does bear repeating in my opinion, no matter how much information is already available.

[Posted: 2/18/2012]

So, let's kick off by asking the very basic question, why ownership? And… is it for me?

I will now proceed to shamelessly copy a recent post from a different thread, just because it's easier, and relevant:

Why ownership?

1. Passive hygiene income – not available to most associates.
2. You don't have to break your back in order to net the same amount as an owner (associate, more likely).
3. Job security.
4. Business write-offs, funding retirement, tax breaks, SEP IRA accounts.
5. Liberty to grow at *your* own pace, in the areas *you* see fitting with *your* philosophy and *your* strengths (endo, CEREC, ortho, implants, etc.).
6., 7., 8., 9., 10. Do not underestimate the sanity to be had from being able to handpick pleasant people to surround you every day at work.

On a related note: In most cases, your "business expenses" as an associate will come off of your post-tax dollars (taxed net). In my case that includes, but is not limited to:

$12,000	Health
$4,000	Disability
$2,000	Malpractice
$3,000	Specialized supplies and equipment
$2,500	Loupes and light
$4,000	CE and related CE travel expenses
$5,000+	Car lease, gas, mileage, car insurance, car repairs, clothes, meals, travel, etc.

$32,500+ *post-tax dollars* in associate overhead expenses alone, most of which would benefit from business ownership.

Now the tough one: Is ownership right for me? Boy, is that a toughie. It really depends.

It is a personally driven decision, but most will tell you that ownership is rewarding financially, yet initially very taxing both physically and mentally (wow, sound familiar?). It is not an easy job.

For more practice-buying threads, visit the following message boards.

Should I Do This or Should I Stay Away? Please Help
Search: Stay Away?

First Time Buying a Practice (Maybe)
Search: Buying First Practice

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 continued from page 44

I would suggest the factors that favor ownership include:

1. High producing associates, eager to expand duties and/or take on additional responsibilities with added reward.
2. The ability to work full time and overtime when needed.
3. Long-term location (no more moving around).
4. Support at home (spouse, family).
5. Financially responsible (you will likely need to prove this to the bank later, in order to obtain financing).
6. Good health. ■

FEB 18 2012

BillyP
Member Since: 07/21/08
Post: 4 of 227

Great topic, I will be following this as I am in the same boat. I'm more leaning to start up because I cannot for the life of me find a dental practice for sale in my area. ■

FEB 18 2012

NileDDS
Member Since: 04/11/10
Post: 6 of 227

Start-up vs. Existing

Start-ups can absolutely be done. It just takes people with more brains and guts than myself. It's a blessing in itself that I can recognize that in myself before it's too late. I'm not your typical risk-taking entrepreneurial type of guy. I tend to be more risk-averse, actually.

I thought a lot about starting-up, and actually really still wish I could. I had a great location, big vision for what I wanted to do and was all fired up. What took the wind out of my sail and the tipping point for my scale was when I started hearing the same message from banks, CPAs and brokers: existing data suggests that this is not the best time to do a start-up (at least in my state/region). You can't argue with that and still call yourself rational.

Start-up:

- You *must* have a home-run location with favorable demographics in order for it to be even remotely feasible.
- Be prepared to stay in the red (bleed money) for your whole first year or two in business (borrowing running costs) – loosing sleep, stomach lining.
- Have to think about and plan for every little minute detail in your practice. That includes writing office manuals/policies, shopping for compressors, marketing, hiring/firing, training new staff, etc.
- It's. A lot. Of. Work.

Existing:

- Source of revenue from day one.
- Somewhat loyal staff, patients from the get-go.
- Tried and tested systems in placed, which pretty much provide you with a platform, upon which you can improve, increase efficiency and productivity = $$$.
- All this allows you more opportunity to learn, tweak and grow, opposed to re-inventing the whole process and spinning your wheels for the first couple of years until you see some profit, growth and stability.
- More predictable = potentially more hours of sleep at night.

Here's the dirty little secret about existing practice purchases: they're almost always under-valued. You get more *bang for your buck* when buying an existing practice.

The closer dentists inch toward retirement, the lazier they get – not necessarily in a bad way. At that point in their lives, they most likely have a very comfortable income, funded retirement, plenty of savings upon which to fall back on, all while allowing their practices to descend into complacency, becoming lazy, fat and inefficient slobs along the way (the practice, not the dentist).

continued on page 48

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From my experience, a practice will usually sell at 60-80 percent of the most recent three years weighted average gross income, when in fact that same practice will have much, much more potential. Something to the tune of 120-150 percent of the most recent years weighted average gross income.

Example (using $100k for simplicity):

A practice averaging gross revenues of $100,000 will usually sell for anywhere between $60k and $80k, and will mostly likely have the potential to be bumped up to a gross of $150k with some simple tweaks, marketing and energy infused into it. That's some low hanging fruit, my friends. You just paid $60-80k for a practice that should be grossing $150k!

OK, now most CPAs, lawyers and consultants will tell you to never *ever* pay for potential. I agree. Pay for historical data, existing figures and proven numbers. But that does not mean that the potential is not there. It always will be, with the right management, different perspective and fresh blood infused into the practice (new procedures, less referrals, signing up for new insurances).

That's good enough for me. ■

FEB 19 2012

Pedo rules
Member Since: 07/29/03
Post: 10 of 227

This is a very interesting thread you have started. I am currently planning on doing a pedo start-up. I have seen a few practices for sale but not in the area where I want to start, actually not even in the same state. The state I want to start up in has only one practice for sale in the *whole* state. So if I want to live there, I can either be an associate (no stability), partner (they don't always work out) or start my own (have the most control).

You are right about the instant cash flow when you buy a practice, but don't you end up inheriting a lot of existing problems and headaches from buying a practice (for example: dealing with high-paid staff that are set in their ways)? ■

FEB 19 2012

southpaw4
Member Since: 08/09/09
Post: 21 of 227

Good thread. Will be following. Interesting contrasts with different areas of the country. I'm in an area that's grossly over-saturated, but I still want a start-up and believe there is potential with careful planning/preparation/research. Buying an existing practice can be better in the right situation, but in my area there are so many darn practices for sale that I feel it is nearly impossible to know what's what, and trusting a broker is not high on my list. Patients in the area also tend to shop around a lot, so keeping patients is up in the air. Opening a start-up with proper preparation is almost as risky as buying an existing over here, hence my confusion and why I've backed away from doing anything for the moment. I'm also a newbie, working for only three months. My ears are wide open. ■

FEB 19 2012

ejones
Member Since: 04/15/08
Post: 22 of 227

There's no right or wrong answer, but I started-up.

Never overestimate the amount of patients that will stay with you in an existing purchase. Some of our best patients came to us after their old doc retired, and the new owner isn't him (but I'm sure is a great guy).

That said, we did a huge amount of demographic research, and so far are seeing a profit and around 40 new patients a month without signing up to be on any PPOs yet… but we planned our marketing strategy from the beginning and work *very* hard at doing everything better.

In hindsight, I'd either start-up again, or find a partnership or slow buy-out to really try to transition some goodwill. Either way, you must do your homework. ■

FEB 19 2012

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Name: **Tim Lott**
Townie Name: **Tim Lott, CPA, CVA**
Member Since: **11/16/2005**
Occupation: **Dental CPA**
Location: **Offices in MD, Serving Nationally**

Name: **Jason Wood**
Townie Name: **jasonpatrickwood**
Member Since: **01/24/2008**
Occupation: **Dental Attorney**
Location: **Offices in CA, Serving Nationally**

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NileDDS
Member Since: 04/11/10
Post: 32 of 227

Ways to find practices for sale?

- Dentaltown classifieds (yes, right here).
- Local dental society, local school alumni Web sites and networking (*very* helpful).
- Networking at dental meetings and study clubs (contrary to common belief, not so helpful, but worth a shot).
- Brokers (National Practice Transitions [Bacarri-Cabral], ETS, Mercer, ADS, etc.).
- Supply reps (also unfruitful in my case).

What questions to ask when buying a practice?

So you might be surprised, but buying an existing dental practice is mostly a game of numbers, not location (in my experience), not what new fancy equipment/toys the practice has, not a lot of things it should be. Pure math.

1. Number of new patients per month
2. Number of active patients
3. Gross billings
4. Net profit
5. Overhead mix (staff salaries, supplies, rent, etc.) – more on this later

If you give me these numbers for any practice, and with my tiny, tiny limited experience, I can tell you if it is a well-run practice. Obviously, there is an additional phase of "due diligence," but these numbers are what get you through the door. Kind of like a new car's window sticker, advertising its options and gas mileage.

I don't need to know where the practice is located (although that would be nice), how new the equipment is, how many staff members even. Just show me the numbers.

OK, the numbers check out. Is this practice a good fit for *you*, and how to evaluate *potential?*

You have to be honest with yourself. If you are a bread-and-butter kind of guy/gal, and do not like high-pressure sales cases (cosmetic, full-mouth, etc.), then listen to yourself. Don't go looking for a prosthodontic practice or a practice where the previous owner has been doing a ton of implants or cosmetic cases, because guess what, *you*:

1. Will inherit all of his/her failures – may have to redo them, will have to redo them, will not redo them as well, will pay his/her high lab bill!
2. Will lose money with every redo, while you could have been producing other dentistry.
3. Might not be viewed as competent in those areas by his staff/patients – lose their confidence early on.
4. Might not find much bread-and-butter work for you at that practice (high mix of niche procedures).

You also must be able to produce around 80-120 percent of what that current owner was producing. If you walk into a practice grossing *around the same amount or less* than what you currently produce as an associate, well guess what… you will get bored pretty quick. Similarly, if you walk into a situation where you will need to gross a time and a half of what you are doing full time at your associateship just to keep your head above water, well, that's a problem too. You will get burnt out pretty quick. When you think of trying to manage and run an entire show, while working 1.5x as hard, well, you may want to shoot yourself actually. This is some serious stuff to not overlook, with pretty heavy consequences.

This is where "potential" comes into play. It's almost an opposite scenario. If you walk into a bread-and-butter practice (best ones to buy btw, in my opinion – they are like a clean white canvas), and you see the owner referring most specialty procedures right and left, and you know that you can keep some of that in house – endodontics in my case – then you have just magically created a major new source of revenue for yourself, which will almost certainly be reflected in increased production. It's an instant out-of-nowhere bump in your gross.

continued on page 52

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 continued from page 50

Similarly, if you see that the current office is doing OK, but is under-resourced or under-managed, then again, you are sitting on a gold mine, provided you have some managerial know-how, and don't mind ruffling a few feathers.

- Under resourced = not marketing enough, not enough staff per new patients (assistants, hygienists, front office), staff poorly/inadequately trained, number of assistants and/or hygienists not consistent with number of new patients = turning away patients, not enough staff to pick up the phone – politely, while not stressed – is also turning people away.
- Under managed = not participating with any insurances, poor utilization of staff members (assistants only doing suction, not trained in patient education, reinforcing doctors treatment plans), hygienists under trained, etc. ■

FEB 20 2012

reccoso
Member Since: 05/06/08
Post: 48 of 227

Having purchased my first and only practice within the last year, I can say this: unless this is your second, third, etc., practice and you've got running a practice down pat 100 percent, you *need* the existing staff (at least initially) for a few reasons:

1. You paid all this money for goodwill, firing all the staff is an easy way to piss away a good chunk of that goodwill. Patients spend way more time interacting and socializing with your staff than they do with you.
2. For someone who's purchasing their first practice, there's a lot to learn and a lot of support to gain from your existing staff. I sure have gotten a lot of help from my staff, even though they're not 100 percent happy with some of the changes I've made, they understand why, and we compromise.
3. When you're buying an existing practice, you need a transition, if you simply clean up the whole place, it's not a transition, it's a drastic change, and people will leave without even giving you a try.
4. Staff will "sell" you and promote you if you're straight up about it, and explain how these things normally go about. For many of them, this is their first time going through a sale, and they need guidance. Oftentimes, the office/team is in a rut and the new energy will get them going, especially if you make positive changes.
5. I had a staff of eight when I took over, one left within a few months because she wanted more money and she was getting paid good money for simply answering calls and not going above and beyond at all (read: smiling was a chore for her!).
6. I then had a good hygienist leave because they were accepted to a second career they had been working toward for a while.
7. Both times, it's worked out because I internally moved people around and hired a new staff member, *however,* even doing this has resulted in more coaching of these two people in new positions – I would much rather be focusing my energies on patient care, etc., at this point than such hands-on-training; imagine if *all* the staff were new, it would be that much more work. Never mind the fact that even though you may pay new staff less in pay, sometimes experienced staff are worth their pay in bringing in additional production and loyalty – e.g., a good RDH who is good at co-diagnosing crowns with the dentist and promoting regular perio for patients, etc., etc. ■

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Difficult Extraction

An extraction on a divergent-root #19 doesn't go quite how the doctor ordered. How would you do it differently?

hazardl
Member Since: 02/19/10
Post: 1 of 31

I did an extraction yesterday that gave me some trouble (#19, irreversible pulpitis, patient didn't want RC). I wanted to know if anyone would approach this extraction differently.

I start almost all extractions with the forceps – I know this is a big no-no on this thread, but sometimes I surprise myself and the tooth will just slip out with a little tug. Obviously, this was not the case here. About seven seconds with the forceps (I had to at least try) and then I went straight to the handpiece to section. Went for the mesial half first. This sucker was tight and the bone was extremely dense. I ended up breaking it off.

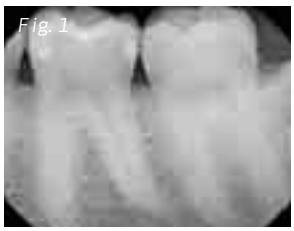
I decided to forget about the mesial for the moment and move on to the distal. Gentle luxation with the straight elevator, some patience and a little bit of prayer paid off and the distal came out fine. But it took work and patience. Like I said, dense bone here.

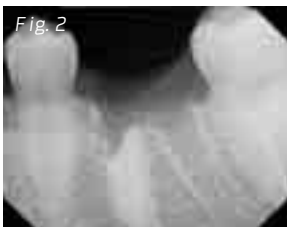
Back to the mesial – this was not so easy and I worked for a long time on this – long enough that I feel bad for my patient. I ended up taking out tons of interradicular bone and more than I would have liked off the buccal. It finally came out. Like I said, this took me longer than I would like to admit – more than 1.5 hours. I spoke with the patient today and he is not having much post-op discomfort or swelling. He thinks I am a hero. I'm glad he's an easy patient.

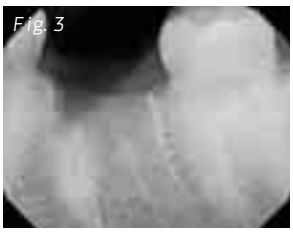
So, where did I go wrong? Or did I? Hindsight is 20/20 and tells me that I should have been more aggressive right off the bat, but it's hard to apply that to other situations, as I don't want to overdo it. At the point where the tooth broke, did I follow the right course of action by removing IR bone? Is there anything else I could have done?

Hypothetically, let's say these roots were even more splayed apart, or even a lone premolar or something where there isn't IR bone to give you space. What's the best way to approach this situation in dense bone? Removal on the B?

I'm looking for ideas and trying to improve. I can usually take a situation like this and learn a lesson or two that makes it so that I don't have to repeat the experience in the future. The problem is that I can't really see much that I could have done differently – but I don't want to do things the same. And so I turn to you. What would you have done?







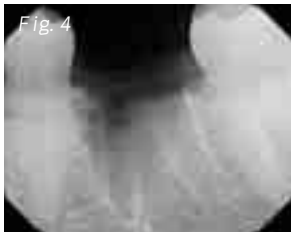


Fig. 1: Pre-op.
Fig. 2: After I took out the distal.
Fig. 3: After working on it for a while. This was an X-ray I told the assistant to take in order to give me an excuse to leave the room and do a hygiene exam (and to help myself relax a little).
Fig. 4: Final X-ray. ■

JUL 19 2012

To read more difficult extraction cases, visit these message boards on Dentaltown.com.

Difficult Surgical Extraction, Loss of Orientation
Search: Difficult Surgical

Iatrogenic Horizontal Root Fracture
Search: Iatrogenic

Divergent roots on pre-op rad = section the tooth. This is my protocol. Always run a sharp periosteal elevator and separate the gingiva. Always luxate prior to forceps. I am sure you will receive a lot of good suggestions. ■

JUL 19 2012

Raj D
Member Since: 06/03/03
Post: 2 of 31

My first suggestion would be to stop taking so many X-rays. I just don't see the need here. No sinus. No third molar with the root tip in the canal or submental space. Just look in the hole, irrigate, suction and look again.

Second, try to elevate first and at least disrupt the PDL and gain a little mobility. The bleeding in the small PDL space acts a little like hydraulic fluid and expands the bone. Next, try cowhorns here. If you feel like you're "torqueing" too hard, section the tooth.

In sectioning the tooth, take a large slot out of the middle of the crown including the top of the interradicular bone, but leave the crown on. Never remove your "handle" unless it's of no use. The idea is to remove enough to allow the crown to be elevated into this slot and "roll" the root in the direction of its curvature. If the crown breaks off at this point you should at least have enough mobility to easily retrieve the root. Sometimes you can grab the 1/2 crown with a 151 and get it out. ■

JUL 19 2012

MrWizard
Member Since: 11/03/09
Post: 3 of 31

Similar to what Raj mentioned, create space in the PDL with a periosteal elevator/periotome/proximator and luxate with an elevator... these two things are best done prior to touching the forceps. You want to create some space and mobility first, even before you section. Try the forceps, if still nothing, then section. Given the divergent roots, it makes sense to section after luxation has been completed. If you're going through the effort to section the roots, then I personally would go more apically in the interradicular area at the start. It looks like your initial sectioning just barely went to the furcation. If you have an instrument like a proximator or luxator, you can oftentimes get the individual roots to just pop out. Otherwise, elevator to both roots, Cryers work well for mandibular molars after sectioning. Removing IR bone made sense vs. removing the buccal bone. I'd preserve the B&L bone as much as possible. ■

JUL 19 2012

adrenalinedoc
Member Since: 08/04/06
Post: 4 of 31

My approach is a little different. After 10 seconds of elevator in the PDL, if it doesn't move, especially with divergent roots, I relieve the gingiva bit around the tooth, decornate, then trough into the furcal. I can do this in five minutes – this is what is comfy for me and least traumatic for the patient. ■

JUL 19 2012

dimitrios
Member Since: 12/01/07
Post: 5 of 31

As mentioned, with divergent roots, sectioning is pretty much a necessity. Once you got the distal root out, you could have gone to the Cryers or East/West. First swipe takes out the septal bone, second swipe gets the mesial root. Or you could have used the handpiece on the distal aspect of the mesial root to create space, then *carefully* trough the mesial aspect (even at the expense of the root fragment – stay well away from #20, go slowly and check your orientation – the biggest mistake made at this point is not having the bur angled enough to the distal, better to trash the root of 19, not 20). After you have created clearance, back to Cryers or East/West to deliver the root. ■

JUL 19 2012

alanrw
Member Since: 05/16/11
Post: 6 of 31

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mileskidds
Member Since: 07/11/08
Post: 8 of 31

I am a public health dentist so I see this kind of thing a lot.

I also begin with forceps but if it feels like it's not going to deliver, I will section the tooth. I will begin by sectioning without laying a flap and attempt to elevate each root. If I feel like I cannot elevate each root or if a root breaks, like what happened here, then the following might help.

1. Adequate flap: You don't have to put a releasing incision for the mandible but make sure you extend it a few teeth on either side so you can see easily and keep the flap out of the way for any bone removal.

2. Trough around the remaining root so you can place your small straight elevator and elevate out the root. A Cryer's East/West can also be very helpful here. It is less traumatic to remove bone with your handpiece than to break it off because you weren't able to access enough of the root to elevate it out. The most destructive procedure is to continually break the root to the apex. You will end up toughing it all the way to the apex. So I remove enough bone initially so that I can get a purchase point to either elevate out the root or expose enough of the root so that I can grab it with a forceps or Rongeurs.

I find that with sectioning teeth the biggest problem is just not sectioning all the way. If you have not actually sectioned the tooth through the furcation and try to separate the two halves, you will just break off one half of the crown, leaving the root. After you section a tooth, the two halves must move independently of each other easily or you probably have not completely sectioned the tooth.

Extractions are all about getting the feel of how much you can push on that tooth before it breaks. It's a lot less than we think. Once you get the feel, things become very easy. ■

JUL 19 2012

drpainlus
Member Since: 03/01/04
Post: 12 of 31

On this tooth, I would have sectioned into mesial and distal halves. When you are through the furcation and feel confident it is in two halves, insert an elevator mesial to the mesial root as apical as you can and push toward the distal while pushing apically. Watch the distal half. If it also moves then the tooth is not sectioned. If the tooth is sectioned, the mesial root will move distally and occlusally. When you feel it's loose enough, use a lower root tip forceps and wiggle it out.

If you are someone who must take a forceps from the get-go, zip off the mesial and distal contacts so you can rotate the tooth out. If you are someone who always starts with an elevator, it is still a good idea to zip away the mesial and distal contacts, otherwise you cause horizontal forces on the mesial and distal tooth. ■

JUL 19 2012

drtommymurph
Member Since: 04/05/02
Post: 25 of 31

We can all agree to disagree.

Lack of orientation is the number-one problem dentists run into when removing a tooth. I get phone calls almost weekly now from dentists who have lost their way and it is always loss of orientation. That is one reason that I am against removing the crown. Another is that if you leave the crown you can use a 151 forceps after sectioning to remove the now single-rooted tooth. ■

JUL 19 2012

Find it online at: www.dentaltown.com
search Difficult Extraction ▶

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Straine Dental Consulting Partners with CDA Foundation for CDA Cares

The California Dental Association Foundation announced a significant new sponsor – Straine Dental Consulting – whose principals Kerry and Olivia Straine provided a $20,000 donation to support the foundation's CDA Cares dental clinic in Sacramento, August 24-25. The California Dental Association Foundation hosts the free dental clinics to provide more than $1 million in free dental treatment and education to more than 1,500 patients at each event.

Industry News

The Industry News section helps keep you informed and up-to-date about what's happening in the dental profession. If there is information you would like to share in this section, please e-mail your news releases to ben@dentaltown.com. All material is subject to editing and space availability.

www.dentaltown.com

2012 Dental Industry Metric Report Now Available

The 2012 Dental Industry Metrics Report is now available from The Anaheim Group, publishers of Dentalfax Weekly. The 414-page report contains performance data on 95 publicly traded dental industry companies. The report includes companies based in Germany, China, England, Switzerland, Sweden, Belgium, Japan, New Zealand, Israel, The Netherlands, Singapore, Canada and the U.S.

The report contains information such as sales growth, earnings per share, market value, return on assets and equity, number of employees, price to earnings ratio, and sales multiple for each company profiled. In addition, the report includes industry-wide averages for insurance companies, manufacturing organizations, lab management firms, practice management companies, distributors and consumer over-the-counter product firms.

AAPD Joins the Partnership for Healthy Mouths, Healthy Lives

The American Academy of Pediatric Dentistry joins "The Partnership for Healthy Mouths, Healthy Lives," a coalition of more than 35 leading dental organizations, to launch the first-ever joint national children's oral health campaign with the Ad Council. Media partners include Sesame Street, DreamWorks and the Cartoon Network. The coalition's primary mission is to teach parents and caregivers, as well as the children themselves, to take control of their own health through oral disease prevention. For more information, visit www.healthymouthshealthylives.org.

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EDA and AADOM Partner for Green Leaders

The Eco-Dentistry Association (EDA) and American Association of Dental Office Managers (AADOM) have joined forces to support office managers around the country in adopting greener practices in the dental office. The "Green Leaders" partnership, funded by a generous grant from the Henry Schein Cares Foundation, aims to educate dental office managers on the environmental and bottom-line benefits of implementing digital modalities, and waste, energy and water-reducing measures in the dental practice. The initiative also focuses on helping office managers authentically reach the burgeoning market of wellness lifestyle dental patients.

Throughout the partnership, the EDA will provide educational resources and technical assistance to AADOM and its members about the significant environmental impact of the dental industry and how easy-to-implement strategies can reduce the practice footprint and support the practice in achieving greater financial success.

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Sesame Communications Releases Website Evaluator for Dental Practices

Sesame Communications, a provider of online patient communication and engagement tools for dentistry, announced the Sesame Website Evaluator, designed to help dentists determine the overall effectiveness of their Web sites. This online tool is available free of charge and provides practices with general guidance and a customized report showing their Web site score, along with specific recommendations for improvement.

NCOHF Names Grant Recipients

National Children's Oral Health Foundation: America's ToothFairy (NCOHF) announces the recipients of four grants. The America's ToothFairy Grant recipients will reach a combined total of more than 30,000 at-risk children with vital oral health services this year. Each recipient – University of Kentucky College of Dentistry in Lexington, Kentucky; Sonrisas Community Dental Center in Half Moon Bay, California; Just Kids Dental in Two Harbors, Minnesota, and; Gateway to Oral Health Foundation in Olivette, Missouri – received a $10,000 grant from NCOHF to fund pediatric programs delivering comprehensive educational, preventive and treatment services for at-risk children.

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A CENTURY of SUCCESS

Family-owned Premier Dental prepares for its 100th year of providing top-tier products for the dental profession.

by Benjamin Lund, Editor, *Dentaltown Magazine*

Since its inception, family-owned Premier Dental has always prided itself on maintaining a reputation of building life-long relationships driven by superior products and delivered by exceptional people. Premier Dental is about to celebrate its 100th anniversary, and in preparation of this monumental commemoration, *Dentaltown Magazine* interviewed Julie Charlestein, great-granddaughter of Premier founder Julius Charlestein, and president of Premier, to learn more about the company's history, its philosophy and its evolution in the dental profession.

Julie, please tell me a little about yourself and your professional history.

Charlestein: I suppose I have been working at Premier Dental my entire life. My earliest memories are from the warehouse, color-coding wood wedges on my days off from elementary school. My professional career began with Premier about 16 years ago, when I worked part time in our medical division. Before then, I worked in the political arena in Washington DC.

During my work at Premier in our medical division, my mentor encouraged me to go to business school, which I did. Once I had my shiny new degree, I wanted to make sure that someone aside from my family would hire me! So, I worked in the telecom arena for a few years before returning to Premier, where I have now been full time for 10 years and serve in the role of president.

Everything about Premier and my job excites me. I am overwhelmed every day by the incredible opportunities before me.

"We have focused most recently on true technological

innovations that bring multiple layers of added benefit to the marketplace."

Above, from left: The late Morton Charlestein, chairman of the board emeritus; Julie Charlestein, president and Gary Charlestein, CEO of Premier. Photo courtesy of Philadelphia Business Journal.

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If you were to meet a dentist on the street who has never heard about Premier Dental, how would you explain the company to them?

Charlestein: Whenever I travel, I try to wear one of our Premier t-shirts that showcases our different brands – Enamel Pro or Traxodent for example. This inevitably sparks conversation, and has led to some long-lasting relationships. I always tell these new friends that Premier is an innovator, and we have built our business on relationships. We develop, manufacture and distribute innovative consumables for the dental professional worldwide.

Tell our readers about the history of Premier Dental and about the company's evolution.

Charlestein: Premier was started in 1913 by my great-grandfather Julius Charlestein. Julius worked as a dental instrument sharpener, and on his way home from work, would pass dental offices. He asked his boss at the time if he could bring some instruments home with him to sell on the way – and that is how he got his start in business.

Premier's evolution is remarkable. We have managed to grow significantly under the leadership of my grandfather Morton, and my father Gary, and with the help of our world-class team. This evolution has come in stages, including our successful partnership with ESPE, and our triumphant trajectory from that point. We have focused most recently on true technological innovations that bring multiple layers of added benefit to the marketplace.

Obviously, many things in the world of dentistry have changed over the course of the century, but one thing that has not is Premier's steadfast belief that it should always operate with the highest level of integrity, and that all should benefit from the work that we do together.

What is your mission? What is your current business philosophy and how is it emulated by your team?

Charlestein: Our mission is to drive relevance through targeted innovation, select partnerships, brand strength and human capitol. We seek to be the "preferred partner" to whomever we are dealing with. These elements guide us with tremendous clarity through our growth strategies. They bring focus as to what types of technologies we are looking to develop, and what types of partners we want to do business with.

Our philosophy never changes; it is always to do what is right.

Premier President Julie Charlestein (center) meets with senior executives.

Tell me about Premier Dental's culture. What's it like to be part of the Premier Dental team?

Charlestein: Premier's culture is truly one of the most special aspects of our organization. We are a driven, hard-working family, but a family that truly cares about one another and wants the best for both the individual team member and the organization as a whole.

Before holidays, my grandfather would always remind the team: "A part of you belongs to Premier." We all believe that. We all believe and feel that we are responsible to each other, and to a cause that is greater than each of us.

To be 100 years old and still be family-owned is a feat in itself. How has Premier Dental managed to stay family-owned for so long?

Charlestein: We have been blessed with great teachers, and people of compassion. Julius and Morton's lessons of humility, love and respect have created the foundation for ongoing understanding. Constant communication and strong agreements are important too!

Traxodent
Hemodent Paste Retraction System

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* Survey of 333 dentists who have used Traxodent at least once in their practice. / Clinical images courtesy of Dr. Shaheen Mehlan DMD, Teaneck, NJ.

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To what do you attribute Premier's successful penetration in dentistry?

Charlestein: Firstly, an undoubted belief in ourselves. We know what our capabilities are, and we set out to exceed our expectations every time. We also allow ourselves to take calculated risks in many elements of our business.

Premier Dental is truly an international brand. In how many countries can you find Premier Dental products?

Charlestein: Being an international brand is so important to us. Premier products can be found in most countries around the globe, and perhaps most exciting is that you will find a combination of legacy products and new innovations as well. Canada is certainly our largest market outside of the U.S.; although we treat Canada as a domestic market.

Additionally, we have a very strong presence in Japan, Australia and Korea due in large part to the fact that my grandfather, who served in World War II, became keenly aware of globalization through his experiences. He traveled the world, and developed relationships in many markets long before others were doing so. Our footprint also continues to grow in European Union countries as well, with specific emphasis on the UK and Germany.

How do you set yourself apart from the competition? What would you say is your single greatest advantage?

Charlestein: A very real difference between us and our competitors is the fact that we are a privately held company. This means many things, including the ability to operate in what we feel is the best interest of our company and customers.

We also have an amazing advantage in having been in business for so many years. We understand the dynamics of the global marketplace, and have developed a number of partnerships that have guided us throughout the years.

My father always says, "We have good products, and people like us." I was always frustrated by this in the sense that it is not "sophisticated business-speak," but the longer I have worked here, and the more I learn, the more I see that he is right.

What is the most memorable customer interaction you've ever had?

Charlestein: I was at the most recent Alliance for Oral Health Across Borders meeting, and was talking with a young dentist from China. It was a bit difficult to communicate, but we were managing. Toward the end of our conversation, I gave her my business card. Once she saw the Premier logo, you could see a sense of understanding come across her face. She smiled broadly, and told me she knew of the brand, that she used the products and that they were "good products."

To be able to create a connection with people all over the world is so rewarding, and to know they are having a positive experience with Premier is astounding.

Aside from your 100th anniversary, what are you excited about in the upcoming year? Can you give us a little sneak peek into any new products you're developing?

Charlestein: Each year brings the opportunity for growth, experimentation and success. This is what has always driven us, and this coming year is no different. We continue to have a strong focus on hygiene and restorative products, so you will see more from us in those arenas.

To learn more about Premier Dental, call 610-239-6000 or 888-670-6100 or visit www.premusa.com. ■

Above: Enamel Pro Varnish (5% NaF Fluoride Varnish)
Right: Enamel Pro Prophy Paste

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The 43 Percent OVERHEAD PRACTICE

by Douglas Carlsen, DDS

There is a humble general dentist from the Chicago area virtually no one has heard from until now. Dr. Richard (Dick) Reid, 56, has never grossed more than $800,000 in his suburban Chicago practice, yet has consistently netted more than $400,000 a year from 1997 to 2011 with 43 percent overhead. He's worked 28 hours per week until the last two years, cutting back to 20 hours with similar income and overhead. Reid has consistently saved more than 20 percent of his net for the last 20 years. How on Earth has he done it?

Dick does not advertise, nor does he self-promote, yet he'd like to help dentists and is available for assistance and consultation. Like Dr. Howard Farran, he's passionate; in Reid's case, about the follies of dental management and finance in the U.S. I recently traveled to Naperville, Illinois, to view this fervent devotee of proper dental systems. His organization is elegant and non-distracted. Herein, is an overview summary of the voluminous examples Dr. Reid provides supporting his 43 percent overhead fundamentals.

For more detail, a YouTube video is available at www.youtube/_DoerMyHudE. Alternatively, search "Doug Carlsen Channel" at YouTube.com or view the video in the comments section of this article on the online *Dentaltown Magazine* October edition.

Dick, you have a lot to say about conventional financial wisdom purported in the dental media. Please comment.

Reid: First of all, we know that general dentists' overhead averages about 65 percent, with some dentists more than 80 percent. Consultants struggle to get dentists below 60 percent. This is crazy! With proper planning at an early age, 50 percent or below is not only feasible, but desirable. We, as a profession, have bought into the idea that more than 60 percent overhead is normal. I totally disagree. Runaway overhead has been the elephant in the room since the 1980s, creating a great amount of stress for us all.

I get so tired of being compared to the $1.3-1.5 million practice. I represent the average dentist who produces $700,000 per year. In all my reading over the years, I find dentists so overwhelmed with the daily work that they don't take the time to pay attention to the business of dentistry. If one doesn't, he or she is destined to work longer, save less and have a lower standard of living in retirement. In this economy, it's imperative that dentists spend money wisely, especially involving large capital expenditures.

What is your life and practice philosophy?

Reid: First, I have strong faith in God and pray daily. It's important to realize that the spiritual side of one's life, no matter what your faith or beliefs, is vital.

I'm into common-sense business fundamentals. "Please" and "thank you" work wonders. We greet patients with a smile and say hello the second they enter the office.

Honesty and integrity are paramount. Remember, you are selling yourself every minute of every day.

We project a happy atmosphere. I personally thank every patient every visit and tell him or her I'm glad to see them. If we're running late, we apologize. We pay attention to office décor, music selection and cleanliness. Our staff relates well.

It's important to know your office financial specifics. You and I talked about many dentists who have real fear about finances. Having a firm grasp on day-to-day costs and receipts is critical.

Also, please realize that you cannot divorce your business life from your personal spending habits. Personal spending can ruin one's ability to save.

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Tell us specifics about your office.

Reid: Our average gross from 1997 to 2011 has been $719,000 with average net over $410,000.[1]

I've had one three-operatory office during my career. Relocation costs of anywhere from $150,000 for a very small office to more than $500,000 for a medium or larger office would have severely curtailed my ability to save over the last 20 years. Once I had my original loan paid, I was able to save more than 20 percent of my net income per year.

Our fees are in the 80th to 90th percentile, reflecting our great service. We pay higher-than-average lab fees, and consequently rarely have remakes – $175 for porcelain, $200 for e.max.

I do not own a CEREC or lasers.

Financially, I conduct all business with a handshake and a smile. We don't have signed treatment plan contracts and never will. We do not have extensive treatment plans; I have a basic "bread-and-butter" practice. I tell patients what they need and we get 95-percent acceptance with a soft-sell approach.

My staff members are hardworking, efficient and caring. My hygienists' and office manager's salaries are appropriate for the area. I do not provide medical benefits; yet have always provided fully funded profit sharing/401(k) benefits. We have one office manager; we don't need that extra "helper."

Hygiene production should be three-times their salary and hygiene has always produced more than 33 percent of my total production.

Our overall accounts receivable is three weeks production. We do all collections in-house.

We have a healthy recall system and fill any holes in the schedule quickly.

We spend zero dollars on advertising.

Our expenses for office and dental supplies, rent and lab bills are much lower than the average office as a percentage of gross. We do not keep a large inventory of supplies and all office and dental equipment is maintained on a regular schedule.

I don't own my space and never wanted to. I've heard several anecdotal stories of runaway costs associated with office build-outs. I'm currently very happy I made that decision, as there is a very small market for practices selling in excess of $1 million in this economy.

Please detail how you monitor the practice's finances.

Reid: The dentist needs to check office receipts and billing procedures daily. This takes very little time once initiated. Any large equipment purchase should be thoroughly evaluated by a third party before purchase.

Have an office expense appraisal done by a competent professional. This is imperative. Next, know your office statistics: especially salaries, lab costs, and office and dental supplies.

Please comment on your retirement savings system.

Reid: I never wanted to work past age 55 (poor market performance has added three more years), so I knew early on that it was essential to save a lot of money in order to retire before 60. I created a plan in my 30s to accomplish that goal.

It is important to accelerate savings from age 50 on (with the government helping to defer more) and to add your spouse to the payroll, if possible, maximizing salary reduction tax savings.[2]

One needs to have a retirement number in mind as early on as possible and a plan on how to make it happen. I invest with Vanguard funds and rebalance annually.

But it all comes down to personal spending. It's imperative to know where your spending goes and how it relates to your savings.

Finally, please comment on debt.

Reid: I never had a home mortgage that was greater than my net income. Also, I'm a firm believer in Brian Hufford's goal of 20 percent savings per year and that debt should never be high enough to inhibit 20 percent savings. As Hufford indicates, your financial health will be hurt if your personal or business debt is too high.

Please note that Dr. Reid does not live a spendthrift existence. He has a large home in an upscale neighborhood, owns a condo in Chicago and drives luxury autos.

Dr. Reid can be contacted at 630-800-6191 or mcr2454@hotmail.com for further information and assistance. ■

1. *Carlsen has seen Reid's IRS documents.*
2. *Reid's total state, federal and self-employment taxes for 2011 were 28 percent.*

Author's Bio

Dr. Douglas Carlsen has delivered independent financial education to dentists since retiring from his practice in 2004 at age 53. For Dentists' Financial Newsletter, visit www.golichcarlsen.com and find the "newsletter" button at the bottom of the home page.

Additional Carlsen Dentaltown articles are at: www.dentaltown.com. Search "Carlsen." Videos available at: www.youtube.com/user/DrDougCarlsen. Contact Dr. Carlsen at drcarlsen@gmail.com or 760-535-1621.

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DOUBLE and TRIPLE YOUR BUSINESS with PATIENT REFERRALS

by Tom Hopkins

The marketing of your dental services could be baffling to you. After all, your primary course of study involved what to do to preserve the health of your patients' teeth and gums – not marketing, sales or accounting. While I can't help you much with accounting, I *can* assist with sales.

When it comes to growing your business, one of the best ways is through patient referrals. If we compare gathering new business leads to gathering food in the woods, the direct mail pieces most dental practices rely on are like hunting with a shotgun. You fire and hope at least some of the shot hits the

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mark. Getting *referred* leads is more like fishing with a net – a very powerful net. So, it's critical that you and your staff learn and use consistent referral-gathering strategies.

In this article, I'll teach you a simple method for gathering referred leads. It has several steps and they should be used if you want to gain the greatest benefit from it. When you do, it will offer you so much more success in developing your referral business that you will gladly make it an automatic part of every patient contact.

Before we begin, set a goal for how many referrals you think you can reasonably expect from each patient. If asking for referrals is truly a new concept for you, begin with a goal of just one referral from each patient, and work your way up to a place where you know the steps so well and they flow so naturally that you'll get at least three referrals from every patient. Even if you get only one referral from each patient, you have the potential to double your business. Isn't that exciting?

Read through the following steps. Please don't balk at them on your first read-through. Just read the rest of the article to understand the method to my madness. This system works. It has worked for my own dentist as well as in hundreds of other professions. Memorize the steps. Once you have them memorized, start using them. The better you know the steps, the better you'll mine the rich lode of referrals that's just waiting for you in your current base of patients.

After you've mastered the steps, teach them to your staff. Let them know how it felt when you first started using them. Then, tell them about the results you started getting (if they haven't noticed already). Encourage them to use the steps as well. They can be included as a natural part of any conversation with patients.

Steps:

1. Listen when your patients talk about their families and their lives in general.
2. After you've served their needs, bring up the different groups of people they've mentioned – family members, soccer teams, volunteer groups, and so on.
3. Ask your patients who in these groups might enjoy the same benefits the patient has.
4. Ask why that person in particular came to mind.
5. Ask for that person's contact information.
6. Ask the patient to call and introduce you to the referral.
7. If the patient shows nervousness or refuses to call, ask if you can use the patient's name when you contact the referral.

Those are the basic steps. Now, let's review them in detail so you'll see how to use each one most effectively.

Step 1: Listen when your patients talk.

I know your patients don't get much time to talk when you're working in their mouths, but you do chat with them before and after completing their examinations and dental work. Use that time to learn more about their lives – not just what's going on in their mouths. Ask open-ended questions. They begin with who, what, when, where, why and how.

- Who do you spend your time with most?
- What are your favorite hobbies?
- When will you go out to dinner next?
- Where are you headed after this?
- Why did you choose our office to take care of your dental needs?
- How will you spend your next vacation?

Those are just a few quick examples. I'm certain you can come up with more. The goal of the questions is to get your patients talking about who they know. Their hobbies might cause them to be involved with clubs. They might dine with friends or relatives. Or, they might be part of a club where luncheons and dinners are common occurrences. They might be headed out to a volunteer opportu-

nity after having their teeth cleaned. Vacations are often spent with family members or close friends.

Be careful not to use all of the questions during a single visit with patients. They would probably get the feeling that you're grilling them. Practice being casual with the questions and speaking naturally. For example, you might ask a question this way, "Mary, you certainly seem like a very sociable person. I'm curious. How do you spend your free time?" With some people you will need to be prepared with another question to gain control of the conversation. As you probably know, some folks will tell you their life stories if you open that door. Keep in mind that your goal is to not only get to know your patients better, but to learn who they know and can refer to you.

Step 2: Bring up the groups of people they know.

Most business people, when asked how they do with getting referrals, shrug their shoulders and say, "Only OK. I ask but don't get many. So, I stop asking." That's because they are not using the right approach. Never say: "Who else do you know that might like to come to us?" because 90 percent of the time the reply will be, "No one comes to mind." That's because you didn't help them "see" the people they know in their mind's eye. You gave them their whole world to consider.

When you ask for referrals, you have to give your patient a group of faces to focus on. You do it like this: "Jane, you're all set for today. Thank you for coming in. What's next on your agenda?" Now, Jane will think very specifically of her next stop – work, school, visiting a friend or relative, whatever. Those people will literally pop right into her mind. Now that you know where your "catch" is, use your net to gather them in.

You would then steer the conversation to getting a name, or two or three. "It sounds like you have a busy day ahead. Thank you, again for fitting us in. I hope you enjoy your quilt club meeting. By the way, who comes to mind in that group who might enjoy the convenience of our early hours like you do?"

You would, of course, mention the benefit that each patient enjoys most about your practice: convenient location, hours of operation, efficiency of your staff (little or no wait time), nice environment, pain-free, excellent work, great people, whatever. You'll never get referrals if you don't ask. And you'll increase your chances of getting referral business by asking the right way.

Step 3: Make note of the names.

When your patient comes up with the name of someone who might benefit from your service, make a note of the name and how the patient knows him or her. "Carol Statler – Jane Parson's quilt club." (Be sure to ask how to spell the names of the referred people.)

Step 4: Ask qualifying questions.

You want to learn what the patient knows about these people as it relates to your solicitation for their services. The basics of qualifying include finding out what part of town they live in; if they have a dentist now; if they are happy with that dentist's services or have mentioned making a change; and what benefit they would prefer in a dentist. While Jane is busy answering questions about the referrals, jot down notes to help you remember specific things about them.

> *"Even if you get only one referral from each patient, you have the potential to double your business."*

People know things about each other that they might not even be aware of until they're asked. Jane might have mentioned to Carol in passing at their last meeting that she would be having her teeth cleaned prior to the next meeting. Carol, in turn, might have said, "Good for you. I hate going to the dentist; too painful of an experience for me. See you next week." And that could have been the extent of the conversation. Jane would probably never remember it – until you ask what brought Carol to mind. Now, Jane cues right back to that conversation and has good information to share with you. All you did was ask for it.

When you get in touch with the referrals, you'll be able to address your letters or begin conversations with them based on Jane's answers to your questions. When you've taken a few notes, move on to the next step.

Step 5: Ask for contact information.

The information you require will depend on your marketing campaigns. If your staff members call people, you will want phone numbers. And, of course you will have to check those numbers against the Do Not Call Registry. The better move is to get an address and send a letter. If the patient is referring a relative or close friend, they'll probably know the address. Ask them to jot it down for you. If they open an address book or the contact list

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in their phone, this is an excellent opportunity to increase the number of referrals you get from one to many. Try this: "Jane, during our conversations, you've mentioned all the things you're involved in. I notice that you keep track of them in an address book/contact list. You wouldn't mind taking a quick moment to run through your list to see if anyone else comes to mind, would you?"

If you've never asked for referrals in the past, this might seem a little pushy to you. I encourage you to just memorize that line and use it as naturally as possible. Make a commitment to try it a minimum of five times. You can do that in a single day. I believe you will be pleasantly surprised at how helpful people will be when asked properly. I know of sales professionals who have received upward of 30 referrals from a single client with that method. No one was offended. No one felt pushed. A simple request was made. The answer might be "no" and that's OK. In most cases, "no" just means "not now." It could just be poor timing for your patient to do that now. Ask again the next time you see her.

Step 6: Ask your patient to call the referral and set up the appointment.

If the last step created some hesitation, this one is bound to make you want to put the brakes on, but please, bear with me. This step is where most novices balk. They won't even try it. But those patients who will make the call will help you comply with the Do Not Call Registry. If the referral's name is on that list, you can't call them without their permission. Your existing patient can at the very least get that permission for you.

Also, keep in mind that this question is simply setting the stage for the final step. Those patients who are uncomfortable calling for you will be so relieved when you offer them step 7 that they'll jump on it. If you had gone directly from step 5 to step 7, you might not have received the same response. Here's how it works: "Thanks so much for the referral, Jane. You know, since I don't get to go with you to the quilt club to meet your friend, would you mind calling her and telling her why you are a satisfied patient of ours and asking permission for us to contact her? Then we can work on arranging a time for me to talk with her."

If your patients are fine with that, then good, start dialing. But if they hesitate and act uncomfortable, take the pressure off immediately by moving on to the next step.

Step 7: Ask to use the patient's name when you make contact with the referral.

Your patients might not know the referral all that well, or they might feel uncomfortable making the call. If this is the case, let them know you understand their hesitation, but ask if you could bother them for one more favor. Ask for permission to use their names when you contact the people they referred to you. They'll probably be relieved to be let off the hot seat and be more than happy to give you permission to use their name.

Those are the steps for getting referrals. Never let patients leave your office empty-handed. Don't just give them a toothbrush. Give them three of your business cards and ask them to give them to others who come to mind before you see them again. If you have your staff conduct follow-up calls on patient services, ask them to ask patients who they gave their cards to. Once again, help them focus on small groups of people they know and ask qualifying questions as to the needs those people might have. If they haven't given the cards to anyone yet, thank them for their business anyway and repeat your request on their next visit.

It might take you a few tries to get this pattern down to where it flows naturally. However, it'll become a natural part of every contact once you see the phenomenal results it generates. Many of my students have gone from getting one or two referrals from five or more patients to getting five referrals from *every* patient. Don't you think it's worth a try? ■

Author's Bio

Tom Hopkins is a world-renowned expert and authority on selling and salesmanship. His simple yet powerful strategies have been proven effective in many industries, including the dental industry, and during all types of economic cycles. The foundation of his training includes both the "people skills" of proper communication and the nuances that impact every situation where trying to persuade others. Tom's style of delivery is practical and entertaining – making the strategies easy to remember and implement. Learn more about how Tom Hopkins can help you increase revenues in your practice at www.tomhopkins.com/blog. To reach Tom, please e-mail him at tomhopkins@tomhopkins.com.

Details about Tom's speaking schedule can be found at: www.tomhopkins.com/live_events.shtml.

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XLDent is a dental records software program designed for optimum workflow in a paperless, mobile environment.

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For more than 40 years XLDent has studied the process of new workflow creation for the purpose of designing one of the best electronic dental records software available. XLDent reduces clicks, screens and key strokes to save time, and offers the most efficient workflows for both clinical and administrative staff. Most competing dental charting systems today were designed around a paper environment, yet claim to be "paperless." Doctors call XLDent every day frustrated by this false promise. Often the design of those systems was based on the appointment book, and the chart was an afterthought. Not so with XLDent! You will find XLDent to be a comprehensive paperless dental records solution. XLDent is designed around the chart, which creates an ideal workflow for the clinical staff. Because the origination point of the dental record is the chart, XLDent's design also creates a better workflow for the administrative staff. Input is done right the first time – in real time – from the treatment room. No double entry or duplication of tasks.

Designed to be Paperless First

Since most competing dental software systems were not designed with real-time digital workflow in mind, attempting to go totally paperless can be clumsy because inevitably some paper still remains. With XLDent, offices find the transition to be very easy because data capture, storage and retrieval of all information is digitized in real time. Users say that XLDent has a commonsense approach to going paperless that is easy to understand and use. Once the staff begins to see the time savings and reduction in repetitive tasks, they embrace the paperless design of XLDent with great enthusiasm. That enthusiasm quickly turns into improved patient outcomes as a result of the team's real-time use of the electronic dental health record.

Mobility Augments Workflow and Improves Patient Experiences

XLDent is the first dental software suite to run in a mobile, tablet PC environment. Mobile tablets improve workflow because clinicians can bring the technology to the patient, not the other way around. Instant access to information provides doctors with clinical decision support. It also allows them to present needed treatment chairside, in a visual format that is easy for patients to understand. Mobile tablets allow doctors to engage patients in their treatment and facilitates formation of a stronger patient/doctor relationship. This helps increase treatment acceptance. ■

Company Contact

For more information on XLDent, visit www.xldent.com or call 800-328-2925.

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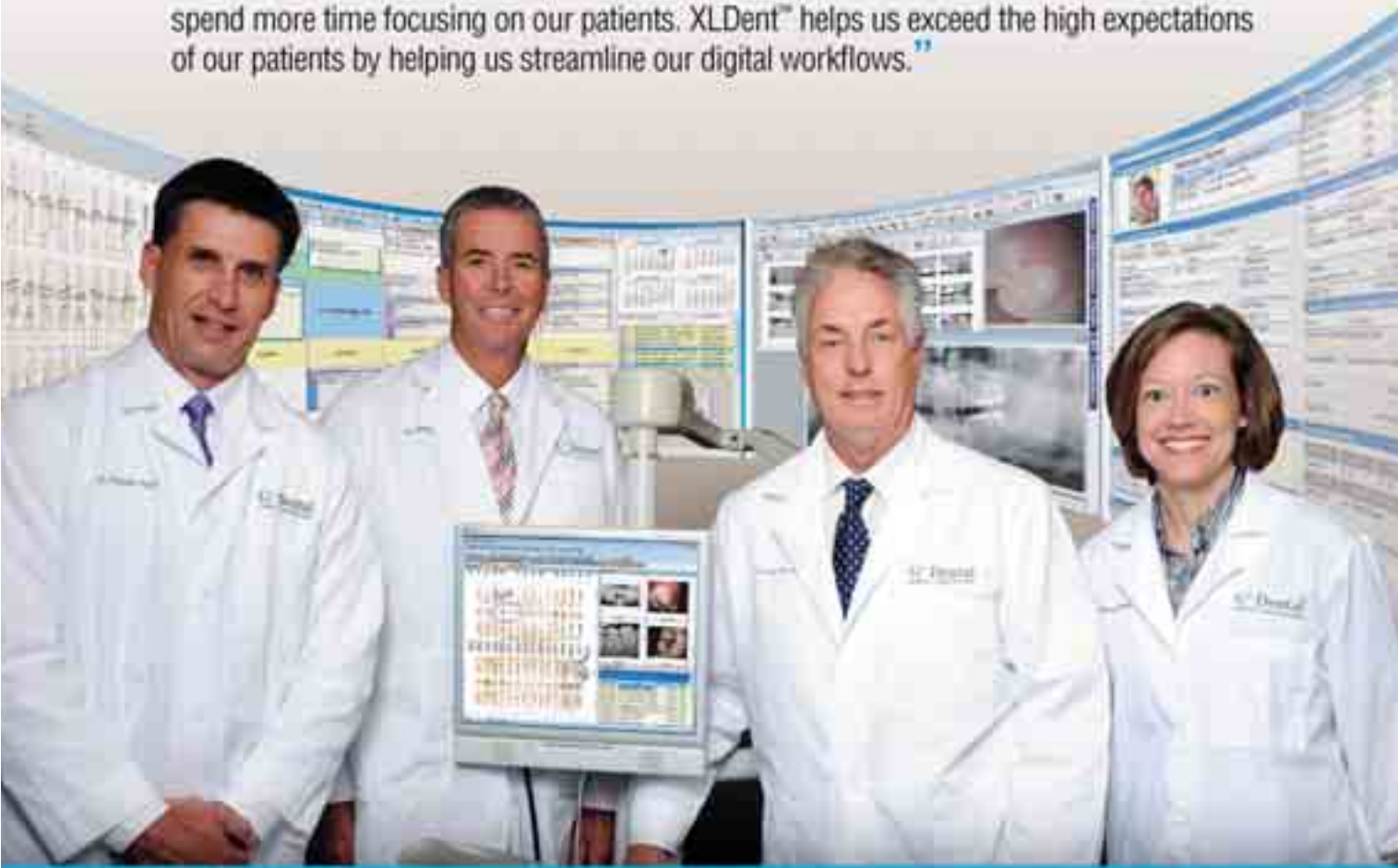

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The Top 10 Mistakes in Building a Dental Web Site (and How to Avoid Them)

by Boris Kurbanov

How important is it to have an appealing Web site? According to comScore, a digital analytics company, more than 139.1 million consumers utilize the Internet to seek health-care information from health-care sites on a monthly basis. Remember, even prospective patients who hear about you from family or friends are still likely to check out your practice Web site before making the decision to book an appointment. So, in this day and age, when most, if not all, of your competitors have a Web site, how does your practice stand out? Your prospective patients are online. Once they find your Web site, what will make them choose you?

Your Web site is your best opportunity – outside of a face-to-face discussion with a patient – to communicate what you and your staff value, and what makes your practice unique. Building a Web site that is primarily focused on patient needs, is user-friendly and is search engine-optimized can be challenging. It starts by asking yourself the following: "What will prospective patients look for when they visit my site, and what elements could potentially turn them away?" To help answer that question, here are the top 10 mistakes to avoid when building a dental Web site.

1. Irrelevant Content

What makes new patients browse your Web site in the first place? They visit to learn about the treatments you offer, as well as learn more about you as a doctor and your practice, not to learn about your hobbies or things that are unrelated to the dental industry. Dental health is a great topic to discuss, but

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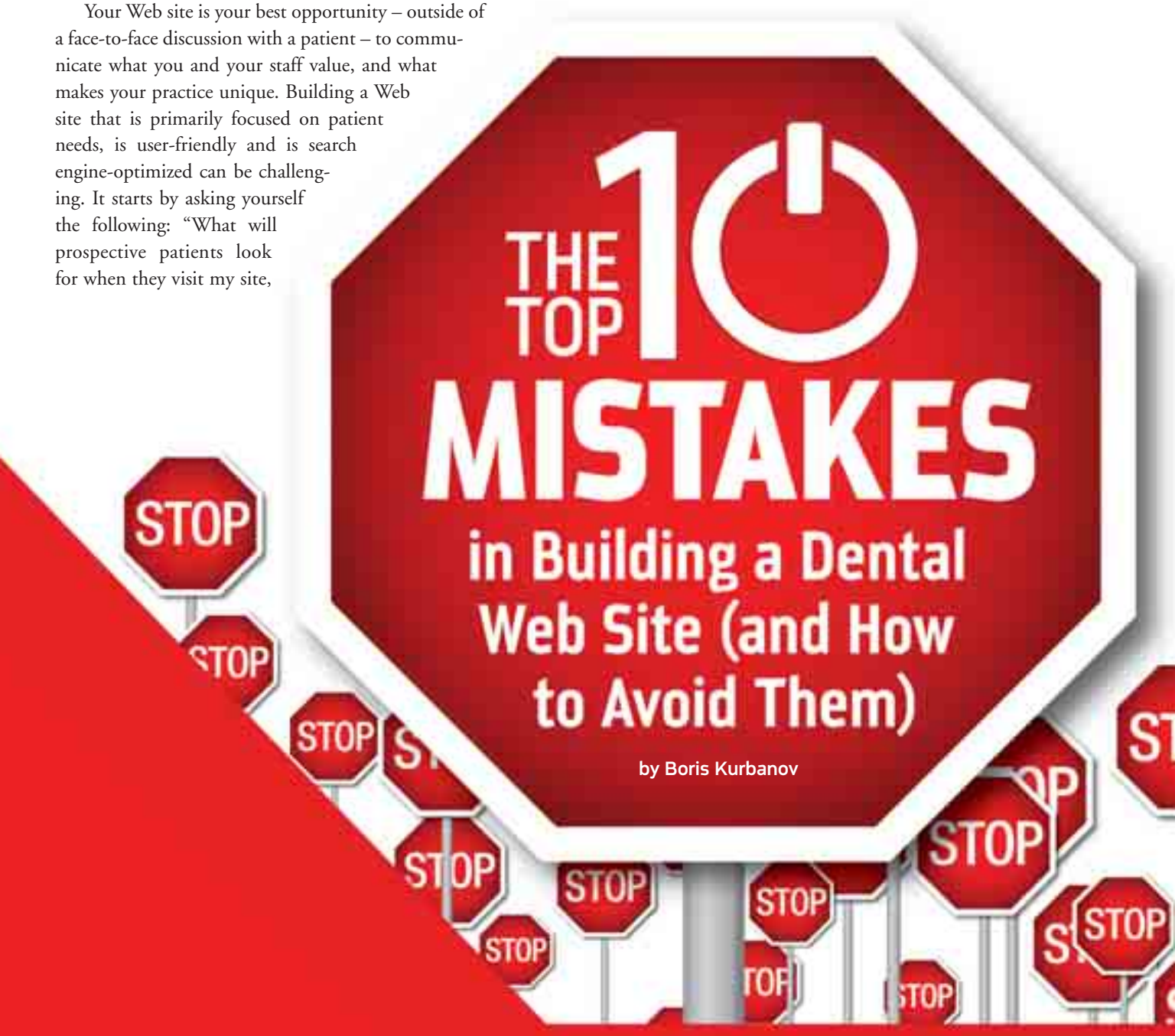

Because I Am A TOWNIE

Name: **Richard Chi**
Townie Name: **richardchidds**
Member Since: **07/30/2008**
Occupation: **General Dentist**
Location: **Chicago, IL**

I went to my first-ever Townie Meeting in Las Vegas because I'm a Townie! When I renewed my subscription to *Dentaltown Magazine* at the Chicago Midwinter Dental Meeting I won a trip to the best party in dentistry. Now, after being a part of the education, entertainment and camaraderie of the Townie Meeting, I can't wait to come back.

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remember not to get carried away with general health topics as that might cause people to tune out.

Think about it this way: You have less than 90 seconds to engage prospective patients and persuade them to further explore your site. Having more than 25 pages on your Web site can be overwhelming for prospective patients.

The content on your Web site should emphasize how much you and your staff care about your patients and their families' well-being. A positive attitude such as, "I love my patients!" or "We love our community!" can go a long way in building trust with patients. Having text that accentuates your warm, caring feelings toward patients or listing your continuing education credentials and how they benefit the patient in a compelling manner are all-powerful. Mobile Web sites with condensed versions of this content also present a short and sweet version of this important content. Lastly, reinforcing how much you love your job as a dental professional is part of conveying how much your practice cares about patient wellbeing and the premium your staff place on high-quality care and a positive patient experience.

The pages you *should* have on your Web site include "meet the doctor" and "meet the staff" pages, information on what to expect during a patient's first visit, before and after photos, frequently asked questions, financial information and directions to your office.

2. Impersonal Doctor and Team Member Bios

Patients love getting to know their doctor, and spend a lot of time finding out "who you are." When getting ready to compile photos and bios for your staff, think about someone who has never stepped foot in your office, or perhaps feels nervous about visiting a dental professional. Most patients are typically not eager to visit a health-care practitioner. Your bio gives you a chance to show them, not just tell them. A photograph of you with a family member, child or pet can reinforce your commitment to treating not just the patient, but the patient's entire family as well. Instead of merely listing credentials and using medical terminology, tell patients in easy-to-understand terms what your credentials, experience and continuing education means for them and their family.

Doctors also love individual photos because they are easy to update (they don't require re-taking group photos) and are more personal than group photos; just add a new photo or swap one out. Simple.

3. Clinical Photos and Images

In other words, less photos of a hygienist reaching into a patient's mouth… Tools, scrubs, blood or masks might scare off someone who is already apprehensive about visiting a dentist. When choosing photos for your bio, it's important to keep it personal, but not too personal. Since patients will be spending one-on-one time with your staff, they like to see who they will be working with – they want to "pre-meet" you and your team before booking their initial visit.

Including happy, cheery photos of confident people throughout the site, and especially on the home page, underscores the office's warmth and approachability while helping your patients relate to you. In fact, featuring actual patients or photos that feature people who look like your patients, gives a personal, unique touch. Photos of actual patients not only show off your work, but also show a strong relationship between you, your patients and the community. Warmth always wins!

4. Buried Contact Information

Imagine visiting a Web site and being unable to find the phone number or other contact information. Remember, the name of the game is to get patients to call you. Make sure your office's contact information is readily available for new patients to be able to book that first appointment. Put it this way: If you're visiting a Web site for the first time and are interested in its products or services, you'd probably want a phone number prominently displayed on the homepage and throughout the site, right? Research shows patients are more likely to call rather than e-mail to schedule their first appointment or consultation, and they're more likely to do so if they find the information they're looking for on your Web site. And what's more helpful and convenient than having the number available to them displayed at every click? Another option is a mobile Web site with a phone number and map to your office readily available.

5. Lack of a Call to Action

Once a prospective patient reaches your Web site, it's up to you to compel them to learn more about your office and pick up the phone to schedule an appointment. Adding a "free consult" or "schedule your regular checkup" button on your homepage or one that is prominently displayed within your Web site compels patients to make that first move. If your office targets the working demographic or a particular area, a button that reads "We're in the heart of Manhattan!" might also be a good idea.

Again, the point of your Web site, besides your virtual introduction to a potential patient, is new patient acquisition. *It's all about the patient.* Avoid sounding "salesy" or gimmicky with text such as "Purchase one tooth whitening, get the second free!"

6. Splash Pages and Animated Introductions

Splash pages, or the pages the user sees before they actually visit your Web site, are typically built in flash (an outdated animation platform) and offer some kind of introductory animation. Not only are splash pages outdated, they are also terrible for your Web site's search engine optimization (SEO). Search engines such as Google, Bing and Yahoo look at the content on the homepage to determine what the site has to offer. If your page is designed entirely in flash or includes other animated introductions, chances are search engines will not be able to spider, or crawl, any text on it.

The bigger problem, however, with splash pages, sometimes called landing pages – or any kind of animated introductions –

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is distraction. In this day and age, people are looking to save as much time as possible. Remember, most visitors to your site want to be informed, not entertained; they are looking to solve a problem like crooked teeth or schedule an appointment to relieve tooth pain. Any animation on your site is a major barrier to getting people to pick up the phone and call. A simple distraction like a splash page can turn a potential patient into a mere passerby.

7. Music

Again: distractions, distractions, distractions. Prospective patients might want to visit your site privately, without anyone else being within earshot of your Web site's music, such as at work or at a local Starbucks. So, unless you sell music, it's best to stay clear of music on auto play. If music, which makes your Web site look dated, absolutely *must* be present, give viewers the option to opt-in. In other words, give visitors the option to turn the music on manually. But, by default, keep the music off.

8. Thematic Web sites

Patients visit your Web site to learn more about dentistry, so your marine- or golf-themed Web site might not necessarily appeal to a mom in search of a dentist for her pre-teen daughter. No matter what, all content must be patient-focused and appealing to women. After all, marketing research tells us that women make the majority of health-care decisions in their households.

What you should be focusing on are teeth, not your hobbies. Besides being confusing and looking out of place, your themed Web site might also inadvertently cause a potential patient to scratch their heads and ask, "Am I paying for his ski trips?"

9. Broken Pages and Bad Links

There's no way for patients to imagine what you might have said about a service you offer or a current promotion. Broken links, or dead links, provide a bad experience for anyone visiting your site. Search engines tend to send visitors to sites they know are maintained and trustworthy before sending them to a site that hasn't been maintained in months.

Bad links or pages that are labeled "under construction" or "coming soon" not only prevent potential patients from accessing pages on your Web site, they might also annoy them to the point of moving on to a competitor's site. Missing and broken links also send a bad message to prospective patients: If you can't take good care of your Web site, why should people believe you can take good care of their teeth?

10. Slow-loading Web Pages

Because Google wants to provide a positive experience for its users, the search engine will try to send users to Web sites that load quickly. Currently it's a moderate ranking factor, but Google and Bing have both declared that this will be a metric they will be placing more focus on with each update.

Again, anyone who is visiting your site will want to find what they're looking for pretty quickly. Avoid any distracting elements, such as pop-ups, at all costs. In fact, avoid pop-unders as well. These days, popular browsers like Firefox block pop-ups by default, but when in doubt, remember: pop-ups are dead. Patient-appealing elements include having a clean, modern design with alluring graphics, clear and consistent navigation, as well as easy-to-find contact information.

Conclusion

Avoiding these 10 mistakes will help you design a successful Web site – one that helps you better connect with current patients, reach new patients and stay relevant on search engines. It is essential, however, that you continue to monitor and maintain your Web site to better connect with patients. In fact, by steering clear of the aforementioned mistakes, your Web site might even act as its own independent team member.

Sesame Communications recently launched Website Evaluator, a free online tool designed to help dentists, in a matter of minutes, determine the overall effectiveness of their website. This tool provides practices with general guidance and a customized report showing their website score, along with specific recommendations for improvement.

Visit: sesamecommunications.com/web_eval ■

Author's Bio

Boris Kurbanov is a published, award-winning author and digital marketing expert who has worked with hundreds of dental practices to increase their online exposure. Boris is a graduate of Western Washington University with a degree in journalism.

Best Practices for Online Reviews

by Jason T. Lipscomb, DDS

Like it or not, we live in a world of reviews. The online review process has brought democratization to a new level. Anyone with a computer or smart phone can review just about anything. Reviews have even gone viral. This whole review process has not gone unnoticed by the dental community. Online reviews have driven some dental practices to great success, while others have succumbed to the wrath of negative reviews. Success or not, online reviews will affect your practice.

In my practice, I have stopped using most conventional marketing. Studies have increasingly shown that the yellow phone book and display ads are on their way out.[1] It is just too convenient for those with smartphones to find what they want quickly. Studies have also shown that people are seeking recommendations from the masses instead of what is fed to them.[2] An online listing with multiple reviews from real people will carry much more weight than a phonebook ad with no real-world recommendations.

1. *http://www.emarketer.com/Article.aspx?R=1008462&dsNav=Rpp:25,Ro:3,N:800*
2. *http://www.marketingcharts.com/interactive/most-consumers-read-and-rely-on-online-reviews-companies-must-adjust-2234/deloitte-consumer-review-purchase-influencejpg/*

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Tracking Your Reputation

by Fred Joyal

Tracking your reputation should be a daily part of your practice. The fact is, there are hundreds of Web sites that could potentially be displaying information or reviews about your practice, and these generally fall into three categories: directory sites, review sites and social media. All of these contribute to your SEO, and a few key sites are widely used by Internet-savvy consumers to assess your business.

I rank them in this order of gravity and impact: At the top, Google and Yelp have almost equal weight; Facebook is the next tier down (your business page, not your personal profile, which search engines can't see); then significantly below that are Twitter, CitySearch, Dr. Oogle, LinkedIn and Angie's List, as well as several others that operate more locally.

When it comes to negative reviews, I recommend you always respond online. As the business owner, you can do that. But don't be defensive; take the tack of being concerned, apologetic, and whenever possible, add positive information about your practice. And you should also respond to positive reviews. Don't just leave them without a comment from you. Thank the reviewer, express your appreciation for the nice comments about you, and be personal. Consumers will read these and see you as someone dialed in to the pulse of your practice, and they will find that appealing.

My company 1-800-Dentist recently launched a tool that simplifies the monitoring process for you. It's called ReputationMonitor, and for a low monthly cost it looks everywhere on the Internet for listings, comments and reviews about your practice, and puts them all into a simple dashboard, so that in five or 10 minutes a day you can stay current with what the online word is on you. For more info, call 855-225-5231 or visit www.1800dentist.com/rm.

ReputationMonitor.

The truth is, even a review from a person you hardly know will influence your decision-making. This is truly the online age and we are all susceptible to a groupthink attitude. It takes a village to influence your spending and decision-making habits.

For those of you who don't know, reviews can be found all over the Web. When we formed our company, Social Media for Dentists (http://www.facebook.com/socialmediadentist) back in 2009, we could see the writing was on the wall. Consumers were looking for recommendations from many places on the Web. They were talking to their friends on Facebook, closely studying reviews on Google, and logging their favorite places on Yelp. Their experiences were becoming a virtual cascade of recommendations. If you think that you don't have reviews or mentions of your business online, you are sadly mistaken. I encourage all dentists to take a look around online and do a Google search on yourself. You might be surprised what you find!

Best Practices for Online Reviews

1. It is imperative that you institute an online review process in your office. This needs to be an everyday part of how you do business. Not having a body of reviews can mean that you are partly invisible online. You have to be found online in this day and age. A simple listing in the phonebook just won't cut it anymore. More and more consumers are looking to listings and reviews on sites like Google. These listings are now translating into consumers finding you on their smartphones. Did you know that the new Apple voice automation system, Siri, pulls listings from Yelp? You have probably seen the commercials many times, and if users ask Siri to find a dentist, they will probably see the dentist on Yelp with the most reviews.

Many workplaces block access to a lot of the Internet, so workers are pulling out their smartphones to find local businesses online. Will they be able to find your dental office? If they do, will you have the reviews to influence their decision?

2. The review process must be easy. It is much easier to get a bad review than it is to gain a good one. Sites like Google, Yelp and Citysearch try to make the review process an easy one, but the potential reviewer will still face some roadblocks. Google requires you to have a Google account to leave a review. The simple process of setting up an account may deter many people from leaving a review, unless they are angry or dissatisfied. The old adage goes that a person who is dissatisfied will tell dozens of people about bad service, while a happy customer might only tell a few. This is definitely true on the Internet. People who are angry with you will stop at nothing to leave a bad review. They will sign up for multiple accounts just to tell you off. So if you think implementing a system of reviews in your office will only lead to bad reviews, well, you already have that system in place.

Making the process easier for your patients will ultimately make it simpler to gather good reviews. I use a system called Demandforce in my office. It integrates with my practice software and automates the review process, making it easy for the patient to leave reviews. I have been able to gather more than 500 positive reviews since implementing this software because it removes the roadblocks. I have recently found some great iPad and iPhone apps that make the review process quite easy. (E-mail me to find out some of my secrets!) You work hard to create a following on Facebook, why not allow them to help you build up a healthy amount of great reviews?

3. Your reviews can help your Google ranking. Now, your Google rank comes from hundreds of factors. The local portion often derives strength from citations. Citations are any mention of your name, address and phone number (NAP). The more mentions of your NAP across the Web, the more positive influence on your rank. Reviews are often considered a part of your citation count, therefore more reviews equal more citations. This is a very simplified version of what actually happens, but a good body of reviews can help!

4. The best way to overcome bad reviews is to overcome them with good reviews. Your reviews are your online reputation. If someone finds you online and you only have two negative reviews, then that is your reputation. You look bad. Now if someone finds you online and you have 50 positive reviews and 2 bad reviews, you look pretty good. Imagine that you are buying a TV on BestBuy.com. You are shopping around for the best deal and perusing the reviews. Do any of those TVs have all positive reviews? Probably not. Would a TV with 200 positive reviews and 20 bad reviews deter you from buying that TV? Probably not. As rational adults, we know that not everyone is perfect and we also know that we cannot please 100 percent of the population all the time. The same goes for a dental practice.

Having a large body of reviews is the best online insurance policy you can have. Even the best dentist in the world will probably get a bad review from time to time; just don't let it be your only entry for your online reputation.

There have been recent studies that show a peppering of negative reviews can give an air of authenticity.[3] Much of the population is becoming more Internet savvy and they are starting to learn how to spot a fake. Too many positive reviews can sometimes come off fake. So if I get a bad review every once in a while about "waiting too long," or "Dr. Lipscomb is losing his hair," I don't worry about it. It will make me look like the real person that I am.

5. Reviews have to be real! Many of you are probably thinking, "Hey, I can write my own reviews." Don't do it! There have been several cases where doctors have been caught writing their own fake reviews on Google and facing the consequences.[4] The consequences can range from fines, dental board discipline or even convictions of fraud. Just don't do it! Reviews are important, but they are not worth damaging your business over.

Be wary of SEO companies that leave fake reviews on your behalf. You will still be ultimately responsible for those reviews and might be removed from Google permanently! Simply find your reviews on Google and click on the reviewers screen name. If they have reviewed five dentists in one day, often in different states, they are likely fake. Don't ever think that you will sneak something past Google.

6. Learn the terms of service for encouraging reviews. Many sites that collect reviews, like Yelp, prohibit you from incentivizing reviews. In other words, they don't allow you to pay or gift your way into getting reviews. Paying for reviews can lead to the same consequences as writing fake reviews.

"I encourage all dentists to take a look around online and do a Google search on yourself. You might be surprised what you find!"

3. *http://www.clickz.com/clickz/column/1725342/reasons-not-fear-negative-reviews*
4. *http://paidcontent.org/2011/03/17/419-ftc-fines-company-for-bogus-online-reviews/*

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7. One of the newest trends in dental reviews is "owning" the online reviews from your patients. Some companies offer services that will have your patients sign disclosure agreements saying that you own any of their online reviews. Anything negative said about your business will result in some legal action. Some legal experts say that many of these cases are unenforceable and may violate free speech.

Like I said before, reviews should be authentic. They gain their power by utilizing free speech in order to shed a positive light on your business. Think about the image you are projecting when you have a patient sign away the right to review your business. I have spoken to several attorneys and successfully battling online malfeasance is an expensive and often unsuccessful task.[5]

8. Dealing with bad reviews can be a tricky task. My favorite method is to create a nice body of positive reviews and let them do the fighting for me. Legal action should always be a last resort. Always consider the placement of the bad review. Can anyone see it in the first place? There have been many cases where a single negative review that probably would have disappeared into the ether was given power by the person being reviewed. Overreacting to a bad review can sometimes give it more visibility than it actually had in the first place.

Try to turn around a bad review by reacting in person. Solve the problem over the phone and you might be surprised what happens. I have seen many reviews where the person reacted by calling the reviewer and making it right. Sometimes the reviewer removed the review or added an addendum praising the business for their prompt response. That looks very appealing to the potential patient! Some reviewers just want their voice to be heard.

Vigilance is the next best weapon against bad reviews. You have to know where to find your reviews in order to address them. Set up a free Google alert for your business and your name. This simple alert will send you an e-mail whenever your name is mentioned on the Web. Report a review if it is untrue or slanderous. Google will remove reviews that contain this content.

Think of reviews as a tool for your practice, not a hindrance. They can bring you great success! Help out other small businesses in the area by leaving reviews for them. The goodwill you spread might just return back to you! ■

5. *http://www.cybertriallawyer.com/*

Author's Bio

Dr. Jason T. Lipscomb is a general dentist who operates two practices in Virginia. He specializes in helping dentists expand their practices through the use of social media. Jason started Social Media for Dentists to help dentists master social media and attract new patients by gaining exposure online. To learn more about creating successful social media and Internet marketing strategies for your practice, visit Lipscomb's Web sites, www.socialmediadentist.com or www.lipscombdentist.com, and at @socialmediadent on Twitter.

SonicFill

A testimonial by Dr. Michael Colleran

When I first heard of Kerr's efforts to produce a bulk-fill product that could make posterior composites quick enough to be profitable, yet clinically sound enough to satisfy the clinician and patient, I was skeptical. Other major dental manufacturers have treaded the bulk-fill posterior road, and the resulting solutions were either not popular, too complex or didn't work.

I still have vivid memories of the flowable composites of the 1990s, which looked bad and didn't last. The percentage of fill in those flowables was so low that the carrier resin would wear out very quickly, and frequently require replacing within two years.

Recently, a number of reliable "dental endorsement" in the industry started rating Kerr's bulk-fill solution – the SonicFill system – very highly.

Now, after using the material three months, I've found both the material and the delivery system perform way beyond expectations. Initial clinical appearance of restorations is very similar to a filling that would have taken an additional 10 to 15 minutes to complete using a conventional multi-increment method.

The way I see it, SonicFill offers three big and distinct advantages over conventional composites: initial flowability that enables good marginal adaptation, low shrinkage and depth of cure.

In regard to flowability, the sonic energy emitted from the SonicFill handpiece makes the material flow three times as much as conventional composite. Even though the material is very flowable when extruded with the sonic vibration, it soon stays where you put it. It adapts to the preparation and is soon ready to carve anatomy.

Giving the qualities of excellent depth of cure and low shrinkage to a restoration creates longevity. Kerr was able to achieve both. The depth of cure is very predictable at 5mm and 1.6 percent shrinkage due to an 83 percent filled by weight (most composites are 75 to 70 percent or less).

Aside from the fact that it was a new product, I was also initially hesitant about the cost of getting into the new system since a handpiece is required.

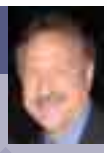
The handpiece is key to the system's success, and is quite a marvel of design and function. The handpiece both extrudes the material and creates the sonic energy, making the material highly flowable. The upfront cost of the handpiece made me hesitate. But in retrospect, it was absolutely worth it. The first time I used it, I was amazed with the effectiveness and speed of this system.

Looking forward, I see an easy payoff of the SonicFill investment in a number of areas, including ease of use and lowering the stress and risk from those monster fills. It's saving between three and 15 minutes or more per procedure. It easily seals margins with no voids.

With SonicFill, I now find that the hardest part of a large filling is the prepping, instead of a difficult, tedious, technique-sensitive restorative material procedure.

SonicFill is easier, better, faster. And that's what it's all about. ■

Author's Bio



Dr. Michael Colleran was raised in Burbank, California, and is a fifth generation Californian. He attended Cal Poly, San Luis Obispo for undergraduate and UOP, in San Francisco for dental school. After graduation he lived in the Sacramento area, practicing in Placerville and Citrus Heights. Wanting to get closer to family, he moved in 2002 to the San Luis Obispo area.

GC FujiCEM 2

Resin Modified Glass Ionomer Luting Cement

Luting cements play an important role in the long-term success of indirect restorations. That is why GC FujiCEM continues to be one of the most trusted dental cements among discerning clinicians with more than 150 million crowns cemented worldwide since 2001.[1] Now, this luting cement is even better! GC America Inc., introduces new GC FujiCEM 2, an advanced resin modified glass ionomer luting cement –with F^2 Flex Fuse technology – to increase bond, flexural and compressive strength in one easy-to-use material.

Resin modified glass ionomer cement is a unique material with unique properties. The two components of this cement are an alumino-fluro-silicate glass, which is the base, and a polyacrilic acid acting as the catalyst. Translucent properties of the glass and adhesive properties derived from the polyacrilic acid form a water-based cement ideal for many types of indirect restorations. The material is a kind of composite resin but is one where the filler takes part in the setting reaction.

In order to achieve optimum results from the material, the clinician should have a basic understanding of the setting reaction of this cement and how to protect it from the oral environment in the early setting stages.

The wide range of chemical diversity of this material presents considerable potential for further development. New GC FujiCEM 2 incorporates a new modified filler-surface treatment to create a strong bond between the glass particles and resin matrix, fusing the cement to the tooth structure and substrate material. Instead of just the conventional monomer, GC FujiCEM 2 also includes a flexible long-chain monomer giving the material its higher flexural strength, which allows it to act like a shock absorber, better resisting occlusal loads.

There are critical elements during any cementation procedure that factor into an overall successful restoration, time being of the utmost importance. GC FujiCEM 2 rules out the need for rubber dam or extra care to control humidity, no need for previous etching and bonding in different steps. Additionally, it has a rubbery consistency for non-messy removal of excess material and extremely easy clean-up.

The physical, chemical and handling properties of glass ionomer luting cement have been greatly improved since the cement was first developed. These improvements, coupled with the cement's compatibility with the pulp, have caused its reputation as a luting cement to take a large step into the future.

Based on resin modified glass ionomer technology, this material boasts the following five key properties:

- **Strong Retention –** Optimal chemical balance for maximum adhesion to tooth structure. The early, high compressive and flexural strength provides the best possible support for your indirect restorations.
- **Sealing Ability and Marginal Integrity –** Superior chemical bonding to tooth structure maintains the marginal seal, minimizing the risk of microleakage and secondary caries.
- **Sustained Fluoride Release –** Designed to protect tooth structure against recurring caries. Like all true glass ionomer cements, the fluoride can be recharged over time.
- **No Post-operative Sensitivity –** Poses no risk of post-op sensitivity for patients because it is non-irritating to tooth structure and surrounding soft tissue.
- **Extremely Thin Film Thickness –** The creamy consistency and low film thickness allow for stress-free seating of restorations. ■

1. *Data on file, GC America. Available at http://www.gcamerica.com/products/operatory/GC_FujiCEM_2.*

JUST WHEN YOU THOUGHT IT COULDN'T GET ANY BETTER

INTRODUCING

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"My office has worked with Lighthouse for well over 10 years and its ability to help us automate our systems has been incredible. Our favorite system is the automated recall system. From the e-mail confirmations, to the text messages and even mailing out postcards – to those not in the 21st century technology world – it has greatly simplified our confirmation process for our staff and decreased our no-shows, meaning greater profitability for our practice." – *Scott Menaker, DDS*

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You Should Know:

Townie Meeting 2013

Wednesday, April 17 to Saturday, April 20, 2013 at the Planet Hollywood in Las Vegas

Being a Townie is more than just having a login name and password on Dentaltown.com, it means being part of a supportive and tight-knit community of other passionate dental professionals. Dentaltown is comprised of hard-working clinicians who – through daily online interaction – help each other become better dentists. And for this group of hard-working dentists, they like to play hard, too. Each year Townies from coast to coast (and even some from abroad) come together for Townie Meeting in Las Vegas – the biggest dental party in the world… with some great CE tossed in.

Like Dentaltown.com, Townie Meeting was started for dentists by dentists. Dr. Sameer Puri ("socalsam"), a West Coast dentist, and Dr. Tarun Argawal ("T-bone"), an East Coast clinician, were in constant conversation on the Dentaltown.com message boards. They gave each other feedback on cases, advice on patients and even shared workout tips. They valued each other's opinions but had never met face to face. Eleven years ago they decided they wanted to meet, and so Townie Meeting was born. Townie Meeting has since grown to be one of the most talked about dental shows each year.

Becoming a part of the camaraderie of Townie Meeting can do wonders for your professional career and confidence. At a meeting built on the dual pillars of learning and community, you will have the chance to network with new and seasoned dentists alike, making friends and mentors for life – so you'll never have to feel like you're practicing alone.

2013 Fee Schedule

	Super Saver Until 10/31/12	Early Bird Until 2/28/13	Regular Until 4/17/13
Dentist	$950	$1,250	$1,550
RDH	$750	$800	$950
Staff, Lab Techs, Assistants, Guests	$450	$550	$750
Dental Students	$450	$450	$550
Social Pass	$225	$225	$250

For more information about the 2013 Townie Meeting, visit TownieMeeting.com. ■

5 Reasons to Go to the Townie Meeting

1. It's in Vegas

It's common knowledge that what happens in Vegas, stays in Vegas. And at the Townie Meeting, *a lot* can happen. Don't be the dentist left in the dark. The 2013 meeting is at Planet Hollywood, where you'll mingle with peers, meet mentors and geek out on dentistry, all with America's playground as your backdrop.

2. You'll See Old Friends and Meet New Ones

Dentaltown thrives because it is much more than just message boards. The community and camaraderie generated online spills onto Las Vegas Boulevard as colleagues who once knew each other only by their Dentaltown display names become friends for life. Townie Meeting is a delightful balance of professional networking and rollicking party!

3. There Are So Many Social Events

Learning is a cornerstone of any conference (especially Townie Meeting), but our event has an equal focus on hobnobbing. A golf tournament, some Texas Hold 'em and the Roaring-'20s-themed opening party – are just a few. Beyond just being social, there are great networking opportunities with Wednesday's Wine and Cheese Reception, an exhibitor's happy hour and a vast array of restaurants and bars to share a drink with colleagues after hours.

4. Attend Top-notch Continuing Education Courses

At the Townie Meeting, you'll find a wide array of continuing education courses from which to choose. The more intimate environment lends itself to a low student-teacher ratio, so CE courses are focused and allow participants the chance to dialogue with the exceptional speakers. For those who would rather soak up a little vitamin D, this year, we're even offering CE courses poolside (talk about laid-back learning).

5. You'll Never Have to Practice Alone

You might be the only doctor in your practice, but Dentaltown gives you the means to never practice alone. With Dentaltown, you're only a stranger once, after that, you're family. Consider Townie Meeting a family reunion you actually want to go to.

The best part is the party never ends. On Dentaltown.com you can interact with the new friends, colleagues and lecturers you met at Townie Meeting. You can connect with professionals who can offer feedback, post cases you need help with or ask questions you might hesitate to ask anywhere else. Upon returning to your office Monday morning with your new community of support, you'll quickly understand what makes Dentaltown different.

The $63,750 Question:

Electronic Health Records

by David Smith, MBA

If 30 percent or more of the total visits to your practice are from Medicaid patients, you are eligible for a total of $63,750 in Medicaid incentive payments (per licensed dentist). Medicaid incentive payments are made over six years with year one at $21,250, and the second through sixth years at $8,500 per year.

And so, you might ask, what is the catch? To qualify, you need to purchase and use a certified electronic health records (EHR) software program that has the ability to demonstrate a standard known as "meaningful use." The Centers for Medicare and Medicaid Services (CMS) created this standard of use requirement to help clinicians implement EHR software in ways that are helpful for private practice and public health quality improvement.

Unfortunately, virtually all of the qualifying EHR systems in today's market are designed to run exclusively in medical offices. This simple fact has made it difficult for dentists to qualify for this government incentive. Fortunately, dental software companies are beginning to take notice. For example, DentiMax is on schedule to have its new dental EHR software certified and available by February 2013. The timing could not be better because most states will have met the Medicaid requirements to make this incentive available to their dentists in 2013.

Steps to Qualify

To qualify for the $63,750 Medicaid incentive, a dental office with sufficient Medicaid visits (again, 30 percent or more) must take the following steps:

1. Each qualifying dentist must adopt a software system that meets a certification standard from an Office of the National Coordinator – Authorized Testing and Certification Body (ONC-ATCB). When you purchase your EHR system, make sure it has this certification. If the software is not "ONC Certified," you won't qualify for the Medicaid incentive payments.
2. Following the acquisition and installation of the EHR software, register for the incentive program on the CMS Meaningful Use Web site (https://ehrincentives.cms.gov/hitech/login.action). After registration for the federal program, you also need to register on the state level. Go to your state Web site and

follow the directions provided there for registration. For a list of state Web sites, see www.cms.gov/apps/files/statecontacts.pdf.

3. After registering on both the federal and state levels, you must provide data that supports the 30 percent Medicaid patient requirement. You must show that, during any 90-day window in the calendar year, at least 30 percent of your patient encounters were patients covered by Medicaid. This population data is typically entered on your state's department of health Web site (www.cms.gov/apps/files/statecontacts.pdf) (Fig. 1).

For each of the second through sixth years, to qualify for the $8,500 yearly payments, you must demonstrate the standard known as "meaningful use" – i.e., show you are using the technology in significant, specifically measurable ways. This standard can best be implemented if your software gives you access to what's known as a Meaningful Use dashboard. This type of active reporting feature lets you quickly see how well you are meeting each of the meaningful use requirements. This tool has proven to be invaluable to doctors in the medical arena in helping them meet the "meaningful use standard."

FIG. 1

Medicaid Visits – Family Dentistry PLLC

All data for the field Provider Code – 5/15/2012 through 8/15/2012

Code	Provider	Medicaid Visits	Total Visits	Percent of Medicaid Visits
ARQ00	David Arquette	100	500	20%
SAN00	Juan Sanchez	150	450	33%
HYG01	Renee Wilson	200	500	40%
HYG02	Janice Hoops	80	300	27%

Fig. 1: Example report showing 30 percent Medicaid patient encounters by provider.

FIG. 2

Fig. 2: Example of a meaningful use dashboard.

Meaningful use requirements read a lot like a Boy Scout merit badge. There are 25 objectives, 15 of which are required (core) and 10 are electives. You must meet 20 objectives to qualify for the incentive: the 15 core requirements and five of the electives (Fig. 2).

Some good news is that meaningful use may actually be easier for a dentist than for a primary care practitioner because of identified exclusions. One such exclusion is for the recording and chart changes in vital signs. Since dentists typically do not take this type of information, they might be exempt from this meaningful use core requirement. Those items where exclusions might apply are shown with a line through them in the following list of meaningful use requirements.

For more information on specific exclusions that might apply, see the information provided at:
www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/EP-MU-TOC.pdf

If you are a periodontist, endodontist and/or maxillofacial surgeon who also sees Medicare patients, you might be eligible for incentives from Medicare.

Summary

Physicians have been actively implementing EHR software systems in their practices for years and are now the beneficiaries of the large associated government incentives. With software companies releasing EHR software designed for dentists,

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15 Meaningful Use Requirements (Core)

~~**Computerized Physician Order Entry**~~	~~30.00 percent of medications entered by clinician~~
Medication Interaction/Contraindication Checks	Turn this on
Patient Problem List	80.00 percent
~~**E-Prescribing**~~	~~40 percent of electronically permissible prescriptions sent electronically (not faxed or written on paper)~~
Active Medication List	80.00 percent
Active Medication Allergy List	80.00 percent
Patient Demographics (include race, language, gender and ethnicity)	80.00 percent
~~**Vital Signs**~~	~~50.00 percent (height, weight and blood pressure)~~
Smoking Status	50.00 percent
Quality Measures Reporting	Yes or no
Clinical Decision Support Rules	Implement one
Electronic Copy of Health Information	Provide electronic copy of records to 50 percent of those who request them
Clinical Summaries	Provide this to patients on 50 percent of visits
Clinical Information Exchange	Perform a test of electronic health information exchange
Electronic Health Information Protection	Perform a security risk analysis

Electives or Menu Set (choose five):

Medication Formulary Checks
Implement this feature in your prescription writing software

~~**Lab Results Import**~~
~~40 percent of labs~~

Patient Lists
Generate one list of patients for use in improving care, quality or reducing disparities in care

Patient Reminders
40 percent of electronically permissible prescriptions sent electronically (not faxed or written on paper)

Electronic Access to Patient Health Record
Provide electronic access to over 10.00 percent of patients

Patient Education
Provide patient education to over 10.00 percent of patients

Medication Reconciliation
Perform medication reconciliation to over 50.00 percent of patients

Summary of Care Record
Provide summary of care record to over 50.00 percent of referrals

~~**Immunization Registry**~~
~~Perform electronic test with state immunization registry~~

~~**Syndromic Surveillance Data**~~
~~Perform electronic test with state syndromic surveillance registry~~

qualifying for these government incentives has become much easier. If you see a significant number of Medicaid patients, you might be eligible for $63,750 in government incentives. The timing couldn't be better for the dental community to take advantage of this opportunity. What are you waiting for?

For more information on this subject, see www.dentimax.com/EHR. ■

Author's Bio

David Smith has a Masters in Business Administration from Westminster College and a BA from Brigham Young University. He has assisted more than 100 medical providers in attaining meaningful use. For the last 15 years, he has worked in the health care information technology market. He has written dental practice management system user's guides, and worked in operations and product management for electronic health record vendors. You may reach David Smith at medtimer@gmail.com.


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"Remember, you are the customer – make the landlord earn your tenancy."

LEASE NEGOTIATION

Dos and Don'ts for Dental Tenants

by Dale Willerton

As an established dentist looking ahead to your commercial lease renewal, you should not passively accept the same lease terms and conditions from your landlord. Without effective negotiation, dental tenants can leave a great deal on the bargaining table such as valuable tenant inducements (paid by the landlord) and even lower rents.

Since 1993, I have been helping dentists and other commercial tenants learn the dos and don'ts of negotiating commercial leases and renewals. When it comes time to renew a commercial lease, a dental tenant must be wary and not agree to terms too quickly. Dental tenancies are valuable to a landlord and should be leveraged by the tenant to secure the best and fairest lease renewal deal possible, without requiring a move (which can be an expensive and time-consuming process). Remember the following tips when renewing your lease.

Do Plan in Advance

Start the planning and site selection process well in advance. Lease renewal negotiations should begin 12 months before the term expires. This will give you sufficient time to look at other sites and do your homework. If you can't get a decent renewal rate, would you rather find out you need to move with three weeks or six months left on your lease term?

Do Negotiate Rent

Don't settle for your same rental rate. Achieving a rent reduction on your lease renewal is a very real possibility. If your landlord is leasing space to new tenants at less than what you are currently paying, a rent reduction for you should be a given. If your current rental rate is artificially high because of your last tenant allowance, a rent reduction on your renewal term could also be in order.

Do Negotiate for Lease Renewal Incentives

If your lease is expiring, ask yourself what inducements the landlord might give to a new dentist just coming into the property. Examples would include free rent and tenant allowances. If these were being offered to a new dentist, then why wouldn't an established dental tenant – with a proven track record – get the same (or more) consideration?

Don't Have False Optimism

Unless you change location or something else about the way you practice, you should not realistically expect your next five years to be better than your first five years. While it can be difficult, frightening, time-intensive and expensive to consider moving after you have been in one location for a long time, this may be necessary.

Do Create Competition for Your Tenancy

Negotiate on more than one location simultaneously – especially with lease renewals. Even if you don't want to move, create options so you can play one landlord against another. Share with each landlord that you are receiving proposals on other sites. Remember, you are the customer – make the landlord earn your tenancy.

Don't Let a Landlord-paid Agent Represent You

It is not uncommon for a dental tenant to believe that the broker/agent is working for them. However, it should be

noted that the agent's commission is being paid by the landlord and even an outside agent might be sharing in that commission. Remember, the higher the rent paid, often the higher the agent's commission. Brokers and agents do a great job, but who are they doing that job for and who is paying them to do it?

Do Negotiate for Lease Renewal Allowances

Often, doctors don't think they can negotiate for a tenant allowance on their renewal term. But they can! Approximately 75 percent of our clients get a tenant allowance on their renewals. Remember, if the landlord is giving allowances to new tenants moving in, why can't you get an allowance too? Even if your space only needs cosmetic upgrades, negotiate this as part of a renewal deal. After all, your tenancy is proven, plus there is less risk for the landlord putting cash into your renewal than taking a chance on a new tenant.

Don't Allow the Landlord to Retain Your Deposit

If your lease agreement requires you to make a deposit for the initial lease term, it is not acceptable for that deposit to continue indefinitely. Ask yourself, are you a security risk? Have your rental payments been on time? If so, resist further security deposits and make sure that you state this amendment in the renewal document. Otherwise, your deposit, which was to be applied to the last month, needs to be replaced for the renewal term.

These are just a few of my dos and don'ts when it comes to negotiating a dental office renewal. Remember, ultimately, that your success will depend on your location and the deal you make. ■

Author's Bio

Dale Willerton is "The Lease Coach," author of *Negotiate Your Dental Office Lease or Renewal* and a recognized public speaker throughout North America. Have a leasing question? Need help with a new lease or renewal? Call 800-738-9202 or visit www.TheLeaseCoach.com. For a complimentary copy of his CD, "Leasing Dos & Don'ts for Dental Tenants," e mail DaleWillerton@TheLeaseCoach.com.

COACHING AN EMPLOYEE

to Meet Your Performance Expectations

by Diane Sullivan

We've all had the experience where a person we hired does not quite measure up to our expectations. So what to do...

The following scenarios will deal with two very common issues: absenteeism, (where we will meet Abby) and rude patient interaction, (where we will meet Rudy).

The story begins with Abby's first day at Anytown Dental. She is very excited about joining this great practice. She has heard from friends that the doctor and staff are nice to work with.

Abby is welcomed by the office manager and is introduced to all the staff members. She fills out all the necessary paperwork, is given an orientation, which includes a review of the office policies, including the attendance policy. She is given an office manual and is teamed up with a reliable and experienced staff member for training.

Fast-forward six months and let's look at how Abby is doing today. The office manager and the doctor are having a private conversation about Abby. Once again she is absent. She is a great assistant, is terrific with the patients, gets along with all the staff, but is absent far too often. This repeatedly puts undue stress on the rest of the staff. She knows the absenteeism policy. Abby has not told us of any extenuating circumstances that prevent her from coming to work.

Does Abby's situation sound familiar? What should the doctor do about her? It's time for a formal discussion and memo to file. The discipline process works most effectively using a step system, increasing in severity if the behavior continues.

Step 1: Memo to file (note detailing the discussion that took place with the employee and addressing the violation of policy)

Step 2: Written warning

Step 3: Final warning

Step 4: Termination

All of these steps serve to document your discussions and will help coach a poor performer to meet your standards. If an employee commits a serious policy violation then starting at a later stage of the process may be necessary, including immediate termination if warranted.

The scenario is only effective if you have a set attendance policy and hold everyone accountable to the same standard. Addressing attendance issues is usually clear-cut. At times you need to make adjustments or exceptions for an employee who is ill or dealing with an ill family member or similar circumstance.

I recommend setting an absenteeism policy that is reasonable for your situation. As an example, I have found that seven instances of absence in a rolling 12-month period, (a period of 12 consecutive months determined on a rolling basis with a new 12-month period beginning on the first day of each calendar

month), is a reasonable number. If an employee has an illness or emergency, that keeps them out of work for several days at a time, that should be considered one instance of absence.

You will find that most employees are never in jeopardy. However, there are always a few that skate close to the edge, no matter what policy you put in place. When you have employees reaching the fifth or sixth instance of absence, an informal discussion should take place to let them know they are reaching the warning stage. Once the seventh instance is reached, begin the step warning process with a memo to file. Any other absence within that rolling 12-month period will take the employee to the written warning step, and another absence, to the final warning step. I recommend a three-day suspension without pay at this point. If the employee is absent once more, then termination is in order. The number of absences you allow in this policy is discretionary; seven is generous and allows for family situations as well. The number you are willing to allow is up to you. I introduced this policy in my current practice. We hold the employees to the standard and absenteeism is rarely an issue anymore.

Once you have the pieces in place, a consistent approach with all employees is critical. If it is perceived that you are not holding one person accountable to the same standards, you lose credibility with the entire staff. Once you establish that you are fair and consistent in the application of the policies, your job gets easier. Use an attendance controller to keep track of your employees' days out sick or unscheduled absences; tardiness can be tracked on these as well. This documentation also helps diffuse any perceptions of discrimination or favoritism. The process works to correct the behavior of a good employee in most cases. If you communicate how you value their contributions when they are at work and let them know this process is to be taken seriously, sometimes the Abbys of the world will smarten up. If not, then in the long run Abby is not a good member of the team. She cannot be relied upon and letting her go is the best solution, for the entire staff.

Meanwhile across town, Dr. Noah Payne is frustrated with one of his newer employees, Rudy. Rudy just does not meet his expectations with patient interaction. He is reliable, flexible and gets along with the staff, but his interactions with the patients are, at best, brusque and at times, downright rude. Dr. Payne has spoken to him informally on several occasions after which he improves for a few days then is back to his usual self. Dr. Payne has just received a call from one of his long-standing patients who is very upset about the treatment she received yesterday.

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She is so dissatisfied that she has requested her records be transferred to a new dentist.

Dr. Payne should follow a similar process that the previous example detailed. Documentation of any critical feedback is important. The doctor should start with a memo to file at least, but given the circumstances, might want to bring the process to the written warning stage. A formal, private conversation with Rudy detailing specific examples of his poor patient interaction is necessary. Rudy must walk away from the conversation understanding that his behavior must change or his employment is in jeopardy. The doctor must communicate that he expects immediate significant improvement or further disciplinary action, up to and including termination will occur.

"The doctor must communicate that he expects immediate significant improvement or further disciplinary action, up to and including termination will occur."

I recommend using a simple form that can be used for all the steps in the discipline process. On this form include: the date, the employee's name, his/her date of hire, the policy violation being reviewed, the dates of previous discussions or warnings, what those warnings or discussions consisted of, the next step in the discipline process and the employee's comments. Also sign and have the employee sign the warning. You can download a copy of a form, very similar to the one I've used for years, by going to Dentaltown.com. Using a simple form helps keep the disciplinary conversations in a consistent format. It also keeps it clear, naming the violation, the expectations and the follow up. You can use this form for each of the four steps.

Sometimes a formal serious conversation is all that is needed to change the behavior. The warning should stay in the employees file for a period of one year. If another instance of poor performance occurs then the next step is warranted until you reach the termination point.

Diane Sullivan's policy violation documentation form can be found at www.dentaltown.com/violation. Feel free to use it in your office. ■

Policy Violation Documentation Form

Step: (circle one) Memo to File / Written Warning / Final Warning / Termination

Date:

Employee name:

Date of hire:

Policy violation being reviewed:

Dates of previous discussions/warnings:

Warning:

Next Step:

Employee Comments:

Employee Signature **Date**

Supervisor Signature **Date**

Author's Bio

Diane Sullivan is the practice manager for a large pediatric practice, Dentistry for Children, P.C., located in South Weymouth, Massachusetts. She managed employees for more than 30 years in large corporations, with focus on human resource management, including hiring, employee relations, labor relations and training and development. In 2003, Diane earned her PHR (Professional in Human Resources). The certification, awarded by the Human Resource Certification Institute, signifies that individuals possess the theoretical knowledge and practical experience in human resource management necessary to pass a rigorous examination demonstrating a mastery of the body of knowledge in the field.

Diane joined Dentistry for Children in 2004, and has managed the organization through a practice management software conversion, implementation of digital radiographs, as well as expansion and refurbishment.

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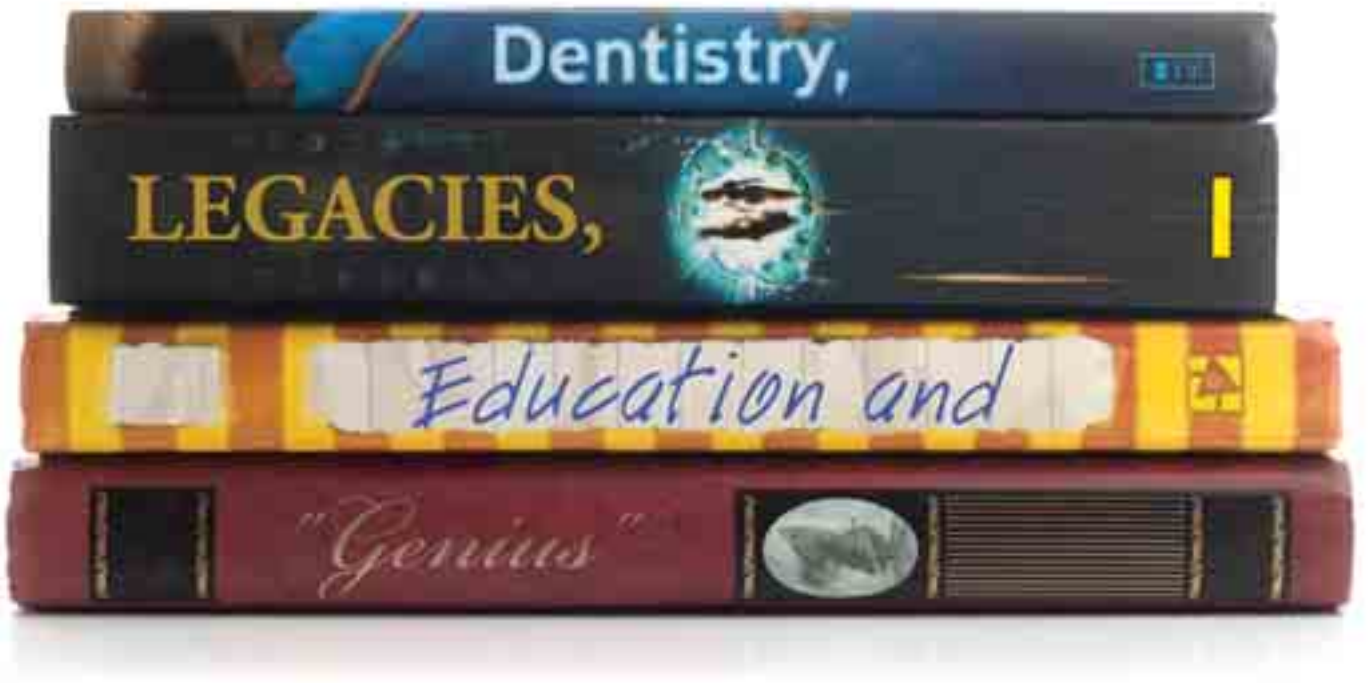

An uncensored, unedited interview with the outspoken founder of Comfort Dental, Dr. Rick Kushner

by Thomas Giacobbi, DDS, FAGD
Editorial Director, *Dentaltown Magazine*


Kushner

Dr. Rick A. Kushner is President, Founder, CEO and CFO of Comfort Dental, the largest and most successful dental franchise in the world. He graduated from Marquette University School of Dentistry in 1977. He recently made a significant donation to Marquette for it's upcoming clinic expansion. Kushner has always advocated and taught a low overhead, high volume, expanded hour, bread-and-butter, group partnership concept geared towards middle-income patients.

When did you transform from dentist to practice management lecturer and owner of a large group practice organization?

Kushner: I never made the transformation. It was an evolution in every sense. I would like to say I had a master plan in place from the start but I wasn't that smart and I'm still not. It all happened concurrently and on a trial-and-error basis. I lectured for about 15 years from the early '80s through the late '90s while I was developing what became the Comfort Dental monster of today. Comfort Dental has been in its present configuration since the early '90s. I only lecture these days to the Comfort partners and dental students. And of course, I'm not invited to lecture any longer.

The practice management model that you developed for Comfort Dental is called "Lean & Mean." What experiences outside of dentistry influenced this concept?

Kushner: About a dozen jobs working my way through school selling everything from ladies shoes to garden tractors must have taught me a lot. Also, I must have been gifted with a great ability to

observe life, a nice dose of street smarts and common sense. Practice management has always been so simply obvious to me, yet is clearly so difficult for most dentists. For example, the observation skill I just mentioned mostly involved observing what other dentists did and doing the opposite. I always felt they were doing things so very wrong.

What are your roles and responsibilities at Comfort Dental? Do you still practice clinical dentistry?

Kushner: First, let me say that I have four of the finest practice management minds and four of the finest people on Earth at my disposal full time. Roy Martin, Bruce Irick, Neil Norton and Mike Bloss are all dentists, have been in my system for decades, and are minority partners at Comfort Dental, Inc. They each have special skills and work in different areas but are all masters of Lean & Mean. I had a personal tragedy five years ago which obviously set me back but I am now involved daily and responsible for every aspect of Comfort Dental. For example, I personally approve all Comfort Dental locations, meet face-to-face with every new Comfort partner, and visit each of 100 offices in 10 states at least once a year. My surviving son Paul is, in effect, our COO and is involved full-time. He has his master's (real estate finance/construction management), is not a dentist and therefore makes great business decisions. We all have our hands full helping our 300+ Comfort Dental partners achieve Lean & Mean practice management. I maintained a clinical schedule for a quarter century until 2002 and have not practiced clinically since.

You recently made a generous donation of $1 million to the Marquette University School of Dentistry. Tell me about your passion for this school.

Kushner: First, the donation is a result of the efforts of all Comfort partners as well as my boss, Cindy Kushner. I just seem to get the credit. I am a Marquette alumnus but that is not the reason for the donation. The reason is that the Dean of the dental school, Bill Lobb, is the greatest Dean ever anywhere. OK, I'm prone to hyperbole but that's the way all of us here at Comfort feel about Bill. You see, Bill Lobb will not allow his dental school instructors (DSIs) to criticize outside dentists or otherwise impart practice philosophy to students. At Marquette, DSIs simply present the facts of various options, teach students to fix teeth and avoid denigrating practicing dentists and styles of practice. This concept, I have found, is very rare in dental schools. For example, we have seven practices in the Kansas City area with many more to come. Yet, a DSI at UMKC dental school has banned me from speaking to his students because I presented to them honestly the conditions they face upon graduation and he didn't like it. I have concluded that the administration at my local dental school, University of Colorado, must encourage its DSIs to denigrate outside dentists and practice styles since they do it so often. Recently, a DSI admissions interviewer at the Colorado dental school didn't even wait for the student to enter dental school. The DSI criticized us to the applicant and incorrectly referred to Comfort Dental as "Corporate Dentistry." So that's why we donated to Marquette. DSIs often do great disservice to their students.

Comfort Dental has considerable experience with new dentists. What are your thoughts on dental education based on this experience?

Kushner: I might surprise you by saying that I believe dental schools generally do a great job under very difficult circumstances these days. Clearly, our recent graduates (we do sell lots of partnerships to experienced dentists, as well) begin their real education when they buy their Comfort partnership, but most are pretty well prepared when they graduate. I've always said that DSIs could prepare their students even better if they focused more on achieving more reps (repetitions) for their students at bread-and-butter services (single unit crowns, RCTs, non-surgical perio, basic prosthodontics, amalgam – yes, amalgam – and exodontia, exodontia, exodontia) and less on imparting their practice philosophy to them. Likewise, I've always believed we'd all be better off if dentists spent less time worrying about what other dentists are doing and more time on figuring out how to provide more affordable primary care services to more patients in need of care.

The majority of dentists are in solo or small group practice. Do you think the profession is making a shift to large group practices to the point that they will employ the majority of dentists in the future?

Kushner: Wow! I guess you're serious. Of course the profession has shifted. Traditional private practice has been dying for decades but too many dentists, always late to the party, don't know it yet. Prospering in a traditional fee-for-service, low volume, high fee, high tech, "cosmetic" practice has always been rare for all but the most talented. Today, it still exists but only by a miniscule and shrinking percentage of the most ultra-talented. Continuing Ed today is nearly all geared towards big fee, high tech, traditional practice and I sincerely believe it harms far more dentists than it helps. At Comfort Dental, our dentists average $365K net income before taxes annually on a 42 percent overhead and most are not ultra-tal-

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ented dentists. We have a good many fine clinical dentists with great skill sets but they all understand what it really takes to be very prosperous in dentistry today: hard work and bread-and-butter dentistry.

What concerns you the most about the future of our profession?

Kushner: This one is really easy and the most important thing I can say in this small venue. No contest, my biggest concern is the tremendous student debt load with which our graduates enter the profession. Too many dentists have made too many bad professional and business decisions for too long as it is. Young dentists with huge debt make even poorer professional and business decisions even more often. Like taking jobs in "corporate dentistry" for $75K (if they're lucky) because they fear going even deeper into debt. Thus fodder for "corporate dentistry." Eight years of higher education, hundreds of thousands of dollars debt and they take jobs for $75K. How did all of this happen? In large part, not enough dentists paid attention to me for a third of a century ranting about high overheads, expanded schedules, inefficiencies and fees that were unaffordable. Now, as much as ever, dentistry is too expensive and dentists manage badly while trying to perform services which are out of reach for 95 percent of our population. DSIs and I probably agree on one thing: corporate dentistry. Corporate dentistry scares the hell out of me for two reasons: first, whether they get their money from the public or from private equity, corporate dentistry will always have only one priority: demonstrate more profit. (By the way, Comfort Dental has only one original money source: me. Oh and a couple of local banks. Of course, every single Comfort partner is equity invested in his/her own Comfort partnership.) And secondly, as a dental "chain" we are unfairly lumped together with corporate dentistry by ignorant dentists including DSIs and of course, some patients. Structurally and philosophically we at Comfort are as far from corporate dentistry as traditional private practice. Had the profession listened to me instead of attacked me over the past few decades, the professional landscape would be saturated with Lean & Mean group type practices so prosperous that there would have been neither need nor room for corporate dentistry. So again, how did corporate dentistry happen? It's dentists' fault. It's DSIs fault. It's not my fault; it's their fault. Dental practices were so bad for so long with their 80 percent overheads and their hygiene-heavy practices that businessmen in business suits looked at them and instinctively knew they could do better and keep the difference in profits. And guess what? They were right. Businessmen in business suits looked at dental practice and knew they could handle our business better than dentists. So they did. Not my fault. I warned dentists but they were smarter than me. Graduates laden with debt and corporate dentistry are a match made in heaven.

"Now, as much as ever, dentistry is too expensive and dentists manage badly while trying to perform services which are out of reach for 95 percent of our population."

What is the best thing going for the profession of dentistry in 2012?

Kushner: I won't speak for the profession but from our standpoint here at Comfort, the answer is the same for 2012 as it has been every year for a third of a century. Other dentists have set the bar so low, chasing five percent of the market with big fees, it's really easy for us to do what we do. I have significant challenges recruiting dentists to invest in a Comfort partnership and then schooling them in Lean & Mean management but we do not lack for patients. We've got patients: 50-75 new patients per Comfort partner per month, month in and month out, year after year. With our competition being corporate dentistry and traditional private practice, there is no mystery why we are so prosperous. Thank you dentists and DSIs. Desperate dental dinosaurs hang on to the failed ideology of traditional practice with a (literal) death grip. I'm a Western American History buff. I've read numerous accounts of plains Indians longing to again live the life of their fathers and grandfathers. How 'd that work out for 'em? I mentioned being attacked by the profession. Before I continue, let me say that there is a group of dentists I love unconditionally: Comfort Dental Partners. I love each and every one of them for dedicating themselves to hard work, bread-and-butter dentistry, all kinds of patients, and me. Having said that, I must say, certainly with many exceptions but too often, I have found dentists to be lazy, jealous, backstabbing, elitist, narrow-minded, arrogant, not very cerebral, and frankly lacking in character generally. The professional attacks on us have run the gamut from deeply impolite, to highly unethical, through grossly unprofessional and even to criminal. By the way, and FYI: The most vicious of these attacks over the years have come from hygienists and hygienists cum dentists. We have been continually sandbagged by neighboring

dentists, hated for marketing, advertising, accepting managed care, our community service, our charity, our branding, our locations and our fees. We have been treated unfairly by dental associations, dental schools, DSIs, dental boards and state legislatures. There is one and only one underlying reason for our career-long upstream battle with the profession: Dentists have an elitist bent and can't or won't compete with us at our fee level, our schedule or our work ethic. I'll admit to being bitterly frustrated over this and trying to confront these personal, professional and political attacks historically. Not any more. For the past five years, I've worked hard to take the high road and embrace the massive differences between the others and us. I simply try to channel the energy into opening another Comfort office. So again, thank you, dentistry. What's the best thing going for the profession in 2012? For us, it's competing with elitist traditional dentists and elitist corporate dentistry.

What is your legacy for the dental profession?

Kushner: Legacy? I am 60 but I'm on anti-aging and feel 40. Just ask the divine Mrs. K who, by the way is a 30-year old 60 year-old herself. So I haven't thought much of legacy because I don't plan on going anywhere for a long time. I have been called a genius but here's how complex my genius is: "Make it cost less, be open and be nice to people." There you have it. I'm a genius with stuff I think I learned in the third grade but dentists don't get it. Now let's get really crazy and add, "since our fees are so affordable, let's be well managed and collect all of those fees at the time of service or even before service and create 42 percent overheads," and finally, "focus on bread-and-butter dentistry." That's it! I'm a genius. My first and only true love is the divine Mrs. K but my passion is Comfort Dental. This passion gives me something euphoric every day. Competitively sticking it to this elite profession using "the kind of patients" they always told me they didn't want anyway. My legacy should be the Comfort Dental model. It should be Lean & Mean Group practices saturating the professional landscape, which allow dentists to retain the greatest parts of the profession… maintaining equity ownership in his/her own practice and management input… while benefitting from the economies and multitude of other advantages of our partnership concept. But it's not going to happen. Not in this profession. My legacy will just have to be a Comfort Dental office on every intersection. I realize I've just scratched the surface on a number of topics. I might be persuaded to write follow up articles to explore these topics further, but you probably won't invite me after you see the hate messages you get as a result of this one, assuming you have the courage to publish it. On the other hand, they didn't listen to me before, maybe this time? Nawwwwww. ■

You Should Know:

Ever heard of crowdsourcing? Zaheer Dodhia, CEO and founder of MycroBurst, built his business by crowdsourcing graphic design. Herein, Dr. Giacobbi talks to Dodhia about how this applies to dentistry and why you should know about this company.

Tell us a bit about your background and what led you to Mycroburst.com?

Dodhia: I started my first online company out of my bedroom in 1997 while I was doing my MBA. Since then, I have launched several successful ventures, the most recent one of which is SocialDon.com, which provides Facebook fan page analytics and monitoring.

I ventured into the design industry in early 2003 with the launch of LogoDesignGuru.com, which provided affordable and quality graphic design services to small businesses using offshore resources. The company did well until we were hit by the economic downturn in 2007. We believe that a good company never falls in love with its own product, so we made the decision to change our business model to crowdsourcing, and in late 2008 we launched MycroBurst.com.

We chose MycroBurst as a name because we offer a wide range of design services – our slogan is "Get drenched in design." Crowdsourcing gives our customers an average of 116 concepts from more than 20 different designers, which results in a high rate of customer satisfaction.

What is crowdsourcing?

Dodhia: Wikipedia itself is an excellent example of crowdsourcing, and they define it as "the act of outsourcing tasks, traditionally performed by an employee or contractor, to a large group of people or community." Outsourcing originally involved one person or a company that performed most of the tasks required. In crowdsourcing you assign or open the tasks to a crowd of people. The rationale behind crowdsourcing is that the intelligence and the output of a crowd will most likely outperform the results from an individual or a company.

MycroBurst

by Thomas Giacobbi, DDS, FAGD, Editorial Director, *Dentaltown Magazine*

How did you hear about Dentaltown.com?

Dodhia: We noticed that a large number of dental practices are using MycroBurst for their design needs. A Maryland-based dentist left positive feedback on our Facebook page. We e-mailed him and thanked him for his feedback, and we asked him which dental publications he read. He said that Dentaltown is his favorite because it's "for the more forward-thinkers and practitioners. It has all the latest and greatest technology and is geared toward more modern dentistry." Also, a dentist in New York City told us that he read about us in a Dentaltown.com forum. So we thought it would be useful to tell you about the way that dental practices are using this innovative new method of crowdsourcing for their branding and design.

How does Mycroburst use this concept to create designs at competitive prices?

Dodhia: We use a contest-based, crowdsourced solution where our designers compete by producing better designs throughout the process. In our system, the customer chooses the design he or she likes best, and the winner takes all. This is a huge driving force for our designer community. Our customers are also a part of this competitive marketplace. The customers who provide regular feedback and offer more compensation for their job to get the best designers.

Can I direct one designer to incorporate concepts I have seen in other potential designs?

Dodhia: Yes, you can ask one designer to incorporate aspects presented by other designers. However, that would work best if you finalized a design and asked that designer to make changes without involving others who had been competing for the job.

What are some of the typical fees for design?

Dodhia: The beauty of our marketplace is that you can name your own price, but we do have minimum amounts in place in order to ensure that designers are paid fairly. Since it's a marketplace, more money will ensure the best designers compete for your job. Business cards and stationery start at $99, logo design and brochure design each start at $199 and Web design starts at $700.

Who are your primary competitors in this space?

Dodhia: Our competitors include CrowdSpring.com, LogoMyWay.com and 99designs.com.

Some graphic artists complain that these crowdsourcing services devalue their skills. What would you say to them?

Dodhia: There are indeed members of the design community, particularly in the U.S. and Europe, who feel threatened by the crowdsourcing model. We currently have more than 30,000 designers registered with us from all over the world, to include the U.S. and Europe. In a difficult economy we are able to give recent graduates or designers who want an extra income the ability to make more money. One American designer from Nevada told us that he likes the logo design platform as an outlet for creativity and extra cash in addition to his day job as a graphic designer at a regional newspaper group. Other designers in countries like the Philippines and Indonesia make a good full-time living designing for MycroBurst contests.

The traditional design market was monopolized by those graphic artists who had the resources to market their services successfully. Our platform gives designers the ability to gain a new customer after successfully winning a project, and opens up design to those customers, particularly small business owners, who would not otherwise be able to afford custom design. I would like designers to see us as a platform to market their services and skills and the opportunity to compete on a level playing field. On our platform, it's their talent and skill that allow designers to succeed.

What other categories use crowdsourcing to their advantage?

Dodhia: Crowdsourcing is being applied in many industries now, including video ads, data collection, start-up funding, translation services, software testing services, content creation such as Wikipedia, and review sites such as TripAdvisor. Heineken launched IdeasBrewery in April for more sustainable packaging ideas, and the consumer goods giant Unilever recently hosted an online event to crowdsource ideas for sustainable production, marketing and sourcing.

Which three Web sites do you visit most often?

Dodhia: I am online 12 to 14 hours a day. I like to visit TechCrunch.com, Entrepreneur.com and CNN, because I like to stay abreast of the latest technology and business innovations.

How can our readers contact MycroBurst?

Dodhia: They can visit our Web site – MycroBurst.com – or they can call 877-525-5646. ■

How to Use VIRTUAL Impression Material

by Jason Olitsky, DMD, AAACD

A simplified approach to taking accurate impressions for IPS e.max restorations

Introduction

Dentists and laboratory ceramists often face complex and time-consuming cases that require materials to simultaneously provide aesthetics and adequate strength. Accurate impressions are of paramount importance for achieving these goals and require the use of materials that capture excellent details for every step of the process, from diagnostic to master impressions.

Virtual impression material, a line of vinyl polysiloxane (VPS) material, simplifies the impression taking process for IPS e.max restorations (Ivoclar Vivadent, Amherst, New York) and expands the possibilities for conservative, minimally invasive smile design. Virtual impression material (Ivoclar Vivadent) can be used for full-arch impressions, eliminating additional steps and saving valuable chairtime. The fast-set wash materials and putty demonstrate exceptional adaptation characteristics that withstand the moist oral environment. The material's precision and accurate detail reproduction ensure marginal integrity and remarkably well-fitting restorations.

Case Presentation

A 22-year-old female in excellent oral health came to the office for a cosmetic consultation with a chief complaint of having "baby teeth" (Figs. 1 & 2). She exhausted professional whitening trays, was not satisfied with the results, and requested in-office professional whitening treatment. Her shade was a B1, and she wanted a much whiter and bigger smile to show off from the field when she cheered for the Jacksonville Jaguars. The patient had prominent facial features including large eyes, and felt her small teeth were over-powered by her other more prominent facial features (Fig. 3).

An initial clinical examination revealed altered passive eruption of the maxillary anterior teeth and short bicuspids; Class III occlusion, edge to edge on the left posterior side; minor wear to anterior tooth #7; and two missing molars, #3 and #19, which had been bone grafted for the next phase of implant placement. The patient's maxillary central length was 8.5mm, and she demonstrated a reverse incisal curve, wide labial corridor and high smile line of approximately 2mm, with gingival exposure at full smile over the centrals. Gingival exposure of 7mm presented in the gingival margin of the premolars and the inferior border of the upper lip.

After reviewing pre-operative photographs and smile design principles on a computer with the patient, a treatment plan was discussed and agreed upon for closed flap osseous crown length-

Fig. 1: Pre-operative view of the patient's smile.

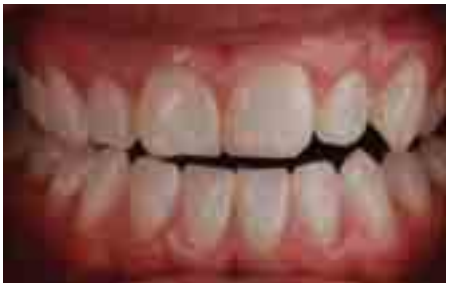

Fig. 2: The patient believed she had "baby teeth" and desired a bigger, whiter smile.

Fig. 3: Full face view of the patient's smile showing a lack of balance with her other prominent facial features.

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Because I Am A TOWNIE

I Teach

Name: **John Nosti**
Townie Name: **John Nosti**
Member Since: **02/23/2004**
Occupation: **Cosmetic Dentist**
Location: **Mays Landing, NJ and Manhattan, NY**

I have lectured to dentists around the world, sharing my passion for cosmetic dentistry. My favorite place to share the latest techniques and methods is through the Dentaltown community. Because of Dentaltown I'm able to reach other professionals on an in-depth, individual level. By offering courses in both *Dentaltown Magazine* and Dentaltown.com and providing insights on specific cases on the Dentaltown.com message boards, I'm helping dentists create better smiles for their patients.

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ening of teeth #4-13, followed by placing lithium disilicate (IPS e.max) veneers. Alternatives to the treatment plan were discussed, including orthodontics to minimize preparation to the posterior left side in edge to edge bite, crown lengthening without porcelain veneers and direct resin veneers.

At the diagnostic appointment, a full series of 12 American Academy of Cosmetic Dentistry (AACD) images were taken, as well as an upper alginate impression, which was immediately poured for fabricating a maxillary release appliance. The patient wore the appliance every night for two weeks to enable the TMJ to seat into its most anatomically stable position, the muscles to relax, and an open bite centric relation record to be taken at the subsequent visit. An appointment was made for closed flap osseous crown lengthening, as well as to obtain open bite centric relation records and VPS impressions for wax-up, stick bite and face bow.

At the next appointment, the bite was recorded and clearance was verified with articulating paper pulling through the posterior contact area. Next, the patient was appropriately anesthetized, the teeth isolated (Optragate), and bone sounded on the facials of all maxillary teeth receiving treatment to gauge the amount of bone to be removed with the er:YAG laser. The patient's smile was digitally designed prior to performing the gum lift to anticipate the necessary gingival recontouring. Immediately following the crown lengthening procedure, upper and lower impressions were taken according to the following procedure.

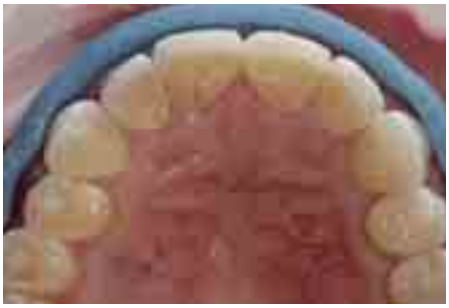

Fig. 4: Occlusal view of the Virtual acrylic reduction guide.

Fig. 5: View of the mock-up displaying one Virtual veneer.

Pre-operative Impressions Using Virtual Impression Material

Step 1: A stock tray was lined with Virtual adhesive, and Virtual putty was mixed and placed in the posterior and seated in the mouth.

Step 2: The tray was removed immediately to create a pseudo custom tray in the posterior, after which heavy body was immediately injected into the tray, and the light body was injected on top of the heavy body and around the facials of the dentition in the impressed arch. The tray was restored.

Step 3: The material was allowed to set for 2:30 and checked for accuracy. The author ensures that the diagnostic impressions of both arches are extremely accurate, since this is the first step of the smile design that sets the standard for the rest of treatment.

Step 4: An earless facebow was lined with Virtual adhesive and the face bow and stick bite were recorded with Virtual Bite Registration Material in the photo studio to facilitate laboratory communication.

The laboratory prescription indicated that the case would be minimal preparation, and some minimal preparation was anticipated on the facials of the central incisors. I prefer to place a fine margin on teeth that require minimal or no preparation for the ceramist. Teeth #12 and #13 would require preparations that wrapped over the buccal cusps to enable the ceramist to jump the edge-to-edge bite, lengthen the incisal edges and normalize the labial corridor. The maxillary canines would require some lingual wrap to control occlusion and provide immediate canine disclusion.

Discussion with the laboratory involved tooth shapes and sizes, as well as final length and other smile design principles. The laboratory was also instructed to mount the case using the enclosed centric relation open record bite and equilibrate interferences to full closure and wax in the new MIP. The laboratory would produce a reduction guide based on the wax-up for use during the preparation appointment.

Tooth Preparation

At the preparation appointment, the patient was anesthetized. Small adjustments were made to posterior inclines recorded on the CR open bite mounted models from the equilibrated models on a semi-adjustable articulator. Utilizing reduction guides fabricated off the laboratory wax-up, proper reduction and ideal room for the IPS e.max minimal preparation veneers was verified (Fig. 4). Once the reduction guide cleared the facials of the teeth, there was enough room to fabricate the intra-oral mock-up from the Siltec impression of the wax-up.

The Siltec impression of the wax-up was filled with a temporary crown and bridge material and seated in the mouth to fabricate a mock-up. After allowing the provisional material to set for two minutes, the matrix was removed, and the bulk flash was cleaned. Aesthetics of the mock-up were reviewed prior to preparation and determined to look excellent.

The mock-up was prepped with .3mm reduction in three facial plains, and 1.5mm on incisal reduction to allow room for the laboratory to cut back and layer the incisal edges (Fig. 5). The mock-up was prepped as if it was actual enamel and, once completed, excess flash was removed and shallow chamfer margins were placed equi-gingival. The author prefers to create a

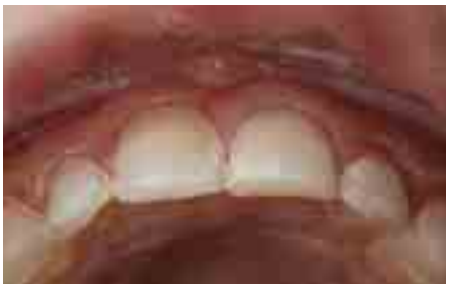

Fig. 6: In this minimal preparation case, a light chamfer was placed on the facial margins.

Fig. 7: The tray was prepared with Virtual VPS Adhesive.

Fig. 8: The fast set heavy body of the Virtual VPS Adhesive was loaded into the tray.

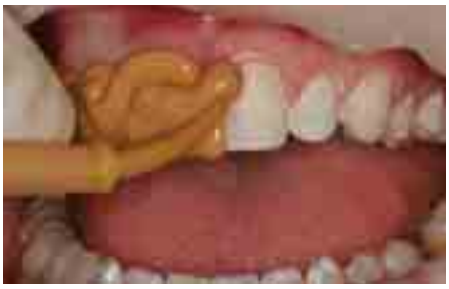

Fig. 9: The fast set light body impression material was expressed around the prepared teeth.

Fig. 10: The tray was seated into the mouth with even figure pressure and allowed to set for 2:30 seconds.

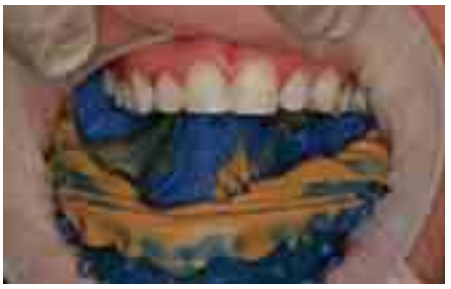

Fig. 11: The impression was removed from the mouth.

Fig. 12:The impression was carefully examined for marginal details.

Fig. 13: The master impression was disinfected with CaviCide surface disinfect spray.

Fig. 14: The master impression was packed for shipment to the laboratory.

slight margin, enough for the ceramist to delineate as a finish line for the restorations (Fig. 6).

Bite Record and Final Impressions Using Virtual Impression Materials

Step 1: The bite was checked and recorded with Virtual bite, and photographs were taken to record preparation shade ND1 with Ivoclar Vivadent ND shade guide.

Step 2: With a custom tray lined with Virtual adhesive, a maxillary impression was taken using fast set Virtual Heavy Body and Virtual Light Body material. No retraction cord or materials were used prior to impressing the case.

Step 3: After the impression was checked for final set, it was removed and carefully scrutinized for marginal details that are crucial for excellent fitting restorations.

Step 4: The impression was disinfected with CaviCide surface disinfectant spray and packed for shipment to the laboratory (Figs. 13 and 14).

Provisionalization

The teeth were provisionalized with a bleach-shaded temporary crown and bridge material. The final shade of the temporaries material on an ND1 prepared tooth approximates a Chromoscope 020/030 shade. The teeth were conditioned with Concepsis (Ultradent Products, Inc., South Jordan, Utah), then spot etched in the center of the teeth, which enhances the strength of the provisional material. The etch was rinsed and the teeth dried and coated with a desensitizer (Telio CS Desensitizer, Ivoclar Vivadent). A primer was then placed on the preparations with a microtip brush and air dried with an Adec Warm Air Tooth Dryer.

The Siltec matrix of the wax-up was filled with a provisional material and seated in the mouth for two minutes. After setting, the matrix was removed and excess flash was cleaned with a sharp instrument. After final setting, the provisional material was trimmed to margins with an eight-fluted carbide flame on the facial and a football-shaped eight-fluted carbide on the lingual. The margins were polished, the incisal edges were

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"The Virtual line of VPS impression materials ensures accurate impressions throughout the restorative process, from diagnostic to master impressions."

rounded, and the incisal embrasures deepened to produce a more youthful smile. The incisal embrasures were opened with a small diamond disk, and the mesial and distal line angles were modified with an eight-fluted-carbide-flame-shaped bur. These areas was further polished, and the provisional then glazed. The provisional was cured with an LED curing light (Bluephase Style, Ivoclar Vivadent) for 10 seconds per tooth.

Laboratory Fabrication

The laboratory poured the impression in stone and created a working model of the IPS e.max veneers (Fig. 15). Each veneer was carefully inspected for exceptional aesthetics while preparing the case (Fig. 16). The details of the impression facilitated laboratory fabrication of exceptionally well-fitting restorations (Figs. 17 and 18).

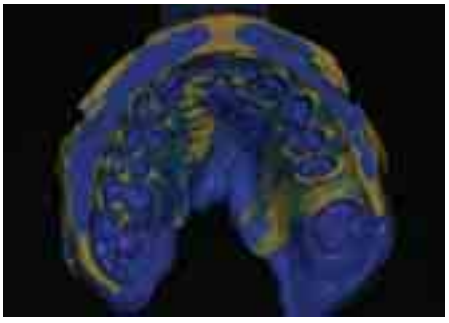


Fig. 15: The laboratory poured the impression in stone.

Fig. 16: A working model for the IPS e.max veneers was created based on the Virtual impressions.

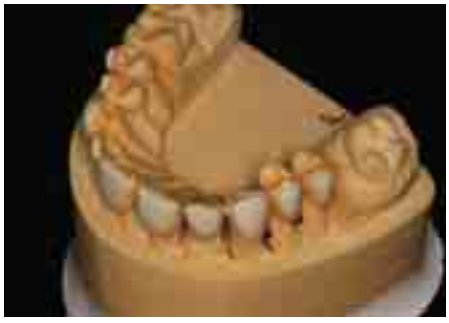


Fig. 17: Each veneer was carefully inspected for exceptional aesthetics while preparing the case.

Fig. 18: Details of the impression simplified fabrication of exceptionally well fitting restorations.

Fig. 19: The aesthetics and function of the provisionals were approved by the patient and doctor.

Fig. 20: The restorations were tried on the model and inspected for fit and aesthetics.

Fig. 21: The final IPS e.max veneers achieved the patient's goals.

Fig. 22: Lateral view of the IPS e.max veneers.

Fig. 23: Post-operative portrait of the patient with her new smile.

Final Cementation

At the cementation appointment, the provisional (Fig.19) was removed. The IPS e.max veneers were carefully evaluated for aesthetics and fit (Fig. 20).The preparations were cleaned with chlorohexadine, and the IPS e.max restorations were tried in one at a time for fit, then two at a time for contacts. Once full seating was confirmed, all veneers were tried on together with try-in paste Variolink Veneer HV+1 shade, Ivoclar Vivadent) (Fig. 21).

The veneers were removed and prepared for adhesive bonding using Variolink veneer light-cured cement, then bonded using the "tack and wave" method. Excess cement was cleaned, the margins were covered with a glycerin gel, and the restorations given a final 40-second cure per surface. The occlusion was adjusted in protrusive and lateral protrusive and confirmed to have immediate canine disclusion.

Conclusion

Using Virtual impression material facilitates laboratory communication and also the fabrication of exceptionally well fitting lithium-disilicate restorations, such as minimal preparation IPS e.max veneers. The Virtual line of VPS impression materials ensures accurate impressions throughout the restorative process, from diagnostic to master impressions. ■

** Information provided by Ivoclar Vivadent*

Author's Bio

Dr. Jason Olitsky, The Smile Stylist, is an accredited member of the AACD, as well as president of the Florida Academy of Cosmetic Dentistry. He was a clinical mentor with the Hornbrook Group and is currently faculty with the Gold Dust Clinical Mastery Series. Jason currently works three days a week with his wife and partner, where 80 percent of their production is based off large cosmetic cases. They started Wallsmiles.com, a site that sells wall art for the dental office and teaches dentists how to get their own patients' pictures on their walls. They created Smile Stylist, a brand committed to promoting, providing and maintaining beautiful smiles for the fashion-forward customer. He is also co-author of *The Naked Tooth: What Cosmetic Denists Don't Want to Know.* Check out Olitsky's technique via his OnDemand Webinar on Dentaltown.com.

You Should Know:

ReputationMonitor

by Thomas Giacobbi, DDS, FAGD, Editorial Director, *Dentaltown Magazine*

I recently had a moment to visit with Fred Joyal regarding the current state of patient relationships. This is much more than just keeping patients happy in the office. The newest battle is watching what happens after they leave the office. Reputation management is something you can automate with ReputationMonitor from 1-800-DENTIST. Here, we talk with Fred Joyal, founder of 1-800-DENTIST.

Is the 1-800-DENTIST brand something that will be more of a subtext moving forward because the breadth of things you are offering now is so far beyond phone numbers?

Joyal: Yes. Certainly from the dentist side, it's become more of an umbrella brand over all our marketing products.

I'm particularly interested in your new offering, ReputationMonitor, and I think some of my dental colleagues might say, "If I don't get involved then I don't have to worry about my reputation online."

Joyal: Ostrich dentistry doesn't fly anymore. Pretending that change is not happening will not prevent change from happening to you.

"Ostrich dentistry doesn't fly anymore."

Tell me a little about the "review culture."

Joyal: Reviews sites have more than doubled in traffic in the last year alone, and patients are now routinely turning to these sites to make decisions about health and service providers. It's become the norm and dentists have to be equipped to deal with this new reality. The problem is, if the dentist is on the wrong side of the digital divide, he thinks there's a whole bunch of other people over there with him, but the truth is, he's on the sinking island.

When a dentist comes to you with a concern about a bad review he has received online, what advice do you give him on how to handle that situation?

Joyal: I tell him that the first step is to see if he has any way of contacting that person. You can contact reviews through Yelp or Google, as the business owner. Say, "I'm sorry that you're upset. Is there anything we can do about it?" Try to fix it.

If you can't find the person and you can't get him to respond, then you respond to the negative review in a non-defensive way. You say, "We're sorry the patient feels this way." And then address the issue. By responding positively and professionally, you are basically writing an ad on the complaint. So people read the rant and then they read you and realize you sound completely sane and have a high standard of care.

And the next step, stay out of it. You're done at that point. You don't go back and forth. You could ask four or five of your patients, "I've got some guy who is shredding me on Google right now, would you go on and respond to his comments as a patient?" Your best patients will do it. Because you're going to have patients who love you and who understand the review world.

In addition to monitoring reviews about a practice, what does ReputationMonitor help track?

Joyal: ReputationMonitor will help you monitor your listing on hundreds of directory sites simultaneously as well as track social media mentions via a feature we call Social Buzz. It will even compare your online performance with local competitors. Keeping your online footprint up-to-date will enhance your search engine optimization and ultimately ensure your practice has a consistent presence on the Internet.

For more information visit:
www.1800dentist.com/reputationmonitor ■

You Should Know:

Dr. Gina Dorfman, founder of YAPI (left) and Shawna McAdams, RDA, YAPI spokeswoman (right).

According to Dr. Gina Dorfman, founder of YAPI, there are three key elements to having a productive, stress-free day in a dental practice: good team communication, team engagement and preparedness. YAPI is a practice management software that speaks to all three. We spoke with Dorfman, a 2000 USC Dental School graduate, to learn more.

You created YAPI to allow dentists to do more dentistry with the same resources and less stress. Can you tell us more about this?

Dorfman: YAPI is a fully integrated and intuitive application that empowers dental teams with real-time actionable practice intelligence delivered through an easy-to-understand visual display. YAPI is the only application of its kind that integrates seamlessly with most dental practice management software.

YAPI

by Krista Houstoun, Assistant Editor, *Dentaltown Magazine*

YAPI automatically pulls specific relevant information from the practice management software, combines it with real-time data and delivers actionable content to everyone on the dental team at a glance. Armed with timely, accurate information, clinical and administrative team members are able to take charge of today, review what happened yesterday and plan for tomorrow.

YAPI is organized around a fully customizable Virtual Dashboard that offers a bird's eye view of the office and improves the flow of information throughout the practice. At a glance, everyone on a dental team knows a patient's status and priority levels: who is ready to be seated; who is filling out paperwork; who came late; who has been waiting a long time to be seated; who needs a hygiene check; and who is running behind schedule. This real-time information enables dental teams to optimize workflow, resolve bottlenecks and handle last-minute changes in the schedule.

The Virtual Dashboard automatically sends real-time, actionable alerts that make everyone on the team aware of any potential issues and help teams make fast, reliable decisions, maximize each patient's visit and handle the unexpected. For example, YAPI automatically reminds team members to collect past due balances, schedule past due hygiene appointments and update medical histories.

YAPI also helps teams prepare for the day ahead and maximize opportunities that each day presents with minimum time investment. Now, in only a few seconds, Virtual Huddle delivers valuable information at their fingertips. Virtual Huddle is dynamic as it's able to show last-minute changes without delays. Because Virtual Huddle is interactive, team members can add additional comments or reminders that they wish to share with their teammates at any time.

How did the idea to start YAPI come about?

Dorfman: YAPI was born out of frustration. I have always been interested in finding simple solutions to solving everyday challenges and I am a big fan of automation. I've been using a very powerful practice management software in my practice since we started, but felt that there were better and easier ways of doing certain things. I've also looked at third-party software but all had one major disadvantage – none were integrated well with my core software to deliver the results I was looking for.

One day I was venting to my father, a software engineer with 30 years of experience in designing business software. He said, "All right, if you were to design a software, what would it look like? How would it work? Who would use it?" At first, I struggled to answer. He pressed on with a lot of "What is the point?" and "What would you do with that information?" questions. We started to think about the possibilities. A few weeks later he called me, "Are you at your computer? Can you look at something?" What I saw made my jaw drop – I was looking at the prototype of YAPI which stands for "Your Actionable Practice Interface."

How many people are working with you on this application?

Dorfman: We are a small family-run company. Being small allows us to make quick decisions and accomplish our goals efficiently. Our greatest strength, however, comes from collaboration with our end users – many of whom are Townies. As a group, Townies are thirsty for information, innovation and improvement. YAPI has evolved exponentially over the past few years due to the feedback and ideas offered to us by our users. It's not unusual for us to get an idea for a feature from one of our users and pounce on it, rolling out a new update almost overnight.

What drives your passion for improving patient flow and productivity for dentists?

Dorfman: I think that every dentist would love to have more productive days that flow well. The consistent keys to having those days are good people and good systems. You've probably heard the saying that good systems enable good people. I've always believed in hiring the best people for my practice. Creating good systems, however, was always hard work.

Systems have to be simple enough for everyone to embrace and follow and they have to be easily reproducible. Most importantly, every member of a dental team has to have the right information and feel empowered to act on this information to accomplish the goals of the practice. Through my participation on Dentaltown.com, I've learned that many doctors struggled with this aspect of practice management. When we created YAPI, we set out to create a set of tools that created structure and empowered good dental teams to perform more efficiently.

To schedule a free YAPI demo or for more information, visit www.yapicentral.com. ■

COSMETIC DENTISTRY

Dentaltown.com Cosmetic Dentistry Forum Statistics (as of September 7, 2012)

Total number of topics: 8,372
Total posts: 134,634

Dentaltown is digging a little deeper. Based on the monthly poll on Dentaltown.com, we're determining explanations for each poll result. Don't forget to participate in the poll on Dentaltown.com each month. The more opinions you can provide us, the more information and statistics we can supply you. The following poll was conducted from August 20, 2012 to September 7, 2012 on Dentaltown.com.

Have you completed any cosmetic dentistry courses in 2012?

No 60%

Yes 40%

Which case would you rather do if the profit were equal?

- 18% Six composite veneers
- 82% Six porcelain veneers

Are you using a preparation guide fabricated from a diagnostic wax-up with your veneer cases?

- 51% Yes
- 49% No

RANDOM QUESTIONS OF THE MONTH:

Do you currently read any magazines in digital format?

- 52% Yes
- 48% No

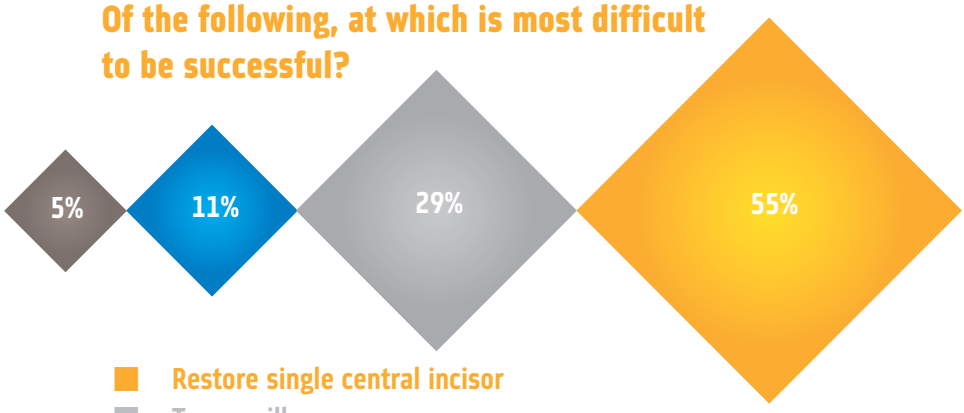
Do you have a personal (not dental practice) social media account on one of the following sites?

- 0% Twitter
- 46% Facebook
- 9% LinkedIn
- 4% Google+
- 41% More than one of the above

What is your restoration of choice for a first molar crown in your mouth?

- 41% e.max
- 7% Lava
- 28% PFM
- 14% Gold
- 10% Other

Of the following, at which is most difficult to be successful?



- Restore single central incisor
- Ten maxillary veneers
- Close open contact on Class II restoration
- Getting access opening filling to match crown

Which of the following crown materials do you believe is most aesthetic?

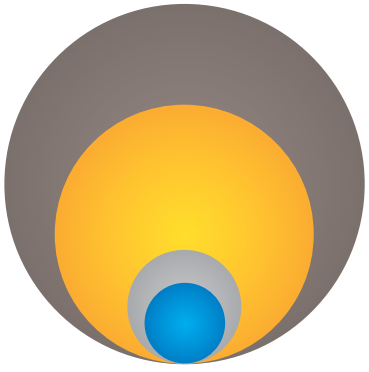
10% Lava

BruxZir 1%

76% e.max

zirconia 13%

Who selects the shades in your practice?



- 31% Dentist
- 6% Assistant
- 60% Combination of dentist and assistant
- 3% Send photos to the lab for most cases

HOW

many shades of composite do you stock regularly in your practice?

- 28% 1-5
- 22% 11-15
- 38% 6-10
- 12% 16+

Current Status of Glass Ionomers

by Dr. Karl F. Leinfelder

Abstract

Continuous research efforts around the world have led to a great number of applications for the glass ionomer. Some of the efforts have resulted in the substitution of this agent for composite resins in primary teeth. When used in conjunction with a surface-penetrating agent, the wear resistance of the ionomer can be improved appreciably. The glass ionomers provide excellent resistance to micro-leakage but they also release effective levels of fluoride ions. At least one clinical study has shown that glass ionomers are clinically effective in reducing the amount of secondary caries, particularly as compared to amalgam.

Glass ionomers can be successfully used as a liner under various types of restorative systems. When used under composite resins they offer great resistance to post-operative sensitivity as well as a fluoride-releasing source. The resistance to post-operative sensitivity can be related to its matched coefficient of thermal expansion with tooth structure. Their effectiveness has led to the substitution of this agent for a flowable composite resin by a large number of clinicians. It should be mentioned that the glass ionomer should be considered for the construction of the floor of the proximal box when the preparation is extended gingival enough to reduce substantially (or eliminate) the enamel wall.

Educational Objectives

At the end of this course the participant will be able to:

1. Identify the advantages of glass ionomers as a restorative agent.
2. Make recommendations for the restoration of posterior preparations in primary teeth in cases of moderate to high incidences of caries.
3. Identify the types of sandwich techniques and the objectives of each.
4. Define methods for restoring abfracted lesions.
5. Discuss the etiology of post-operative sensitivity.

*This written self-instructional program is designated for **1.5 hours of CE credit** by Farran Media. Participants will receive verification shortly after Farran Media receives the completed post-test.* *See instructions on page 130.*

Glass ionomer cement (GIC) was developed as a luting agent by professors Wilson and Kent nearly 40 years ago.[1] A patent for this innovative concept was subsequently applied for in 1969. Its interesting history is shared with a couple of other restorative systems including polycarboxylate cement (PCA) and silicate cement. While the PCA was the first restorative system to bond to tooth structures, silicate cement effectively released fluoride ions to actively resist or prevent caries. The glass ionomer actually possesses both these potentials.

The powder component of the original glass ionomer was similar to the powder of silicate cement.[2] In general, it is a finely ground ceramic glass, soluble in acids. The primary component of the GIC was SiO_2 and Al_2O_3. It contained also lesser amounts of NaF, CaF_2 and $AlPO_4$. The liquid component on the other hand consisted of polyacrylic acid and tartaric acid (approximate ratio of 10:1). The reaction between the liquid and the powder is essentially an acid-base reaction. The reaction is rather complex.

Over the years the formulation has changed. Today, glass ionomers are considerably easier to manipulate. One of the great improvements has come about with the addition of a resin component. Commonly referred to as RMGI or resin modified glass ionomer, they are widely used for any application from liners to bases to luting agents. By incorporating the resin, many of the physical and mechanical properties have been improved dramatically. Most notable amongst the changes was the ability to control the setting time. One of the more interesting systems was Vitremer (3M ESPE). Identified as a photocured glass ionomer cement, this agent consists of a difunctional molecule. One end of the polymeric chain exhibits a chemical affinity for glass and the other end for tooth structure. Interestingly, this system will cure with light radiation or in a self-cure mode.

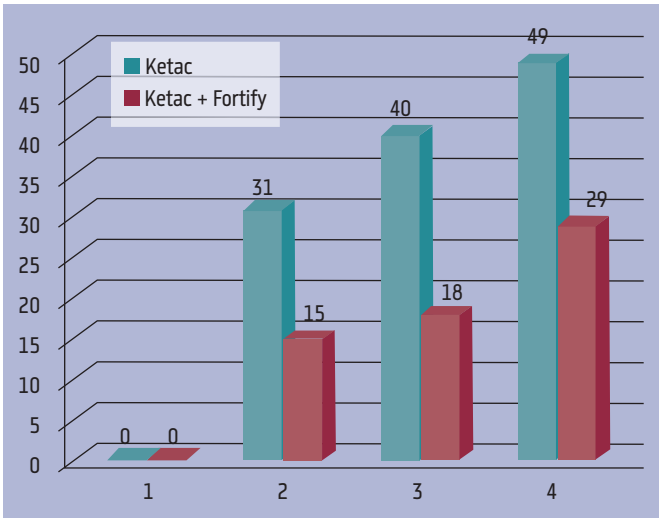


Fig. 1: In vitro wear rates of KetacFil and KetacFil + Fortify.

Clinical Considerations

The use of aesthetic restorative agents has become quite acceptable in pediatric restorative procedures. In this regard, composite more closely resembles the physical nature of natural teeth. However, composites might not be the best choice when dealing with posterior teeth. It is now recognized that caries, when present, progresses appreciably faster under composite restorations than it does with amalgam. The exact reason(s) incidentally has not been published. It is quite possible that the metal ions associated with amalgam (silver, copper, tin, zinc or even mercury) might serve as anticariogenic agents. In the case of composite resins there is nothing in the composition to generate such an action.

It is for this reason that glass ionomers have been recommended by some as a possible aesthetic material for the restoration of Class I and II cavity preparations in primary teeth. Unfortunately the glass ionomer might not be sufficiently wear-resistant over long periods of time (i.e., six to eight years). It has been suggested that perhaps a surface penetrating agent such as Fortify (Bisco) might be useful in enforcing the occlsual surface, thereby rendering it more resistant to clinical wear. Traditionally, the only way to determine efficacy would be clinical studies.

Using an in vitro device developed at the University of Alabama, it is now possible to determine the long-term wear rate and marginal integrity of aesthetic restorative materials.[3] Specifically, the instrument will generate the actual wear resistance of direct filled aesthetic restorative materials that normally occurs in three years of clinical service in three days. Examples of restorative agents that can be tested for long-term clinical performance include composite resins (direct and indirect), compomers and glass ionomers. Resistance to marginal degradation or "ditching," which is common to microfills when used on occlsual surfaces, can also be predicted. A comparison of 10 different posterior composite resins for wear over a three-year period showed remarkable correlations to the in-vitro data. Values measured for each year agreed to within three microns for each material tested. Such a device has helped various manufacturers to test their product using the in vitro device before actually marketing their system.

In a study conducted at the University of Alabama, teeth were restored with a glass ionomer (KetacFil) and then were surfaced with Fortify. Using the wear-determining device developed at UAB, the wear rates of the glass ionomer were measured and compared to those that received the Fortify treatment (Fig. 1).

1. *Wilson AD and Kent BE: A new translucent cement for dentistry; the glass ionomer cement. Br Dent J 132(2): 133-135, 1972.*
2. *Crisp S and Wilson AD: Reactions in glass ionomer cements V. Effect of incorporating tartaric acid in the cement liquid. J Dent Res. 55:1023-1031, 1976.*
3. *Leinfelder, K.F., Beaudreau, R.W. and Mazer, R.B. An in vitro device for predicting clinical wear. Quint. Inter. 20:755-761, 1989.*

continued on page 126

The application of the surface-penetrating sealant (Fortify) enhanced the wear resistance by approximately 40 percent. The positive effect of the Fortify can be seen throughout the entire testing period. The total time of testing was equivalent to three years of clinical use. It is probable that by the end of three years that the surfaces of the glass ionomer restorations need to be recharged with the sealant since the depth to which the sealant had penetrated originally might be worn away. At least one clinical study has demonstrated that Fortify appreciably enhanced wear resistance of composite resins as well as marginal adaptation (marginal integrity).[4,5]

The procedure for using the surface penetrating sealant is quite simple. Upon completion of the cavity preparation and surfacing with an appropriate conditioner, a glass ionomer restorative material (Fuji IX, Fuji II LC, KetacFil) is used to restore the tooth. Upon completion of cure (light) the occlsual surface is acid etched for approximately 10 seconds. After washing and drying, Fortify surface-penetrating agent is applied with a small brush or cotton pledget, lightly air dispersed and then light-cured. Since the film thickness of this agent is only 5 microns, it doesn't interfere with the occlusion. Due to the very low viscosity of the surface penetrating agent, it rapidly penetrates the microporous surface, thereby enhancing its integrity. Interestingly, there are two variations of the Fortify; Fortify and Fortify Plus. The latter contains colloidal silica and as a result will generate a relatively smoother surface.

Further Uses

Glass ionomers like composite resins have been available to the dental profession for nearly four decades. Both of them have experienced major advances not only in clinical characteristics but applications as well. Glass ionomers, particularly those that have been modified with a polymer component, have been recommended for the following uses:

1. Liners/bases under various restorative materials
2. Cavity preparations in primary teeth (Classes I and II)
3. Cervical restorations (abfractions and caries)
4. Defects and undercuts
5. Caries control (temporary restorations)
6. Core buildups
7. Luting agents for crowns, inlays/onlays

Many clinicians routinely use a glass ionomer liner in conjunction with teeth to be restored with either composite resin or amalgam. Interestingly, the incidence of post-operative sensitivity is dramatically reduced when the preparation is lined with glass ionomer. While the thickness of the liner is not critical, it is recommended that it should be at least one millimeter in thickness. It is important to cover the entire pulpal floor, pulpal axial line angle and the dentin located on the gingival floor. The glass ionomer can serve as a substitute for the flowable composite resin.

The avoidance of post-operative sensitivity probably can be attributed to the fact that glass ionomers inhibit micro-leakage and thus post-operative sensitivity. The reason can be related to the fact that the coefficient of thermal expansion of the glass ionomer is very close to that of tooth structure.[6] Consequently, any increase or decrease in temperatures will cause the two substances to expand and contract similarly. This then avoids the effect of a pumping action at the interface, which will cause negative pressure on the surface of the odontoblastic processes and then pain.

The concept of pain or post-operative sensitivity (POS) has been widely investigated by Brännstrom. In essence he has demonstrated that anything that causes a movement of the odontoblastic fluids over the body of the odontoblastic process will create a negative pressure.[7] This, in turn, will create a painful response. Positive pressures, by the way, do not.

A diagrammatic illustration of the factors that generate sensitivity are illustrated in Figure 2. There are numerous clinical conditions that contribute to fluid flow over the surface of the odontoblastic process. The first of these is the application of air onto the surface of the cut dentin. Without an anesthetic, the patient invariably complains of pain or sensitivity. The burst of

Fig. 2: Mechanism of Sensitivity

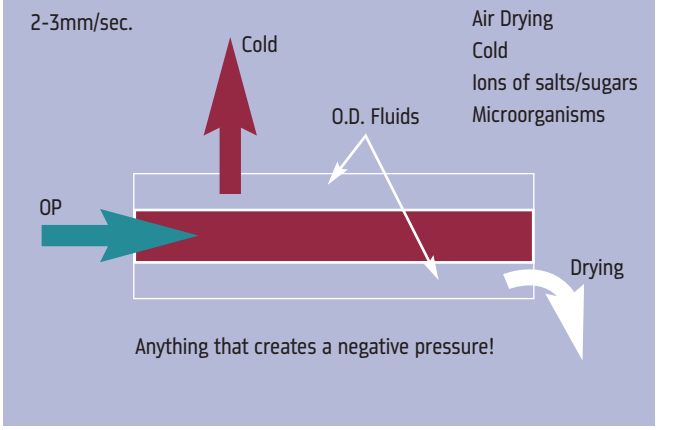


Fig. 2: Diagrammatic illustration of cause of post-operative sensitivity.

4. *Dickinson, G.L., Leinfelder, K.F., Mazer, R.B. and Russell, C.M. Effect of surface penetrating sealant on wear rate of posterior composite resins. JADA 121:2, 251-255, 1990.*
5. *Dickinson, G.D. and Leinfelder, K.F.: Assessing long term effect of surface penetrating sealants: JADA 124:68-172, 1993*
6. *Bullard, H., Leinfelder, K.F. and Russell, C.W.: Effect of coefficient of thermal expansion on microleakage. JADA 116:871-874, 1988.*
7. *Brännstrom, M, The effect of dentin desiccation and aspirated odontoblasts on the pulp. J Prosthet Dent 20(2): 165-171, 1968*

air creates an evaporation of the fluids, thereby creating a temporary negative pressure. The sensitivity will continue until fluids from the inner region of the process migrate over the affected area. This normally takes several seconds.

According to Brännstrom, cold temperatures applied to the freshly cut dentin and cervical lesions cause a contraction of the fluids surrounding the odontoblastic process. This in turn creases a negative pressure and again a painful response. The pain will continue until the temperature of the fluids increases back to normal physiologic conditions. Ions of sugar and salts will contribute to pressure changes and painful response. The same can also be said of microbial activity. The glass ionomer, when placed on the freshly cut dentinal surface, effectively acts as a seal. Not only does it bond to the surface of the tooth but it also closes off the dentinal tubules.

Incidentally, when the proximal box (Class II preparation) is sufficiently deep so that little or no enamel exists, it is recommended that the box portion consist of glass ionomer. Procedurally, the glass ionomer should form the box portion of the preparation to a thickness of about 2mm. It is well-recognized that the proximal region of the Class II is the Achilles' Heel of this type of restoration. Again, lack of micro-leakage and fluoride release provide insurance against clinical failure.

Identified as the sandwich technique, there are two types. These include the open and closed technique. If any of the surfaces of the glass ionomer liner are exposed to the oral cavity it is referred to as open. If none of the glass ionomer is exposed (completely imbedded) it is identified as a closed sandwich technique. A diagrammatic illustration of the two types is presented in Figure 3.

Fig. 3: Sandwich Techniques

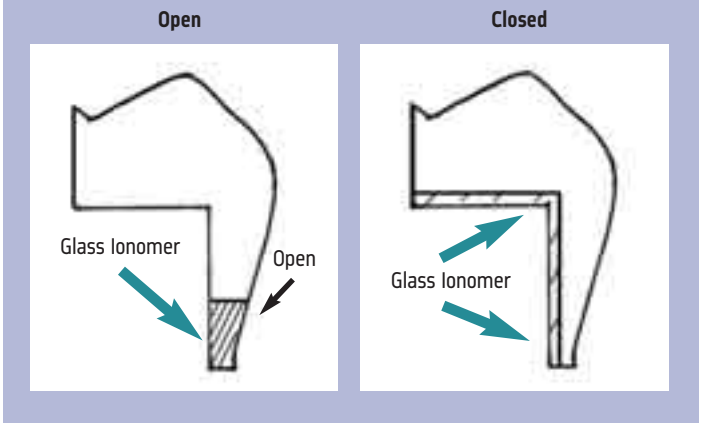


Fig. 3: Diagrammatic illustration of open and closed sandwich techniques.

"Today glass ionomers are considerably easier to manipulate. One of the great improvements has come about with the addition of a resin component."

Abfractions/Caries

Defects occurring in the cervical regions can be treated in a number of ways. The manner selected, however, can depend upon the general age of the patient. In general, the technique is somewhat similar for both the abfracted lesions and those involving carries.

Abfracted Lesions

In recent years there has been considerable information published and discussed related to "natural" occurring defects in the cervical region (both facial and lingual). Although not unanimously agreed upon, it is generally believed that the defects identified as abfractions are due to a deflection of a tooth or teeth beyond its normal physiologic limit. Small cracks begin on the tooth surfaces which then propagate until small pieces break away (abfraction).[8]

Regardless of whether the defect was created by deflection or caries, the principles of restoration are similar. In the case of elderly patients, the occlusion is evaluated for occlusal prematurity, particularly as it relates to the tooth on which the defect occurs. If a prematurity or heavy contact is uncovered, it should be corrected. Next the surface of the defect is slightly roughened with an appropriate instrument.

This is followed by generating a small mechanical undercut on both the occlusal (incisal) and gingival aspect of the defect. Next, acid etch (or etch with bond depending upon which bonding agent is used) followed by bonding. After completion of the hybridizing procedure, it is recommended that a glass ionomer (Fuji IX or Fuji II LC) be used to restore the defect. Glass ionomers are the materials of choice in dealing with geriatric patients. As one ages, the normal physiologic flow of salivary fluids is reduced thereby inhibiting washing of the surface. The glass ionomer is believed to compensate for this aging problem by releasing fluoride into the surface of the defect.

In the case of younger patients, a micro-fill or wear-resistant flowable resin should be considered as the restorative agent. While some of the current day glass ionomers are

8. *Lee WG and Eakle WS: Possible role of tensile stress in the etiology of cervical erosions of teeth. J Prosthet Dent 52(7):341-380, 1989.*

continued on page 128

quite aesthetic, they might not exhibit the same surface characteristics and translucency as the microfills. Other than the restorative agent, the technique used for either young or older patients is essentially the same.

Caries Resistance

Silicate cements have long been credited for eliminating or reducing the potential for generating primary and secondary caries. The many years of history associated with their use has convinced the profession that silicate cement is most effective in this regard.

Given the same time frame for glass ionomer it is more than likely that the same relationship will be established. Interestingly, however, a study conducted by Haberman and Burgess at LSU School of Dentistry has demonstrated the caries retardation effect associated with glass ionomers (Fig. 4). While full proof of caries prevention would take a large number of patients and years of investigation, this study has made an important inroad.

In that study the authors selected a group of patients who exhibited poor caries resistance. In those patients they inserted amalgam and two types of glass ionomer. At the end of two years, the amount of secondary caries associated with the amalgam restorations was significantly greater than in the case of the restorations of glass ionomer.

Treatment of Cavity Preparations Prior to Restoration

The literature is filled with recommendations for treating the preparation prior to insertion of the restorative material.

Fig. 4: Percent of Caries Free

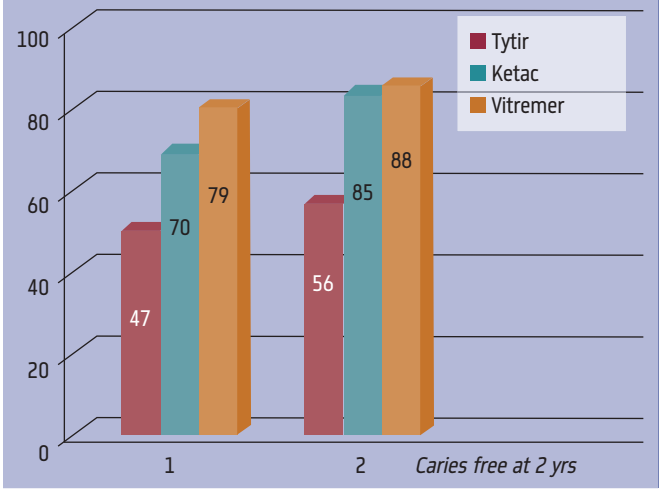
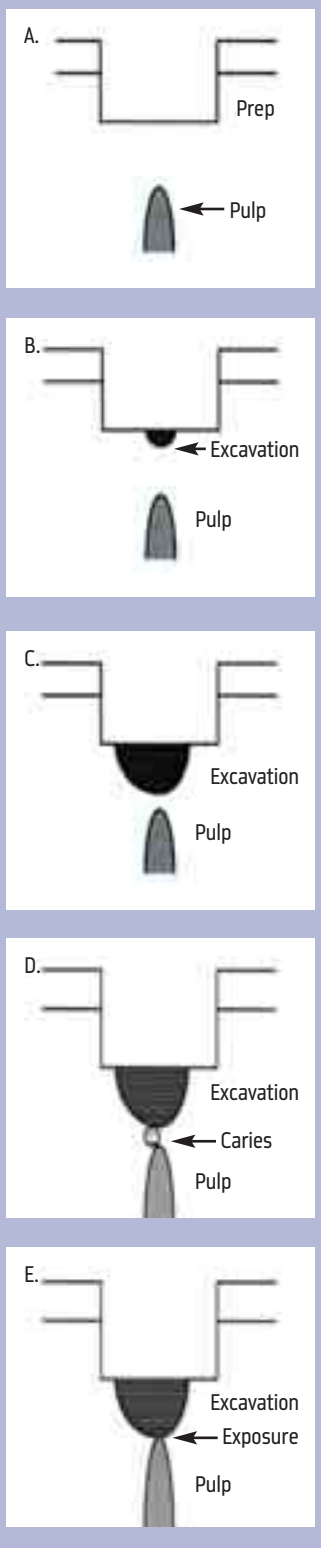


Fig. 4: Percent of recurrent caries associated with restorations of amalgam and glass ionomer.

Fig. 5: Techniques for Treating Cavities



Standard Preparation:
Hybridize

Extended Preparation:
Hybridize

Deep Excavation:
(possible micro exposure)
$Ca(OH)_2$
Glass Ionomer
Hybridize

Residual Caries:
(<1mm in diameter)
$Ca(OH)_2$
Glass Ionomer
Hybridize

Pupal Exposure:
(slight)
$Ca(OH)_2$
Glass Ionomer
Hybridize

Fig. 5: Diagrammatic illustration of techniques used for treating cavity preparations.

"In the case of a standard cavity preparation, it is recommended that the preparation be hybridized (amalgam or composite). Such a treatment not only prevents post-operative sensitivity but also prevents the invasion of micro-organisms into the dentinal tubules. Even in conservative preparations (composites) it is recommended that a glass ionomer liner or flowable composite resin be employed."

While general agreement exists prior to the advent of composite resins, the more current literature is less unanimous in suggesting types of treatment. As a result, there are now clinical questions about the use of glass ionomers, dentin adhesives, liners, bases (i.e., calcium hydroxide) and even acid-etching pulpal exposures.

General recommendations for treatment of the preparation, depending upon the extent of dentin removal, are presented in Figure 5. In the case of a standard cavity preparation, for example, it is recommended that the preparation be hybridized (amalgam or composite). Such a treatment not only prevents post-operative sensitivity but also prevents the invasion of micro-organisms into the dentinal tubules. Even in conservative preparations (composites) it is recommended that a glass ionomer liner or flowable composite resin be employed. No calcium hydroxide (Dycal, Dentsply) is suggested. Should the preparation be extended two to three millimeters beyond the normal outline form, the same treatment is appropriate.

Now if the preparation is extended just short of the pulpal chamber, then a thin layer of calcium hydroxide over the extended portion of the preparation is recommended. Since Dycal ($CaOH)_2$ liberates hydroxyl ions, the resultant increase in pH kills any of the caries-producing micro-organisms that might be present. The surface of the $CaOH_2$ is then covered with a thin layer of glass ionomer. Next the preparation is hybridized and then restored.

If removal of a small amount of residual caries (i.e., 1mm) is left to prevent the possibility of a mechanical exposure, the area is covered by $Ca(OH)_2$. Next the liner of $Ca(OH)_2$ is surfaced with a one to two millimeters of glass ionomer. After hybridizing the restoration is inserted. If, however, a small exposure occurs during a deep excavation, the slight exposure (after cessation of the hemorrhaging) is covered with a millimeter of Dycal. After setting, the surface is then covered with a one to two millimeter layer of glass ionomer. The glass ionomer serves to prevent transmission of condensation forces and thereby distention of the $Ca(OH)_2$ into the exposed surface. Such a condition could cause necrosis of the pulp.

The use of glass ionomer is quite popular on a worldwide basis. For some reason they have been less than totally accepted as a direct and indirect agent in the United States. Fortunately this has changed in recent years due to the excellent clinical results reported by the profession. ■

Author's Bio

Dr. Karl F. Leinfelder earned both his Doctor of Dental Surgery and Master of Science (dental materials) degrees from Marquette University. He joined the faculty of dentistry at the University of North Carolina in 1970. In 1983, he joined the School of Dentistry at the University of Alabama and is the recipient of the Joseph Volker Chair. He also served as Chairman of the Department of Biomaterials until 1994. Presently he holds positions at both universities; adjunct professor at University of North Carolina and professor emeritus at the University of Alabama. Dr. Leinfelder has published more than 275 papers on restorative materials, authored more than 150 scientific presentations, two textbooks on restorative systems and has lectured nationally and internationally on clinical biomaterials.

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Post-test

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1. The glass ionomer cement (GIC) was developed by which of the following investigators?
   a. Black
   b. Kent
   c. Buonocore
   d. Brännstrom

2. The primary component of glass ionomer cement is which of the following?
   a. SiO2
   b. PCA
   c. ZnO2
   d. PMMA

3. Which of the following agents have been added to GIC for the purpose of enhancing their handling characteristics?
   a. Fortify
   b. PCA
   c. Resin
   d. NaF

4. Which is the best restorative material to use for pediatric patients with a moderately high caries rate?
   a. Amalgam
   b. Composite
   c. Compomer
   d. Glass ionomer

5. Which restorative material is associated with the greatest progression of clinical caries?
   a. Amalgam
   b. Composite resin
   c. Silicate cement/glass ionomer
   d. Porcelain

6. The use of a surface penetrating agent (Fortify, Bisco) will enhance the wear-resistant characteristics of both composite resins and glass ionomers. The amount of reduction in occlsual wear is approximately:
   a. 10 percent
   b. 20 percent
   c. 40 percent
   d. 100 percent

7. The clinical effectiveness of Fortify on glass ionomer restorations is due to which of the following?
   a. Generation of a copolymer
   b. Creation of a hard glassy surface
   c. Penetration and filling of subsurface spaces
   d. Development of a surface with a lower coefficient of friction

8. The correlation of wear generated either clinically or by means of the UAB in vitro wear device is quite high. The average difference between the two is no more than how many microns per year?
   a. 0
   b. 3
   c. 10
   d. 20

9. The avoidance of post-operative sensitivity can be attributed to which of the following conditions:
   a. Matched coefficients of thermal expansion between the tooth structure and the cement
   b. Reduction in electrical current
   c. An increase in pressure on the odontoblastic process
   d. Conservative use of zinc phosphate cement

10. In the case of minimal pulp exposure, the ideal agent recommended for the application to the surface of the exposure is?
    a. Glass ionomer
    b Calcium hydroxide
    c. Acid-etching agent
    d. Dentin bonding agent

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Current Status of Glass Ionomers by Dr. Karl F. Leinfelder

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❑ Orthodontic Resident
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❑ Pediatric Resident
❑ Periodontics
❑ Periodontic Resident
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❑ Public Health
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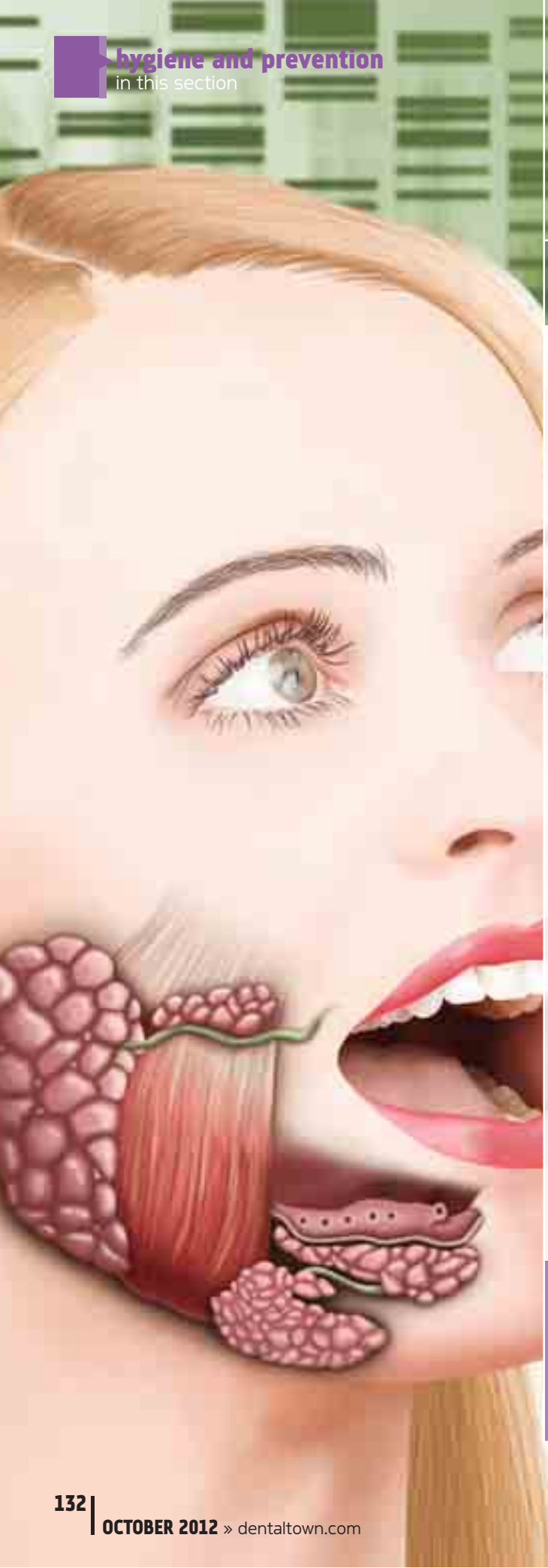


Risk Assessment

by Trisha E. O'Hehir, RDH, MS
Editorial Director, Hygienetown

If you see bleeding, bacteria and toxins are entering the blood stream. For many years, risk assessment meant clinicians looked for bone loss on radiographs and told patients they would lose their teeth if they didn't treat their periodontal disease. To my surprise, not many people were losing their teeth to periodontal disease, so that message wasn't effective. However, the thought of bacteria and pus entering the blood stream from the mouth and moving throughout the body did make sense to patients. Just the idea of the oral infection flowing through the circulatory system to other parts of the body was enough to motivate patients to accept treatment, maintenance and their responsibility for daily biofilm control.

Research is now accumulating that links periodontal disease and many systemic conditions. It began with only a few studies demonstrating a link between diabetes and periodontal disease, and the influence of pregnancy hormones on bacteria causing gingivitis. We now have research that confirms the obvious – a connection does exist between the mouth and the rest of the body. Other studies show the benefits of bacterial and genetic testing and computerized risk assessment. With this information, risk assessment takes on a new dimension that enhances treatment planning, care and monitoring.

Despite the growing evidence of a link between oral and systemic health, no studies confirming direct cause and effect between oral health and systemic health have been published. Such studies would be unethical to perform. Controlling all variable and allowing periodontal disease to progress to observe systemic problems would never receive ethical approval. Such studies are not needed to encourage patients to maintain a healthy mouth and a healthy body. ■

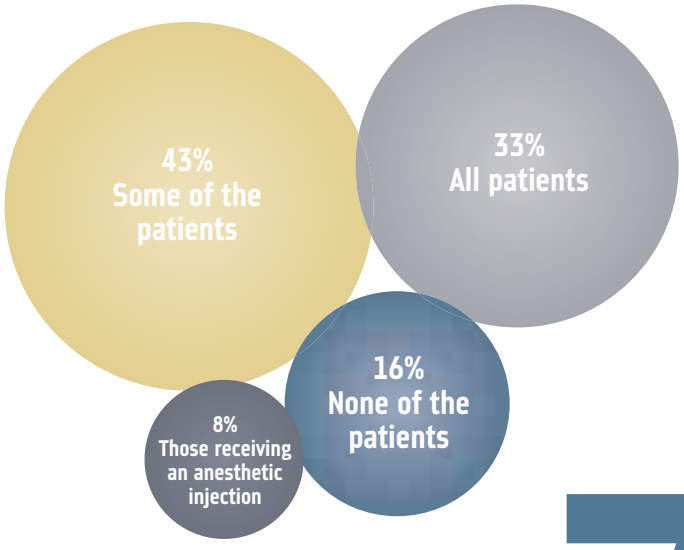
Inside This Section

Hygienetown Research:

How do your hygiene colleagues feel about risk assessment? Read the results below of our online poll, conducted from August 7, 2012 to September 7, 2012, to find out. And don't forget to participate in the poll on Hygienetown.com each month—the more opinions you can provide us, the more statistics we can supply you.

RISK ASSESSMENT

Blood pressure is checked on:



Do you measure flow rate and buffering of saliva?

- 6% Yes
- 94% No

Do you use bacterial testing in your practice?

74% No

26% Yes

Does your practice offer genetic testing to determine periodontitis risk?

- 8% Yes
- 92% No

Does your practice order blood tests for patients?

- 5% Yes
- 95% No

Do you check the pH of saliva?

- 9% Yes
- 91% No

Does your practice offer nutritional counseling?

- 56% Yes
- 44% No

Does your practice use a CAMBRA form to track caries risk?

- 15% Yes
- 85% No

Erectile Dysfunction Linked to Periodontitis

Several pathophysiological factors are common to both periodontitis and erectile dysfunction: systemic inflammation, oxidative stress and endothelial dysfunction. One study of 305 men showed chronic periodontitis more prevalent among men with erectile dysfunction while another study of 70 men found no direct correlation. Periodontal inflammation was recently shown in an animal model to impact penile endothelial cells.

Researchers at Taipei Medical University in Taipei, Taiwan analyzed the data from Taiwan's National Health Insurance Research Database of 22.6 million of Taiwan's 22.96 million residents. Data was collected from all medical claims for both in-patient and out-patient visits. A subset of 32,856 men with erectile dysfunction was compared to a group of 164,280 randomly selected controls with no diagnosis of erectile dysfunction. Periodontal examination and treatment is part of the insurance plan, providing the diagnosis of chronic periodontitis. For this study, a diagnosis of chronic periodontitis must have occurred twice to be considered.

Those with erectile dysfunction were 3.35 times more likely to have a previous diagnosis of periodontitis compared to the controls after adjusting for income, age, geographic location, hypertension, diabetes, hyperlipidemia, coronary heart disease, obesity and alcohol use or abuse. The association was strongest among those under 30 years of age at 4.54 times. In those over 69 years of age the odds ratio was 4.84. Neither patients nor clinicians feel comfortable discussing sexual dysfunction, but with this strong correlation between periodontitis and erectile dysfunction, the conversations might prove to be beneficial.

Clinical Implications: Sexual dysfunction might become a topic for clinicians to discuss with patients as they discuss the link between erectile dysfunction and periodontitis. ■

Keller, J., Chung, S., Lin, H.: A Nationwide Population-Based Study on the Association Between Chronic Periodontitis and Erectile Dysfunction. J Clin Perio 39:507-512, 2012.

Perio Reports Vol. 24, No. 10

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Alcohol Consumption Linked to Periodontitis

Alcohol abuse is a global problem that can impact social, economic and health aspects of life. Alcohol consumption has been associated with periodontitis, and in some cases those who consumed alcoholic beverages also had poor oral hygiene.

Researchers at the Federal University of Minas Gerais and the University of Taubate in Brazil collaborated on a study evaluating the influence of alcohol on periodontal health. From a group of just over 1,000 patients waiting to be treated at three clinics in Brazil, a total of 542 subjects were accepted into the study. The group of both men and women ages 35 to 55 years received a complete periodontal examination and were divided into four groups based on alcohol consumption. Alcohol consumption was reported to be 69 percent of the sample, with 11 percent considered alcohol dependent. The percentage of each group that had periodontal disease is listed below:

1. No or occasional use – 17 percent
2. Moderate use – 24 percent
3. Intense use – 30 percent
4. Alcohol dependence – 53 percent

For this study, periodontal disease was defined as having four or more teeth with one or more sites probing 4mm or more or 3mm of clinical attachment loss. Smoking was also taken into consideration in the final evaluation. The risk of periodontal disease was increased in those who consumed alcohol and smoked: 3.43 to 7.91 times for smokers and 1.22 to 3.01 times for non-smokers.

Clinical Implications: Clinicians know intuitively that alcohol use/abuse has contributed to periodontal disease and these findings confirm those observations. ■

Lages, EJ., Costa, F., Lages, EM., Cota, L., Cortelli, S., Nobre-Franco, G., Cyrino, R., Cortelli, J.: Risk Variables in the Association Between Frequency of Alcohol Consumption and Periodontitis. J Clin Perio 39:115-122, 2012.

Recognizing Undiagnosed Diabetes in Dental Patients

According to the Centers for Disease Control and Prevention, one-quarter of those affected with Type 2 diabetes are undiagnosed. These people are unaware of their condition. Early detection and intervention can prevent diabetes in cases of pre-diabetes or sub-diabetic hyperglycemia. Screening for diabetes should be extended from the medical community to dental professionals since periodontal measurements can be indicators of the disease.

Researchers at Columbia University in New York, recruited patients with at least one of four self-reported risk factors for diabetes. Periodontal examinations were provided for more than 500 subjects over the age of 30. They were also tested for HbA1c levels using a finger stick blood test with chair-side analysis. Smoking history was also included as this is the number-one risk factor for periodontitis. Five days later, subjects were invited back for a fasting plasma glucose test (FPG). Those with scores of over 100mg/dL on this test were advised to see a physician.

Two clinical parameters correctly identified 73 percent of previously unrecognized hyperglycemia cases: 1) four or more missing teeth and 2) 26 percent of teeth with probing depths measuring 5mm or deeper. When the chair-side HbA1c results were added, correct identification of pre-diabetic cases increased to 92 percent.

Clinical Implications: Dental professionals have an opportunity with two dental variables and one blood test to identify undiagnosed diabetes and refer to a medical professional. ■

Lalla, E., Kunzel, C., Burkett, S., Cheng, B., Lamster, I.: Identification of Unrecognized Diabetes and Pre-diabetes in a Dental Setting. J Dent Res 90(7):855-860, 2011.

Gingival Bleeding Used for Diabetes Testing During Dental Visit

The traditional finger-stick test is used to collect a drop of blood that is then placed on a collection card, sealed in a foil pouch and mailed to the laboratory where it is tested for hemoglobin A1C (HbA1c). In the dental office, oral blood is suggested for this testing to avoid the finger stick.

Periodontal patients at New York University College of Dentistry participated in the study. The 120 study subjects ranged in age from 23 to 87 years and included 50 males and 70 females. In addition to clinical, medical history and socioeconomic information, blood samples were collected from both finger stick and gingival crevicular blood. Bleeding upon probing sites were isolated with cotton rolls to prevent saliva contamination during blood collection. Samples were allowed to air dry for 15 minutes and then sealed in foil envelopes for mailing to the laboratory.

Based on the finger stick tests, 17 percent of the subjects were found to be in the diabetes range with an additional 55 percent in the pre-diabetes range. Not all subjects had bleeding upon probing, so only 102 were tested based on crevicular blood. Within that group, 27 were found to be contaminated with other substances. Final analysis included 75 patients with both finger stick and crevicular blood sample tests. The correlation between the two tests for diabetes and pre-diabetes was 0.842.

Clinical Implications: In a dental office, crevicular blood samples are an option for collecting samples for HbA1c testing. ■

Strauss, S., Tuthill, J., Singh, G., Rindskopf, D., Maggiore, J., Schoor, R., Brodsky, A., Einhorn, A., Hochstein, A., Russell, S., Rosedale, M.: A Novel Intraoral Diabetes Screening Approach in Periodontal Patients: Results of a Pilot Study. J Perio 83:699-706, 2012.

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Severity of Periodontitis Influences Carotid Artheromas

Periodontitis is an infectious, inflammatory disease that may influence risk for astherosclerotic changes in blood vessel walls. Several factors are involved in the progression of cardiovascular disease: age, smoking, hypertension, cholesterol levels, sedentary life style, family history and male sex. Periodontal disease is considered one of the risks for cardiovascular disease.

Researchers at the University Dental Clinic in Murcia, Spain compared periodontal disease levels and several indicators of cardiovascular disease. One group of 30 adults were systemically healthy and had periodontitis. The second group of 30 adults was both systemically and periodontally healthy. Ultrasound examination of the right carotid artery was done to measure the internal thickness of the vessel wall. Other standard measurements were collected: blood pressure, cholesterol levels, blood glucose, BMI, smoking, lifestyle and periodontal status.

Internal carotid wall thickness was similar for both groups. Plaque accumulation on the vessel wall was evident for 57 percent of those with periodontitis compared to 20 percent of those who were periodontally healthy. Those with the most severe periodontal disease were more likely to have measurable plaques on vessel walls. Age is also a risk factor for both periodontitis and heart disease and in this study was the most predictive factor for atherosclerotic changes.

Clinical Implications: This study doesn't show that periodontitis causes atheroma formation in the carotid artery, but periodontitis should be considered one of several risk factors for cardiovascular disease. ■

López-Jornet, P., Berná-Mestre, J., Berná-Serna, J., Camacho-Alonso, F., Fernandez-Millan, S., Reus-Pintado, M.: Mearurements of Atherosclerosis Markers in Patients with Periodontitis: A Case-Control Study. J Perio 83:690-698, 2012.

Periodontal Pathogens and Arthritis

Rheumatoid arthritis (RA) is a chronic inflammatory disease with disease progression similar to chronic periodontitis (CP). The etiology of RA is still unknown, but it has been suggested that an infectious agent in a susceptible host could trigger the RA inflammatory process. Several agents being considered are mycoplasma, Epstein-Barr virus, cytomegalovirus, rubeola virus and periodontal bacteria.

Researchers at San Luis Potosi University in Mexico evaluated a group of 19 subjects with both CP and refractory RA to see if periodontal pathogens or DNA from these bacteria could be found in serum and synovial fluid. Sub-gingival plaque samples were taken after blood and synovial fluid samples, to avoid any bacteremia. Plaque samples were taken from the upper right first molar, the lower right central incisor and the lower left premolar.

The two most common bacteria found in all three areas were *P. intermedia* and *P. gingivalis.* DNA from periodontal pathogens was found in all samples of serum and synovial fluid.

Samples from the serum and synovial fluid were cultured to see if bacteria could be grown, but none did. It was concluded that the free DNA form was transported through the blood stream from the periodontal pockets to the knee joint, where it has been shown in mice to trigger an inflammatory response with release of cytokines and bone destruction.

Clinical Implications: This preliminary study shows the potential for periodontal pathogens to travel from the mouth to joints where inflammation is triggered. Not all people with RA also experience CP but more research will determine if periodontal bacteria do in fact trigger RA. ■

Martinez-Martinez, R., Abud-Mendoza, C., Patiño-Marin, N., Rizo-Rodriguez, J., Little, J., Loyola-Rodriguez, J.: Detection of Periodontal Bacterial DNA in Serum and Synovial Fluid in Refractory Rheumatoid Arthritis Patients. J Clin Perio 36: 1004-1010, 2009.

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A Clinical Example of Risk Assessment

by Rachel Wall, RDH, BS with Stacy McCauley, RDH, MS and Kim Miller, RDH, BS

Risk assessment has been a buzzword in dentistry for many years. While many teams look for a cookie-cutter approach to their treatment protocols, the time has come to set clear guidelines and standards for treatment planning, taking into consideration clinical findings, the patient's medical and dental history, and personal concerns.

Risk assessment requires high-level critical thinking. Even with all the risk assessment forms, programs and testing products available, these tools can't do all the thinking for you and might be overwhelming for both the clinician and the patient when we attempt to implement them all in a short period of time.

The goal of this article is to provide a real-life risk assessment example with strategies for helping strengthen critical thinking skills to improve provider-to-patient communication and enrollment success.

Moving Toward Assessment

Have you ever experienced this? A patient sits in your chair and you're immediately overwhelmed by the need to introduce the latest in oral cancer detection, caries prevention, complete periodontal charting and don't forget photos to present his restorative needs.

It can feel overwhelming not only to you but to your patient. He can feel he's being "sold" every new gadget and product you have. Risk assessment is the key to overcoming the feeling of being overwhelmed and using critical thinking to identify the most critical need the patient presents today. If the patient presents with significant decay on many teeth and has one 4mm bleeding pocket, this patient has a higher risk for tooth loss from the progression of the decay than he does for tooth loss due to periodontal disease. Perhaps you review daily oral hygiene and

plant the seed to re-evaluate the inflamed area soon, but speaking to repairing the decay to save the teeth and then recommending an anti-cavity homecare regime is the top priority at this time.

First and foremost, ask your patient this question "What is your primary concern today?" The patient's concerns and questions are always the starting point for setting priorities for the current visit as well as future treatment appointments. The daily schedule is only a guide for what might occur with each patient. Being flexible and focusing on the patient's current need rather than what he was scheduled for is a key building block in developing higher-level risk assessment skills. The time commitment and relative complexity of some risk assessment tools can be overwhelming. And while they are valuable, they can't do the thinking for you.

Clinical Example: Nick*

Nick is a 40-year-old white male with arthritis, high blood pressure and attention deficit disorder (ADD). He is taking Crestor for high cholesterol, Vyvanse for ADD. Six months ago he presented as a new patient with generalized, moderate periodontal disease, moderate alveolar bone loss, moderate to heavy bleeding, red, swollen tissue and moderate to heavy subgingival calculus and plaque biofilm. It had been several years since the patient visited the dentist. As a motivated, health-conscious patient, he moved forward with non-surgical periodontal treatment right away. Arestin was used at the time of therapy in sites measuring 5mm or deeper with bleeding. The patient began using dental floss regularly, a power toothbrush, as well as mouthrinse to elevate the pH.

Tooth #16 is present and creating a bacterial reservoir contributing to infection in adjacent teeth. Orthodontics, removal of #16 and restoration of deteriorating, old restorations were all recommended, however, treatment of periodontal infection was set as the first priority.

Nick returned for re-evaluation two months after active therapy. Pocket depths and bleeding points were reduced yet there still remained 4mm bleeding pockets in the UL adjacent to #16. The area was reinstrumented and oral hygiene was reviewed. Three months later, he returned for a periodotnal maintenance visit. When asked what his primary concern was that day, Nick stated he had noticed an increase in bleeding on brushing and flossing. A periodontal exam revealed an increase in pocket depth and bleeding in localized areas.

Upon reviewing the medical history and positing the open-ended inquiry: "Tell me more about the arthritis," he shared a history of rheumatoid arthritis as an immune system response to psoriasis outbreaks. He stated his immune system "overreacts" when he has psoriasis flair up and results in the arthritic symptoms.

Another open-ended question was asked: "Who in your family has a history of periodontal disease?" He then shared that his mother lost half her teeth at a very young age. He also reported a family history of heart disease.

Remember, he's taking Crestor for high cholesterol and Vyvanse for ADD.

Let's Review the Facts

- Vyvanse increases the stress hormone Cortosol. There has been evidence showing the relationship of periodontal disease progression and this hormone.[1]
- There is evidence that periodontal disease might independently increase the risk for cardiovascular disease.[2] Nick has a family history of PD and CVD.
- The periodontal disease has quickly gone from remission to active in localized areas.
- The patient has an exaggerated immune response to psoriasis outbreaks resulting in rheumatoid arthritis (RA).
- Multiple studies and scientific reviews have shown evidence that periodontal pathogens (especially *P. gingivalis)* and oral infections seem to be linked to the onset of RA [3&4]

The risk assessment conversation sounded like this:

RDH: "Nick, before I check the health of your gums, I see on your medical history you circled arthritis. Tell me more about that."

Nick: "I have psoriasis that usually flairs up in the winter. My immune system overreacts and then I also have a rheumatoid arthritis flair up with pain and joint stiffness."

RDH: "I see you're also taking Crestor for high cholesterol. I'm wondering if you have a family history of heart disease or gum disease. Can you tell me about that?"

Nick: Yes, my mother lost at least half her teeth at a very young age and there is heart disease in the family on my mother's side.

RDH: I believe the gum infection might have a connection to the RA. I'm going to check your gums again today just like we did before. I will call out a lot of numbers and remember, 1-3 is normal and healthy gums don't bleed. I'd like you to remember the lowest and highest numbers and if you feel pain anywhere, please let me know. This should not hurt.

[Complete periodontal exam was performed; pocket depths and bleeding points were called out loud.]

RDH: Nick, you heard when I did the gum exam that there are several areas where the pocket depths have increased and there is bleeding. This means the infection is again active. I'm

*Name has been changed.

1. *Rosania AE, Low KG, McCormick CM, Rosania DA. Stress, depression, cortisol, and periodontal disease. J Periodontol. 2009 Feb;80(2):260-6.*
2. *Friedewald, Cornman, Beck, et al. The American Journal of Cardiology and Journal of Periodontology Editors' Consensus: Periodontitis and Atherosclerotic Cardiovascular Disease. J Perio July 2009*
3. *Straka M, Trapezanlidis M, Dzupa P, Pijak R. Associations between marginal periodontitis and rheumatoid arthritis. Neuro Endocrinol Lett. 2012;33(1):16-20.*
4. *Detert J, Pischon N, Burmester GR, Buttgereit F. The association between rheumatoid arthritis and periodontal disease. Arthritis Res Ther. 2010;12(5):218. Epub 2010 Oct 22.*

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suspicious there might be something going on in your body that is also causing you to have an exaggerated response to the gum infection, just like you have with the psoriasis.

Gum disease and RA have a lot in common. They are both the result of inflammation and some studies have shown that there's a two-way relationship and that active gum infection might influence the severity of the RA. It's in your best interest to get this gum infection under control and to determine if you have a genetic reason for your exaggerated response to inflammation.

The good news is we can test for that very easily. Based on your medical history and the fact that the inflammation has returned so quickly, I recommend both a bacterial test to see what bacteria are present and whether oral antibiotics will be helpful and a genetic test to see if you are positive for the gene that causes this overreaction to inflammation (Fig. 1 & 2). The cost of these two tests together is about $300. The sample collection is very simple and we can do that today.

The other thing that concerns me is that you have high cholesterol and a family history of heart disease. Studies have also shown that untreated gum disease might be a risk factor for heart attacks and strokes. Keeping the infection in remission might help reduce your already high risk.

I also recommend you shorten the time between visits to see us. This way I am able to help you in disrupting the bacteria at the base of the gums. These are areas you cannot reach with your brush and floss. How does this plan sound to you?

Nick: Let's do it. I really want to know more about the immune system issue and I'm determined to get this gum disease under control.

Nick was scheduled for periodontal maintenance but because of the importance (and his motivation) to stop the progression of his PD we took a different treatment route. It's important to not only treat periodontal disease clinically, but also recognize the risk factors involved.

Treatment Provided and Planned for the Future

- Homecare instructions were reviewed with the additional recommendation to change powerbrush head frequently, use interproximal brushes and a water-flossing device.
- To determine if Nick truly has an exaggerated inflammatory response, a saliva sample was collected for genetic testing.
- The same saliva sample was used to determine if periodontal pathogen levels were high and if a systemic antibiotic would be appropriate adjunct therapy.
- Education, enrollment and treatment planning used the better part of the 60-minute appointment. Periodontal maintenance treatment was rescheduled two weeks later when test results were ready. At that time it could be determined if systemic antibiotics were appropriate.
- Due to the identified risk factors, Nick's maintenance interval was shortened to eight weeks.
- Restorative treatment plan was developed and referrals to appropriate orthodontic and surgical specialists were made.
- Future treatment would include re-evaluation to determine if repeating the non-surgical therapy, referral to periodontist and/or medical doctor are appropriate next steps.

Fig. 1 & 2: Test results show Nick lacks the type of bacteria which would benefit from oral antibiotics.

Putting It into Practice

This example demonstrates how the hygienist used high-level processing of information to discuss risk with the patient. This approach requires knowledge, preparation and time. With practice, it becomes easier and faster to process risk information and make a treatment recommendation. A few things to consider:

- **Review charts ahead of time.** Being prepared by reading the patient's chart notes ahead of time will help you begin to put his history and your knowledge of oral-systemic health together in your mind. Figure 3 provides a checklist for chart review.
- **Regularly update the medical history.** If patients balk at completing a detailed history it might be because they don't know why you need it. Connect the dots for them. Share that the most common side effect of prescription medication is dry mouth and that puts them at increased risk for gum disease and cavities. Also share that you will use medical history to see if there's anything they can do medically to help prevent future dental problems and vice versa.
- **Use open-ended questions.** When asking about medications, rather than saying "Do you have any changes?" ask "What medications are you taking?"
- **Study.** In order to use risk assessment in your daily practice, you must study the connections between dental disease and systemic health. Several continuing education courses on this topic are available online on both Dentaltown.com and Hygienetown.com. Each issue of *Dentaltown Magazine* and Hygienetown (digital) includes Perio Reports research summaries. A new organization focuses on this topic exclusively, the American Academy of Oral Systemic Health (www.aaosh.org). PubMed.com allows you to easily search and view abstracts of research articles on just about any medical/dental topic. Want to learn more about RA and PD? Just type in rheumatoid arthritis and periodontal disease in the search field.
- **Review the case.** Regularly spend time as a team reviewing cases. Nick's case would be perfect for review and discussion. This calibrates your team and ensures everyone understands and supports the recommended treatment and can reinforce its importance with the patient.

Fig. 3: Daily Patient Chart Review Checklist

- ❑ Perio status and date of last perio exam
- ❑ Date of last hygiene visit
- ❑ Review notes from last recare and treatment visit
- ❑ Date of last X-rays
- ❑ Outstanding treatment plan items
- ❑ Medications and medical conditions
- ❑ Intra-oral photos of outstanding treatment or need for new photos
- ❑ Patient preferences – likes ultrasonic, prefers Prophy Jet, sensitivity
- ❑ Recare status of family members
- ❑ Has the patient recently referred other patients
- ❑ Personal notes or events
- ❑ Date of last oral cancer screening
- ❑ Notes from specialists
- ❑ Homecare notes
- ❑ Biteguard or other appliances

- **Make recommendations personal.** Always remember to find something specific to the patient that supports your treatment recommendation and speak to that. Is it the patient's history of stroke and desire to prevent recurrence? Is it his diabetes that he has a hard time managing?

Conclusion

This process of treatment planning using risk assessment requires moving to a new level of patient care. It's an incredible opportunity to leave the rote, day-in day-out routine of dental practice and dive into an exciting world as part of the patient's health-care team focused on risk assessment. So often, dental professionals find themselves going through the motions of prophy after prophy or crown after crown to "fix" the existing problem without looking at the big picture – the cause of the disease and associated risks.

Diagnostic data collection takes time. Processing the data takes time. Communication takes time. Give yourself permission to take the time to incorporate risk assessment into your patient care and see your patients achieve a higher level of health. ■

Author's Bio

As owner of Inspired Hygiene, **Rachel Wall, RDH, BS,** partners with dentists, hygienists and office managers to elevate their hygiene services, systems and profits. In addition to coaching, Rachel draws from her 20 years of experience as a hygienist and practice administrator to deliver to-the-point articles and speaking programs. She has spoken across the country including the Townie Meeting, RDH Under One Roof, the AACD annual session. Inspired Hygiene's programs include in-office coaching, a free weekly e-zine, the Hygiene Profits Mastermind group and the new Profitable Perio Online Workshop. To contact Rachel, e-mail her at Rachel@InspiredHygiene.com or call 877-237-7230.

No Proof that Gum Disease Causes Heart Disease or Stroke

Oral-systemic health is a debated topic. Townies discuss the difference between a link and conclusive evidence.

JGonzalesRDH
Member Since: 06/17/07
Post: 1 of 23

Interesting article regarding a comprehensive literature review panel from the American Heart Association found there was no conclusive data suggesting any causative link between periodontitis and cardiovascular disease. Even more tantalizing, that periodontal treatment is not shown to reduce risks of atherosclerosis. They are suggesting that common risk factors (like smoking) are more likely the "link." ■

APR 19 2012

CAJ
Member Since: 10/26/04
Post: 2 of 23

I still believe your mouth is a window to your body's health. If your oral health is poor it reflects your overall health. There is no harm in reducing bacteria and inflammation, it can only be healthier. ■

APR 21 2012

skr RDH
Member Since: 07/21/07
Post: 3 of 23

I hope I don't sound like I am saying "I told you so," but this is barely even news. There were only some correlations ever found, nothing more. And the potential for so many third variables influencing both diseases has always been very high, for example socioeconomic and cultural factors. So I believe it was premature to be selling this to patients as if the link was established as causative. I felt irresponsible trying to sell the idea to patients so I rarely discussed it with them unless they brought it up. I even felt a touch of distaste at the idea of using this proposed link as a hammer to scare patients into compliance with their perio routine. I prefer to communicate with patients how I would like to be treated by a health-care provider – honestly, accurately and in-depth according to the science. So I applaud the ADA and the BCDA for coming on, clear and clean on this issue.

That does not mean that the link doesn't exist and is not actually causative, just that I won't buy into it until the link is better proven. I also have a gut reaction toward skepticism about this link, however, I am also open to the potential that I am 100 percent wrong. ■

APR 21 2012

JERSEY DEVIL
Member Since: 11/04/05
Post: 4 of 23

There might not be any proof that gum disease causes heart disease but having chronic gum disease is not good for the immune system. Today we understand that diseases are not necessarily caused by one thing, but a culmination of many things that weaken the immune system that protects the body. This only further complicates the problem of finding a cure for diseases like heart disease, stroke, high blood pressure and cancer.

Having been a patient with systemic lupus erythematosus, in remission since 1990, I live day to day knowing that it could return at any time. I understand this and take full responsibility for myself. This is all I have ever asked of my patients. If they are prone to a specific disease due to their DNA or as in my case, no fault of their own, then they have to take the necessary steps to help themselves.

We understand that continuing to bite your cheek changes the cells and can lead to oral cancer, so we suggest to our patients not to do it and we make necessary adjustments so it does not happen. Is this the main cause of oral cancer? Of course not, but we still suggest they don't do it. I feel the same way about heart disease. It's not the only cause, but it doesn't help and can exacerbate it. The American Heart Association in their stance has not helped the patient in anyway by contradicting the advice we give our patients. We are not lying to them, we are only trying to promote overall good dental and medical health.

Many factors are involved in maintaining good oral and physical health. Having high amounts of bacteria pumping through you arteries and veins from your infected mouth due to poor oral hygiene can't be a good thing. ■

APR 21 2012

We have known for many years that there is a correlation, which we know does not prove cause and effect. However, neither is there conclusive evidence proving that there is no link between perio disease and heart disease. I am keeping an open mind pending further research. ■

APR 22 2012

Lindadouglas
Member Since: 06/09/16
Post: 5 of 23

Making it clear that periodontal disease is "linked" to heart disease and doesn't "cause" heart disease is a good message. That is an accurate evaluation of the science. As SKR points out, heart disease is multi-factorial.

On another note, science and logic don't sell our message of oral health. If it did there would be no more caries or periodontal disease. In fact, consumers "buy" based on emotions, not science and logic. If science was an effective marketing tool people wouldn't smoke, be overweight or have diabetes. However, the marketing of cigarettes, fast food and soda appeal to emotion and that's what hooks the purchaser.

Rather than marketing oral health to patients based on the oral-systemic link, let's focus on "kissability," or at least "fresh breath." This is what people are buying right now. Tie kissability to your treatment and you will successfully "sell" your oral health message to patients. ■

APR 25 2012

Trisha O'Hehir
Member Since: 05/22/03
Post: 7 of 23

If a patient has several open wounds subgingivally, anaerobic bacteria are going to be swimming around the blood stream and visiting all parts of the human anatomy. Why do we treat all open wounds on our bodies with a matter of urgency?

We are concerned that this will have other health implications other than just being a nuisance. I personally find it hard to believe that the mouth would be any different and it's only a matter of time before a causal link is established.

I also agree with Trisha that our best approach to eliminating gingival disease and preventing it is by selling a positive message (kissability) and not using a negative approach (you're going to die if you don't floss). People generally think they're invincible and it's not going to happen to them. ■

MAY 17 2012

Timothyives
Member Since: 12/13/08
Post: 19 of 23

Find it online at: www.hygienetown.com

search No Proof ▶

Beethoven's grave

A tourist in Vienna is going through a graveyard and all of a sudden he hears some music. No one is around, so he starts searching for the source. He finally locates the origin and finds it is coming from a grave with a headstone that reads: Ludwig van Beethoven, 1770-1827. Then he realizes that the music is the "Ninth Symphony" and it is being played backward. Puzzled, he leaves the graveyard and persuades a friend to return with him.

By the time they arrive back at the grave, the music has changed. This time it is the "Seventh Symphony," but like the previous piece, it is being played backward.

Curious, the men agree to consult a music scholar. When they return with the expert, the "Fifth Symphony" is playing, again backward. The expert notices that the symphonies are being played in the reverse order in which they were composed, the ninth, then the seventh, then the fifth.

By the next day the word has spread and a throng has gathered around the grave. They are all listening to the "Second Symphony" being played backward.

Just then the graveyard's caretaker ambles up to the group. Someone in the crowd asks him if he has an explanation for the music.

"Oh, it's nothing to worry about," says the caretaker, "he's just decomposing."

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