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The mission of the Pennsylvania Dental Journal is to serve PDA members by providing information about topics and issues that affect dentists practicing in Pennsylvania. The Journal also will report membership-related activities of the leadership of the association, proceedings of the House of Delegates at the annual session and status of PDA programs.

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To most insurance companies you're at best a client.

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Oral Health Literacy

I feel like I am yelling at the top of my lungs and no one can hear me. At the same time others are saying exactly the opposite of me. Which one of us is right?

Recently the StarPhoenix newspaper of Saskatoon, Canada reported an ever increasing number of children with severe dental caries were in need of sedation dentistry. Reporter Janet French interviewed several families for her article, “The Lost Children” (February, 18, 2012).↑

Ms. French reports that there are currently 1,900 individuals on the Saskatoon waiting list for sedation dentistry and three-fourths of these patients are under 10 years of age.

“More than half of the kids having dental surgery self-identify as aboriginal, the Ministry of Health says. Babies, toddlers and preschoolers who live in Saskatchewan’s three northernmost health authorities are put under for teeth woes at more than three times the provincial rate.”

So those of us in the United States ask why. Why are Indian reservations in North America plagued by rampant caries? And the answer has always been right in front of us. Poor oral literacy, bad habits and lack of early intervention top the list of several reasons.

When young, uneducated parents give their babies bottles with juice, milk or other high sugar or carbohydrate drinks and let them fall asleep, the parents are inviting rampant caries. When parents don’t bring their children in for dental visits until they are in severe pain, they are inviting disease and infection. When parents don’t help their children choose the right foods due to cost and availability, they are inviting dental disease. And when no treatment is given due to lack of available care and cost, the children lose.

In each example, the loser is the child. It’s not their fault, but they are the ultimate victim. The solution seems rather simple, but seems so difficult to achieve. If the current generation of parents could be educated into helping their children avoid early caries they could prevent the pain and suffering that many of these same parents experienced as young children. If parents could have the dental I.Q. to know not to give a bottle of juice to an infant while falling asleep, or make a point of getting to a dentist for an exam, they could be giving their children an invaluable gift.

If parents could help their children make good food choices and brush regularly so much pain and suffering could be avoided. More importantly, if these communities had better oral health literacy there would not be such an outcry for public monies for the treatment of dental disease. The Saskatchewan government paid First Nation more than $500,000 during 2011 for sedation and dental care for 800 children. If the childhood caries rate was significantly lower, the monies could be used for other health initiatives and there would be less pain and suffering for the young children.

The problems facing families of these northern tier territories of Canada are really just snapshots of what’s going on in the United States. Maybe the problems are not as severe in our large cities and rural communities as those described above, but just imagine what is going to happen as funding is cut further for federal and state programs for dental care. Imagine what old dental problems are going to resurface as many communities opt to discontinue water fluoridation. Imagine what is going to happen as fewer people are offered work-related dental insurance and imagine what is going to happen as the cost of dental care continues to rise. Children are once again going to have rampant caries at an early age. Parents will feel the pain of economic decision making. Choices like what foods to buy and when to see the physician or the dentist become difficult choices. When a child complains of a toothache, will the parent make an appointment with the dentist or tell the child that he or she can’t see the dentist because the family can’t afford it? Will the parent settle for store-bought Ambesol to relieve the symptoms?

Lawmakers argue that there is not enough money in the public pot to cover the cost of dental care. In October 2011, Pennsylvania, and other states, stopped offering the few dental services it did offer to adults and limited the dental care covered for children. All across Pennsylvania, adults that were previously covered under state medical assistance were no longer eligible for many types of dental care.↑ What do you see as the end result of denial of benefits? More pain, more suffering, more infections, more hospitalization, more medications more emergency procedures.

What if we could get a do-over? Not just in Pennsylvania, but across the country. What if we could bring oral health literacy to the current generation of young parents? Teach them how important it would be to start their children caries free. Don’t share utensils and spread oral disease, learn to brush and floss, seek care for early dental problems, all of the basic building blocks of oral health literacy. This type of education is expensive and requires many years to get a foothold. It seems to have worked with smoking. Fewer adults and adolescents smoke now than in recent history. The message got to this generation. The message of oral health literacy can also reach a generation, but it requires effort on the part of dentists.
and dental organizations. It also requires no more negative comments from lawmakers and anti-fluoride activists. Our message must get through in order to combat this plague. **We must yell and shout louder than anyone else around us.**

—BRT

**Read more:**
2. http://www.dpw.state.pa.us/provider/doingbusinesswithdpw/dentalcareproviderinfo

**Endorsed Vendor Corner**

Beginning in 2011, PDA and PDAIS teamed up to offer our members secure, high-quality products and services at competitive prices through the PDA Endorsed Program. PDA and PDAIS are committed to increasing the value of your membership and to reduce reliance on dues income. Endorsements generate royalties for PDA, based on member participation. Non-dues income is used to fund vital membership programs and benefits. The cost of endorsed products is never inflated to generate royalties for PDA.

For more information on our endorsed vendors, visit [www.pdaais.com](http://www.pdaais.com), then click on PDA Endorsed Programs.

**Vendor Spotlight:**

Elavon, the endorsed payment processor for PDA, is pleased to announce a new dedicated Account Executive for our partnership. William (Bill) Hoyer resides in York County, and has an extensive background in the financial industry. Bill will be available to personally assist dental offices to build a processing program based on the individual needs of the practice. Please feel free to contact him to begin building your payment program at (717) 880-9945 or william.hoyer@elavon.com.
Dear Dr. Terry,

I read your Impressions column entitled “Dental Conundrum” (November/December 2011 issue) with great interest. As you indicated, access to care, and more specifically barriers to care, is an issue that plagues dentistry. You elegantly discussed some of the barriers that exist in a non-traditional sense. You touched on an area of great concern to me, that dental fear is a major cause of dental avoidance behavior, and thus a major barrier to routine dental care for a significant portion of the population.

As a practicing dentist anesthesiologist and dental educator for the past 32 years, I have seen firsthand the dental havoc wreaked upon patients due to their incapacitating dental phobias. You pointed out that although dental professionals are perceived as trustworthy by the public, many people still avoid dental care because of the anticipated discomfort. Organized dentistry has not done a good enough job in educating the public to the fact that properly trained dentists can and do provide services to allay fear and apprehension, alleviate pain and provide comfort to thousands of patients with debilitating fears.

The American Dental Association (ADA) held an “Access to Care Summit” in March 2009 with a stated goal of creating a common vision for long-term improvement to access to oral health care. Curiously, representative groups for anesthesia in dentistry were not invited to this summit. Clearly, the ADA does not consider dental anesthesia to be an important issue for access to care. How can this be? We are in a profession perceived by the public to willfully, wantonly and sadistically cause pain and suffering. Think of the many references to painful dental procedures as an allegory for the worst things life has to offer. Laurence Olivier as the sadistic dentist asking Dustin Hoffman, “Is it safe?” in Marathon Man, or Steve Martin as the mad, nitrous oxide sniffing dentist in “The Little Shop of Horrors,” used the dental profession for dramatic and comic effect. Even President Obama, in his State of the Union address in 2011, stated that the bank bailout was so offensive to the public that it was tantamount to a root canal. To paraphrase another famous movie quote, “We should be mad as hell, and we’re not going to take it anymore.”

Here in Pennsylvania we have the ability to be on the forefront of the access to care issue, especially with our ability to remove the fear of pain barrier from the public perception. The University of Pittsburgh School of Dental Medicine has been training dentist anesthesiologists since 1949. Many of these practitioners are providing much-needed services in various communities throughout the state, enabling countless patients to receive dental treatment in a comfortable and safe manner. This includes patients with severe phobias, medically complex patients, pediatric patients and patients with special health care needs.

Regardless of what many may think of the Dental Organization for Conscious Sedation (D.O.C.S.), they have done more to promote public awareness of the fact that dentists are capable of providing “sedation dentistry” than the ADA to this point has ever been willing to do. It is certainly apparent that patients are actively seeking these services.

Three times in the decade of the 1990s, the American Society of Dentist Anesthesiologists (ASDA) petitioned the ADA for specialty recognition. Each time their application was rejected, citing lack of need for such a specialty. Dentistry is still the only health care profession that rejects pain and anxiety control for the comfort of the patients they purport to serve. Even veterinary medicine has an anesthesia specialty. Advances in medicine are enabling patients with severe medical complexities to live longer, productive lives. Patients with special needs, many with significant behavioral and medical issues, are being mainstreamed. The number of dental phobic patients is not diminishing. Who better to help manage these patients than those specifically trained to do so? Dental students across the country recognize this, and are demanding training in dental anesthesia in order to better meet the needs of their prospective patients. Currently, there are 11 accredited training programs available for postgraduate training in dental anesthesia. These programs received a record number of applications this year. To meet the increased demand, more programs are in development. Graduates from these programs have many opportunities available to them.

ASDA currently has an application pending with the ADA for specialty recognition. The ADA House of Delegates will vote on this application at the 2012 ADA Annual Session. This is the chance for dentistry to finally live up to its stated goal of improving access to care by removing this barrier. There is virtually no downside to this new specialty. With it comes improvements in patient safety, advances in education and research, and access to care. Who could oppose that? Pennsylvania dentists should be proactive in their support of the ASDA’s application. I urge you to contact your ADA delegates and trustees and tell them that you want to see a new specialty in dentistry this coming October.

Thank you for the opportunity to express myself. I look forward to your response.

Respectfully submitted,

Joseph A. Giovannitti, Jr., D.M.D.
Professor, Department of Dental Anesthesiology
Director of Anesthesia, Center for Patients with Special Needs
University of Pittsburgh School of Dental Medicine
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One of Governor Tom Corbett’s first orders of business this year was to introduce his proposed budget for FY 2012-2013. The proposed General Fund budget is $27.14 billion, a decrease of more than $20 million or 0.1 percent, from 2011-2012. The Governor’s budget refocuses the investment of tax dollars in the core functions of government, including: adhering to fiscal discipline, promoting limited transparent and effective government, supporting free enterprise and job creation, funding student and promoting educational excellence, protecting public health and safety and maintaining the human services safety net. In summary, the Governor’s proposed budget is balanced with no tax increases.

Now, the General Assembly is immersed in the daily grind of appropriations hearings with all the executive agencies. The challenge now will be to pass the Governor’s budget by the constitutionally mandated date of June 30.

The Commonwealth also is entrenched in redistricting each House and Senate district to reflect the 2010 population statistics. A Legislative Reapportionment Commission is required to remap Pennsylvania’s 203 House and 50 Senate districts. Recently, the state Supreme Court and a federal judge ruled the new maps invalid, requiring the existing 2001 borders be kept for the 2012 elections. Legal and legislative options are under review. The redistricting mess, however, does not affect voting districts for federal office, as those new maps were approved by the Legislature.

In January, PDA hit the ground running in pursuing its legislative priorities for the final year of the 2011-2012 legislative session. Having listened to members’ concerns about advocating for issues that affect you and your patients’ health, PDA is aggressively lobbying a number of issues on your behalf.

### State Issues

**PDA Lobbies for Legislation Prohibiting Insurers from Capping Non-Covered Services**

Dentists who participate with insurance companies are being asked to sign contracts that will prohibit them from charging patients their usual and customary fees for non-covered services. The impact of this contractual change for dental practices could be significant if the reimbursement for non-covered services is too low for dentists to cover their overhead expenses, pay their employees and other basic functions. Dentists may have to choose between economic hardship and disrupting relationships with patients if they need to drop out of network.

This is a business decision on the carriers’ part, with full awareness of the implications for their provider networks. With a continued down economy, this is a calculated risk they may be willing to take to reduce costs and shift risk to provider networks to remain competitive in the marketplace.

Sen. Kim Ward’s (R-Westmoreland) bill, SB 1144, currently resides in the Senate Banking and Insurance Committee. Rep. Thomas Murt’s (R-Montgomery) bill, HB 1537, currently resides in the House Insurance Committee. PDA’s lobbyists, staff and volunteers continue to meet with members of the Senate Banking and Insurance Committee and the House Insurance Committee to push for a committee vote on both bills.

**PDA Lobbies for Insurance Coverage for General Anesthesia for At-Risk Patients**

PDA supports HB 532, legislation introduced by Rep. Stan Saylor (R-York), which would require all insurers to cover the costs associated with administering general anesthesia to children seven years of age and younger and special needs patients. Over 29 states require that dental plans pay for related medical expenses, such as the administration of general anesthesia, when needed to provide dental care. Not providing this coverage limits access to care for those patients who require extensive dental work or need general anesthesia because of behavior management issues. These patients simply do not get the care they need because they cannot afford the significant costs associated with the administration of general anesthesia.

HB 532 has more than 50 co-sponsors and strong bi-partisan support from both House and Senate leaders. PDA’s lobbyists and staff have met with staffers in House Majority Leader Mike Turzai’s (R-Allegheny) office and in Rep. Stan Saylor’s office and were advised that it is a question of “when” and not “if” the bill will move. PDA expects action on the bill during the budget season.

**PDA Testifies at a Public Hearing on SB 388**

On February 9, the House Insurance Committee held a hearing on SB 388, legislation introduced by Sen. Pat Vance (R-Cumberland), which would require all actively practicing licensees to carry a specified amount of liability coverage. The bill requires most licensees to maintain liability coverage in the minimum of $1,000,000 per occurrence or claims and $3,000,000 per annual aggregate. Licensees must show proof of having purchased insurance to the State Board of Dentistry within 60 days of the bill’s enactment. The bill exempts volunteer dentists in community-based settings and dentists whose employer provides coverage.

Dr. Bernie Dishler, PDA president-elect, testified on behalf of PDA in support of the bill. The committee had several questions concerning the bill, however, the consensus among members of the com-
committee was that they support the concept. PDA expects the bill to pass the General Assembly before the end of the year.

Medical Assistance

During the FY 2011-2012 budget process, PDA learned that the Department of Public Welfare (DPW) proposed changes to the adult Medical Assistance program for those 21 years of age and older. Those changes went into effect in September 2011 and included:
- One partial upper denture or one full upper denture and one partial lower denture or one full lower denture per lifetime. Additional dentures will require a benefit limit exception.
- One dental exam and prophylaxis per 180 days, per adult recipient. Additional dental exams and prophylaxis will require a benefit limit exception.
- Crowns and adjunctive services, periodontal and endodontic services were cut unless the recipient receives a benefit limit exception.

Following the Governor’s budget address, DPW Secretary Gary Alexander explained how the budget will impact DPW and what departmental budget changes are in store for the coming year. This includes reforms focusing on program efficiency and streamlining of services, such as:
- $168 million in savings from consolidating multiple human services programs into a single block grant
- $59 million in savings from reducing provider reimbursement rates or considering alternative provider cost-containment initiatives
- $50 million in savings by implementing an automated audit system to identify provider payment waste, fraud and abuse and by enhancing the review process for high-cost cases

PDA has learned, however, the $59 million in savings for reducing provider reimbursement rates is in regards to almost all nursing homes, and to a lesser extent hospitals. We will continue to monitor the budget process to ensure that the $59 million reduction in provider rates do not extend to dental providers. PDA is continuously working with DPW officials and legislators to request that funding remain in the adult Medical Assistance program, and will oppose any further cuts.

National Issue

ADA Works to Repeal McCarron-Ferguson

The ADA continues to lobby to repeal parts of the McCarron-Ferguson Act, which allows states to regulate and tax insurers while giving the insurance industry a limited exemption from federal antitrust laws. This gives insurers an unfair advantage over health care providers and patients by limiting competition and the ability for collective action. ADA’s legislation to repeal certain parts of this Act would level the playing field and force insurers to comply with the same rules governing providers. Repealing McCarron-Ferguson would also benefit patients by creating a more competitive atmosphere among insurers for a subscribers business.

Your help is always needed to ensure PDA’s success within the legislative arena. Please take time make sure you are part of our advocacy program called Soft Edge, which sends action alerts to you via email, allowing you to include your contact information and send a letter directly to your representative or senator.

Be assured that PDA is at the forefront of all legislative and regulatory activities in Pennsylvania. We monitor dozens of bills affecting dentistry and communicate PDA’s position with lawmakers regularly. Check out our legislative bill tracking report at www.padental.org/GR for a full list of those bills, or contact government relations staff at mss@padental.org for more information.

Save the Dates!

All members are invited to the ADA Washington Leadership Conference (WLC), scheduled for May 7-9 at the JW Marriott Hotel in Washington, D.C. Participants have the opportunity to hear from legislators, political experts and others impacting the political scene in Washington. There also is a day at the Capitol, where you will have the opportunity to meet with members of Pennsylvania’s House of Representatives and Senate.

All members, spouses and dental students are encouraged to attend PDA’s Day on the Hill, schedule for June 5, in Harrisburg. PDA forms teams to visit with members in the General Assembly who are in positions of leadership or who sit on a key committee that votes on PDA’s legislation. We arrange these meetings in advance, send you background information and talking points on our issues and arrange for your transportation to the Capitol.

Now more than ever your participation in dentistry’s advocacy efforts is needed. Please consider joining with other colleagues to speak with legislators at the federal and state levels on important oral health care topics. How else can dentistry make an impact at our state and national Capitols without your insight and expertise?

For more information on the WLC and Day on the Hill, contact Marisa Swarney at (800) 223-0016, or mss@padental.org.
Informing Your Patients about Organized Dentistry

Did you know that more than 85 percent of your patients already know about the American Dental Association (ADA) and what it represents, according to a 2007 Public Opinion Survey? They know it’s the largest and oldest organization that represents the dental profession and advocates for its members and well-being of the patients they treat. So why not distinguish yourself and enhance your reputation as a dentist who cares about the public’s oral health by promoting your membership in organized dentistry?

For many of you, if you display your ADA/PDA member decal, sent with your annual membership card, your patients see that message when they first walk through your office door. It proudly states you are a member of these prestigious organizations and you have diligently renewed your membership for the current year. If you haven’t received, or need more than one decal for more than one office, please don’t hesitate to contact PDA at (800) 223-0016 to request a member decal.

Another way you could be informing patients about organized dentistry in your office is through ADA informational brochures to educate patients on periodontal disease, tooth whitening or orthodontic treatment, to name a few topics. These educational brochures, written in plain language, are specifically created to help you explain a treatment plan to your patient. Using these educational brochures saves you time and energy and can save the patient serious cash in the long-run when helping to stress the importance of preventative treatment.

Many members know the importance of membership in various organizations, which is why they proudly list their affiliations on their office website, often in the “About Me” section. In addition to listing your affiliations, many organizations will allow you to use their logo and some even have a special “I am a member of...” logo. This is just one more way to showcase your commitment to professional associations.

Both the ADA and PDA websites have “Find a Dentist” directories, which allow the public to find a dentist based on location, specialty, etc. Members receive a complimentary listing, which can help market your practice to patients. These member profiles are an easy and economical marketing tool; all the work is done for you!

One of the newer features to PDA’s website is the “Members Making a Difference” spotlight, which promotes your pro-bono and community service. By showcasing your philanthropic efforts, patients truly see dentists and the dental profession in the caring manner that you really personify. It’s no secret that many patients fear or avoid the dentist due to a variety of factors, but when they see a picture or video of their local dentist making a positive impact in their community; it’s well received and offers a valuable reminder that dentists are health care providers and want only the best well-being for their patients.

Be sure to take advantage of these simple member benefits that help promote your practice. Displaying affiliations with well known organizations, such as ADA and PDA, is a great way to show patients that you not only care about them, but the dental profession as a whole.
Welcome New Members!

Following is a listing of members who have recently joined PDA, along with the dental schools from which they graduated and their hometowns.

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NO SMALL ACHIEVEMENT: DREAMING BIGGER

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It’s 3 a.m. I need to go to bed. Or should I keep studying? Will I pass this pathology exam tomorrow? I wonder how many patients will “no-show” me this week. Will I satisfy my clinical requirements in time to graduate? Can I actually afford the Starbucks that’s been keeping me awake the past few hours?

Man, life was a lot simpler when there was only one question: “Will I get into dental school?”

My classmates and I certainly didn’t choose the easiest career path. In fact, my first three years of dental school haven’t exactly gone how I had imagined. In college, there’s a universal misconception among pre-dental students, that “getting in is the hardest part.” Ha – yeah right!

Life begins to get crazy shortly after freshmen orientation.

Once the honeymoon phase is over, the classroom takes its toll. I like to describe the didactic courses as a sprint-marathon combination, where there are many highly intense classes that never seem to go away. Here at Temple, we are still taking more than 20 credit hours of class each semester, even into the fall of our third year. When will this end? Will I ever get my social life back?

Only discussing the classroom would be half of the story. So far, some of my fondest dental school memories are from the sweat shop of dental school, the pre-clinic. Picture this: 125 students in one long room, all waxing teeth for the first time. Yes, 125 Bunsen burners at once gets pretty hot after a while, however, I loved my time in the pre-clinic. Some of my closest dental school friends are the “alphabetically close” people who sat next to me. How did I take for granted the days when messing up a crown prep meant unscrewing the tooth and replacing it with a new one?

If it weren’t for the pre-clinic, our curriculum would be nearly identical to our medical school counterparts. Subsequently, my classmates and I would have had a lot more time to study during daytime hours. Maybe that’s why my sleep routine has been so out of whack the past three years. This brings up another pre-dental misconception, that in dental school, you only learn about teeth.
Not true. I could tell you the blood supply to the stomach, pharmacology of antidepressants, and the histology of liver cells. I know this is great information to have, but at times the class work can be overwhelming to say the least. Personally, I find it difficult to muster up motivation to study for things which don’t translate directly to clinical practice. Now that Part 1 of the National Boards is behind me, hopefully I will never again be tested on the muscles of the forearm.

Transitioning into the clinic was my first glimpse of light at the end of the tunnel. Finally, someone on campus treats us with respect. I’m officially a student doctor now. I have patients and responsibilities. When my alarm clock sounds each morning, I no longer have the option to stay in bed and skip class. Patients need to be seen, chairs need to be scheduled and lab work needs to be completed. No more messing around, we’re actually learning now. Sometimes I feel like I learn more in a single clinic session than I have during an entire semester in the classroom. I wonder how a three-hour clinic session will translate to “real life?” I’m not sure if I can pay off my student loans by scheduling one or two restorative procedures in three-hour appointments. Will my hand skills eventually get faster or should my speed increase drastically with an assistant?

No sooner than I get comfortable in the clinic, graduation suddenly appears on the radar. I’m finally getting the hang of all this paperwork and bureaucracy. Dental school is becoming more manageable, but seriously, get me out of here! I’m ready for the next part of this learning curve. Life after dental school slowly begins to present options. My student debt seems to be getting more realistic. Should I specialize? What are my residency options? Is an AEGD worth the time? Maybe I should just start working ASAP.

It seems like the more I learn, the more questions I have. Dentistry is such a specialized career path; there are few people who can truly relate and offer us students solid advice. I am constantly picking the brains of the older faculty and row instructors at our school. I am always watching what they do and listening to what they have to say. I know there is a wealth of knowledge to be learned from the generation of dentists who have “been around the block.”

Someone told me that I will learn the most about dentistry during the first few years in practice after school. I wonder if this is true. Am I fooling myself to believe life after dental school gets easier? Many of these questions I am uncertain about, however, I do know that dentistry is not for everyone. Is it for me? I believe so. I love the challenges, pressures and rewards of working with the patients at our school. I believe that becoming a lifelong learner is a critical prerequisite to be happy in this field. I challenge my generation of young dentists to never stop asking questions, as we seek the advice and mentorship of the experienced dentists who have shaped the face of this wonderful and rewarding profession.

Jordan Bower, of Harrisburg, is a third-year dental student at Temple University. He is active within the Temple American Student Dental Association (ASDA) chapter and is editor-in-chief of the students’ quarterly newsletter. His interests include hunting, travel, church and Philly sports. After graduation, Jordan wants to continue learning general dentistry by working at an established practice.
Tech Talk
By Erik Eisen

There are quite a few tech related buzzwords floating about out there. It seems that no matter where you look or whom you talk to everyone has something to say about technology. Chances are, you have heard somebody talking about things like the cloud and maybe something called managed services.

Let’s start with “The Cloud.” Cloud computing is a concept that actually dates back to the 1960s. Wikipedia’s definition is “technologies that provide computation, software, data access, and or storage services that do not require end-user knowledge of the physical location and configuration of the system that delivers the services.” In English, it simply means, using a product or service that relies on computer programs and data that exist somewhere other than your local network. Most people who use the Internet have been using the cloud for years. If you have ever used Google’s Gmail or Microsoft’s Hotmail you have participated in cloud computing. If you have ever bought anything from Amazon, you have used their cloud of servers to purchase that widget online. So what does all of this mean to the average dental practice?

There are many reasons why a practice may or may not want to use cloud services. Things like electronic claims, offsite backup (as long as it is HIPAA HITECH compliant) and email are natural cloud services that make sense to use because it is generally cost prohibitive and far too time consuming for all but the largest of regional or national multi-location practices to provide on their own. There are several cloud-based practice management solutions available that may be right for your practice. They are mostly geared toward start-up practices but some established offices have chosen to go this route. An advantage might be that there is no software to buy and generally there are no maintenance fees for the software. A disadvantage is that if your connection to the Internet goes down you can’t use the software. You also need to be aware that the monthly fee for a cloud-based subscription, although possibly only a fraction of the cost of outright purchasing a traditional software product, will continue as long as you use the software. Talk to your IT partner for a closer look at what is right for your practice.

A managed services provider (MSP) is an information technology (IT) services provider, who manages and assumes responsibility for providing a defined set of services to their clients proactively, or as determined that the services are needed. Most MSPs bill an ongoing flat or near-fixed monthly fee, which benefits their clients by providing them with predictable IT support costs. A good MSP plan will provide your practice with server and workstation security patches and updates, both local and encrypted offsite backup, antivirus coverage and updates, remote and onsite technical assistance.

Here is a tale of two dentists named Dr. Jones and Dr. Smith. Dr. Jones doesn’t think that he can afford to have a full service maintenance plan for his network and has a “guy,” a patient of his who is also an IT expert. Dr. Jones has his office
manager backup his data and handle all of the computer issues in the office. For the ones she can’t, she calls the IT guy and he helps out as needed. One day Dr. Jones decides he needs to let go of his office manager. She finds out, and one night before she leaves deletes all of the data on the server, destroys all of the backups and destroys all of the CDs to re-install the software to run his practice. Dr. Jones calls his IT guy and finds out he is on vacation in Jamaica and will be back in 10 days. Dr. Jones has no idea what patients are coming, who owes him money, what his treatment plans are or what any of the X-rays or intraoral images look like. He is devastated.

On the opposite side of the spectrum, Dr. Smith has a similar practice but he has contracted an MSP provider to manage his network, including his backups and antivirus software. Dr. Smith is covered in the event any of his computers or his server might crash from a virus or hardware failure. Dr. Smith had a practice management issue and had his office manager call the software provider for help. During the service call, the tech support person was installing a new software update and inadvertently corrupted the data. Dr. Smith calls his MSP and asks for help. In a few minutes, Dr. Smith’s data is restored and his practice is functioning again. I have actually personally been involved in dealing with both scenarios that I have described here, and although the names have been changed, they are both very real.

You would not drive without having proper insurance or for that matter perform a procedure that you do not have any education and experience performing. The fact is that if you don’t have your interests covered by an experienced competent MSP provider, you are just plain looking for trouble. If you fall behind in keeping up with things such as backups, patches and security, the odds are that you’ll face an IT outage or another problem down the road that will negatively impact your practice including substantial productivity and revenue losses as a result.

Erik Eisen is President of Concate Dental Systems, a full service IT firm providing technology guidance to dental practices of all sizes and specialties in Pennsylvania, New Jersey and Delaware.
How Do Dental and Medical Insurance Influence Oral and Maxillofacial Surgery in Pennsylvania?
By John L. Alonge, MS, DDS

I can honestly and proudly state that when I graduated from The University of Maryland Dental School in 1983 I was prepared to commence my career in a great profession that I remain passionate about to this day.

One of the important tenets drilled (pun intended) into us as students was providing comprehensive planning and treatment to the patients who trusted in our expertise. I was fortunate to be selected by the United States Air Force for General Practice Residency Training and later for exceptional Oral and Maxillofacial Surgery Residency Training. In all, I served our country for 11 years, in which I worked in a system of care where the needs of the patient, whether active duty, dependent or retiree always came first. For the first 11 years of practice I was able to diagnose and then render ideal treatment to whomever was in my treatment room. Upon entering private practice I was stunned how third-party payers dictated treatment and thus access to care.

Like my talented and compassionate referring colleagues, I spend a great deal of time educating our mutual patients as to the nature of their problem, the appropriate treatment to this valuable barrier to care is the exclusion, denial and inappropriate reimbursement to this valuable dental specialty that is uniquely trained and qualified to provide state of the art care to an endless supply of beneficiaries.

Because of the varied scope of practice, oral and maxillofacial surgeons render care that bridges dentistry and medicine, which results in having to deal with additional layers of insurance issues. To the OMBS/business-person, the conundrum is whether or not to participate with third-party plans.

In northwestern Pennsylvania participation typically results in agreeing to a discount of 35-40 percent of one’s fee schedule for office procedures. Reimbursement for orthognathic and TMJ surgery, when covered, is typically at such a low reimbursement (often an 80 percent discount) that many have chosen to no longer treat these conditions.

Oral and maxillofacial trauma reimbursement is an even bigger issue. For those surgeons certified by the American Board of Oral and Maxillofacial Surgery, it is a requirement to be on a hospital staff. Most hospital bylaws regarding staff membership require doctors to be on an emergency call schedule. Care rendered to emergency department patients typically results in no remuneration, as it is rare for these patients to have insurance other than public assistance plans (which demonstrate poor financial payment for our unique expertise).

When injuries involve motor vehicle accidents, we are affected by 31 PA Code, Chapter 69, Section 18 of Act 6 (1991), which relates to insurer payments for medical treatment provided to insured persons covered by automobile insurance policies. It specifies payment at 110 percent for the Medicare reimbursement allowance, which includes the prevailing charge at the 75th percentile. Additionally, if benefits limits have been exhausted, the provider may only bill the insured for the remaining services not paid under the automobile insurance policy. I have observed the gradual disappearance of my specialty providing orthognathic, TMJ and trauma surgery due to exclusionary language and insulting remuneration and dread that the next areas that third party...
plans will adversely influence will be impacted teeth, obstructive sleep apnea and implant surgery.

Not only does one agree to accept reduced reimbursement but one also has to employ additional staff to serve as a liaison between the doctor, patient and the patient’s insurance plan(s). With the help of costly sophisticated practice management software we routinely submit clean claims yet have to continuously monitor third party payer’s compliance with Act 68 - The Clean Claims Act 1998. Currently we are at a political disadvantage due to restrictions allowed by the legislative and judicial branches of our government that currently favor insurers. The unfair advantage over health care providers and patients provided to insurers by the McCarran-Ferguson Act (1945) repeatedly comes into question and we currently are dealing with a boilerplate issue in the debate over non-covered services.

In summary, for most of us the major part of our practices involve third-party payments by entities who maximize their position and profits by establishing themselves in an intermediary position between the provider and the patient; so that on one hand, they decide the quantity and thus quality of care; on the other hand, it is they who are permitted to decide the level of pay for services rendered.

Despite the known underutilization of benefits and the shortcomings of this arrangement, our only paths are to lobby against the most powerful group in Harrisburg or simply realize that dentists are uniquely trained and qualified professionals and that insurance plans, in their current form, could not exist if dentists did not participate.

The Uncertain Future of Health Care in Pennsylvania
By Marisa Swarney
Director of Government Relations

Under the federal Affordable Care Act, Pennsylvania would be required to set up a state-run health insurance exchange by 2013. The law has been challenged in federal courts in various parts of the country, with 28 states and other groups as plaintiffs, and more than 30 legal cases overall. The United States Supreme Court will hear oral arguments in March, with a ruling on constitutionality coming down this summer.

In 2010, Insurance Commissioner Michael Considine released a statement that read, partially,

“The Pennsylvania Insurance Department has submitted its exchange establishment grant proposal to HHS requesting funds to complete the planning and begin the development and design of a state-run health insurance exchange. The Governor continues to believe that the law requiring the purchase of health insurance is unconstitutional. However, it would not be prudent to be caught unprepared.”

With that, Pennsylvania grudgingly joined other states moving forward with health insurance exchanges, simply in an effort to exert more control than the federal government over its implementation and operation should states be forced to make exchanges a reality. The federal government promptly awarded the Pennsylvania Insurance Department (PID) the grant needed to contract with a consulting firm, KPMG LLP, to present all the research and information needed for the state to consider while developing an exchange, scheduled to become fully operational by January 2014.

KPMG and other consultants will develop a report on the Pennsylvania insurance market, including the individual, small and large group markets. The first half of the report is to address current regulations and characteristics of each market and provide an analysis of the current level of health insurance competition. The second half of the report will analyze how the development of an exchange will impact the current insurance market. Consultants will also analyze the current demographic, economic and health status of the uninsured, individual and small group markets to better understand those most likely to purchase insurance (subsidized or other) through the exchange.

PID also plans to establish formal workgroups comprised of officials from the Department of Public Welfare and PID because they have oversight over the Medical Assistance (MA) and Children’s Health Insurance Program (CHIP), respectively. These agencies will be most affected by the exchange.

The workgroups are tasked with addressing the following:

➢ Medical Assistance and CHIP eligibility screening
➢ Eligibility determinations for the advance payment of premium tax credits, cost-sharing reductions and other applicable state health subsidy programs, and how best to integrate existing eligibility determinations systems
➢ Eligibility verification, including verification with external data sources
➢ MA and CHIP enrollment
➢ Expanding “express lane” processes when appropriate
➢ Developing strategies for compliance with the “no wrong door” policy among MA, CHIP and other individuals with subsidized insurance.

The consultants have provided a preliminary assessment of how a state-based exchange may interact with state and federal programs like MA and CHIP. Their general consensus is that Pennsylvania is fortunate to already have technology in place for MA and CHIP that might be leveraged in the development of certain functions of an exchange, like eligibility determinations. The consultants further explained that these systems have policies, procedures and training materials that
provide a start point to develop and support some of the exchange’s portal functions or provide an interface with commercially operated portals.

The essential benefits that MA and CHIP (and, possibly, other subsidized plans) must offer include a range of pediatric dental services. PDA believes that the essential health benefits package must include, at the very least, access for preventive health services, such as caries risk assessments, sealants, periodic cleanings and fluoride varnish applications. Plans offering pediatric oral health services should be designed to meet patients’ basic needs by facilitating the establishment of a “dental home” by age one for every covered child. The ADA is recommending that states review CHIP benefits as a good starting point for developing a pediatric oral benefit.

While Pennsylvania’s infrastructure is in decent enough shape, the reality is that the Affordable Care Act mandates several new function capabilities that almost no state has in place. The consultants are assessing the applicability of systems developed by “early innovator” states like Wisconsin, and some in the private sector. PDA is monitoring the development of the health insurance exchange in Pennsylvania and represents the profession at meetings with other stakeholders, regulatory officials and legislative members. At the federal level, the ADA has contracted with Leavitt Partners, a consulting group, to develop a “toolkit” to guide state dental organizations through the process of implementing the federal health care law.

The U.S. Supreme Court has scheduled three days of oral argument for March 26-28, totaling five and a half hours of actual argument time, on the constitutional issues surrounding the Affordable Care Act. Legal experts expect the ruling to come down in late June or early July, smack in the middle of the presidential campaign. Should the court strike down the law, it is unclear how proponents of the law would proceed should President Obama win a second term. If the court upholds the constitutionality of the law, then the November election would be the final opportunity to stop its implementation, as all Republican candidates have committed to repealing or stripping the law before it kicks in.
A View of Dentistry
History and Origins

Some of you may have heard of the Indian Health Service (IHS) Division of Oral Health (DOH), but I am willing to wager that few you of know of its history, origins, challenges and successes. This article explores a little of the history, explains the current challenges and relates a story where the IHS DOH has had modest success.

The history of the United States government providing health services for Native Americans (American Indians and Alaska Natives or AI/AN) dates back to the late 1700s, when the provision was designed to “control the spread of infectious diseases.” This health care developed through various laws and treaties, originally under the War Department, but eventually passed to the Department of Interior (under the Bureau of Indian Affairs, or BIA) and in 1955, it passed to what is now known as the Department of Health and Human Services (HHS). Under the HHS, it became the responsibility of the U.S. Public Health Service and is now known as the Indian Health Service (IHS). The IHS has facilities in 35 states and a total of approximately 350 facilities (ranging from health stations to health centers to complete hospitals) that are controlled by the federal government or the tribes. There are over 560 federally recognized tribes, and each enjoys sovereign nation status with the United States.
The history of dental care for Native Americans originated more recently with the first dentists being appointed to the BIA in 1913. In the 1940s, with the passage of the Physician-Dentist Draft Act, there were 14 Public Health Service Commissioned Officer Dentists assigned to help with manpower shortages on reservations. Today there are between 650 and 700 dentists working in the IHS as Commissioned Officers, Federal Civil Servants or direct Tribal Hires (contract) alongside dental hygienists, dental therapists, dental assistants and front office staff.

Public Health and the IHS DOH

By its nature, oral health care in the IHS DOH is based on a public health model, and there are marked differences between the services delivered at an IHS dental clinic and what is offered at a typical private practice dental office. Communities, as well as the individuals, are the “patients” treated in the IHS, and as such, the dentists assess both the individual’s and the community’s needs. Just as the individual needs periodic examinations, the community or population needs periodic surveys to diagnose the community’s needs over time. “The goals of public health dentistry are socially determined” while the goals of private care are determined by what the individual patient wants and can afford to buy.

Emergency care, prevention and basic restorative care are the basis of care in the IHS. In a system of care in which resources are limited, “the decision to do one thing is by default the decision not to do something else.”

In the IHS, the dentists, hygienists and assistants work as part of a team and “rarely is a major decision in public health made on one’s own.” The IHS dental team is accountable to the community (tribes and tribal councils or health boards), who decide which services will be offered, and congress and the taxpayer, who largely decide how many funds are available to provide these services. Although some outside clinicians do not fully understand these goals, the IHS dental teams have the same basic goals as the private dentist: the betterment of the oral health of the patients they serve.

Dental disease in the AI/AN population vs. the general U.S. population

The 2010 Oral Health Survey was the most recent assessment of the entire AI/AN population, but that survey is still undergoing review, so I will talk about results of the 1999 Oral Health Survey. That survey found the following results:

- Child Caries rate - Untreated
  - 68% of AI/AN adolescents had untreated tooth decay, this compares with
  - 24% of similarly aged children in the general U.S. population

- Adult Caries rate - Untreated
  - 68% of AI/AN adults, aged 35-44 years old and
  - 61% of AI/AN elders have untreated tooth decay, this compares with
  - 26% of adults (aged 35-44 years) had untreated caries in the general U.S. population

- Periodontal Disease rate
  - 59% of dentate AI/AN adults, aged 35-44 years old, and
  - 61% of dentate AI/AN elders have periodontal disease, this compares with
28% of 40-49 year old adults who have destructive periodontal disease in the general US population.

Challenges and Barriers to Care

Why do these profoundly high rates of oral disease persist among the AI/AN population? The explanations are numerous and complex, but prominent among them is underfunding and under-prioritizing.

- **Underfunding** – The dental care that the AI/AN population receives is largely provided by the IHS, and the IHS is funded by the federal government. The amount of funding the IHS DOH has received in the budget, while there have been modest increases during the last decade, has not kept pace with the AI/AN population increases (1.0-1.4 percent increase every year for the last decade) nor the cost of health care inflation over the same time. As a result, there are only enough dental clinics and dentists, hygienists and dental assistants to meet about a quarter of the needs of the AI/AN population. The patients must often travel 50 miles or more (one way) to the nearest clinic and that is along narrow, winding and hazardous roads – a trip that can take two hours each way. The clinics, while often modern and well equipped, may be undermanned to handle the large number of patients that come in for emergency care or regular appointments on a given day.

- **Under-prioritizing** – The majority of the AI/AN population lives in conditions that compare more to third world countries then you would think of as existing in the United States:
  - Crowded living conditions, no running water, no electric power are more the norm with families that live on reservations. Often wood burning stoves are the only source of heat and cooking.
  - The working prospects of Native American are poor at best. Many who live on reservations farm or do crafts such as weaving, pottery, or making jewelry, and they have the highest poverty levels of any ethnic group in the United States. The U. S. Census reports that Indians have incomes that average less than half that of the general U.S. population, with more than 20% of reservation households making less than $5,000 annually.
  - Health conditions are abysmal - diabetes, obesity, heart and breathing conditions occur at much higher rates than in the general U.S. population.
  - And the psychological consequences of these disparities are inevitable - depression, alcoholism, substance abuse rates are high.
Sometimes as bad as the symptoms of a toothache or loose teeth (due to periodontitis) are, given the choice between putting a meal on the table for the family or going to the dentist, well, the choice is obvious. Sometimes the choice is harder to understand. I’m talking about the choice to drink excessive alcohol or take illegal drugs instead of brushing one’s teeth or choosing to eat a healthy diet. But psychological consequences of these living, working and health conditions often lead to hopelessness, which contributes to a downward spiral of depression which leads to alcoholism and substance abuse.

Encouraging News

Among all the bad news there are a few bright spots.

The IHS has begun initiatives and collaborations designed to help extend access to health services and health education to much of the AI/AN population, which lives in very rural and remote areas. Some of these include the Community Health Representatives (CHRs), the Public Health Nurses (PHNs), and Dental Health Aid Therapists (DHATs), who work under the supervision of a dentist and live in very remote villages not connected by any roads to other areas of Alaska. The DHATs are just a recent addition and it is early to see any significant change in dental health resulting from their efforts. But just between 1996-1998 and 2002-2004 death rates have fallen among the AI/AN population due to cerebrovascular causes by 18.8 percent, due to diabetes by 3.8 percent, and due to heart disease by 14.9 percent, and these statistics are in large part due to the efforts of CHRs and PHNs.

One of DOH’s success stories is the IHS Early Childhood Caries (ECC) Collaborative. This collaborative started in 2010 and seeks to link IHS dentists and hygienists with their health and community colleagues – family medicine and pediatric doctors, nurses, CHRs, Head Start and WIC staff in the IHS – to enlist their help to cut the rate of early childhood caries by 25 percent by 2015. This small but significant reduction is the aim after decades of ECC rates hovering near 70 percent. All of these community partners are called upon to “lift the lip” and assess the child’s need to see a dentist, make the referral to the dentist if necessary, and, if possible, place fluoride varnish on the teeth when they are seen in their regular visits. By this collaboration, we are seeking to extend the access to children 0-5 years of age who are normally seen by these health care and community partners, but who, at these ages, are seen rarely in the dental clinic. We have found that by age 2 or 3 an AI/AN child can have a mouthful of cavities before they ever visit the dentist.

The dentists and hygienists part of the collaboration is to see the referrals quickly, confirm the diagnosis and provide early intervention to those who need it. The treatment they provide includes Interim Therapeutic Restorations (or ITRs) of glass ionomer and sealants for teeth that are not decayed. The preliminary results after just two years are promising. For more information visit www.ihs.gov/doh/ecc.

How you can become involved

Come work for the Indian Health Service. You will find that you live and work in some of the most beautiful parts of the country and that you will be serving a population that is truly in need of your services. Dentists who

Window Rock, Arizona is a major landmark and location of the administrative capital of Navajo Nation.
work for the IHS enjoy excellent compensation and benefits and a team approach to dentistry that encourages professional growth.

A good place to start learning about our positions for dentists and hygienists is at our website www.dentist.ihs.gov. There you will find a synopsis of the three career paths that are open to you – the Commissioned Corps of the U.S. Public Health Service (CC) (age limits apply), the Federal Civil Service (CS), or Direct Tribal Hire. The link for “Search Vacancy Database” provides information about our current vacancies. You can also register at “My IHS Profile” to receive a booklet about our opportunities, a fold-out map of our facilities, and a DVD that explores the lives of some our dentists. If you want to pre-apply, submit a resume and cover letter along with your profile. The cover letter should state where you would like to work, when you are available to start and which career path you would like to work in. All three career paths are eligible to apply for either the IHS Loan Repayment Program (http://www.ihs.gov/loanrepayment) or the National Health Service Corps LRP (http://nhsc.hrsa.gov/loanrepayment).

Can’t afford to “give it all up” for life in the scenic country? The IHS has two options to experience the adventure and be involved in public service for as little as two weeks:

- Volunteer through the American Dental Association – a program with the Bemidji Area (Minnesota, Wisconsin, or Michigan) or Aberdeen Area (North and South Dakota and Nebraska) or the Hopi Tribe in Northern Arizona. The ADA reimburses dentists for lodging, travel and meals. The contact is Mr. Gary Podschan, manager of the ADA’s American Indian/Alaska Native Dental Placement Program at podschung@ada.org or (312) 440-7487.

- A few other opportunities exist through the Indian Health Service for dentists willing to volunteer two weeks or more of their time. Send a resume and cover letter that states which part of the country you want to serve in, how long you will commit to serving and when you are available to DentalJobs@ihs.gov.

We will send out a notice to our field programs, and if a program has a need which matches your availability they will get in touch with you.

For questions about this article contact the author, Dr. James Schaeffer, DMD, MPH, deputy director, Division of Oral Health, Indian Health Service at James.Schaeffer@ihs.gov.

About the Author

CAPT Jim Schaeffer is a native of Pennsylvania, where earned his DMD from Temple University School of Dentistry in Philadelphia in 1986. Most recently he earned an MPH from University of North Carolina in Chapel Hill in 2011. He has led a varied career in dentistry beginning with active duty service in the U.S. Navy Dental Corps, followed by roles as dental director for a community health center and a general dentist in practice in Charleston, SC. He served as a contract dentist for the U.S. Army assigned to Fort Myer, Virginia, and then joined the US Public Health Service Commissioned Corps in 1999.

His previous assignments with the Commissioned Corps include Deputy Chief at the Commissioned Officers Dental Clinic of the National Institutes of Health (NIH) and Career Development Officer at the Office of Commissioned Corps Operations (OCCO). CAPT Schaeffer joined IHS in October 2006 as Deputy Director in the IHS Division of Oral Health (DOH). In his current role he assists the DOH staff in a number of activities, including recruitment, health promotion/disease prevention, and personnel-related matters.

References:

7 A 1999 Oral Health Survey of Native American and Alaskan Native Dental Patients – Findings, Regional Differences and National Comparisons, U.S. Department of Health and Human Services, Indian Health Service, Division of Dental Services.
New Online Calendar

We are excited to announce the launch of our new, user-friendly online calendar. Not only does it offer a more reader-friendly format, but events can easily be sorted by type or searched by keyword such as location or topic. The calendar features a wide array of events - everything from continuing education opportunities to district and local events to dental student outreach - and allows for online registration for select events. This convenient and efficient method for registration is available to members, dental office staff and students. It allows for decreased cost related to credit card processing fees and increased efficiency of PDA staff time, and provides online payment and real time confirmation of your attendance.

If your district or local society would like an event listed on our calendar, please visit www.padental.org/event to submit the event details.

Our website is a valuable resource offering you a wealth of information 24/7. Looking for a CE course in your area? Check out our online calendar. Looking to reach out to another PDA member? Do a quick search on our Member Directory. Want to know what’s going on in the state legislature? Visit our Advocacy section. There’s all this and so much more right at your fingertips.

Most of our publications are available for download, and are conveniently located under Resources and Programs. Also available in this section is information about programs such as our Statewide Mentoring Program, Placement Service and classified ads.

The site continues to expand, with staff regularly adding content pertinent to you. Please take some time to explore all the information and resources we make available, much of which is exclusively for PDA members.

Suggestions and comments are always welcome and can be sent to Natalie Kinsinger at nmk@padental.org.

PDA Offers Two Continuing Education Courses

Optimize Your Practice: Understanding the Code, presented by Charles Hoffman, DMD. Accurate and consistent procedure reporting on claim forms or patient records are necessary for a successful office. This course will review the structure of the Code on Dental Procedures and Nomenclature (CDT Code). Familiarity with the CDT Code enables you to document dental services, as well as recognize claim adjudication errors.

The course will cover:
- The structure and content of the CDT Code’s 12 categories of service.
- How to recognize the procedure codes used to document and report common clinical scenarios.
- How to identify when third-party payers use the Code inappropriately in claims processing.

Radiology Facts: What you May Have Forgotten Over Time, presented by Kathleen M. Schlotthauer, RDH. Gain a better understanding of how X-rays are generated and how the various factors of kVp, MA, film speed, time, film placement and processing impact their outcome. This course will focus on intraoral images and provide an overview of radiographic principles needed to ensure diagnostic images.

The course will cover:
- How to generate X-rays that produce quality images.
- Factors that affect the quality of the radiographs and how to correct technical errors.
- Quality checks, including the time intervals for maintaining the quality of the radiographs.

Both courses are scheduled for May 11 at the Holiday Inn Harrisburg East in Harrisburg.

Please note that the four hours earned at the coding course will not count toward the licensure requirement in Pennsylvania. To learn more or to register, log on to the continuing education section of PDA’s website at www.padental.org, or contact Rebecca Von Nieda, at (800) 223-0016, extension 117.
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Upcoming Events

Fall All Day Program: Friday, October 14, 2011
The Buck Hotel, Feasterville, PA
“Virtues of Profitable Dentistry”
Presented by Dr. Howard Farrran DDS, MBA, MAGD
A noted international lecturer on faster, easier, more efficient dentistry. He has captivated audiences around the world with his innovative, informational and entertaining style. In his seminar entitled, “The Virtues of Profitable Dentistry” he gets down to the nitty gritty details of running a thriving family practice. He can show any dental team how they too can achieve their dreams and goals. Dr. Farrran is the founder and publisher of Dentaltown Magazine, which is mailed to more than 118,000 dentists in 43 countries each month.

Fall Dine Around: Wednesday, November 2, 2011
The Dandelion Restaurant 124 South 18th Street, Philadelphia, PA
“Current Topics in Head and Neck Cancer, Screening, Evaluation, and Treatment of Oral Cavity and Oropharyngeal Cancer”
Presented by Dr. Lango MD

Winter Entertainment Event: Thursday, January 19th, 2012
Del Frisco’s Steakhouse 1426 Chestnut Street, Philadelphia, PA
Featuring the breathtaking magic of Oz Perlman (back by popular demand!) and stand up comedian and writer Doogie Horner

Zocalo 3600 Lancaster Avenue, Philadelphia, PA
“The Fully Integrated Practice: It’s All About The Patient”
Presented by T. Andre Shirdan

CPR: Friday, April 27, 2012
The Buck Hotel, Feasterville, PA

Spring All Day Program: Friday, May 18th, 2012
The Buck Hotel, Feasterville, PA
“A Sound Recession Proof Restorative/Hygiene Practice; Integrating the Team and Creating the Value”
Presented by Dr. Lou Graham

Annual Golf Outing: June, 2012
Philmont Country Club

For more information on Eastern Dental Society, please contact Dr. Michael Salin at Info@Eastern-Dental.org or (215) 322-7810, or visit us online at www.Eastern-Dental.org
**Dr. Bruce A. Singer**

The following tribute, written by Dr. Jeffrey B. Sameroff, is being reprinted from the February issue of the Montgomery-Bucks Dental Society Bulletin.

It is with sadness that I inform you that our dear friend and colleague Bruce Alan Singer passed away on Thursday, January 19 at the age of 64.

Bruce Singer was a prosthodontist who practiced in Jenkintown and lived with his wife Becca in Ambler. He was a native of Philadelphia, graduating from Springfield High School, Moravian College and Temple Dental School, where he also earned his specialty certificate in fixed prosthodontics.

Early in his career, he worked as a clinical instructor and assistant professor at the University of Pennsylvania’s School of Dental Medicine. His incorporation of advanced photography into cosmetic dentistry led to many articles published in periodicals such as the *Journal of The American Academy of Cosmetic Dentistry*, *Pennsylvania Dental Journal* and *Dentistry Today*. For several years, he served as the Director of Scientific Photography in the Dental Division of Albert Einstein Medical Center.

He shared his knowledge of dentistry and photography with many generations of students. He taught and lectured around the country on dental esthetics and dental photography at such meetings as the Center City Study Club, the Greater Washington Study Club, the Yankee Dental Meeting in Boston, at the NYU Dental School International Symposium, the Holiday Dental Conference in Charlotte, NC, the Detroit Dental Society, the Montana Academy of General Dentistry, the Annual Meeting of the American Academy of Cosmetic Dentistry and the Bavarian Dental Society in Munich.

Bruce was the immediate past president of Montgomery-Bucks Dental Society. He was also a past president of the Delaware Valley Chapter, American Academy of Osseointegration and General Chairperson of the Valley Forge Dental Conference where he also served on the scientific program committee. He was an associate in the Department of Restorative Dentistry at the University of Pennsylvania for many years.

Last year Bruce won a 2011 Great Idea Award from the Pennsylvania Dental Association for his work with young dentists. He had recently merged his practice with Yorktown Dental Associates, led by Dr. Youngkun Kim and Dr. Bernard Dishler, the incoming president of PDA. He served as an alternate delegate to PDA’s Annual Session and was slated to be a delegate this year.

Bruce was a superb clinician with a very successful practice limited to prosthodontics and cosmetic dentistry. He was trusted and well respected by his colleagues. Bruce will be greatly missed by his family, his colleagues, his patients and his friends.

— Jeffrey B. Sameroff, DMD

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**IN MEMORIAM**

**Dr. Daniel J. McDonald, Jr.**
Greenville
Univ. of Pittsburgh (1956)
Born: 1/19/1924
Died: 11/19/2011

**Dr. Harold D. Mock**
Cheswick
Univ. of Pittsburgh (1959)
Born: 1/1/1932
Died: 12/15/2011

**Dr. John A. Bruno**
Pittsburgh
Univ. of Pittsburgh (1981)
Born: 1/1/1954
Died: 11/9/2011

**Dr. David Krasner**
King of Prussia
Temple Univ. (1955)
Born: 5/3/1932
Died: 12/17/2011

**Dr. Dr. Todd M. Angelo**
Jefferson Township
Univ. of Pittsburgh (2001)
Born: 9/28/1973
Died: 11/4/2011

**Dr. William F. Lenker**
Paoli
Univ. of Pennsylvania (1960)
Born: 11/4/1934
Died: 11/6/2011

**Dr. Daniel J. McDonald, Jr.**
Greenville
Univ. of Pittsburgh (1956)
Born: 1/19/1924
Died: 11/19/2011

**Dr. John A. Bruno**
Pittsburgh
Univ. of Pittsburgh (1981)
Born: 1/1/1954
Died: 11/9/2011

**Dr. Todd M. Angelo**
Jefferson Township
Univ. of Pittsburgh (2001)
Born: 9/28/1973
Died: 11/4/2011

**Dr. William F. Lenker**
Paoli
Univ. of Pennsylvania (1960)
Born: 11/4/1934
Died: 11/6/2011

**Dr. Norman C. Freeman**
Cherry Hill
Temple Univ. (1960)
Born: 1/1/1928
Died: 2/2/2008

**Dr. Jay S. Miller**
Newville
Temple Univ. (1947)
Born: 1/1/1921
Died: 11/2/2009
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I survive the day at the office. Get out of the car. Drag my sorry cheeks into the house and look into the mirror. Red alien eyes stare back at me. My right eye beholds a map of the Mississippi delta on my left eye. I have post-nasal drip. I have pre-nasal drip. This rhinovirus has come from a real Rhino. I picture it cavorting with its fellow ungulates in the upper reaches of the Ganges. No armor will protect them from this virus. I make my way to the den. Fall into a recliner. The touch of my butt causes the phone to ring. 

“Dr. Galeone?”

“Yeah...?”

“It’s the Nightmare Answering Service. We got a call from a Mrs. Khan about her son, Lucifer. He’s having a problem with a tooth and is in great pain. She’d like a call back at...”

Why me, I think. Shouldn’t they really be calling his psychiatrist? This kid gets into more trouble than Charlie Sheen. How convenient that the “problem” started the very minute I left the office! I put off returning the call for 10 minutes figuring I might get lucky and die. But no. My head cold escapes its namesake, expands like flash gas into my left zygoma, down my neck, through the center of my heart and then shoots down the colonic highway. A cramp causes my body to form a right angle and throws me from the chair. Simultaneously the fourth lumbar vertebra tears into my sciatic nerve. Giddy with pain, I claw my way to the bathroom. And almost make it.

When I stop whimpering I call the Khans. In the background I hear little Lucifer screaming and I hear his father screaming at him to stop screaming. It’s so loud I almost miss what Mrs. Khan is screaming on the phone. I think I previously mentioned that my father wanted me to become an attorney. But Noooo! I knew better. I would destroy my life in my own way. I tell the Khans I’ll see them at the office in half an hour.

I hate to be in the office alone with a patient mostly because I don’t know where anything is. So I call Mercedes, my dental assistant, and there’s no answer. Cell phone. No answer. Text. No answer. Email. No answer. Husband’s cell. She’s at the gym. Another visit to the porcelain shrine at the end of the hall. I call the gym. She just left. I call suicide prevention hotline. They tell me to “suck it up.” Ten minutes later Mercedes calls. She sweaty. She has to take a shower but will meet me at the office as soon as she can get there.

Mrs. Khan’s neck looks like the trunk of a Baobob tree. There is a vein pulsing to the beat of Flight of the Bumblebee. The mister has stayed at home to watch baby Genghis. Like an eel having a grand mal seizure, little Lucifer is thrashing about the dental chair. But his mother has him pinned as if ready to pith him. I get a glimpse inside his mouth. Oh, what have I done, Lord? True, I have evil desires. But You have not given me the looks, intelligence or cunning to realize
them. I must draw Lucifer’s festered tooth. I am in an antihistamine daze. Where is Mercedes? Did she stop for a pedicure? No, here she is. She limps into the operatory. Sorry, she says, my heel broke off, and she kicks her shoes into the corner.

I tell her about my miserable life. About how I have been forsaken. She prepares a syringe of local anesthetic. I am trying to line up the needle with the proper anatomy but the inside of his mouth is shaking at eight on the Richter scale. During the injection he hurls unflattering epithets, denunciations and even describes, in vivid detail, my final damnation. Actually, he does a tad better than I’d anticipated. I try to convince him it won’t be so bad. But there is no change in decibel level. That’s when I realize that the devil was named after this kid and not the other way around.

It’s the lower left second primary molar we are after. On the third attempt I manage a fly-by grab with the forceps. It’s a little loose and comes pretty easy. But at the sight of her son’s tooth having an out of mouth experience, Mama Khan’s eyes roll up under her lids and she slumps to the floor. Mercedes gets a cold towel. I tilt up her chin to protect the airway and as her eyes slowly roll open I am hit on the top of my head with what feels like a Mongolian trooper’s saber but what is really the 151 forceps.

“Help, help,” yelps Lucifer. “He killed my mother. He killed my mother.” And with that he dashes out of the operatory, down the hall, through the waiting room, out of the building, across the parking lot and into the vast dark world. Barefoot, Mercedes takes off after him. Blood is drooling down the side of his face and his fading screams can be heard in the distance. He killed my mother. Thank God Mercedes is a practicing gymnast. No, really. We should rename the town of Jim Thorpe.

It is no longer than 15 minutes when the flashing red and blue lights of the police cruiser pull up outside the office and Mercedes, Lucifer and Officer Wong come barreling into the operatory. Lucifer’s bleeding has stopped. Mrs. Kahn is obviously alive and well and sitting in the dental chair. But that doesn’t seem to make any difference. Wong gives me a suspicious look. After filling out his report he tells me that that’s all… for now… but, he’s keeping an eye on me. I don’t really give a rat’s rump. I’m just glad to be headed home again.

—RJG
University of Pittsburgh

Contact: Lori Burkette
Administrative Secretary
(412) 648-8370

March 30
The Art and Science of CAMBRA
Dr. Doug Young

April 14-15
Local Anesthetics for the Dental Hygienist — Part 2
Hands-On/Limited Attendance
Dr. Paul Moore
With Faculty, Department of Anesthesiology and Department of Dental Hygiene

April 21
T. F. Bowser Memorial Lecture:
The New Perio Medicine Hygiene Protocol
Dr. Timothy Donley

April 28
Surgical Crown Elongation
Dr. Pouran Famili
Dr. Ali Seyedain

May 12
Dental Radiography:
DANB Exam Prep Course
Gayle Bull, RDH
Victoria Green, RDH

June 8-9
Recognition and Management of Complications During Minimal and Moderate Sedation — Part 2
Hands-On
(Registration Deadline: April 1)
Dr. James C. Phero, DMD
Dr. Joseph A. Giovannitti Jr.
*Please note: A ten-lesson online course offered through the adaonline.org must be completed prior to taking Part 2.

Off-Campus Programs

Altoona

April 19
Restoration of the Complex Denture, Fixed & Implant Patient: Pitfalls to Avoid
Dr. Carl F. Driscoll

Bradford

April 26
Can I Do That, and Get Paid, and Enjoy It?
Dr. Robert N. Obradovich

September 13
Restorative Dentistry
Dr. Jan K. Mitchell

October 25
Complete Denture Fundamentals
Dr. Michael Waliszewski

Butler

April 19
Periodontics 2012: Pearls for the General Practice
Dr. Francis Serio

Erie

April 19
ABCs of Pediatric Dentistry
Dr. Mary Beth Dunn

Greensburg

April 20
Restoration of the Complex Denture, Fixed and Implant Patient: Pitfalls to Avoid
Dr. Carl F. Driscoll

Johnstown

March 30
New Modalities in the Treatment of TMD
Dr. John E. Pawlowicz III

April 25
Updates in Oral Medicine & Managing Medically Complex Patients
Dr. James Guggenheimer

Scranton

March 28
Achieving Excellence in Treating and Counseling the Oncology Patient
Sandra Boody, CDA, RDH, MED

April 18
Restorative Dentistry
Dr. Jan Mitchell

Steubenville, Ohio

March 29
Options for the Restoration of the Dental Implant
Dr. Steve Kukunas

April 26
The ABCs of Pediatric Dentistry
Dr. Mary Beth Dunn

Titusville

April 25
Can I Do That, and Get Paid, and Enjoy It?
Dr. Robert N. Obradovich

WilliamSPORT

April 18
Periodontics 2012: Pearls for the General Practice
Dr. Francis Serio

October 21
The New Perio Medicine Hygiene Protocol
Timothy Donley, DDS, MSD

Pittsburgh VAMC

April 18
What’s Hot and What’s Getting Hotter
Dr. Howard Glazer

May 9
Restorative Dentistry
Dr. Jan K. Mitchell

Pottsville

March 29
Can I Do That, and Get Paid, and Enjoy It?
Dr. Robert N. Obradovich

April 26
Options for the Restoration of the Dental Implant
Dr. Steve J. Kukunas

Reading

April 20
Smart Bonding: Extraordinary Solutions for Ordinary Problems
Dr. Howard E. Strassler

October 26
The Periodontal Patient – Management and Implications for Overall Health
Dr. Frank Scannapieco
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<tr>
<th>Temple University</th>
<th>St. Marys</th>
<th>Dental Society of Chester County and Delaware County</th>
<th>Montgomery-Bucks Dental Society</th>
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<tr>
<td>Contact: Dr. Ronald D. Bushick or Nicole Carreno (215) 707-7541/7006 (215) 707-7107 (Fax) Register at <a href="http://www.temple.edu/dentistry/ce">www.temple.edu/dentistry/ce</a></td>
<td>Contact: Rebecca Von Nieda, PDA (800) 223-0016, ext. 117</td>
<td>Contact: Dr. Barry Coher (610) 449-7002 <a href="mailto:DKUdental@aol.com">DKUdental@aol.com</a></td>
<td>Normandy Farm, Blue Bell <a href="http://www.mbds.org">www.mbds.org</a> (215) 234-4203</td>
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<td>April 20 Infection Control: That Thing You Do, Why Do You Do It? John A. Molinaro, PhD</td>
<td>May 11 Managing the Balanced Oral Environment – Assessing, Restoring and Maintaining Dental Health Nels Ewoldsen, DDS, MSD</td>
<td>April 20 Optimal Aging — Living to 100 Barbara J. Steinberg, DDS</td>
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<td>April 25 Orthodontics: What the General Dentist Needs To Know Harold Slutsky, DMD</td>
<td>May 9 Forensic Odontology – Everything You Want to Know, but Didn’t Know Who or What to Ask Richard M. Scanlon, DMD</td>
<td>May 18 My Patient Keeps Getting Cavities… Dr. Brian B. Novy</td>
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<td>May 9 Radiology Facts – The Spectrum of Dental Radiology: Improving Diagnostic Images Safely and with Accuracy Kathy Schiotthauer, RDH</td>
<td>September 14 Pharmacotherapeutic Considerations for Dental Practice – It’s more than Pen Vs and APAP/HCs Daniel Becker, DDS</td>
<td>Philadelphia County Dental Society</td>
<td>Eastern Dental Society</td>
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<td></td>
<td>October 19 Title: Contemporary Oral Surgery Overview for the General Dentist William L. Chung, DDS, MD</td>
<td>Contact: Teresa F. Ravert Executive Director (215) 925-6050 Fax (215) 925-6998 e-mail: <a href="mailto:philcodent@aol.com">philcodent@aol.com</a> or visit the web site at <a href="http://www.philcodent.org">www.philcodent.org</a></td>
<td>Contact: Dr. Michael Salin (215) 322-7810 <a href="mailto:info@Eastern-Dental.org">info@Eastern-Dental.org</a></td>
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<td>May 9 Current Concepts in Minimally Invasive Dentistry Dr. Ron Kaminer (in cooperation with Dental Team Concepts: Triodont, Veloscope, GC America)</td>
<td>May 18 The Buck Hotel, Feasterville A Sound Recession Proof Restorative/Hygiene Practice; Integrating the Team and Creating the Value Dr. Lou Graham</td>
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<td>The Institute For Facial Esthetics</td>
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<td>Fort Washington Contact: Linda Maroney CE Coordinator (215) 643-5881 On-Line Registration: <a href="http://www.iffe.net/registration">www.iffe.net/registration</a></td>
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<td>March 26 Advanced Guided Surgery with Zygomax Thomas J. Balshi, DDS, PhD, FACP Glenn J. Wolfinger, DMD, FACP Stephen F. Balshi, MBE</td>
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<td>Brookville</td>
<td>Wellsboro</td>
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<td>Heritage House</td>
<td>Pennsylvania College of Technology Contact: Rebecca Von Nieda, PDA (800) 223-0016, ext. 117</td>
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<td>Contact: Rebecca Von Nieda, PDA (800) 223-0016, ext. 117</td>
<td>May 4 The Prosthodontic Sextet for Esthetic Longevity and Success Fritz Kopp</td>
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<td>April 13</td>
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<td>April 20 Direct Composite Restorations — Components for Success James Braun, DDS</td>
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<td>Orthodontics: What the General Dentist Needs To Know Harold Slutsky, DMD</td>
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<td>Giannilli’s II Restaurant &amp; Banquet Facility, Greensburg Contact: Rebecca Von Nieda, PDA (800) 223-0016, ext. 117</td>
<td>Contact: Rebecca Von Nieda, PDA (800) 223-0016, ext. 117</td>
<td>Contact: Dr. Lou Graham (in cooperation with Dental Team Concepts: GC America)</td>
<td>Normandy Farm, Blue Bell <a href="http://www.mbds.org">www.mbds.org</a> (215) 234-4203</td>
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<td>April 20 Treatment Planning for Advanced and Complex Dentistry and Esthetic Implant Dentistry Cyril J. Eivan, DMD</td>
<td>September 7 The Orchards Restaurant Update on Local Anesthetics and Analgesics for the Dental Professional – Old Drugs and New Drugs Dr. Elliot V. Hersh</td>
<td>October 3 Advancing Your Vision in Restorative Dentistry Dr. Lou Graham (in cooperation with Dental Team Concepts: GC America)</td>
<td>April 20</td>
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<td>May 11 A Simple Path to Excellent Endodontics Michael J. Ribera, DMD, MS</td>
<td>October 12 The Orchards Restaurant Clinical Operating Microscopes: They’re Not Just for Endodontists Anymore Dr. John B. Nase</td>
<td>December 7 Possibilities in Dentistry: Cosmetic, Restorative, Implant Dentistry &amp; How to Implement Them into Your Practice Dr. David Little (in cooperation with Caulk/Dentsply)</td>
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<td>November 16 The Chambersburg Country Club Update in Esthetic Restorative Dentistry Dr. Terence E. Donovan</td>
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<td>My Patient Keeps Getting Cavities… Dr. Brian B. Novy</td>
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Practice for Sale

Practice Sale

Dental Practice Sale
Cumberland County - 4 op General. Rev. $400K. Sharon Mascetti at Sharon.mascetti@henryschein.com or (484) 788-4071. www.snydergroup.net.

Practice Sale

Practice for Sale

Practice for Sale
Camden County, NJ- Perfectly wonderful general dental practice sale! 6 ops, digital, over 2,000 active pts, 3,000 s/f leased space. Rev $1.15M. Call Donna Costa (800) 988-5674.

Practice for Sale

Practice for Sale
Northampton County - Well established 35 y/o practice. 4 ops with Panorex. 1,500 active patients. Rev $383K. R/E available. Call Sharon at (484) 788-4071 or email sharon.mascetti@henryschein.com. www.snydergroup.net.

Dental Practice Sale
Delaware County - Hot Area! 3 ops + 1 - All FFS. Rev. $200K. Donna (800) 988-5674. donna.costa@henryschein.com.

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