ADVISOR

THE OFFICIAL PUBLICATION OF THE ILLINOIS ACADEMY OF GENERAL DENTISTRY

Midlevel Providers: Social Justice or Social Discrimination

By Dr. Paula Jones, Past-President
Academy of General Dentistry

There has been much ado regarding the development of the midlevel provider in dentistry. The midlevel provider, although undefined by the ADA, has become a very controversial issue and the consequences of its reality could have a profound effect on public health and the profession of dentistry for the indeterminable future. (For the purpose of this article, midlevel provider is defined as a non-dentist providing treatment without the supervision of a dentist.)

The whole situation started with the DHAT (Dental Health Aid Therapist) in Alaska. These therapists, with only 18 months of post high school training were being used by the Alaska Tribal Coalitions to treat Native Americans who lived in isolated and sometimes inaccessible areas of that state. Remote supervision by a dentist (electronic) was the only means used for treatment planning. Restorations were placed and extractions were performed by these "midlevel" providers with very little training in emergency protocol and only helicopters were available for transport to any kind of medical facility if needed.

Since the establishment of the DHATs in Alaska, several other types of midlevel providers have been proposed with varying levels of education and scopes of practice within some of the contiguous 48 states. We, as a dental profession, need to have a philosophical and practical dialogue regarding the necessity of developing a new dental practitioner before more states adopt this untried, probably deleterious, method of possibly solving the Access to Care issue which has become the mantra of policy makers and legislators in Washington, DC.

The State of Illinois is being used as a testing ground for training these DHATS and the pilot program is funded by the Kellogg Foundation. Dr. Caswell Evans (currently on the faculty of UIC-CoD), director of the pilot program and also Chair of the Advisory Committee for the "study" conducted by the Research Triangle Institute International on DHATS has stated that the development of midlevel providers will help to ease the access problem that is rampant across the US. He told UIC students at a Lunch and Learn session on Oct 26; that the access to care issue and the health disparities evident in the US is a matter of social justice. He stated that midlevel providers are needed in the underserved areas so that everyone in the US has access to dental care. He continued that if the profession denies the development of these midlevel providers, then the onus of the access problem is on the dentists -- that we have a responsibility to society-at-large to make sure that dental treatment is accessible to all.

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President's Message

By Dr. Betty Haberkamp

As I look outside, the weather is finally changing. The temperature is cooling, the wind is blowing, and the rain is starting. But the leaves are beautiful! The mix of colors and watching leaves gently float to the ground is always amazing. Now that we are warm and cozy inside, perhaps with a fire going, it is time to return to our efforts in continuing education and advocacy.

Many of our AGD dentists have just returned from Orlando. They represented all of us at the ADA annual meeting and were very vocal on the work-force issues reference committee. AGD staff continually monitors the issues that affect general dentists and will bring information to our attention as necessary. AGD Washington Briefings can be emailed to you and it will keep you abreast of the latest legislative action and their impact on General Dentistry.

Most of us in AGD are dedicated to Continuing Education. We are "CE junkies"! Many classes are offered in our state. Our components in Chicago, Central Illinois and Northern all offer courses

throughout the year. As the Illinois AGD, we have lectures prior to the Chicago Dental Society Midwinter Meeting.

We also hold our annual meeting during the CAGD seminar prior to the ISDS Annual Session. We have several Mastertrack programs going with hands-on (participation) and protocol learning. Check our calendar of CE offerings on page . If you still feel you need more CE just go to www.AGD.org and consult the CE database. Most branches of the AGD will list their courses and instructions as to how you may register for the course. The more we learn, the better care we can give our patients.

As the leaves disappear and the snow flies, I hope to see you at our next CE offering. Thank you to the officers and board of IAGD who work tirelessly on behalf of our member dentists.

Midlevel Providers: Social Justice or Social Discrimination

Continued from page 1

The ADA has stated that as many as 75% of dentists do pro bono charitable dentistry on a regular basis. It is time that the responsibility for the lack of access to dental care be shared by 100% of the dental profession in concert with the social agencies and legislators who need to increase the funding of Medicaid programs across the US. I submit to you this question: Is it fair and just to relegate the care of the neediest and possibly the most medically compromised individuals in our society to a less qualified practitioner? If the most needy in our country are the socioeconomically compromised, the medically compromised, the mentally compromised; then do these most needy deserve a lower tier of treatment?

I also submit to you that this is a form of discrimination because it is this group of people who will be on the receiving end of the two tiered system of dental care. The National Dental Association in their position paper on Midlevel Providers has stated that it is not only discrimination, "it is un-American for a government to propose or allow a different standard of health care for the poor versus the privileged". The NDA believes that all citizens are entitled to equal healthcare. Where do you stand? The AGD at the most recent ADA meeting took a stand.

The AGD fought hard to keep the ADA's gold standard of dental practice--that the dentist is the head of the dental team and that dentist, who has the education, degree and license, is the only practitioner qualified to diagnose, treatment plan and perform irreversible/surgical procedures on dental patients. The AGD White Paper on Access to Care was cited frequently as having the solutions to the Access problem in our country. Check out the AGD website (www.AGD.org) under the Advocacy tab to see how the AGD defended the safety of patients, the structure of the dental team and the quality of dental care in the United States.

Chicago Component Seminar Report

By Dr. William Kisker

On September 15th, Maggiano's in Oak Brook was the site of the Chicago AGD hands-on seminar titled "Advanced Esthetics: Soft Tissue Management Around Teeth, Implants, and Pontics" presented by Dr. Brian Vence.

Dr. Vence maintains a private practice in West Dundee with a special interest in comprehensive esthetic and restorative dentistry. He received his dental degree in 1985 from the University Of Illinois School Of Dentistry and completed a hospital residency at the VA Wadsworth-UCLA in 1986 and a mini-residency in TMJ disorders. Dr. Vence founded the Chicago Academy of Interdisciplinary Dentofacial Therapy in 1992, a study club designed to define and promote excellence in dentistry. He has manuscripts published in *Quintessence of Dental Technology, Practical Periodontics and Aesthetic Dentistry, The Journal of Prosthetic Dentistry* and *Compendium of Continuing Education.* He is a member of the American Academy of Restorative Dentistry, the American Academy of Esthetic Dentistry, the International College of Dentists and the American College of Dentists. Dr. Vence began the seminar with a detailed review of the science of implantology and treatment planning. He gave a very knowledgeable account of the details that need to be considered when determining the best route for a successful outcome.

The primary thrust of his presentation was the esthetics of placing implants in the anterior portions of the mouth especially when the implants are mixed with natural teeth. He reviewed the importance of bone contour for the health and long term survival of overlying soft tissue. He completed the lecture portion with a presentation on how to fabricate an esthetic temporary crown for a new implant.

After a delicious lunch served by Maggiano's, the attendees took part in the hands-on portion of the course. The participants were guided by Dr. Vence, Ron Dubois from Biohorizons, and Robert Mopper from Cosmedent. With materials provided by these companies and assistance from Brasseler, participants practiced the steps necessary to fabricate properly contoured and polished bis-acryl crowns for newly placed implants. Participants also had the opportunity to place Biohorizons implants into plastic mandibles before placing the temporary crowns.

We would like to thank the many sponsors who made this presentation possible including Biohorizons, Cosmedent, Brasseler, PNC Bank, and Clear Choice. We would like to thank Maggiano's for the warm welcome and excellent food.

Upcoming

Chicago Seminars

March 11, 2001
"Lasers in Periodontology and Restorative Dentistry"
Dr. Robert Convissar
Marriott Oakbrook Hills

May 13, 2011
"Diagnosis and Treatment of Obstructive Sleep Apnea"
Dr. Ira Shapira
Maggiano's – Schaumburg

Midlevel Providers: Speak Out!

By Dr. Robert Kozelka

As this issue of the Advisor reaches you, the results of the Election of 2010 are in. The billions of dollars spent on media advertising set all time records. There is little doubt that in today's political climate, money talks. Amazing to me is that this kind of spending is taking place in the shadow of the worst economy of my lifetime. Politicians listen to dollars.

Although these politicians listen to their contributors, they will also listen if enough people speak out.

Remember, in the final analysis, it is your vote that puts them in office. Whether you voted for the winner or not, they now represent you! By now you should know about the Mid Level Provider and the impact this legislation will have on how you will practice your profession of dentistry in the near future. If the Mid Level Provider is approved in our state, not only will it change how you practice, it will very definitely affect your ability to earn an income.

I have heard from some doctors that the Mid Level Provider is a "done deal" and there is nothing we can do about it. This is simply NOT true! Send an email to your state representative and state senator. Let them know you are opposed to the Mid Level Provider. Tell them it will severely damage the way quality health care is delivered to the citizens of Illinois. They will listen if enough of us speak up.

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Membership Committee Update

By Dr. Theresa Lao

State-wide News

Illinois AGD was one of nine constituents chosen to participate in a membership campaign spearheaded by the national office. Letters for member recruitment were sent out to all Illinois dentists in mid September. Both IAGD President Dr. Betty Haberkamp and AGD President Dr. Fares Elias highlighted the many benefits of AGD membership in the mailing.

The Refer-a-Colleague and Refer-a-Classmate program is ongoing and members who participate are entered into monthly drawings for great prizes.

Also, a drawing for Kindles will be held for all members who pay their 2011 dues during the months of October and November 2010.

As a reminder – new members who sign up after October 2010 receive membership for the remaining year as well as the whole 2011!

Don't procrastinate – renew your AGD membership now and invite a colleague to join the only organization that is the voice for general dentists!

Dental School Activities

Sixty-eight new D1's and thirty International Dentist Degree Program students were presented their white coats during the University of Illinois College of Dentistry's White Coat Ceremony on Friday August 27, 2010. Keynote speaker was Dr. Bruce Graham, Dean of UIC COD.

Dr. Ann Boyle, Dean of Southern Illinois University School of Dental Medicine, officiated at the White Coat Ceremony in Alton on Saturday October 2, 2010. Fifty D1's were donned their coats during the ceremony.

Do you know about this AGD Member Benefit?

More than 1,000 AGD members are searching the AGD CE Database for continuing education (CE) courses every month. Are you one of them? Stop wasting your time on search engines such as Google that only end up complicating your searches or giving you too many options to choose from. The CE Database is a searchable database of CE offered throughout the United States and Canada. The AGD CE Database is easy to use and gives you simple search options based on credit hours, topic, date, or location all in one spot. Most of the courses are PACE-approved so you know that you will be receiving quality courses that will count toward Fellowship or Mastership. Make searching for CE easier on yourself, and search the AGD CE Database today.

Academy of Dentistry International Convocation

By Dr. Cheryl Mora

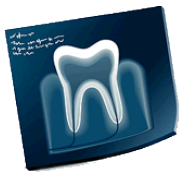
The Academy of Dentistry International held its Annual Convocation in Orlando October 6-8, 2010 at the Renaissance Orlando Resort Hotel at Sea World. The Academy of Dentistry International is an international honor society for dentists dedicated to sharing knowledge in order to serve the dental and oral health needs and to improve the quality of life of the people throughout the world. ADI is the concept of Albert Wasserman, D.D.S., of San Mateo, California, U.S.A. This transnational organization is devoted to the advancement of dentistry throughout the world and to the elevation of dental standards by continuing education. Along with the sponsorship of dental education and service projects, this Academy directly aids in the improvement of the dental and oral health and well-being of people worldwide.

Several IL AGD members had the privilege of becoming members of this distinguished organization at the Convocation held on October 7th. They are: Dr. Kirk J. Hess of Hillsboro; Dr. John H. Houseman of Jerseyville; Dr. Curtis R. Mitchem of Champaign; Dr. Cheryl L. Mora of Vernon Hills; Dr. Wallace F. Strow of Morton; and Dr. Rosemary Villa of Chicago.

On Wednesday evening, the new inductees flew in to Sea World's arctic exhibition on a Jet-copter simulator ride to enjoy dinner while exploring the beauty and grace of the beluga whales, penguins and walruses. On Thursday morning, Brian K. Smith, DDS, MD, an Oral & Maxillofacial surgeon from Case Western University gave a lively presentation on providing emergency care in the dental office setting. The Convocation took place Thursday afternoon, and was followed by the Gala Reception and Banquet. All the Inductees had a great time and were welcomed like family into the Academy.

The Academy of Dentistry International is no stranger to AGD. Dr. Sue Bishop, our IL AGD Regional Director is Past President (2007-2008) of ADI and our Dr. Fares Elias, President of AGD is a Fellow. Dr. Elias recently wrote an article for the ADI Informer. In the article he says, "The ADI shares the same values and principles with the Academy of General Dentistry, which I serve as president. The AGD's mission is to serve the needs and represent the interests of general dentists, to promote the oral health of the public, and to foster continued proficiency of general dentists through quality continuing dental education in order to better serve the public. It is not a coincidence that the founders of both organizations at totally different times and locations dreamt of two separate organizations with continuing education being their cores. That is what distinguishes these two organizations from others and they need not forget that distinction or lose it altogether."

Continuing Education and Service are core values of both AGD and ADI and we congratulate those AGD members for embracing the altruistic philosophy of the Academy of Dentistry International and have distinguished themselves in their professional and personal activities. For more information about the Academy of Dentistry International see their website at ADINT.org.



Is There an "In-and-Out" Dental Clinic Near You?

By Dr. H.L. Waldrop

Having just graduated from Dental School and being the possessor of overwhelming education loans, it seems that today's young dentists are desperate to whittle down the debt they carry. Along with the current economic recession, this presents the "In-and-Out" Dental Clinic an environment in which to flourish. This unique dental business model is profitable, serving emergency patients and those who want limited treatment in a time when the number of jobs are shrinking as are the paychecks.

The formula seems to be: find a vulnerable recent dental graduate in heavy debt: put them to work in a population area with patients wanting limited dental care; then pressure these new providers to produce high volumes of dentistry. These "In-and-Out" clinics take advantage of highly visible locations, extended hours, marketing budgets, and deep pockets.

In some areas, this is a mirror to what happens in the retail market, when a big retailer comes to main street small-town America. Most of the "Mom and Pop" stores cannot compete with the pricing, marketing, manpower, or buying advantages and must close.

This proliferation of "In-and-Out" Dental Clinics can cause many problems for the traditional dentist. Many independent dentists find themselves with a declining patient base; and because they are using "old" equipment and falling behind in skills, knowledge and techniques, they become unable to compete.

You may be that middle-aged dentist, finding your practice, skill, and patient base eroding because you are far too busy with life to be concerned with a new unconventional dental clinic that has just opened down the street. Dentists, if they want to survive in this new business climate, need a carefully executed plan that is constantly being upgraded and improved.

How do we turn this trend around? I say, become proactive and defend your livelihood! If you wait, it may be too late for you to make the necessary financial or physical changes—too late to upgrade your skills, equipment, staff, or whatever else you need to do to compete. Eventually, the "In-and-Out" clinics will decline. But in the interim, these opportunists are taking advantage of our new graduates, the economic environment, and our complacency.

Things we can do:

Approaching the young dental student/graduate:
We need to provide these young students and recent graduates with alternatives to the "In-and-Out" clinics. We need to educate them about what can happen if they go down that road. Become a mentor.

Consider giving a young dentist a job!
Take one of your potential competitors and make them a colleague!

Appeal to those with Complicated Cases:
Simply appeal to those potential patients who the "In-and-Outs" do not want to treat.

Upgrade your skill:
Join the AGD and go to those excellent seminars they provide. Build on the great experience you have and expand your abilities.

Treat your patients with exceptional care:
If you upgrade your skills you also need to upgrade your patient care. The perception of exceptional care is probably more important than the actual care you provide. I am not saying you should "fake it" by not providing quality care, but rather make sure that you show the patient how much you really care.. A great dentist once said, "Patients don't care how much you know till they know how much you care."

For example--How many dentists are you aware of who actually make follow up phone calls to the patients they treated that day? How much would it cost you to make these calls? How long will it take you? What is the perception of the patient, having received this simple routine courtesy? Your receptionist should be able to provide such a call list in minutes.

Increase your Compensation:
If you need to take more time with a case to provide the level of care you wish to provide in order to compete, then you deserve a corresponding increase in compensation. Ask yourself if what you know and what you are capable of delivering is being compensated at a level that makes you happy to go to work. If not, then your fees are too low.

General Practitioners at the ADA House of Delegates

The Academy of General Dentistry (AGD), through its Professional Relations Committee (PRC) and members of its Executive Committee, represented the interests of general dentists and their patients at the 151st American Dental Association (ADA) Annual Session in Orlando, Fla., Oct. 9 to 13, 2010.

One critical issue before the delegates of the ADA was whether to maintain policies supporting the proven and effective "gold standard" of providing oral health care through the traditional dental team model or to relax these policies. The AGD maintained that, without the existing policies, the ADA would not be controlling the dialogue with foundations and policy makers that are working to create a two-tiered system in which treatment of the poor and disadvantaged would be relegated to individuals with far less training, doing procedures that are now done by dentists only.

The AGD is proud to have workforce policies that are consistent with the ADA "gold standard," and the AGD stood with the ADA leaders who sought to maintain those standards. Your AGD president, president-elect, and PRC testified before the ADA Workforce Reference Committee to preserve ADA workforce policies that protect the health and safety of patients.

It should be noted that the resolutions originally presented to the HOD were consolidated from a dozen or so into four, each of which covered one of the areas listed above, and that numerous substitutions and amendments were offered.

In the end, the ADA, for the most part, maintained its current policies on dental hygiene programs and in defining irreversible/surgical procedures. Relative to the statement on pilot studies, the ADA moved in the direction of supporting some studies that don't violate policy and wants to position itself as the resource for the formation, execution, and interpretation of such projects. Regarding allied dental personnel, it would be appropriate to say that the general dentist remains the captain of the dental team, although the debate on supervision is likely to continue.

Supporters of maintaining the ADA "gold standard" fought diligently and were able to secure in the policy statement that only a dentist can diagnose, treatment plan, and perform irreversible/surgical procedures.

Essentially, four different areas were considered by the ADA House of Delegates (HOD). They were:

1. a comprehensive policy statement on allied dental personnel;
2. whether pilot studies should be undertaken to study the efficacy of independent mid-level providers;
3. defining who can perform irreversible/surgical dental procedures;
4. oversight of dental hygiene programs.

However, given that numerous amendments were made to all of the policies, it also could be correctly stated that neither the proponents of change nor the advocates of maintaining the ADA "gold standard" had a clear victory or clear defeat, although the AGD's positions and talking points were used to mitigate most of the potential damage. One thing is for certain: These debates will continue.

It should be clearly noted that the AGD successfully collaborated in its advocacy efforts with other dental groups. While victory may not have been clear-cut, this success was and is a victory for general dentists and, more importantly, their patients.

On a very positive note, the AGD stood proudly in support of the American Student Dental Association in its advocacy of a successful policy on dental student outreach programs and also with the National Dental Association in its advocacy of a successful policy on recognition of access to care and opposition to what would be a two-tiered system of care.

Finally, the AGD's breakfast event was very well-received, and the opportunity was used to clearly convey the AGD's position on workforce issues. We received a great deal of positive feedback regarding the information in the presentation at the breakfast, the talking points and testimony and the collaborative efforts with many groups. The AGD's advocacy efforts in Orlando helped the AGD to maintain a tremendous amount of credibility within organized dentistry and positioned itself as a resource for information and a strong voice for the patients and the profession.

Endodontics Review: Intracanal Medicaments

By Dr. William Kisker

In endodontics one of the primary goals is a "clean" canal. This means as devoid of bacteria and pulpal remnants as possible. No longer is it expected that the intracanal environment will be sterile nor is it necessary for success. In addition to instrumentation intracanal medicaments play a key role in canal preparation and cleaning. An ideal intracanal medicament is one that lubricates, dissolves organic debris and the dentin smear layer with low toxicity and surface tension in addition to disinfectant qualities. Removal of the dentin smear layer seems to improve apical sealing of the root canal obturation. A brief review of the more common medicaments may help in improving the success of the readers endodontic therapy.

Sodium Hypochlorite

This is perhaps the most common medicament. It has significant anitmicrobial activity, but at the cost of high toxicity. The "hypochlorite accident" has been the subject of many case reports since the substance causes almost instant necrosis of any living tissue it touches. It is vital that it does not get pushed beyond the apex. This ability to destroy tissue makes it useful for removing pulal remnants from the canal. The ability to disinfect and dissolve tissue has been shown to increase when the liquid is heated or agitated with ultrasonic tips.

Sodium hypochlorite does not have excellent wetting ability and therefore had limited ability to penetrate canal irregularities like fins. Several companies including Vista and Ultradent have marketed hypochlorite preparations with wetting agents to improve its penetration of irregular shaped canals.

Calcium Hydroxide

A very high (basic) pH makes calcium hydroxide useful for several applications including apexification and canal disinfection. It is water soluable making clean up relatively fast and complete. Usually used in a paste form it is very difficult to deliver past the apex. A small amount of CaOH delivered beyond the apex will have minimal local effects.

Because the CaOH is a paste it is not useful as an irrigant. It is best suited for long term application in the canal such as between endodontic appointments. Given several days CaOH can thoroughly disinfect a contaminated root canal and dissolve pulpal remnants.

EDTA

Ethylenediaminetetraacetic acid is a colorless and water soluable polyamino carboxylic acid. EDTA is a chelating agent which means that it bonds metal ions. It is able to soften dentin which aids in instrumentation. This feature makes it a common ingredient in file lubricants used in endodontics. EDTA helps to remove the smear layer from the internal surface of root canals providing better apical seals. EDTA seems to most effectively remove the smear layer in the middle third of the tooth and requires a 15 minute application for optimum results. It is more efficient at removing the smear layer than sodium hypochlorite and less toxic. The ability of the EDTA to remove the smear layer is concentration dependent. Apical cleaning is improved with higher concentrations of EDTA. Most commercial versions of EDTA for dentistry are 17% concentrations which provides moderate results.

Chlorhexidine

Chlorhexidine gluconate has several uses in dentistry, most notably in periodontics as a 0.12% oral rinse. In endodontics chlorhexidine at 2% concentration is highly effective at killing bacteria in the canal. It is equivalent to sodium hypochlorite in its antimicrobial ability but lacks the high tissue toxicity and ability to dissolve organic debris. **(continued on next page)**

Choosing the "Right" Consultant to Achieve Success and Provide Efficient, Proficient, and Profitable Dentistry

By Dr. Mohamed Harunani

In order for a practice to be successful, there are two things that always have to be kept in the forefront of one's thoughts. These are: Profitability and Patient experience/Service. Your success in each of these areas is determined by how well you learn and deploy them to attain practice success.

Most of the consultants in the field today concentrate on practice management, assuming that the clinical aspects of the practice are just fine. This theory can be challenged. Most of us have great skills, but do we have the "best practices" in all the clinical areas? Do we deliver care in the most efficient, proficient and profitable way?

The obvious answer to both questions is "no", since we cannot be good at everything. However, most consultants do not discuss this for many reasons, including the fact that they do not want to tread on the ego of the dentist and, as dentists, we all know that there are many ways to do the same procedures. Most of us take continuing education and implement some changes after every course. Taking CE is a form of group learning, which has its own advantages and disadvantages. But in additions to CE we might ask, "Why not have individualized learning in what is actually the most profitable part of our practices, that is, the dentistry itself?" This becomes more evident if the training can be customized to address our individual needs. It is much more efficient and advantageous, since the training is very specific--and since this is taking place in a "home" environment, you also get assistance in the implementation of the lessons and the staff also gets the training, if needed.

If the dentistry is delivered in an efficient, proficient and profitable manner, the rest becomes easy. Combine this with good systems and protocols in place for the management of the practice, and one cannot but succeed. Thus choosing the "right" consultant is one of the more important tasks.

When one is considering consultants, you have to take into consideration the availability of clinical expertise that can be provided to you. Your consulting team should be your mentor and tech support for not only the operations/management of your practice, but also in the clinical arena. This will give you the comfort to expand your mix of services and have the ability to provide more procedures for your patients, resulting in staying busier and being more profitable.

From my experience, the greatest need for these specialized consultants (that can provide clinical and management coaching) is among those single practitioners that have less than 10 years in private practice. We have all learned from our mistakes and I can assure you that it is cheaper and far more efficient to learn from others who have made these mistakes and corrected them than to make the mistakes yourself.

We all want to be "better dentists" and we all provide "excellent" dentistry. Yet we all see the less-than-ideal work that comes into our offices. Who did that work? One must be self-critical and ask "how does my work compare to the best that I have seen?" The self satisfaction that you will receive by knowing that you are providing the very best is just exhilarating. Thus before making a decision about looking for a consultant, please think about what is it that you would like to see happen and understand your needs well. Most offices can use some level of operations/management help, but many also need improvement in the clinical aspects. Unfortunately this need is so very often ignored.

Before taking on the expense of hiring a consultant, one needs to decide if one is willing to commit to the recommended changes. There is no point in paying for the resources and not benefiting from them.

Once one has committed to making changes, one needs to spend some time in evaluating if one really needs a consultant or if one just needs an audit.

Choosing the "right" consultant…

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An audit looks at some of the facts above and will give one an idea if there is room to improve and if so, by how much. This audit can be done by yourself or an outside person. We, as dentists, are generally not very objective about ourselves and yet are super critical of others. Thus having a close friend or an outside person do the analysis will generally give a truer picture.

Below are some questions to ask yourself before considering or employing any consulting services:

- Do you have a busy-ness problem – do you have openings in your schedule?
- Do you have a steady flow of new patients coming in?
- Do you have good recall rates?
- Do you have high levels of patient debt?
- Are you struggling to maintain revenues and profitability?
- Do you suspect that your business could be performing better – but don't know where to start?
- How protected are you from a liability stand point?
- Do you have short term and long term goals?
- Do you have goals set for each area of practice?
- Does the staff run the office?
- Are your expenses in line with the national average or best practices figures?
- Do you know where most of your profit comes from?
- What is your mix of services?
- What is the profitability of the services that you provide?
- Are you providing these services in the most efficient method, clinically?
- How compliant are you with all the various rules and regulations?

Specific things that will need evaluation are:

- Is yours the best practice that it can be?
- Do you use a key-practice- indicator based approach?
- What are the dynamics of the practice ?
- What is working well and what is not?
- Understanding of your profit centers and areas of shortfalls.
- Understanding of patient experience successes and shortfalls.
- Analyzing the data on a regular basis.
- Setting goals and setting your benchmarks.
- Comparison of key practice indicators for your specific practice.
- Understanding how to impact Return On Investment
    - Increase utilization by attracting new patients and/or increased patient retention
    - Patient loyalty
    - Providing patients a higher perception of value

After the audit, one should be able to determine if help is needed. Also it can be determined if one needs a consultant for just the business aspects, business and clinical aspects or just all around. Most practices need all around help and yet concentrate on just the business aspects. Clinical success is not only having perfect margins, it is having systems in place that expedite, streamline and provide quality assurances. This total practice evaluation would evaluate and, if need be, implement systems for front desk duties, assistant duties, clinical protocols, hygiene protocols, etc

Once it has been determined that help is needed, what kind of help AND if one has made a commitment to change, then the search for a consultant can begin. Finding the "right" consultant can be a challenge. Anyone coming in can make suggestions, are you willing to take them and if so, at what cost? Some things to consider are:

- Is your consultant willing to customize their plan to fit your specific needs/environment?
- Is your consultant going to be able to help you in the clinical areas with one-on-one training of clinical aspects so that you can expand the scope of your practice?
- Can your consultant give you a clinical evaluation?
- Is your consultant going to review your OSHA and other regulatory compliances?
- How does this consultant get paid?
- Can you afford the consultant?
- It is best to look for consultants that will charge based on how much improvement they bring to your practice. That is, both entities have their agendas/goals aligned. It is only fair that consultants get paid for their expenses and expertise. Thus the final cost to you could be - a set fee for the initial evaluation, a percentage of increase in your practice income and actual expenses that are reasonable.

Choosing the "right" consultant…

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This is most equitable, since all the parties involved have a stake in the growth and success of the practice.

Large payments before any true benefit is realized by the practice does not make sense. If a consultant is confident in their skills and believes in you and your success, they should be more than willing to get paid based on the results they can help you achieve and not the time spent or the materials provided. As the process progresses, payments can be made on a periodic scale based on the results of the quarterly financial review of the practice.

Some of these contracts can be very long term. Once the changes have been made and the benefits realized, there is not much gain for the practice, thus you should also be specific as to how long this contract lasts, since you do not want to pay for the rest of your career. Three years seems like an adequate period of time to realize the changes and to reward the consultant for his/her efforts, since they did not take any sum of money upfront.

In conclusion, the process of achieving success is a ladder. Once you are on the ladder, there are rungs below and rungs above. Only you know where you are and how high you want to climb. Thus be fair to and critical of yourself when you engage in your evaluation process.

- Determine if you need a consultant for just your business aspects, business and clinical aspects or just all around.
- Are you committed to recommended changes?
- Do you have an understanding of what could be achieved?
- Search for a consultant.
- Determine if you have the right fit in your consultant.
- Employ the consultant.
- Periodically review goals with the consultant.

Endodontics Review: Intracanal Medicaments

(Continued from page 9)

Chlorhexidine has the ability to neutralize matrix metallo-protenases left behind by bacteria that break down adhesive bonds between restorative materials and dentin. This could have long term benefits to canals filled with bonded sealers like resilon.

Citric Acid

Less common irrigant usually employed in a 10% solution that has the desirable properties of some antimicrobial properties and the ability to remove the smear layer faster than EDTA. Because it is a chelating agent and acidic it can soften dentin to aid intrumentation and has some ability to break down protein bonds which may aid in removing organic debris. Its antimicrobial ability is less than sodium hypochlorite and chlorhexidine but more than EDTA.

No one medicament provides the perfect combination of features. The best all around irrigant is probably sodium hypochlorite since it has superior disinfection and tissue dissolving ability. But after cleaning and disinfection removing the smear layer to improve apical seal will require another treatment with EDTA or citric acid.

There are many proprietary formulations of intracanal medicaments available for sale. Products like Biopure MTAD are combinations using some of the above materials to provide multiple functions in a single rinse. This convenience comes at a potentially high cost. As with all aspects of dental practice use your best judgement based on your education and the information available.

Welcome New Members!

Mr. Juan S. Abadia
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Alia M. Ahmed
Chicago, IL

Ms. Maryam Ahmed
Chicago, IL

Ms. Nida Akhter
Villa Park, IL

Mr. Amjad Jalil Algazaha
Willowbrook, IL

Mr. Hussain Ali
Chicago, IL

Ms. Lauren M. Allegretti
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Chicago, IL

Ms. Simona Ziliute
Chicago, IL

Upcoming Events

AGD

National-Annual Meeting

2011 July 25-31 San Diego, CA
2012 Jun 16-24 Philadelphia, PA
2013 June 23-30 Nashville, TN

IAGD

2011 Feb. 23 Practice Management-Dr. Roger Levin-Chicago, IL

CAGD

2011

Mar. 11 Lasers-Dr. Robert Convissar-Marriott OakBrook Hills

May 13 Sleep Apnea-Dr. Ira Shapira-Maggiano's Schaumburg

Sep. 16 Practice Management-Dr. Steve Razer-

Nov. 4 Endodontics-Dr. Hanson-

2012

Mar. 9 Financial Planning

May 11 Simplified Dentistry-Dr. Mohamed Harunani

CIAGD

2010

Nov. 12 Pharmacology-Dr. Karen Baker-SIUSDM-Alton, IL

Nov. 13 Emergency Medicine-Dr. Larry Williams-Alton, IL

Mastertrack

2011

Apr. 15-16 **Orthodontics –** Dr. Neil Warshawsky-Hi Point Dental Lab-Rolling Meadows, IL Protocol reporting sessions start at 1:00 pm on Thursday preceding the listed courses.

[Contacts for all Mastertrack programming: Dr. S. Wachtenheim 847-858-1927, tzaner2@aol.com or Dr. G. Zehak 708-484-0235]

Illinois AGD in Action!

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Make Time for Meetings

See details about upcoming meetings inside!

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Date of Birth _____ ADA No. (if available) _____
Bus. Address _____
City _____ State _____ Zip _____
Res. Address _____
City _____ State _____ Zip _____
DENTAL SCHOOL ATTENDED:
Name_____
From _____ To _____ Degree _____
Name_____
From _____ To _____ Degree _____
Are you a general dentist? Yes No Do you limit your practice? Yes No
If yes, what specialty? _____
Are you in private practice? Yes No
If not, explain (Armed Services, Public Health, Education, Etc.)
_____
Are you a member of a state dental association? Yes No
If so, which association? _____

I promise to abide by the Constitution and By-laws as well as the Principles of Ethics of the Academy of General Dentistry.

Date _____ Signature _____

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AGD FEES AND DUES:

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Registration Fee $15.00
Annual National Dues $354.00
State Dues $ 34.00
Component Dues: $5.00

2nd Yr. Graduate $112.00
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