THE 2023-24

Dental UPDATE

A 20-hour Survey of Pressing Clinical, Practice Management, Legal and Risk Management Issues in the Practice of Dentistry

American Educational Institute, Inc.

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David R. Victor, JD
CEO

Dear Registrant:

You practice in a dynamic and challenging environment. While keeping clinically current is imperative, it isn't enough. You must also acquire the knowledge necessary to successfully manage your practice, avoid legal pitfalls and minimize myriad liabilities exposures. ***The 2023-24 Dental Update*** is designed to assist you in that endeavor.

In one course you will receive 20 hours of vital instruction from national experts in the fields of dentistry, law, medicine, asset protection, pharmacology, accounting, and practice management. And their presentations include topics ranging from treatment acceptance, private equity owned multi practice platforms, liability exposure minimization and financial literacy, to medically complex patients, the oral-systemic connection, patient dismissal and safe sedation.

To help you assess your level of comprehension we offer brief self-evaluations that may be taken either before or after the presentations concerned. These tests are included in this syllabus and are identified by the black edges of the pages on which they are featured.

As always, I am very interested in your reaction to this year's presentation. Please do me the favor of taking the time to complete the evaluation questions presented on screen for each presentation. In addition, I encourage you to contact any of our faculty members directly with questions or comments.

Finally, I urge you to take advantage of the experience and expertise of your colleagues taking the course via our real-time and interactive chat feature. Should you have any technical or other questions about the program's operation just ask them at our help desk and AEI's experienced staff will respond promptly.

Thank you for your participation and please accept my best wishes for a safe, enjoyable and enlightening visit.

Cordially,
American Educational Institute, Inc

David R. Victor, Esq
Chief Executive Officer

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COURSE OBJECTIVES

After completing ***The 2023-24 Dental Update*** you should have acquired the knowledge that will better enable you to better:

- Recognize the clinical and radiographic features of **odontogenic and hard tissue lesions**
- Identify the pros and cons of **private equity practice acquisition**
- Better understand the impact of **Caries Disease, Periodontal Disease, HPV-OPC, and Occlusal Disease on oral health**
- Identify strategies and techniques for **increasing dental treatment acceptance**
- Identify, diagnose, and treat common pediatric mucosal conditions
- Identify **asset protection** structures and strategies
- Identify the elements of an ethical, legal, and effective patient dismissal protocol
- Identify and understand major sources of chronic systemic inflammation
- Discuss ways to maximize **asset protection and tax efficiency**
- Understand the characteristics, enforcement, and negotiation of legal contracts in the dental practice
- Design and implement **effective dental practice systems**
- Identify manifestations of and treatment options for **pre-cancerous and cancerous oral lesions**
- Discuss the treatment implications of the **medically complex patient**
- Identify relevant legal and risk management issues associated with **cone beam computed tomography**
- Understand risks to and approaches for safe **office-based sedation**
- Understand important dental office lease and buildout terms and issues
- Identify and assess dental practice financial health through **effective analytics**
- Discuss the **impact of communication on practice risk**

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FACULTY DISCLOSURES

The individuals listed below constitute everyone with control over the content of ***The 2023-24 Dental Update***. None of them have a financial relationship with a commercial interest whose product or services are discussed in the presentation(s) over which they have control:

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Robert D. Kelsch, DMD, of Rockville Centre, New York, is a specialist practicing clinical and microscopic oral & maxillofacial pathology, and Director of Clinical Oral Pathology in the Division of Oral Pathology of the Department of Dental Medicine at Northwell Health. He is associate professor in the Departments of Dental Medicine and Pathology and Laboratory Medicine at the Zucker School of Medicine at Hofstra/Northwell. Dr. Kelsch is also an attending physician at several area hospitals and holds numerous advisory council, consultant and course director positions at medical foundations, medical centers and professional organizations. He is a Fellow of the American Academy or Oral and Maxillofacial Pathology where he was a member of its executive council and chair of several committees. Dr. Kelsch is a Director of the American Board of Oral and Maxillofacial pathology, an editor at several medical and dental journals, the recipient of a number of professional awards and prolific writer and speaker.

You may contact Dr. Kelsch with your questions and comments at 718-470-7341, or by email at rkelsch@northwell.edu.

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Differential Diagnosis of Odontogenic and Hard Tissue Lesions

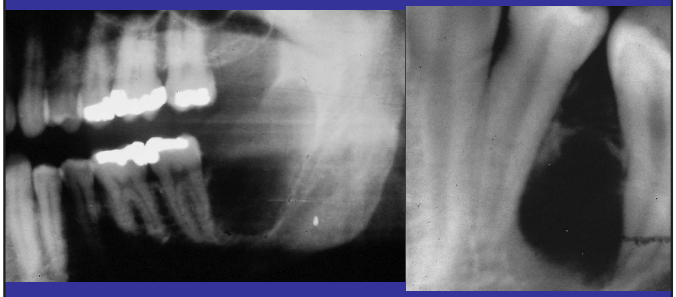
DIFFERENTIAL DIAGNOSIS RADIOLUCENCIES

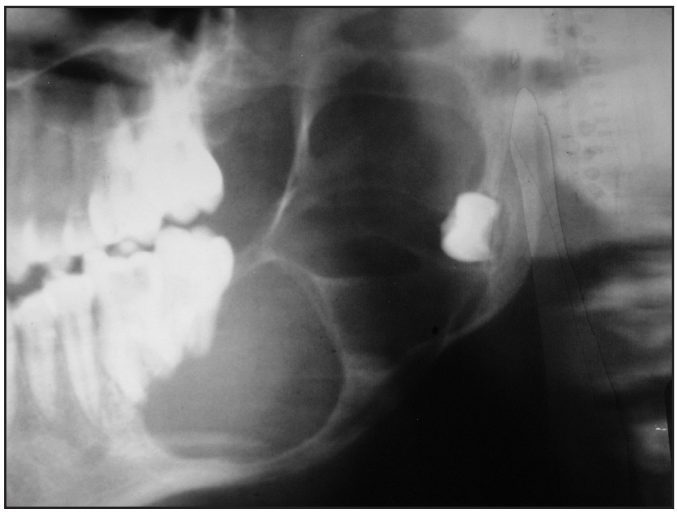
- ODONTOGENIC CYSTS
- ODONTOGENIC TUMORS
- CENTRAL GIANT CELL GRANULOMA
- SYSTEMIC DISEASE
- MALIGNANCIES
  - METASTATIC

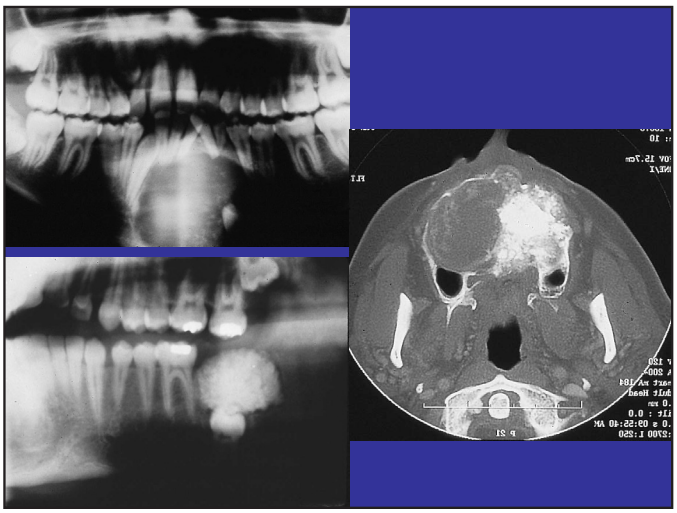
DIFFERENTIAL DIAGNOSIS RADIODENSITIES

- ODONTOGENIC CYSTS
- ODONTOGENIC TUMORS
- BONY LESIONS
  - BENIGN FIBRO-OSSEOUS LESIONS
  - MALIGNANCIES

ODONTOGENIC LESIONS





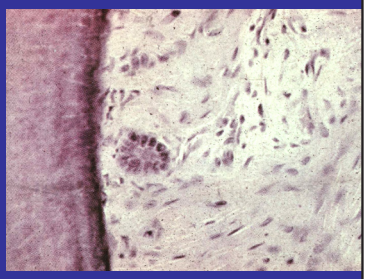


ODONTOGENIC CYSTS

- INFLAMMATORY
  - PERIAPICAL
  - RESIDUAL
  - PARADENTAL
- DEVELOPMENTAL
  - DENTIGEROUS CYST
  - ODONTOGENIC KERATOCYST
  - GORLIN CYST
  - GINGIVAL/LATERAL PERIODONTAL CYST
  - GLANDULAR ODONTOGENIC CYST

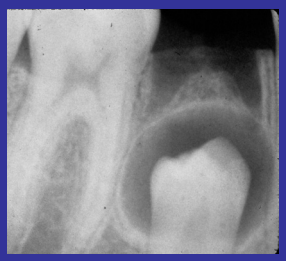
ODONTOGENIC CYSTS

- LINED BY EPITHELIUM DERIVED FROM ODONTOGENIC EPITHELIUM
- DEVELOPMENTAL OR INFLAMMATORY
- EPITHELIAL LINED CYSTS WITHIN BONE UNCOMMON



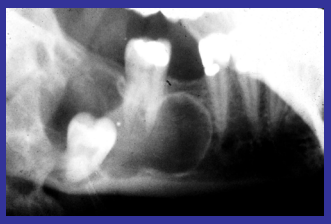
DENTIGEROUS CYST

- ANY UNERUPTED TOOTH
- MANDIBULAR THIRD MOLARS
- RARELY DECIDUOUS TEETH
- OCCASIONALLY ASSOCIATED WITH SUPERNUMERARY TEETH
- 10-30 YEARS OF AGE
- USUALLY ASYMPTOMATIC AND DISCOVERED ON ROUTINE RADIOGRAPHS
- LARGER CYSTS - PAINLESS EXPANSION/FACIAL ASSYMETRY
- ENLARGE DUE TO INCREASED OSMOTIC PRESSURE WITHIN LUMEN



DENTIGEROUS CYST

- RADIOLOGY
  - UNILOCULAR RADIOLUCENCY CROWN OF UNERUPTED TOOTH
    - WELL DEFINED
    - SCLEROTIC BORDER
  - MULTILOCULAR IF LARGE
  - RELATIONSHIP -
    - CENTRAL, LATERAL CIRCUMFERENTIAL

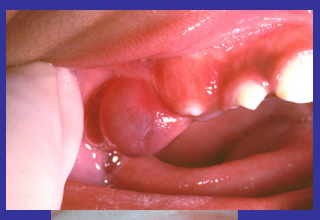


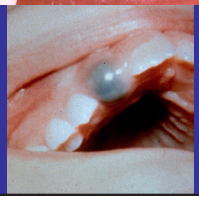
DENTIGEROUS CYST

- TREATMENT
  - ENUCLEATION AND EXTRACTION OF TOOTH
  - MARSUPIALIZATION
  - EXCELLENT PROGNOSIS
  - RARE RECURRENCE
  - RARE NEOPLASTIC TRANSFORMATION - AMELOBLASTOMA, SQUAMOUS CELL CARCINOMA, MUCOEPIDERMOID CARCINOMA

ERUPTION CYST

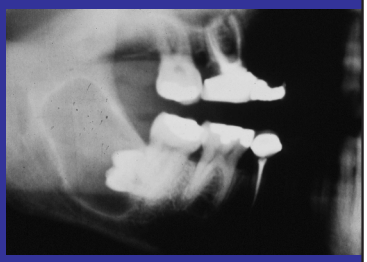
- ERUPTION HEMATOMA
- SOFT TISSUE ANALOGUE OF DENTIGEROUS CYST
- TOOTH WITHIN SOFT TISSUES OVERLYING ALVEOLAR BONE
- USUALLY IN CHILDREN UNDER 10 YEARS
- MOST COMMON IN MANDIBULAR MOLAR REGION
- GINGIVAL SWELLING ASSOCIATED WITH ERUPTING TOOTH
- TRAUMA INDUCES BLEEDING INTO CYST FLUID IMPARTING PURPLISH-BROWN COLOR





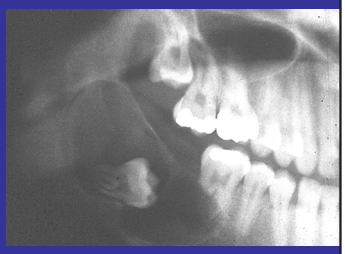
ODONTOGENIC KERATOCYST

- MAY BE ASSOCIATED WITH BASAL CELL NEVUS SYNDROME
- SMALLER CYSTS ASYMPTOMATIC - ROUTINE RADIOGRAPHS
- TEND TO GROW ANTEROPOSTERIORLY WITH MINIMAL EXPANSION
- WELL DEFINED RADIOLUCENCY
- CORTICATED MARGINS
- 25-40 % ASSOCIATED WITH UNERUPTED TOOTH
- UNCOMMON ROOT RESORPTION



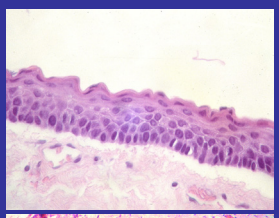
ODONTOGENIC KERATOCYST

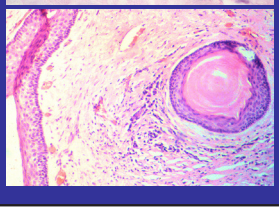
- GROSSLY THIN FRIABLE WALL: DIFFICULT ENUCLEATION
- LUMEN - CLEAR FLUID OR CHEESY MATERIAL - KERATINACEOUS DEBRIS

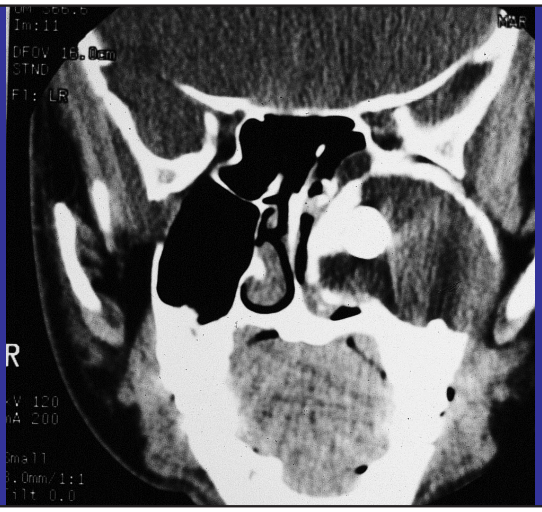


ODONTOGENIC KERATOCYST

- HISTOPATHOLOGY
- THIN FIBROUS WALL DEVOID OF INFLAMMATION
- FLAT EPITHELIAL CONNECTIVE TISSUE INTERFACE - NO RETE RIDGES, SEPARATION
- UNIFORM 6-8 CELL THICKNESS OF STRATIFIED SQUAMOUS EPITHELIUM
- WAVY/CORRUGATED PARAKERATOTIC SURFACE EPITHELIUM
- PALISADED CUBOIDAL/COLUMNAR BASAL LAYER
- SATELLITE CYSTS

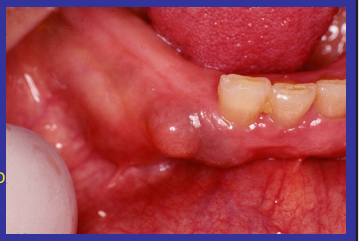


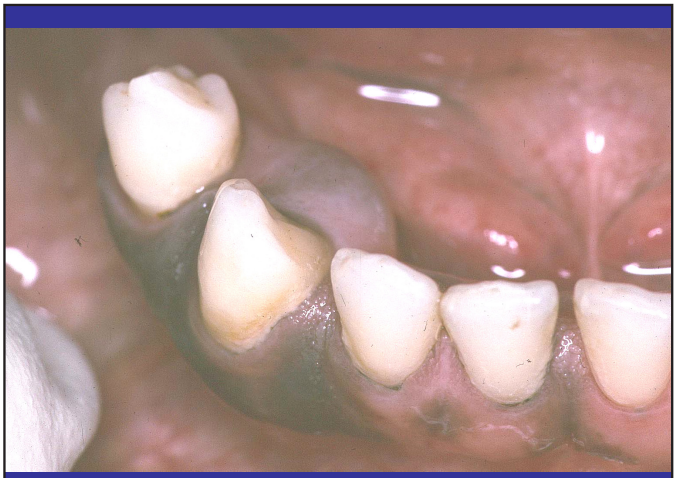




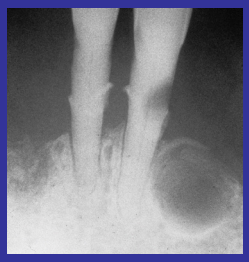
GINGIVAL CYST OF THE ADULT

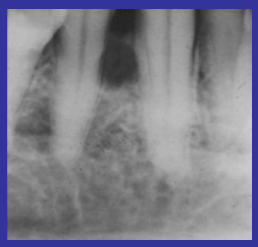
- UNCOMMON; SOFT TISSUE COUNTERPART OF LATERAL PERIODONTAL CYST
- ARISES FROM DENTAL LAMINA RESTS
- 60-75% MANDIBULAR CANINE/PREMOLAR REGION
- 5TH DECADE
- FACIAL GINGIVA/ ALVEOLAR MUCOSA
- PAINLESS, BLUISH, DOME SHAPED SWELLINGS
- SUPERFICIAL CUPPING OUT OF ALVEOLAR BONE





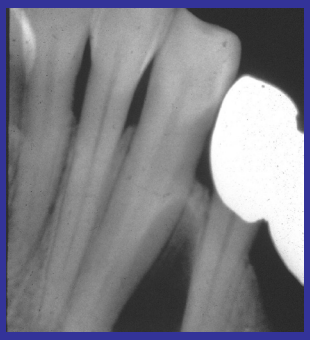
LATERAL PERIODONTAL CYST

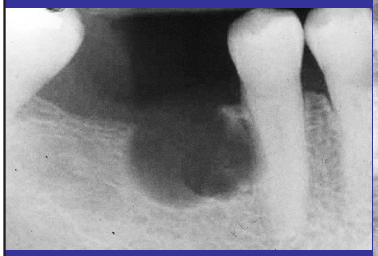


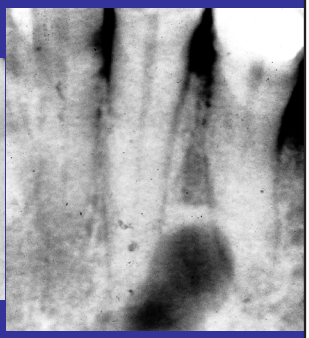


LATERAL PERIODONTAL CYST

- ASYMPTOMATIC
- MALE PREDILECTION; >30 YEARS
- 65% MANDIBULAR CANINE/PREMOLAR AREA
- WELL CIRCUMSCRIBED RADIOLUCENCY LATERAL TO ROOTS OF VITAL TEETH <1.0 CM IN DIAMETER
- MULTILOCULAR - BOTRYOID ODONTOGENIC CYST
- RULE OUT OKC/ INFLAMMATORY ETIOLOGY

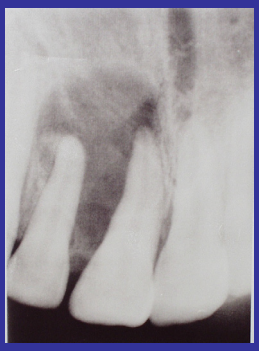


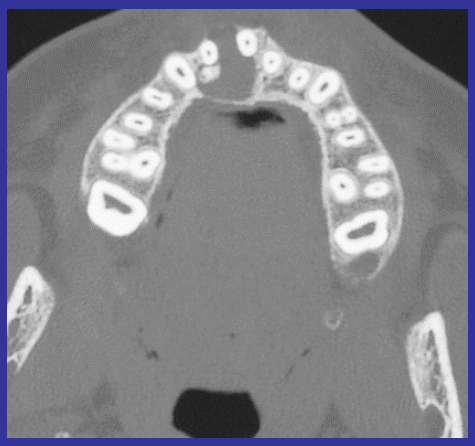


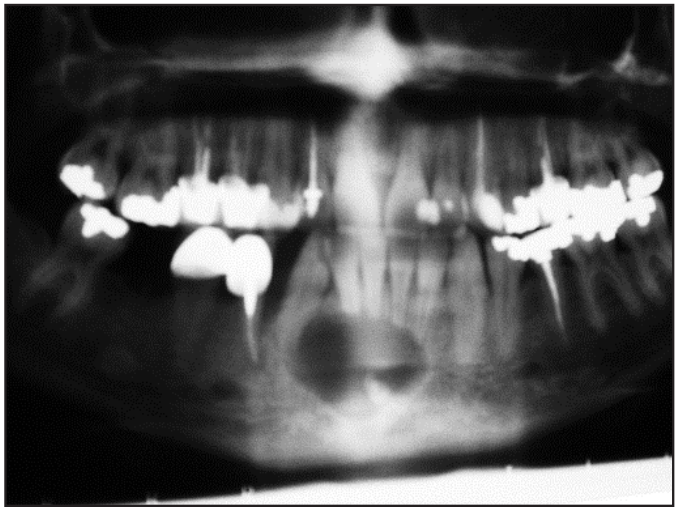


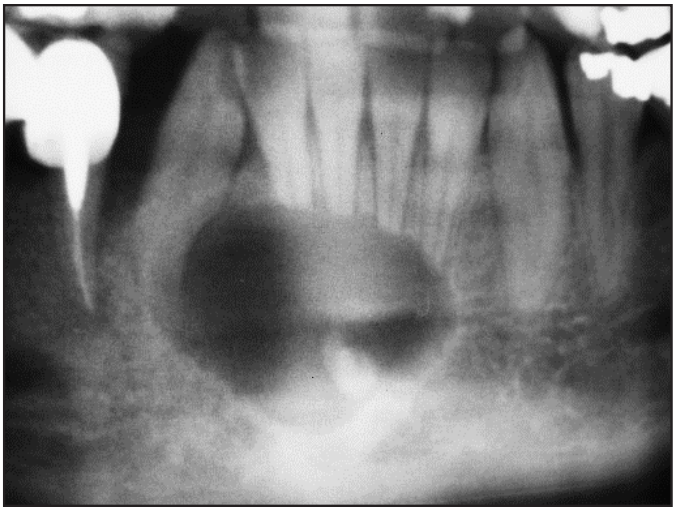
CALCIFYING ODONTOGENIC CYST

- RADIOLUCENCY
- UNILOCULAR, WELL DEFINED 50% IRREGULAR CALCIFICATIONS OR TOOTH LIKE DENSITIES (“SALT AND PEPPER”)
- 30% ASSOCIATED WITH UNERUPTED TOOTH USUALLY CANINE
- ROOT RESORPTION AND DIVERGENCE SEEN









ODONTOGENIC TUMORS

CLASSIFICATION

TUMORS OF ODONTOGENIC EPITHELIUM WITHOUT ECTOMESENCHYME

– AMELOBLASTOMA
– CALCIFYING EPITHELIAL ODONTOGENIC TUMOR
– SQUAMOUS ODONTOGENIC TUMOR
– CLEAR CELL ODONTOGENIC TUMOR

– MALIGNANT COUNTERPARTS

CLASSIFICATION

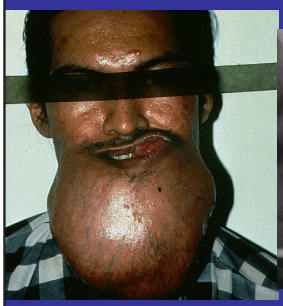
ODONTOGENIC EPITHELIUM AND ECTOMESENCHYME WITH OR WITHOUT DENTAL HARD TISSUE FORMATION(MIXED)

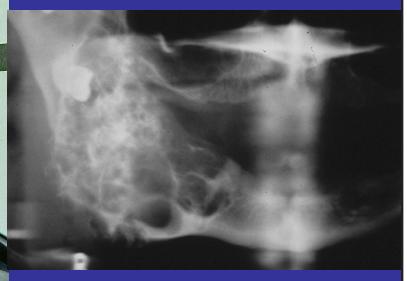
– AMELOBLASTIC FIBROMA
– AMELOBLASTIC FIBRO-ODONTOMA
– ADENOMATOID ODONTOGENIC TUMOR
– COMPLEX/ COMPOUND ODONTOMA

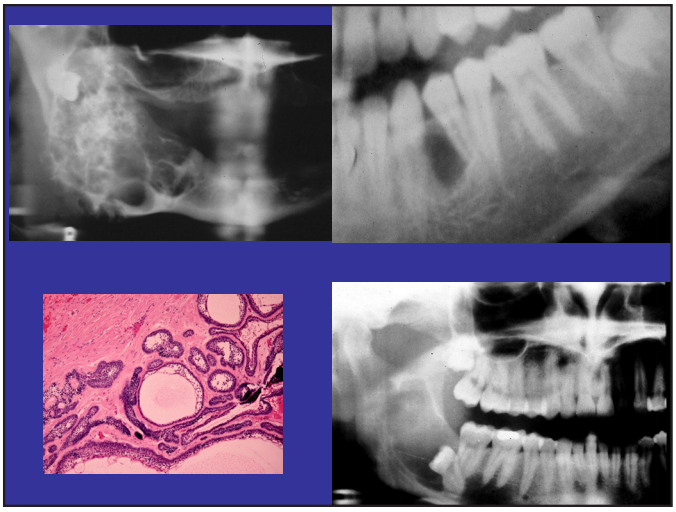
CLASSIFICATION

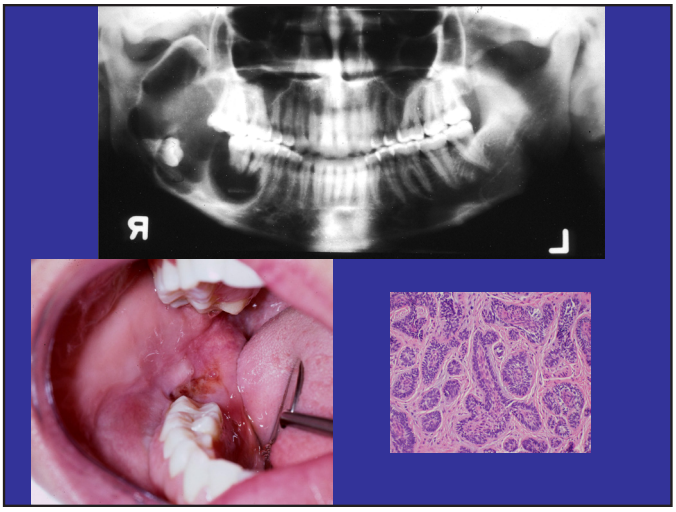
ODONTOGENIC ECTOMESENCHYME WITH OR WITHOUT INCLUDED ODONTOGENIC EPITHELIUM

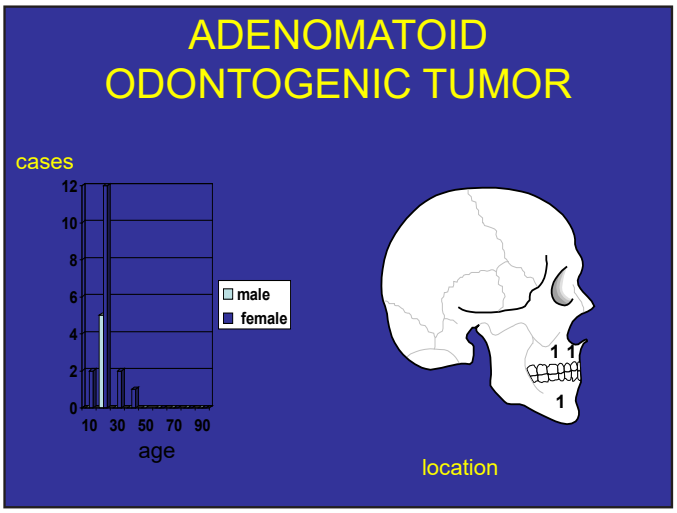
– ODONTOGENIC FIBROMA
– MYXOMA
– CEMENTOBLASTOMA

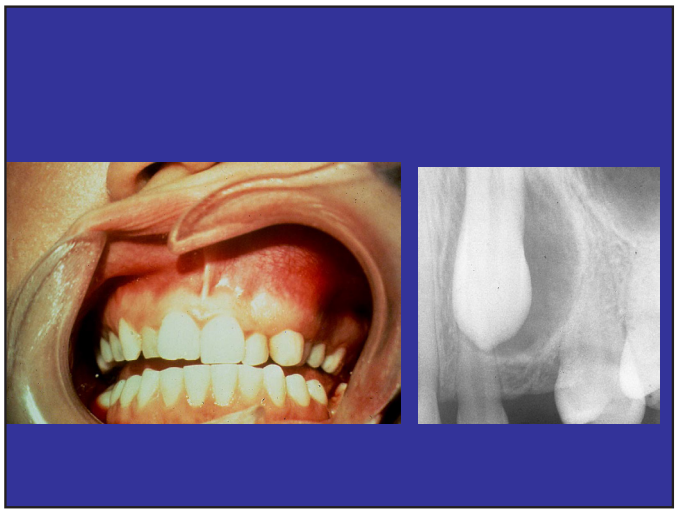


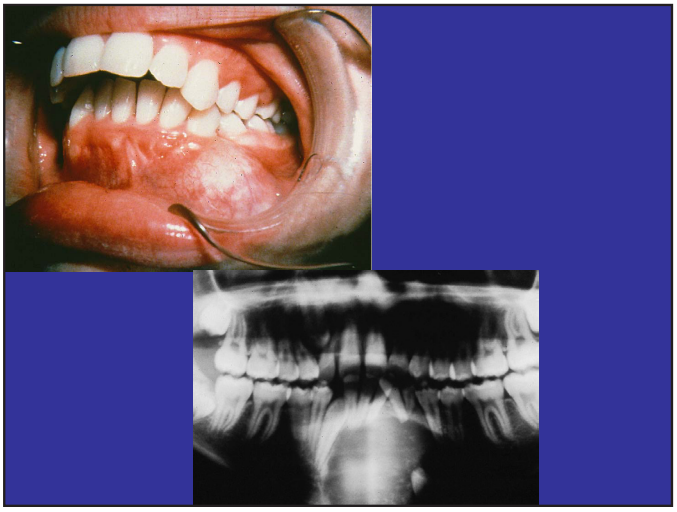


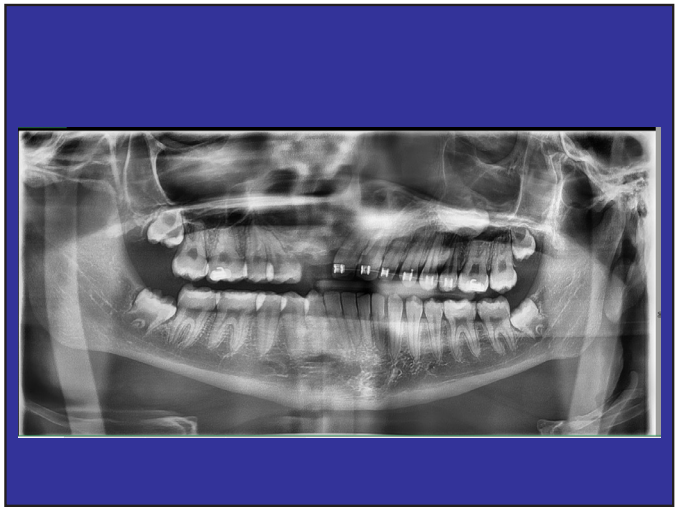





ADENOMATOID
ODONTOGENIC TUMOR
cases
12
10
8
6
4
2
0
10 30 50 70 90
age
male
female
1 1
1
location

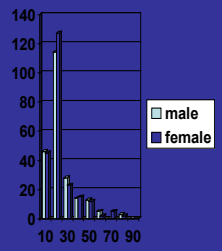






Odontomas

cases



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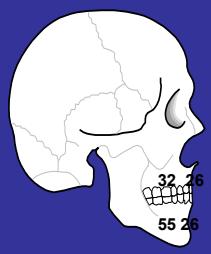

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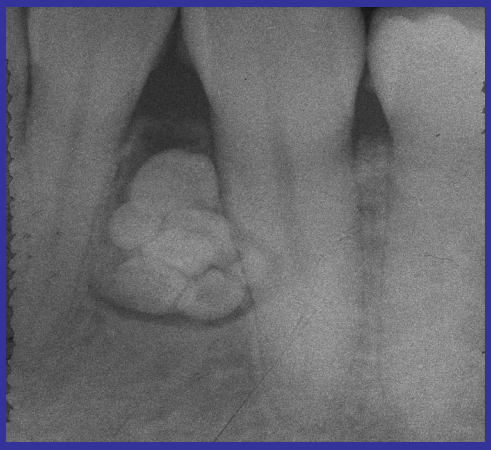
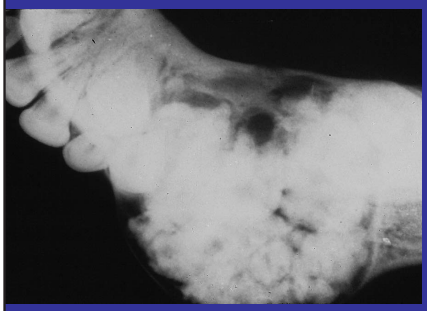
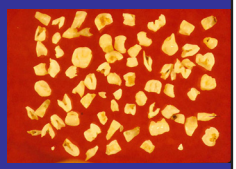
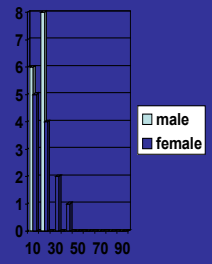






Ameloblastic Fibroma/ Fibro-Odontoma

cases



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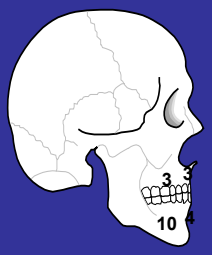

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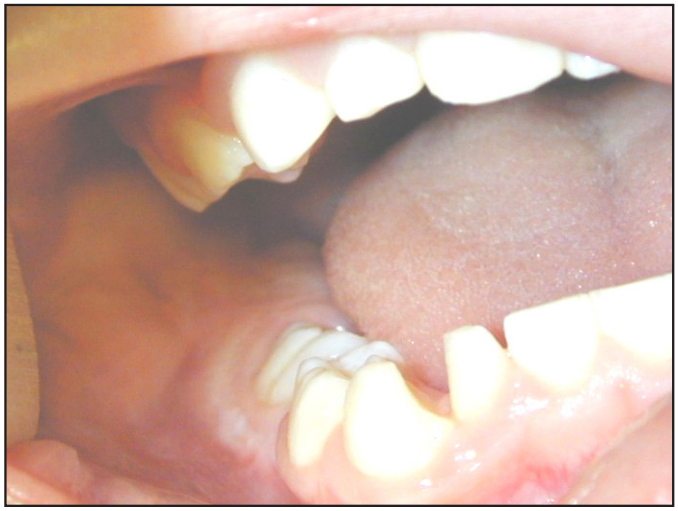

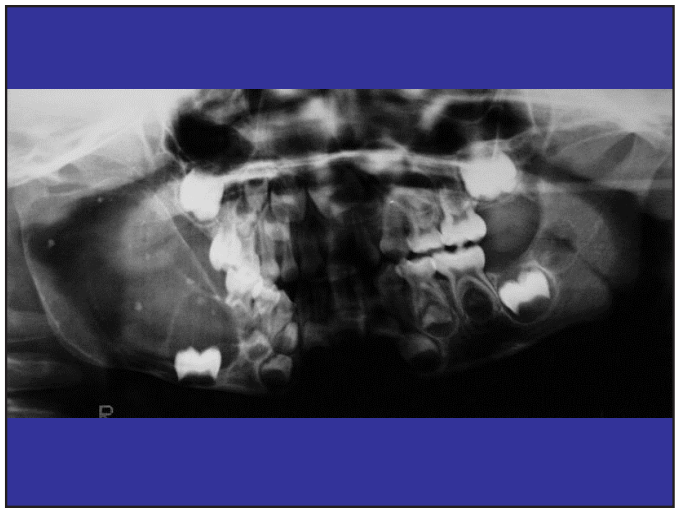

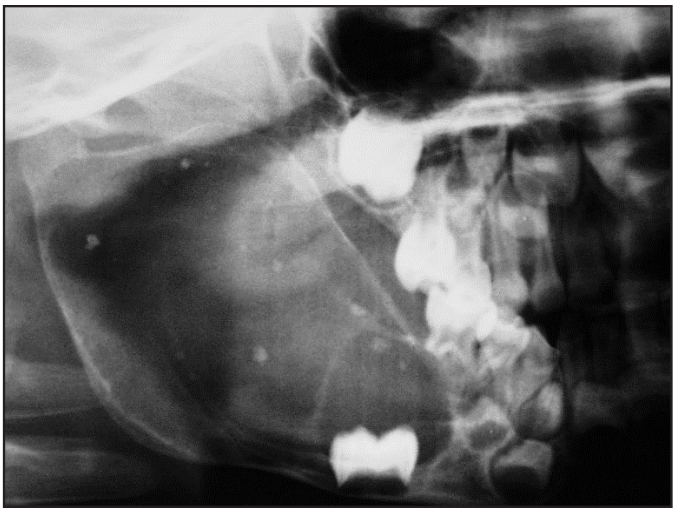

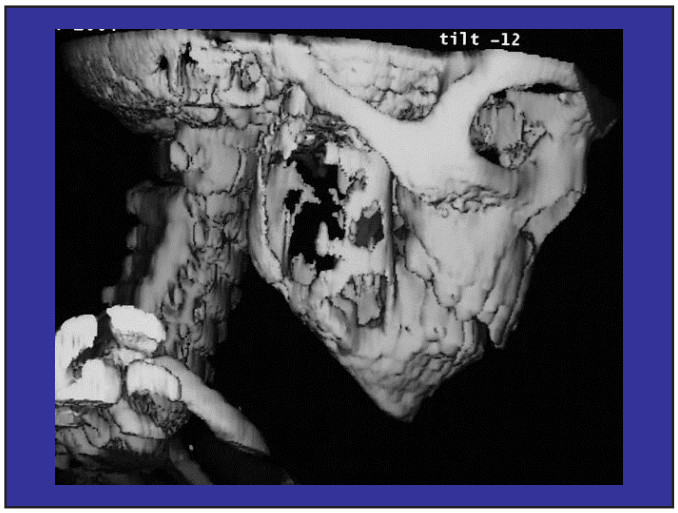
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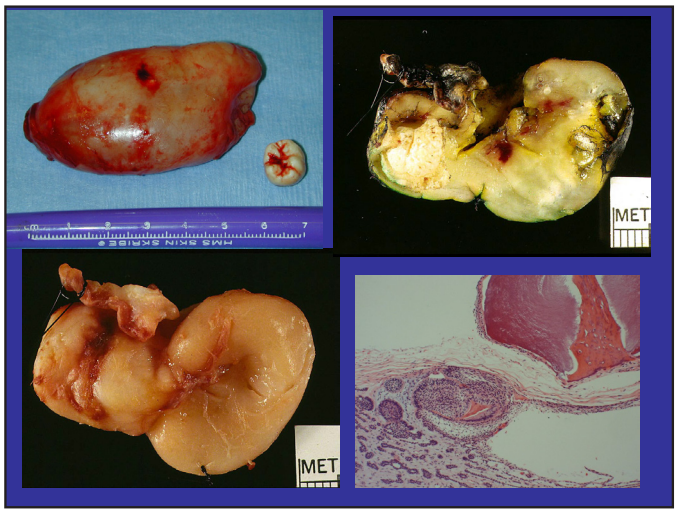
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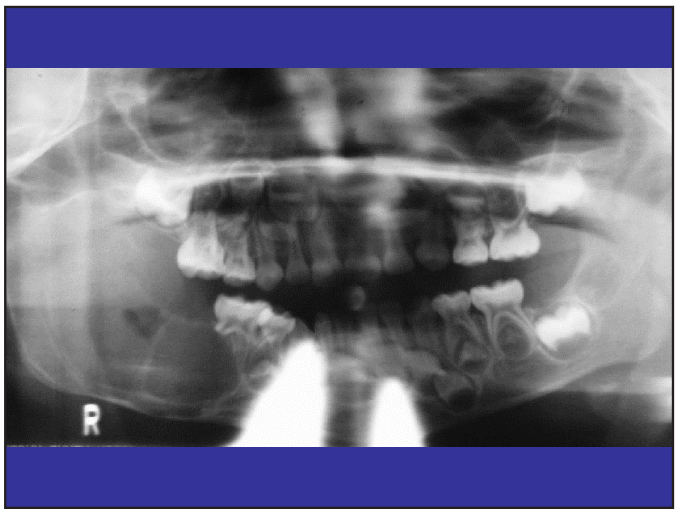
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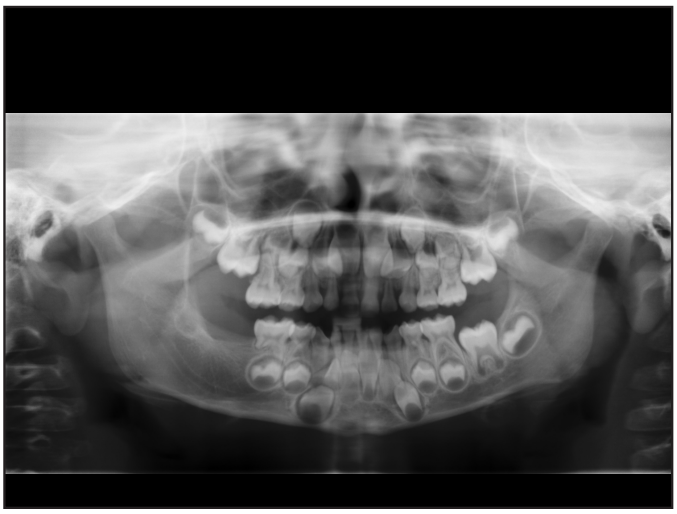

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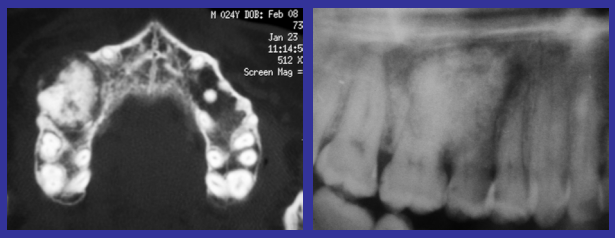

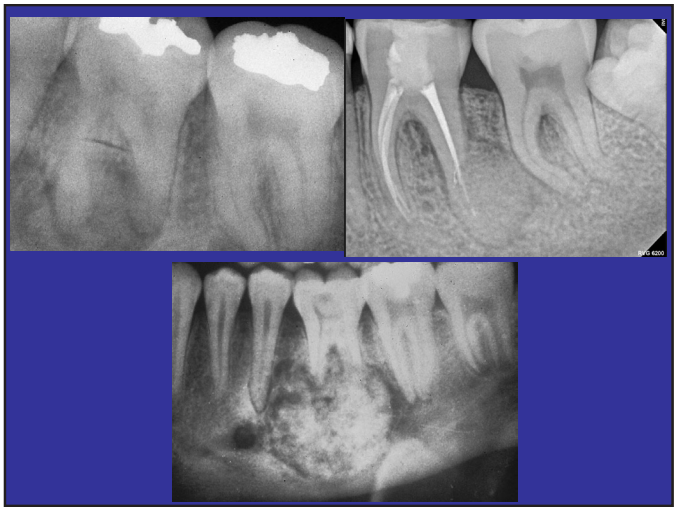

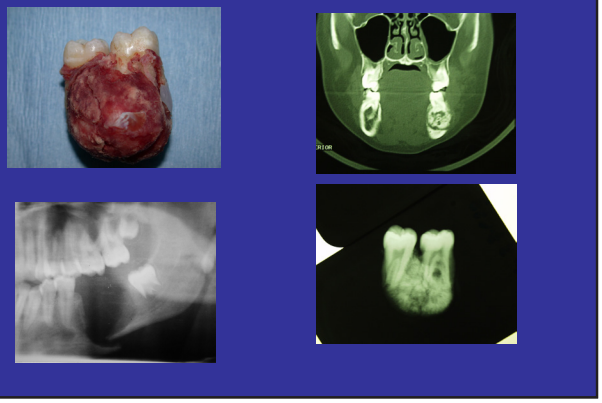

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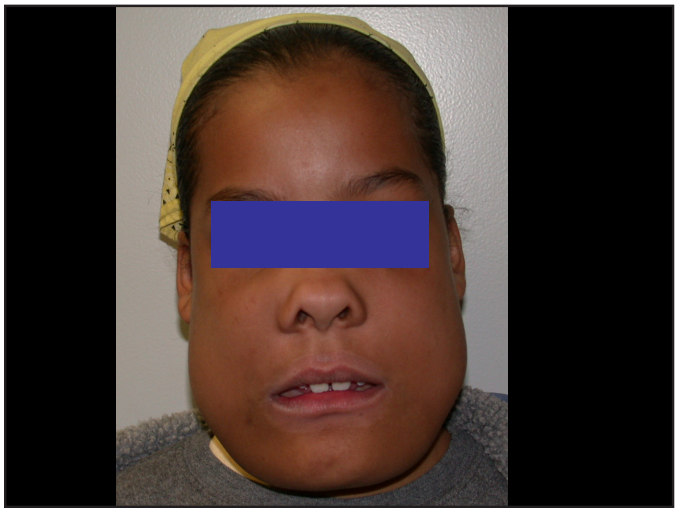

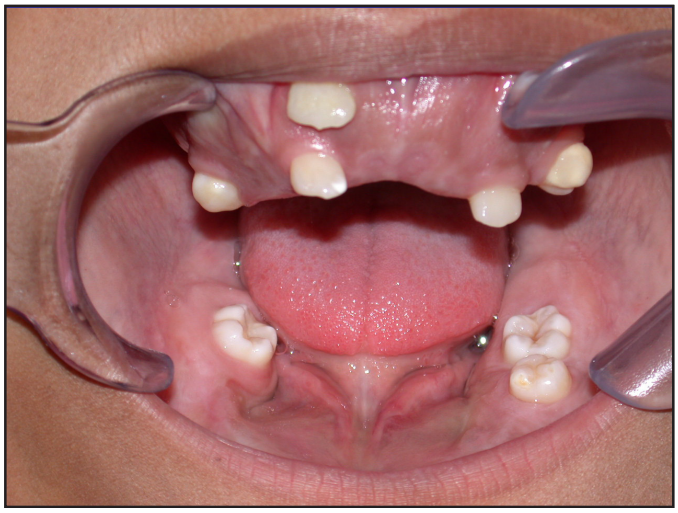

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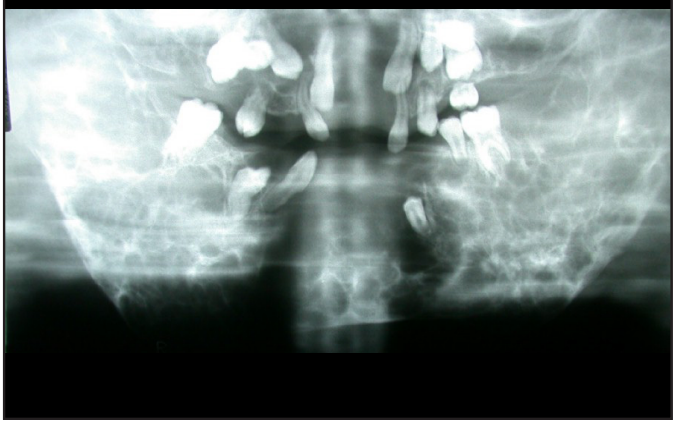
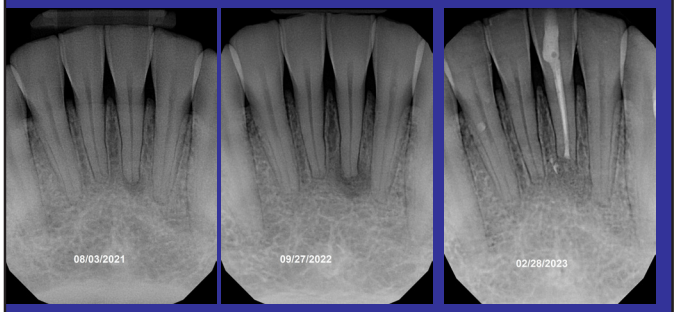
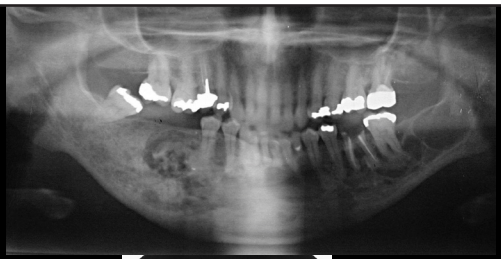
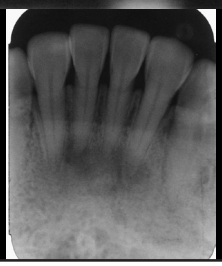


PERIAPICAL CEMENTAL DYSPLASIA

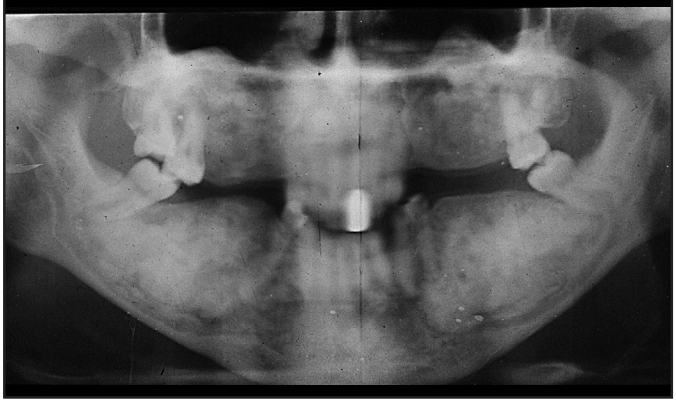


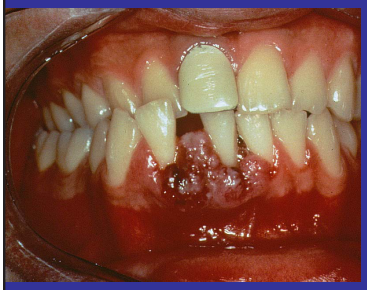


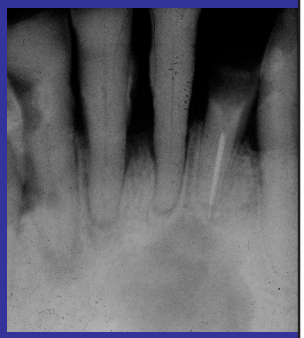


FLORID OSSEOUS DYSPLASIA

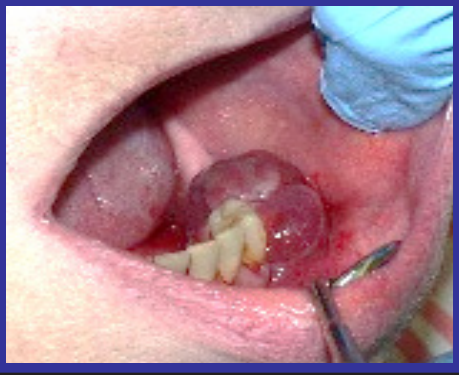
FLORID OSSEOUS DYSPLASIA

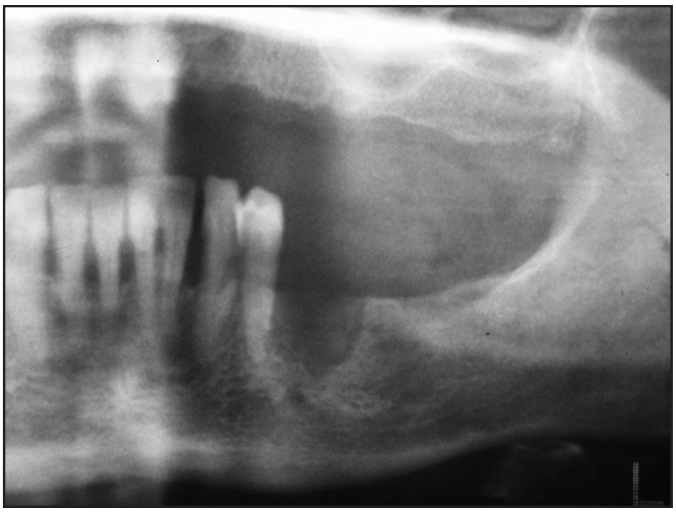




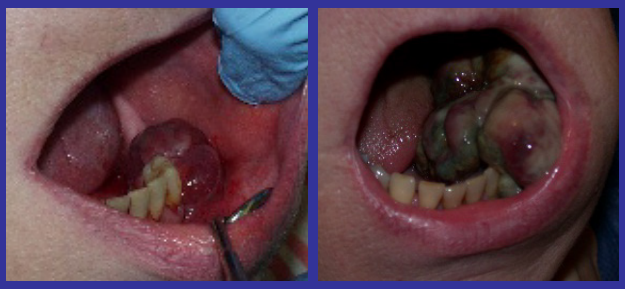


65-YEAR-OLD FEMALE
RECENT EXTRACTION OF PERIODONTALLY INVOLVED PREMOLAR

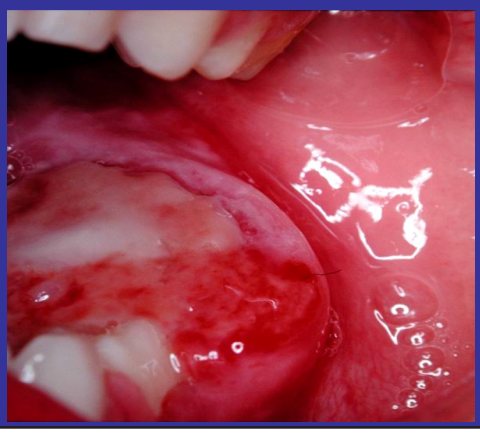


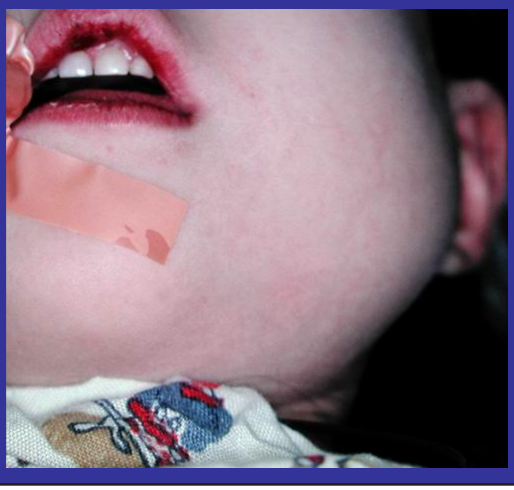


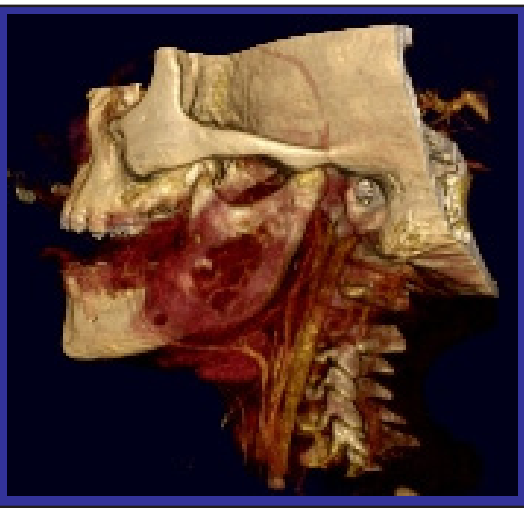
METASTATIC RENAL CELL CARCINOMA



4-YEAR-OLD WITH INTRAORAL SWELLING







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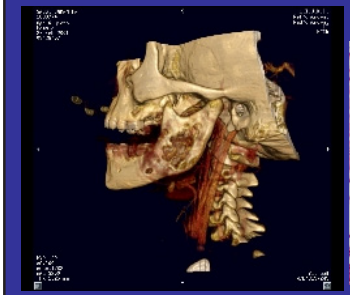
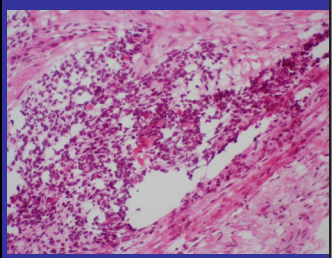
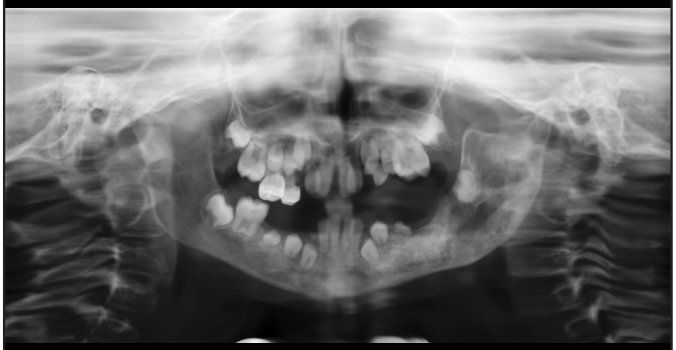
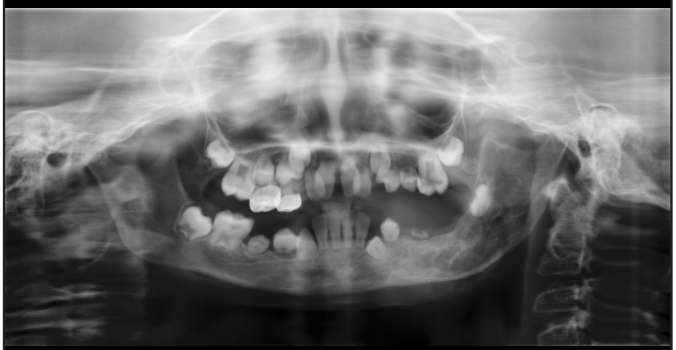




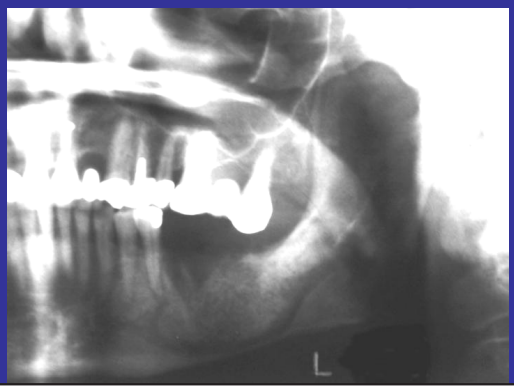
6 MONTH FOLLOW UP

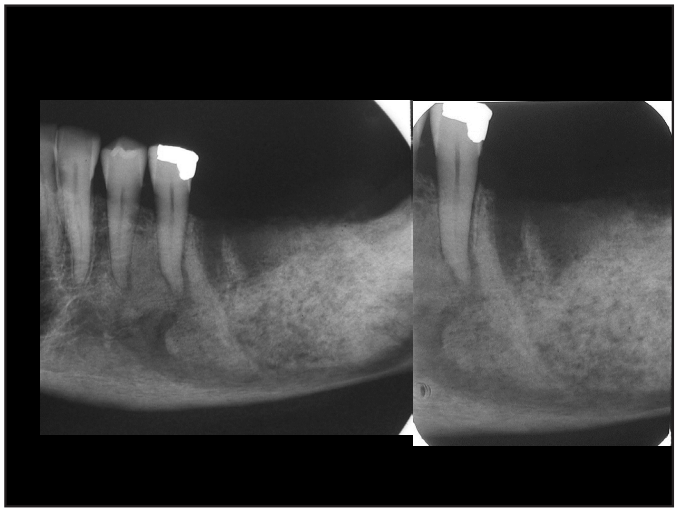


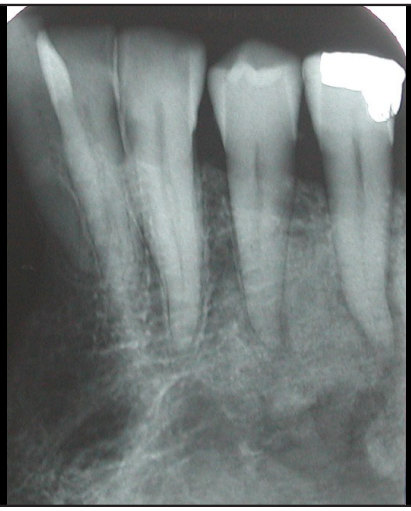
1 YEAR FOLLOW UP

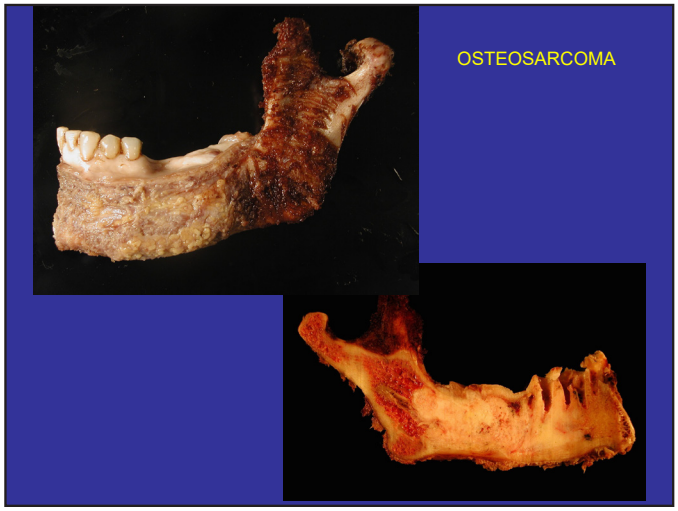


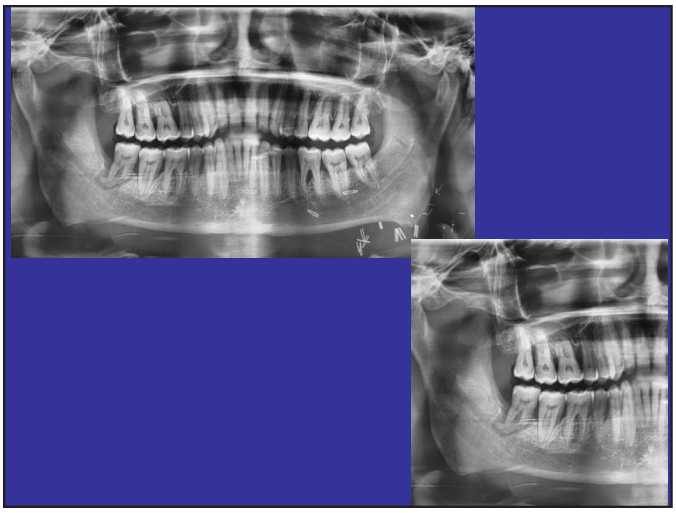
55-YEAR-OLD FEMALE
- PAIN LEFT MANDIBLE, #19 EXTRACTED











SELF EVALUATION

Differential Diagnosis of Odontogenic and Hard Tissue Lesions

True/False

1. A dentigerous cyst is always associated with the crown of an unerupted tooth.

2. Ameloblastoma is a malignant odontogenic tumor.

3. Metastatic malignancy may present as a soft tissue lesion growing from a recent extraction site.

4. Most patients presenting with florid osseous dysplasia are older Caucasian females.

5. The most common location for a lateral periodontal cyst is the mandibular canina/ premolar area.

Answer Key: 1. T, 2. F, 3. T, 4. F, 5. T

Carole C. Foos, CPA

Carole C. Foos, CPA of Cincinnatti, Ohio is a partner in OJM Group, a physician focused financial planning and asset management firm and a Certified Public Accountant (CPA) offering tax analysis and tax planning services to the firm's clients. Ms. Foos has over 25 years of experience in accounting, tax planning and financial consulting. She is a co-author of numerous books for physicians, including *Wealth Management Made Simple* and *Wealth Planning for the Modern Physician: Residency to Retirement*. Ms. Foos has authored numerous articles and presented many lectures, webcasts, and podcasts on tax planning and wealth management.

You may contact Ms. Foos with any questions or comments at (513) 309–3946 or by email at carole@ojmgroup.com.

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Selling to Private Equity: The Pros and the Cons

Carole C. Foos, CPA

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  - Click the link in the reply text
- Visit ojmbookstore.com and enter **AEIOJM** at checkout
- Scan the QR Code

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CURRENT M&A TRENDS

- Financial sponsors acquiring existing platforms from other financial sponsors
  - Buyers paying strong valuations
  - Pressure on new sponsor to find creative and aggressive growth
- Acceleration of medium and smaller practices being acquired
  - Independent practices receiving heightened interest
- Practices selling or raising capital as part of consortium
  - Grouping independent practices and presenting as one platform
    - Additional valuation / arbitrage
    - More diverse market of buyers

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WHY IS PRIVATE EQUITY INVESTING

Growth Market
Number of Americans >65 will more than double over next 4 decades
Skin cancer, knee and hip replacements, PT, anti-aging

Durable Market
Recession and extraordinary event resistant
Industry bounced back more quickly than most post-pandemic

Consolidation Opportunity
Still a critical mass of independent practices
Approx 50% of Dermatologists still work in practices wholly owned by physicians (1)

Recurring Revenue
Multiple service offerings for patients
Low patient attrition rates
Predictable backlog

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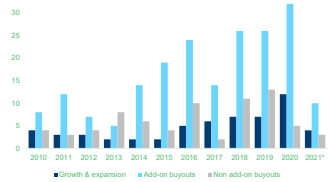
(1) Kane, Carol, Policy Research Perspectives: Recent Changes in Physician Practice Arrangements, American Medical Association, May 2021

ORTHOPAEDIC MARKET EXAMPLE

US Private Equity Activity in Orthopaedic Healthcare (1)

US Private Equity Activity (#) in Orthopaedic Healthcare by Type



Strong Market Fundamentals

Approximately 80% of 2020 private equity activity in the Orthopaedics market was related to healthcare services. (1)	Despite the disruption of COVID-19, 49 orthopaedic transactions closed in 2020. (1)	Orthopaedic practices are among the best at establishing multiple profit centers through robust, ancillary service offerings.	Over the past 10 years, the number of non-health system physician practice acquisitions in orthopaedics has increased from 2 to 7 per year.(2)

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(1) Source: PitchBook | Geography: US | * As of May 25, 2021
(2) "Private Equity Investment As A Divining Rod for Market Failure: Policy Responses to Harmful Physician Practice Acquisitions." USC-Brookings Schaeffer Initiative for Health Policy, October 2021

THE UPSIDE OF A SALE TO PRIVATE EQUITY

- Significant Cash Infusion
  - Pay down debt
  - Invest in new technology
  - Expand the practice
  - Fund retirement
  - Succession / exit plan
- Gain management expertise
  - Improve efficiencies
  - Increase profitability
- Offload back-office headaches
- Potentially increase revenue due to greater ability to negotiate with payors, reduce expenses through vendor negotiations / block purchases

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DOWNSIDE OF A PRIVATE EQUITY SALE

- New focus on returns and profitability
  - Could be a conflict with doctor's view of patient care
- Loss of full managerial control for owner(s)
- Changes to practice culture and priorities, employee retention
- Loss of control over practice operations
- Change in owner compensation and retirement plans
- Concern over long term impact on healthcare services
- More vigorous and regular reporting

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PRACTITIONER'S PERSPECTIVE

Regulation:
- Increasing percentage of burnout among dermatologists
- Drivers include fraud and abuse statutes governing compensation methodologies, licensing and reporting obligations, and regulations governing uses of patient health information

Focus on the Patients:
- Shedding of administrative duties
- Patient service delivery and revenue collection become the priority

Personal Financial Goals:
- Practice owners can receive attractive all cash payments
- Exit strategy for practice owners
- Physicians have the opportunity to receive a "second bite of the apple" with a private equity group

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THE PRIVATE EQUITY MODEL

- Funds of money, managed by finance and operating professionals, backed by high-net-worth individuals, pension funds, and university endowments (to name a few).
- Acquire a majority equity stake in a physician practice (i.e., platform investment) while leaving the physicians with a minority equity position in the practice.
- Over a three-to-seven-year period, the private equity group wants to increase the value of the practice in order to resell the platform investment and receive an attractive return.
- Means of increasing Adjusted EBITDA (1) and value for a medical practice investment:
  - Acquiring additional practices (i.e., add-on acquisitions)
  - Open new locations and bring on additional talent
  - Expand and diversify services (Mohs, cosmetic, dermatopathology lab, clinical trials, etc.)
  - Synergies: Cost savings or new revenue created by the combination of one medical practice with another.

Synergies → Increased Adjusted EBITDA → Higher Practice Valuation

(1) Earnings before Interest Expenses, Income Taxes, Depreciation and Amortization Expense. Adjustments can include excess physician owner's compensation, and one-time expenses

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STRATEGIC OPTIONS

Status Quo	Continue to execute current operating plan and retain existing structure
Sale to Strategic Buyer or Financial Sponsor	Sell to a larger practice and become a subsidiary OR sell to private equity to gain capital and management expertise
Recapitalization	Utilize debt or combo of debt and minority equity

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VALUE DRIVERS

Owners should constantly evaluate ways to build value, beginning with 3 core pillars of value assessment

Stability	Profitability	Growth
• Talented core provider team with diversification across specialties. • Established organizational structure with both executive and physician leadership in place. • Existing footprint in a competitive regional market. • Consistent track record of historical financial performance and production levels across providers.	• Organization has demonstrated ability to achieve profit milestones over a multi-year period. • Financial and operational data reflect industry best-practices and provide meaningful insights as to the operational health of the practice. • Adjusted EBITDA margins are ideally achieving, or are on a path towards, 20% Adjusted EBITDA margin or greater.	• Practice has a proven ability to add providers, expand specialties, and add ancillary service offerings. • The financial and operational performance of the practice reflects a historical track record of growth, and ideally a forecast supported by historical trends. • Leadership has a clearly articulated growth plan to continue to build value as a platform or under the umbrella of a larger organization.

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STEPS TO BUILDING VALUE

Build talent throughout the provider, mid-level and administrative ranks. Create a system of evaluating and recruiting and retaining talent.	Whether it be operating in a distinct geography, or performing a unique set of services, a practice should strive to be a leader in a defined niche.	Create an organization that offers diversified revenue sources, which could include pain management, physical therapy, Orthopaedic Urgent Care, and ownership of Ambulatory Surgical Centers (ASCs).
Bench Depth	**Establish a Niche**	**Ancillary Services**
With the industry migration towards value-based care, it is important that practices can demonstrate a path to success under this new system.	Quality of actionable information is critical for both managing and selling a practice. Key steps to take include utilizing a fractional or full-time CFO to serve as an advisor to practice owners and establishing systems and process for financial and operational management.	Develop a detailed strategic growth plan, supported by financial projections. Highlight what added resources can do to improve practice performance. Working with advisors, practice owners should periodically reevaluate options that could help drive or present optimal exit / liquidity solutions.
Success Under Value Based Care Model	**Financial Controls and Operating Metrics**	**Strategic Planning**

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IMPROVING PRACTICE VALUE

- **Talent**
  - Hire and retain physicians, PA's other medical talent
  - Balanced ratio of physicians to PA's, etc.
- **Financials**
  - Transparent books and records
  - Reviewed or audited financial statements
  - Perform diligence in preparation of sales transaction
  - External firm can provide credibility to numbers
  - Adjusted EBITDA margin of 20% or greater
  - Periodic review and elimination of overhead
  - Avoid legal and regulatory issues
- **Diversification**
  - Range of services
    - Mohs, laser, spa, PT, research, radiology
- **Geographic Market**
  - Size and location
  - Additional locations

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IMPROVING PRACTICE VALUE

- **Strategic Plan**
  - Written strategic plan provides steps for efficient operation and growth
  - Offers buyer a roadmap
  - Utilize as a "map" to know where practice is going
- **Growth**
  - Ability to grow substantially over 3-7 years
  - Maintain historical practice performance
  - Articulate future growth opportunities
- **Synergies**
  - Cost savings or new revenue
    - Improved negotiating leverage
    - Referrals
    - New in-house capabilities

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EBITDA

Adjusted Earnings Before Interest Expense, Taxes, Depreciation & Amortization Expense

Practice Net Income
+ Interest Expense
+ Income Taxes
+ Depreciation Expense
+ Amortization Expense
+ Excessive Physician Owner Compensation
+ Non-Recurring Practice Expenses
+ Extraordinary Practice Expenses
+ Synergies with a Buyer's Platform

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SUMMARY

- Sale can provide cash infusion, growth and succession opportunities
- Sale will also bring a reduction in control and changes to practice dynamics
- Multiple options for sales: another practice, private equity, consortium merger
- Regardless of interest in selling, makes good business sense to increase practice value
- Ways to increase value include acquisition and use of talent, strong financials, diversification and strategic plan for growth

Synergies → Increased Adjusted EBITDA → Higher Practice Valuation

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CORPORATE PLANNING PROCESS

DIAGNOSTIC vs. TREATMENT

ADVICE & EXPERTISE FOR A FLAT FEE

BUILDING A RELATIONSHIP

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PERSONAL
WEALTH PLANNING

DIAGNOSTIC vs. TREATMENT

ADVICE & EXPERTISE FOR A FLAT FEE

BUILDING A RELATIONSHIP

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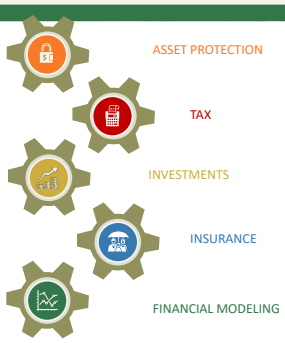

SPECIAL OFFERS

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- Contact the presenter:
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  - 877.656.4362
  - carole@ojmgroup.com
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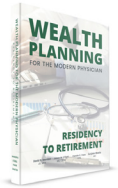

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SELF EVALUATION

Selling to Private Equity: The Pros and the Cons

1. Why is private equity interested in acquiring physician practices?

a. Recurring revenue
b. Growth market
c. Recession proof
d. All of the above

2. What is one upside to a sale to private equity group?

a. Loss of control
b. More vigorous reporting
c. Offload back office headaches
d. New focus on returns

3. T/F - EBITDA includes an add-back for excessive physician owner compensation.

4. T/F - Hiring and retaining additional physicians and PA's is an example of building value through ancillary services.

5. Groups of independent practices pooling together to present as one platform is called

a. Financial sponsor
b. Consortium
c. Independent practice group
d. Private equity

6. T/F - Due to the disruption of COVID, no orthopaedic transactions with private equity closed in 2020.

7. T/F - A sale of controlling interest to private equity can lead to unwanted changes in patient care.

Answer Key: 1. D, 2. C, 3. T, 4. F, 5. B, 6. F, 7. T

Susan Maples, DDS, MSBA

Dr. Susan Maples, of Holt, Michigan, is a long time, family and advanced restorative dentist who, following her receipt of a master's degree in business, developed a passion for organizational behavior, executive leadership, and target marketing. An expert in mouth-body connections, Dr. Maples is a practitioner of Total Health, or Integrative Dental Medicine. She is also a sought-after national presenter to both dental and medical audiences, serves on the executive board of the American Academy for Oral & Systemic Health, and is a Fellow of the International College of Dentists.

You may learn more about Dr. Maples at DrSusanMaplesSpeaker.com, Total-Health-Dentistry.com, and TotalHealthPractice.net. You may contact her with questions or comments at Susan@drsusanmaples.com

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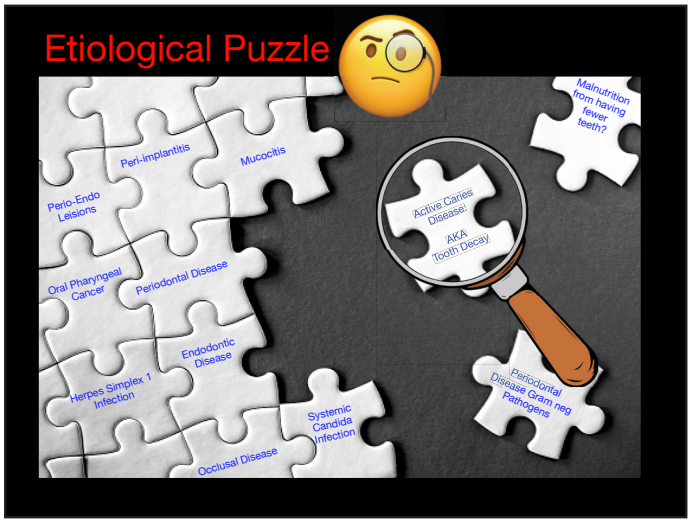
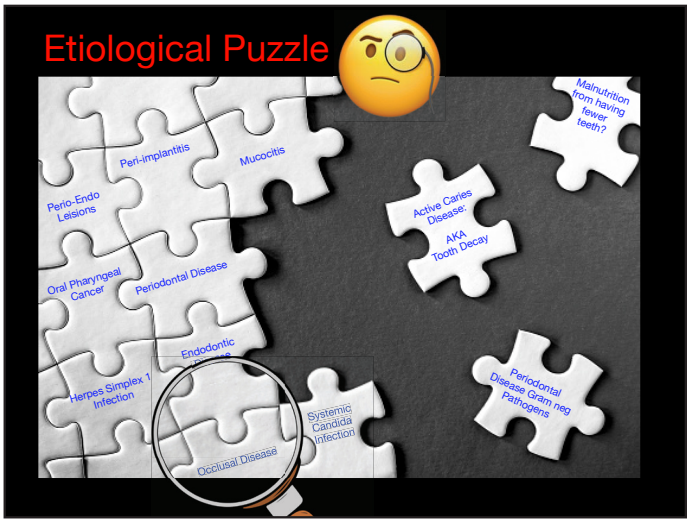
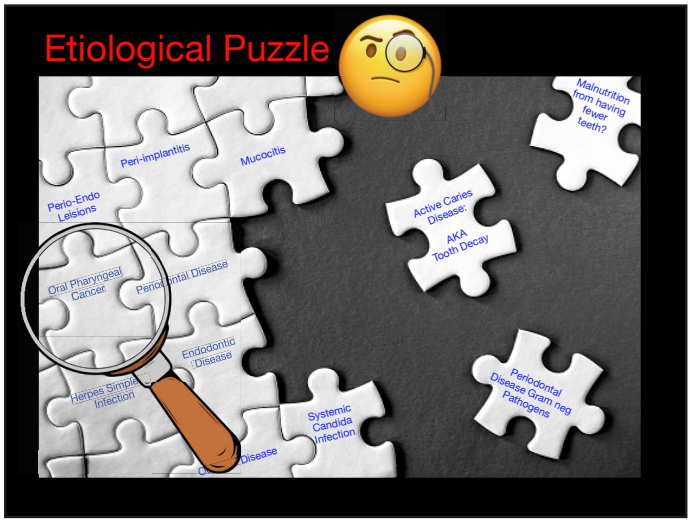
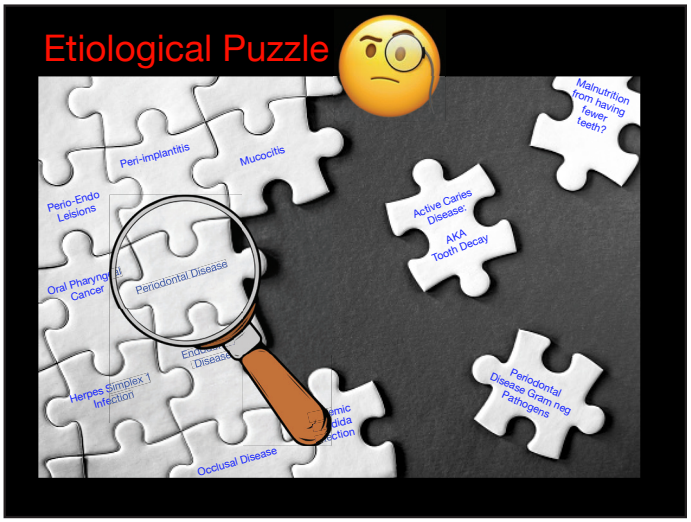
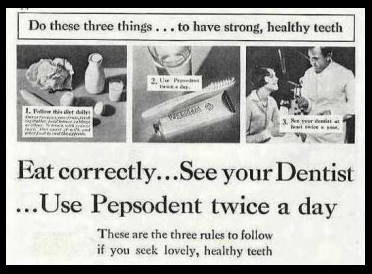
Four Major Diseases Impacting Oral Health: Parts 1 & 2











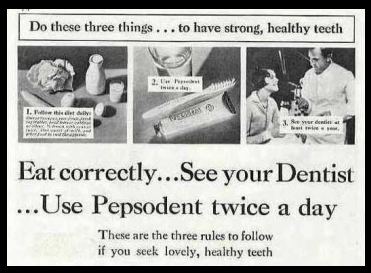
- Caries Disease
- Periodontal Disease
- Oral Cancer
- Occlusal Disease

11

12

You're sure you're right?
How fine and strong.
But were you ever just as sure,
And wrong?

13



- Caries Disease
- Periodontal Disease
- Oral Cancer
- Occlusal Disease

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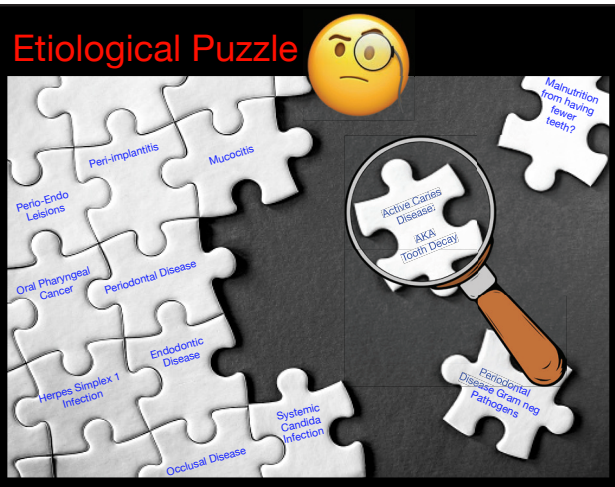
Our Healthcare Team Matters

15

Etiological Puzzle



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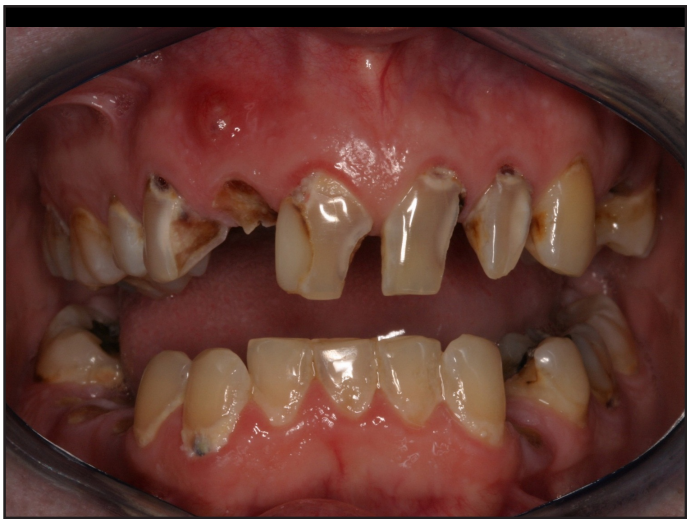
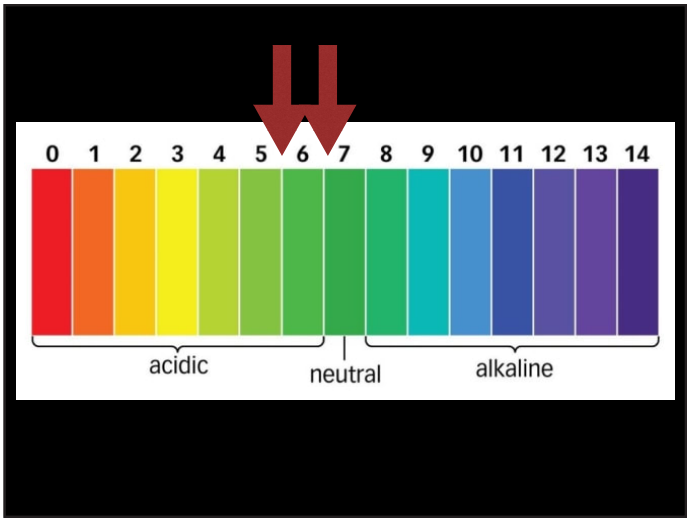
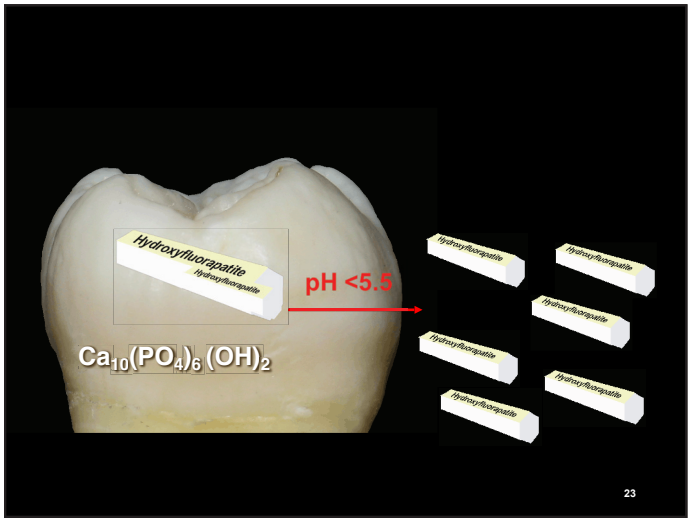
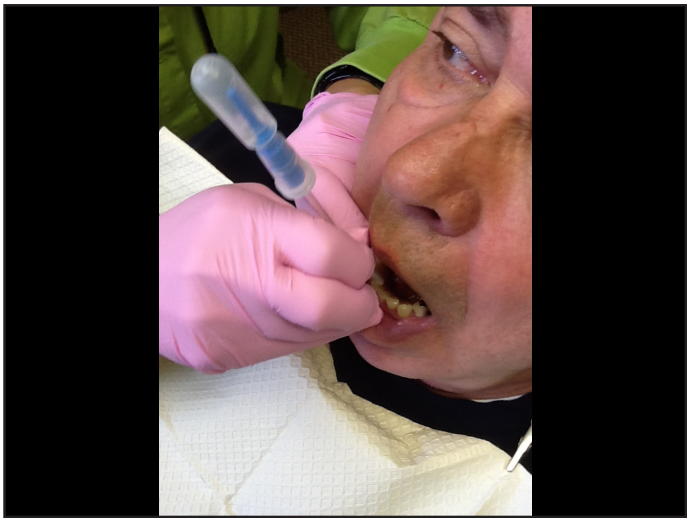


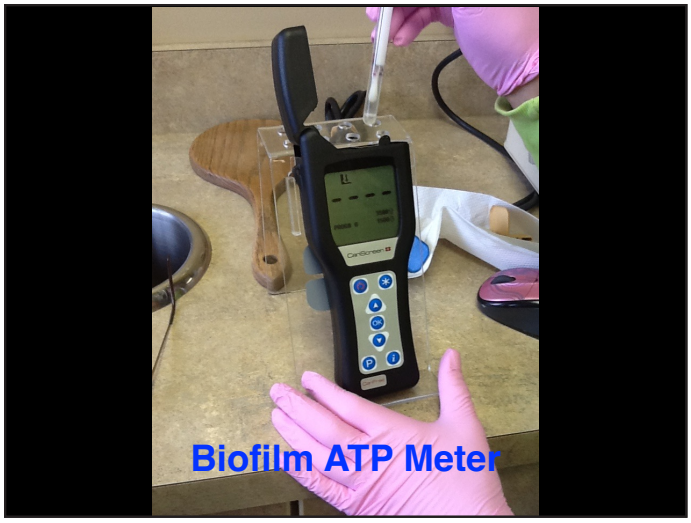
Our Challenge

How do we "treat" Caries Disease?









EAT Your kid vs. today's food craziness: It's a lot to swallow!

DRINK Bubble, Fizz, Guzzle Gulp: W

DIGEST Support the bugs in your kid ug them!

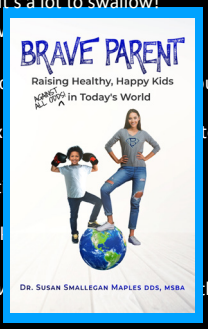
BREATHE Growing the tongue box to come!

SLEEP The greatest underrated front

FEEL & THINK Brainiac-Yak Ya

CHEW & SMILE Oral health w letale!

MOVE Foster a daily dose of get-up and go!



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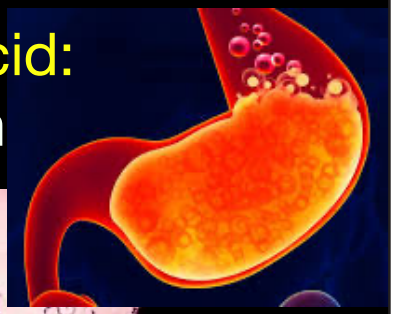
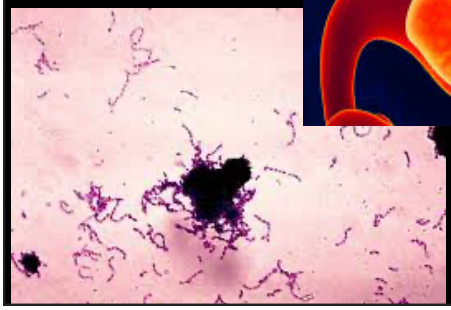
Intrinsic Acid: Production

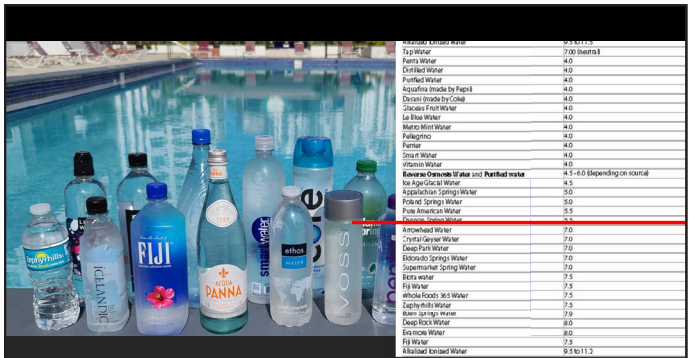




27

Extrinsic Acid: Consumption

28



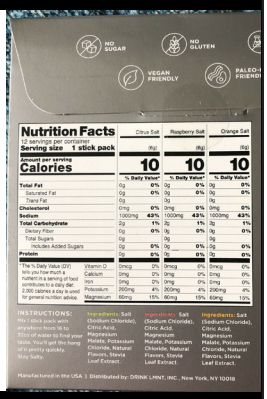
Tap Water	7.00 (neutral)
Poland Springs Water	5.5
Pure American Water	5.5
Arrowhead Water	7.0
Crystal Geyser Water	7.0
Deep Park Water	7.0
Eldorado Springs Water	7.0
Supermarket Spring Water	7.0
Fiji Water	7.5
Whole Foods 365 Water	7.5
Zephyrhills Water	7.5
Evian Water	8.0
Deep Rock Water	8.0
Fiji Water	7.5

pH BOTTLED WATERS

P4Denti

- Calories 0
- Total sugars 0 g
- pH 2.85
- Caffeine 60 mg

- Calories 10
- Total sugars 0 g
- pH 2.55 / 2.77
- Caffeine 0 mg



- Calories 200
- Total sugars 55 g
- pH 3.29
- Caffeine 48 mg

- Calories 140
- Total sugars 34 g
- pH 3.10
- Caffeine 0 mg

- Calories 260
- Total sugars 62 g
- pH 3.00
- Caffeine 240 mg

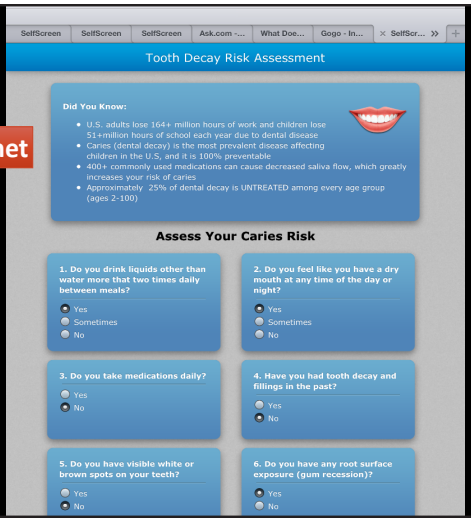
- Calories 25
- Total sugars 4 g
- pH 3.14
- Caffeine 180 mg

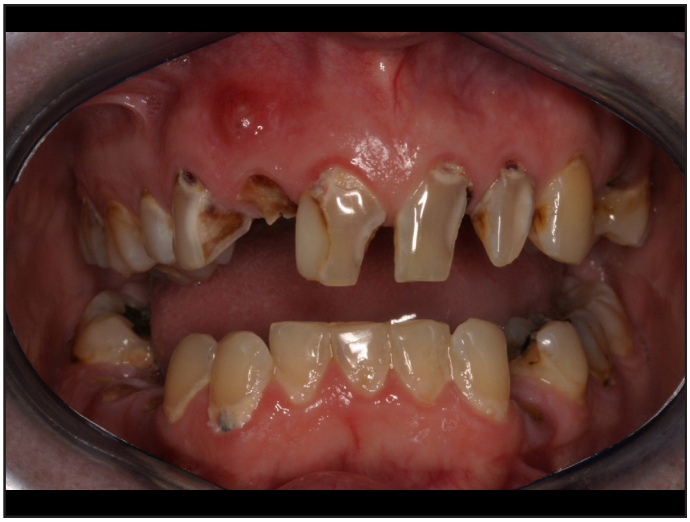
- Calories 100
- Total sugars 7 g
- pH 5.36
- Caffeine 0 mg

Amount Per Serving	
Calories	100
	% Daily Value*
Total Fat 0g	0%
Saturated Fat 0g	0%
Trans Fat 0g	
Cholesterol 0mg	0%
Sodium 125mg	5%
Total Carbohydrate 22g	8%
Dietary Fiber 0g	0%
Total Sugars 7g	
Includes 7g Added Sugars	14%
Protein 0g	0%

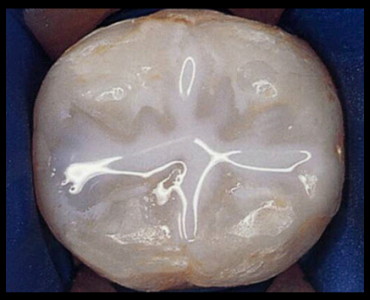
- Calories 32
- Total sugars <2 g
- pH 3.42
- Caffeine 0 mg

SelfScreen.net





Communicating with Healthcare Professionals

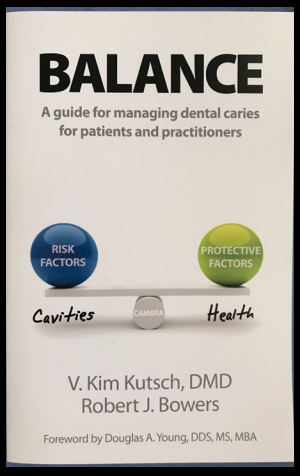


- Need to be maintained.
- ADA says we are only using sealants 18% of the time.
- 100% effective over 12 months
- 98% effective over 44 months

43

Our Challenge

How do we put kids in the driver's seat to a preferred future?



45

CARIFREE

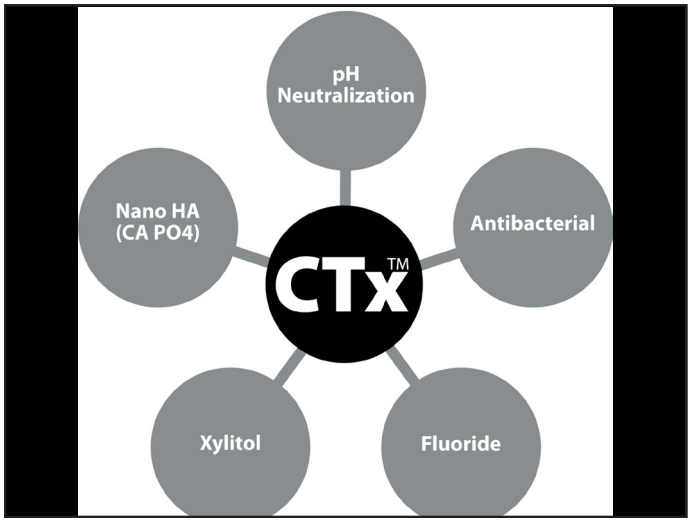
Receive a sample box and schedule a webinar to learn more!

Hands-On LEARNING LAB

Kinesthetic Learning For Kids

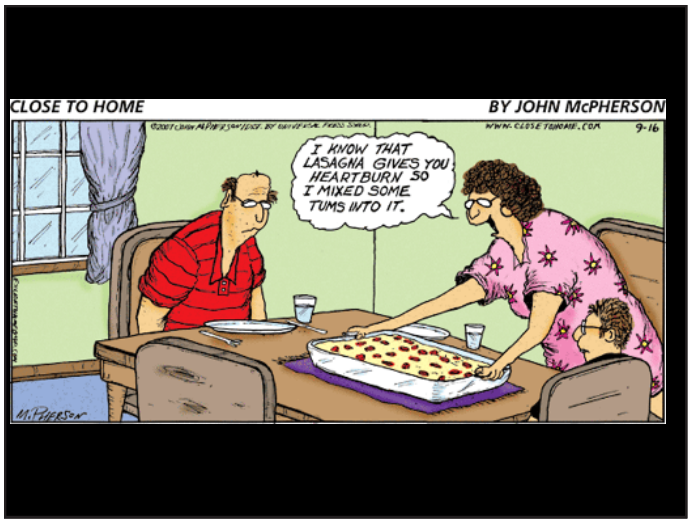
Our Challenge

How do we "treat" Caries Disease?

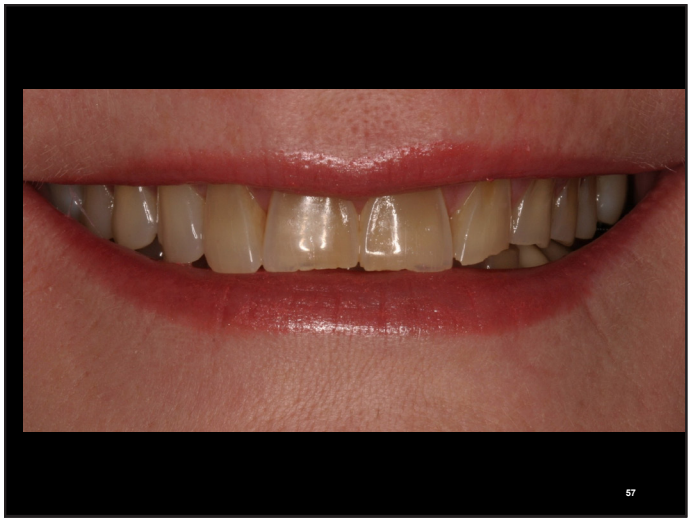


60% US adults report some reflux

20-30% …at least weekly


CLOSE TO HOME
BY JOHN McPHERSON
WWW.CLOSETOHOME.COM
9-16
I KNOW THAT LASAGNA GIVES YOU HEARTBURN SO I MIXED SOME TUMS INTO IT.


Airway Reflux?
56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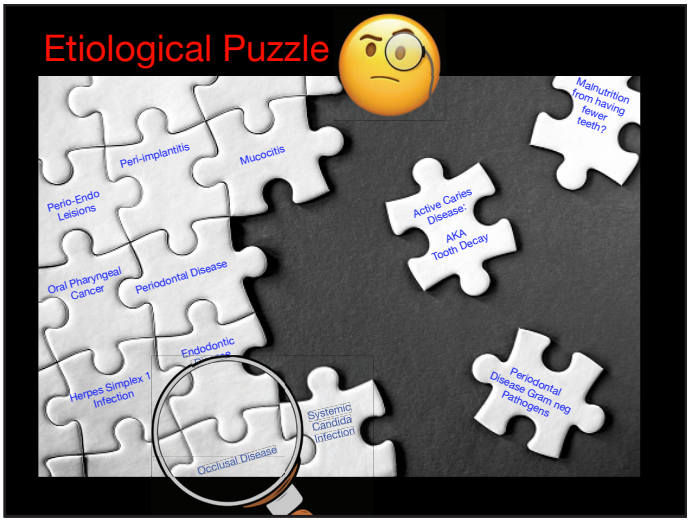
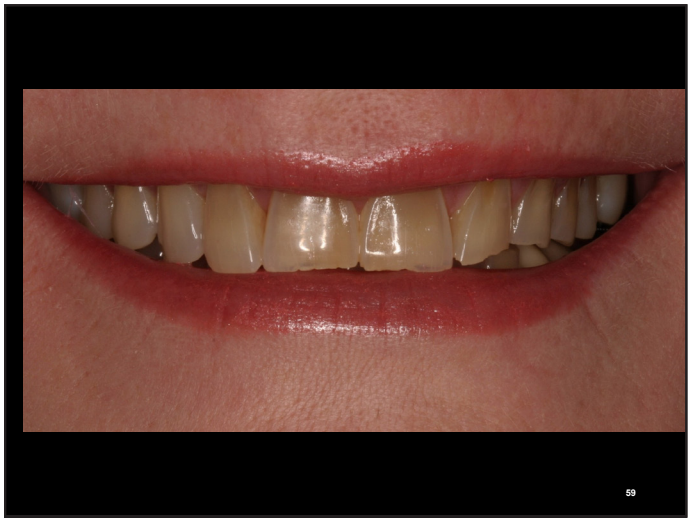

Etiological Puzzle
Peri-implantitis
Mucocitis
Malnutrition from having fewer teeth?
Perio-Endo Lesions
Active Caries Disease AKA Tooth Decay
Oral Pharyngeal Cancer
Periodontal Disease
Endodontic
Herpes Simplex 1 Infection
Systemic Candida Infection
Occlusal Disease
Periodontal Disease Gram neg Pathogens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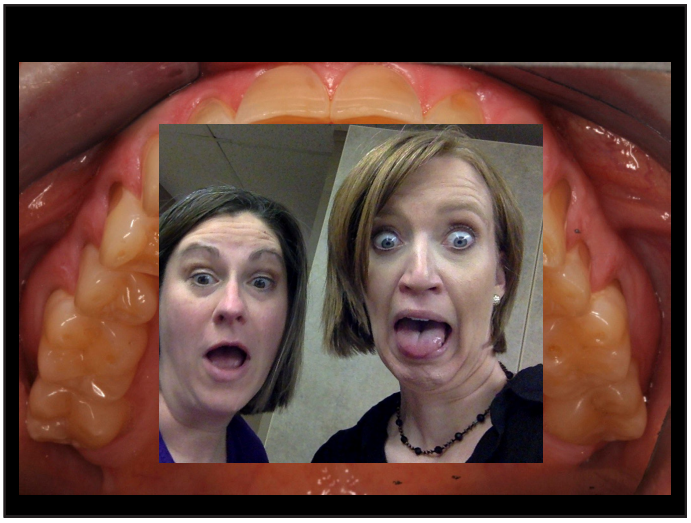
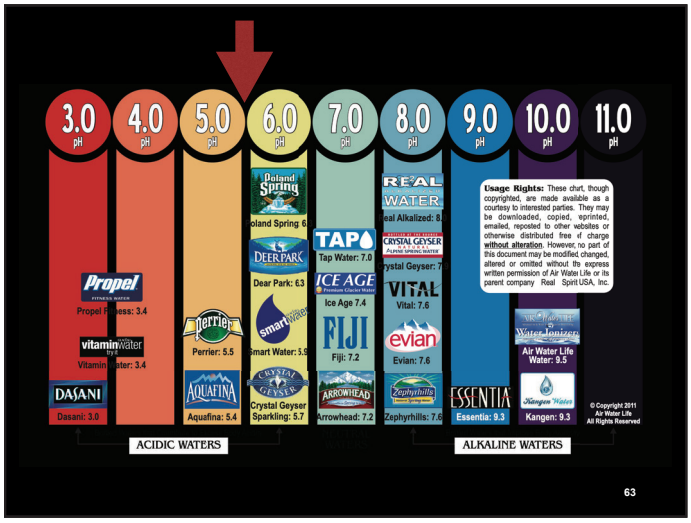


Proton Pump Inhibitors (PPIs)

- Prilosec (omeprazole)
- Prevacid (Iansprazole)
- Nexium (esomeprazole)
- Dexilent, Kapidex (dexlansoprazole)
- Aciphex (rabeprazole)
- Protoix (pantoprazole)
- Regard (rapid release omeprazole)

62



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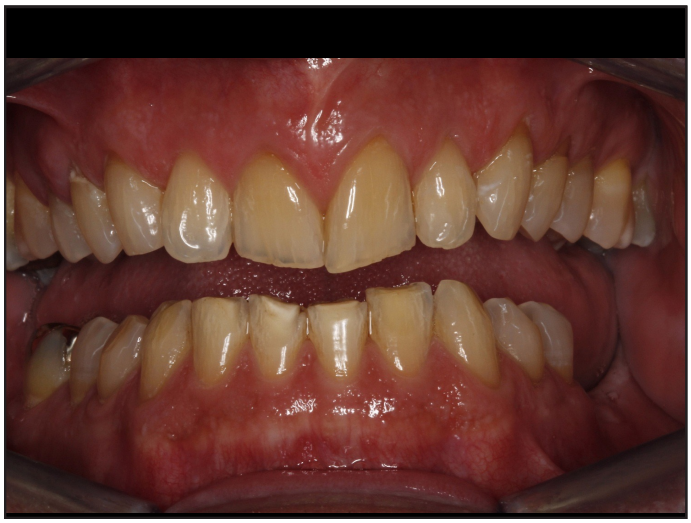
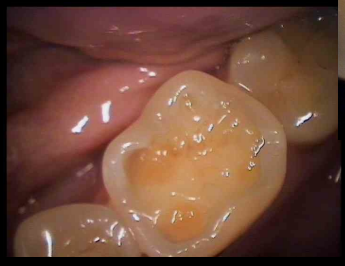
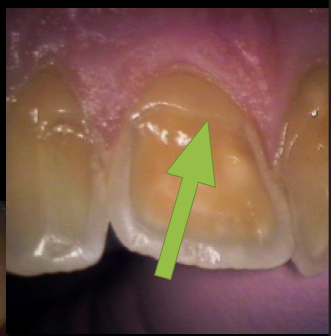
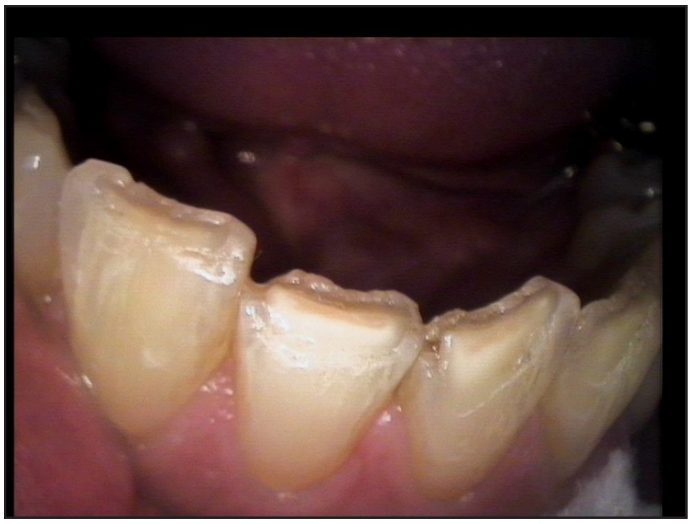
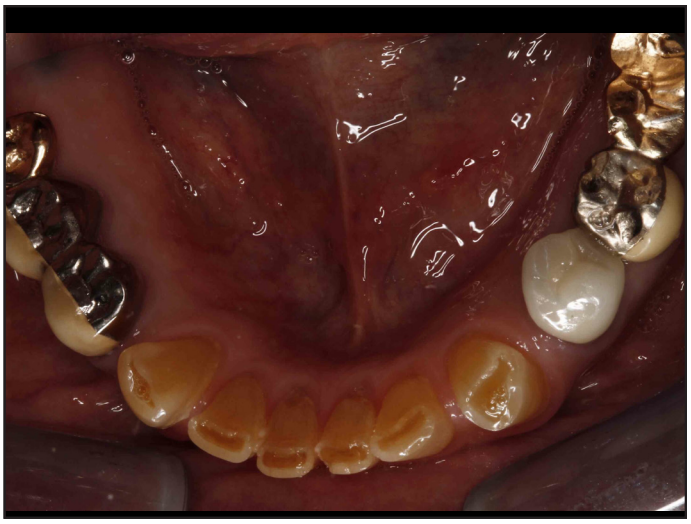


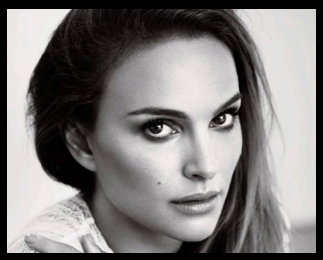
Bulimia or Reflux with nocturnal bruxism ?

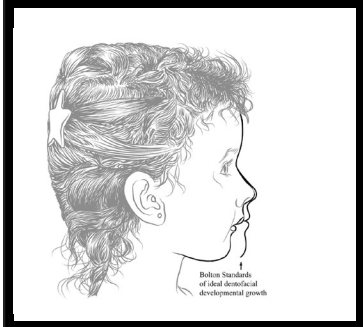


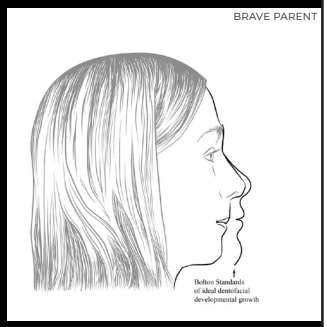


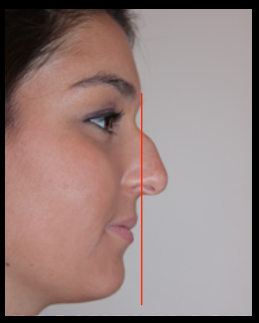






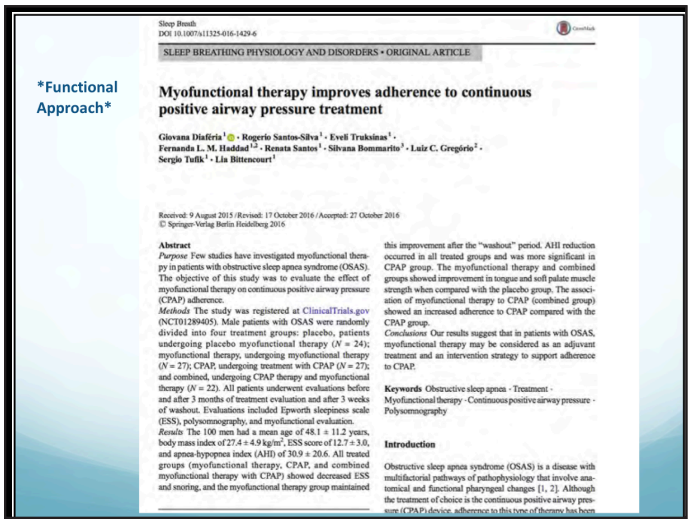

Bolton Standards
of ideal dentofacial
developmental growth


BRAVE PARENT
Bolton Standards
of ideal dentofacial
developmental growth



CPAP
Or
Sleep Appliance?

Functional Approach



Sleep Breath
DOI 10.1007/s11325-016-1429-6

SLEEP BREATHING PHYSIOLOGY AND DISORDERS • ORIGINAL ARTICLE

Myofunctional therapy improves adherence to continuous positive airway pressure treatment

Giovana Diafério[1] · Rogerio Santos-Silva[1] · Eveli Truksinas[1] · Fernanda L. M. Haddad[1,2] · Renata Santos[1] · Silvana Bommarito[3] · Luiz C. Gregório[2] · Sergio Tufik[3] · Lia Bittencourt[1]

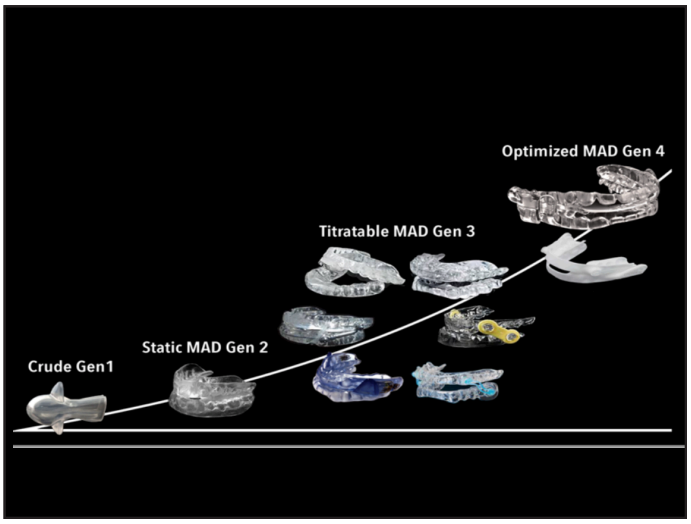
Received: 9 August 2015 / Revised: 17 October 2016 / Accepted: 27 October 2016

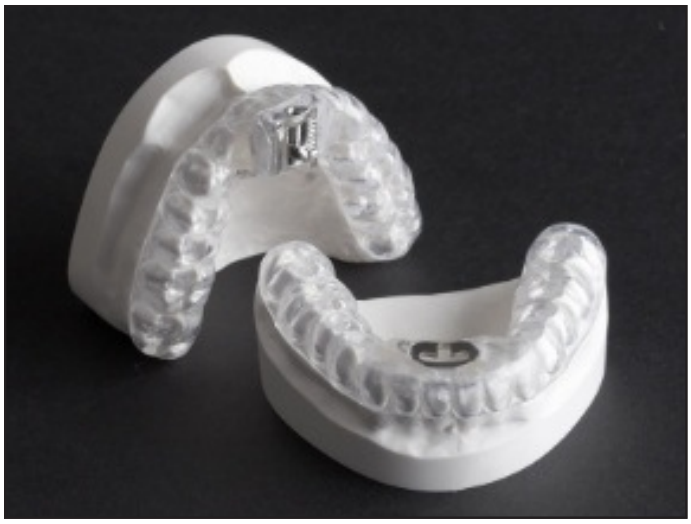
Abstract
Purpose Few studies have investigated myofunctional therapy in patients with obstructive sleep apnea syndrome (OSAS). The objective of this study was to evaluate the effect of myofunctional therapy on continuous positive airway pressure (CPAP) adherence.
Methods The study was registered at ClinicalTrials.gov (NCT01289405). Male patients with OSAS were randomly divided into four treatment groups: placebo, patients undergoing placebo myofunctional therapy ($N = 24$); myofunctional therapy, undergoing myofunctional therapy ($N = 27$); CPAP, undergoing treatment with CPAP ($N = 27$); and combined, undergoing CPAP therapy and myofunctional therapy ($N = 22$). All patients underwent evaluations before and after 3 months of treatment evaluation and after 3 weeks of washout. Evaluations included Epworth sleepiness scale (ESS), polysomnography, and myofunctional evaluation.
Results The 100 men had a mean age of 48.1 ± 11.2 years, body mass index of 27.4 ± 4.9 kg/m², ESS score of 12.7 ± 3.0, and apnea-hypopnea index (AHI) of 30.9 ± 20.6. All treated groups (myofunctional therapy, CPAP, and combined myofunctional therapy with CPAP) showed decreased ESS and snoring, and the myofunctional therapy group maintained this improvement after the "washout" period. AHI reduction occurred in all treated groups and was more significant in CPAP group. The myofunctional therapy and combined groups showed improvement in tongue and soft palate muscle strength when compared with the placebo group. The association of myofunctional therapy to CPAP (combined group) showed an increased adherence to CPAP compared with the CPAP group.
Conclusions Our results suggest that in patients with OSAS, myofunctional therapy may be considered as an adjuvant treatment and an intervention strategy to support adherence to CPAP.

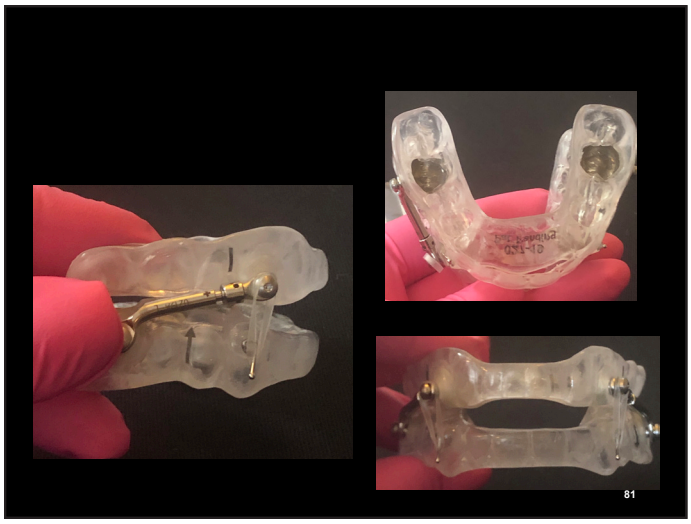
Keywords Obstructive sleep apnea · Treatment · Myofunctional therapy · Continuous positive airway pressure · Polysomnography

Introduction

Obstructive sleep apnea syndrome (OSAS) is a disease with multifactorial pathways of pathophysiology that involve anatomical and functional pharyngeal changes [1, 2]. Although the treatment of choice is the continuous positive airway pressure (CPAP) device, adherence to this type of therapy has been



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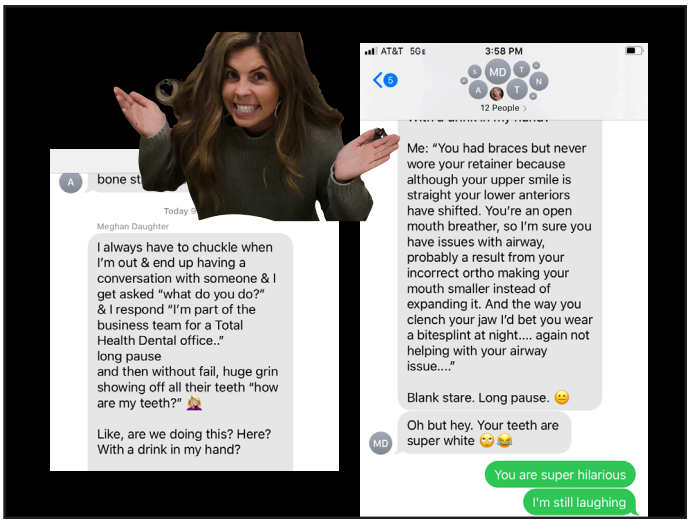
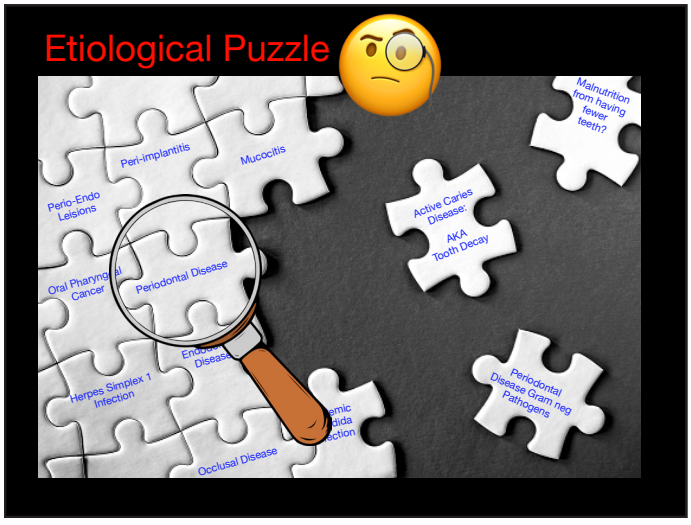
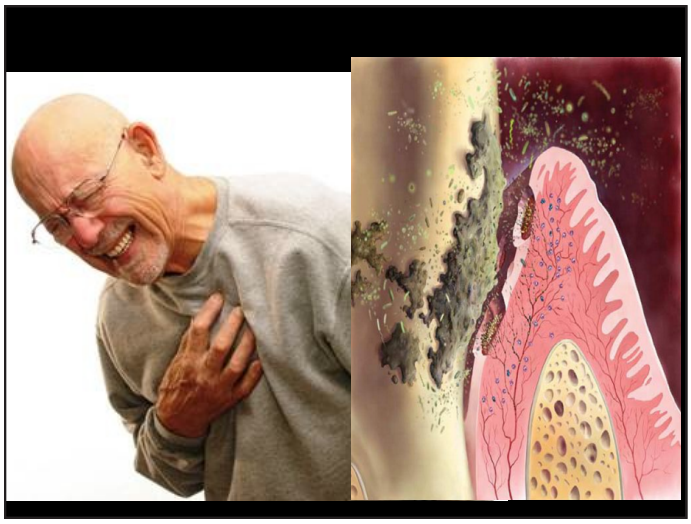
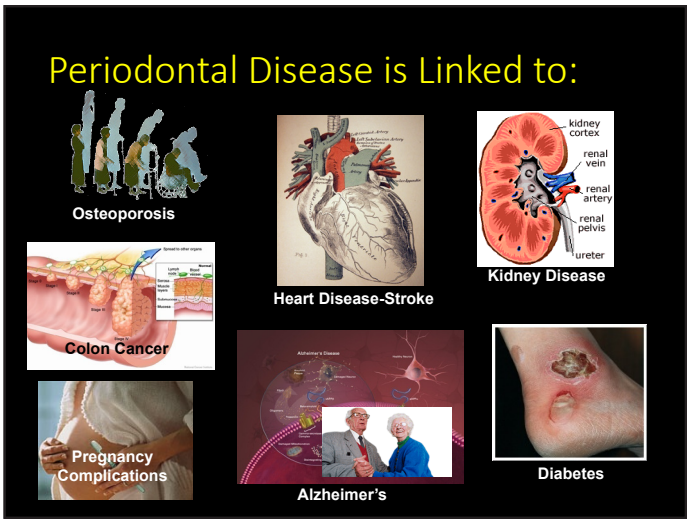
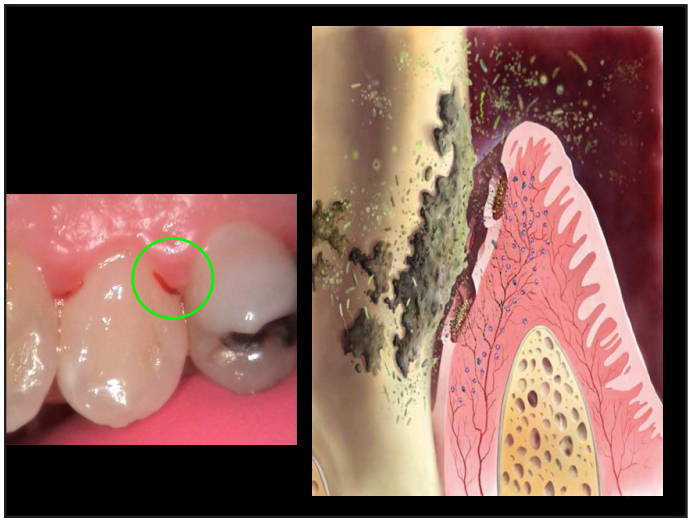

AT&T 5G
3:58 PM
12 People
bone st
Meghan Daughter
I always have to chuckle when I'm out & end up having a conversation with someone & I get asked "what do you do?" & I respond "I'm part of the business team for a Total Health Dental office.." long pause and then without fail, huge grin showing off all their teeth "how are my teeth?"
Like, are we doing this? Here? With a drink in my hand?
Me: "You had braces but never wore your retainer because although your upper smile is straight your lower anteriors have shifted. You're an open mouth breather, so I'm sure you have issues with airway, probably a result from your incorrect ortho making your mouth smaller instead of expanding it. And the way you clench your jaw I'd bet you wear a bitesplint at night.... again not helping with your airway issue...."
Blank stare. Long pause.
Oh but hey. Your teeth are super white
You are super hilarious
I'm still laughing

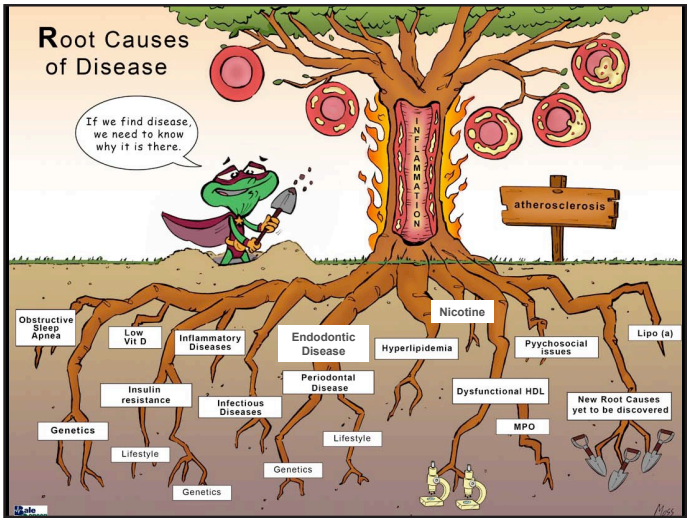

Etiological Puzzle
Peri-implantitis
Mucocitis
Malnutrition from having fewer teeth?
Perio-Endo Lesions
Active Caries Disease: AKA Tooth Decay
Oral Pharyngeal Cancer
Periodontal Disease
Herpes Simplex 1 Infection
Periodontal Disease Gram neg Pathogens
Occlusal Disease


Oral-Systemic Links to Periodontal Disease




Periodontal Disease is Linked to:
Osteoporosis
Heart Disease-Stroke
kidney cortex
renal vein
renal artery
renal pelvis
ureter
Kidney Disease
Colon Cancer
Pregnancy Complications
Alzheimer's
Diabetes

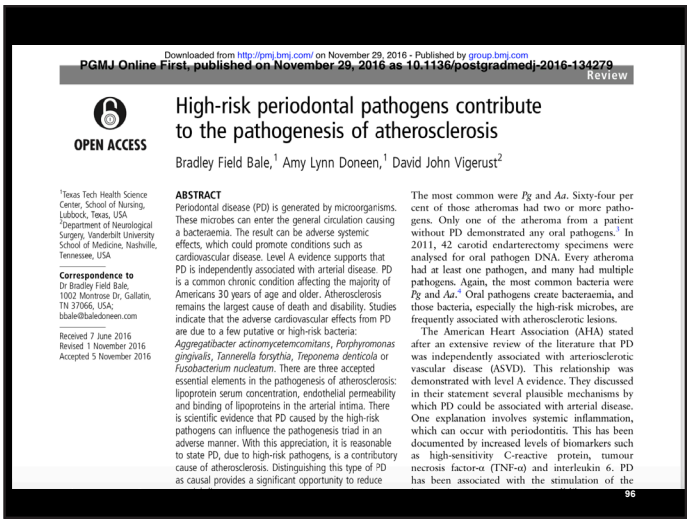



Root Causes of Disease
If we find disease, we need to know why it is there.
INFLAMMATION
atherosclerosis
Obstructive Sleep Apnea
Low Vit D
Inflammatory Diseases
Endodontic Disease
Hyperlipidemia
Nicotine
Pyychosocial issues
Lipo (a)
Periodontal Disease
Insulin resistance
Infectious Diseases
Dysfunctional HDL
New Root Causes yet to be discovered
Genetics
Lifestyle
MPO
Lifestyle
Genetics
Genetics


2016
93


94


95


Downloaded from http://pmj.bmj.com/ on November 29, 2016 - Published by group.bmj.com
PGMJ Online First, published on November 29, 2016 as 10.1136/postgradmedj-2016-134279
Review
OPEN ACCESS
High-risk periodontal pathogens contribute to the pathogenesis of atherosclerosis
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[2]Department of Neurological Surgery, Vanderbilt University School of Medicine, Nashville, Tennessee, USA
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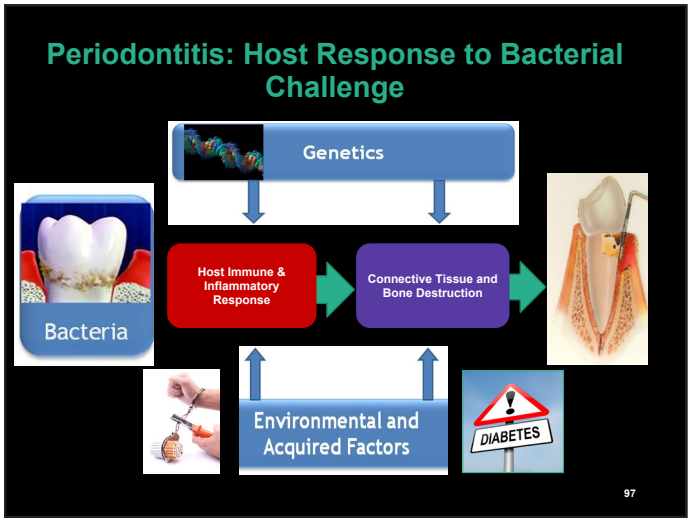
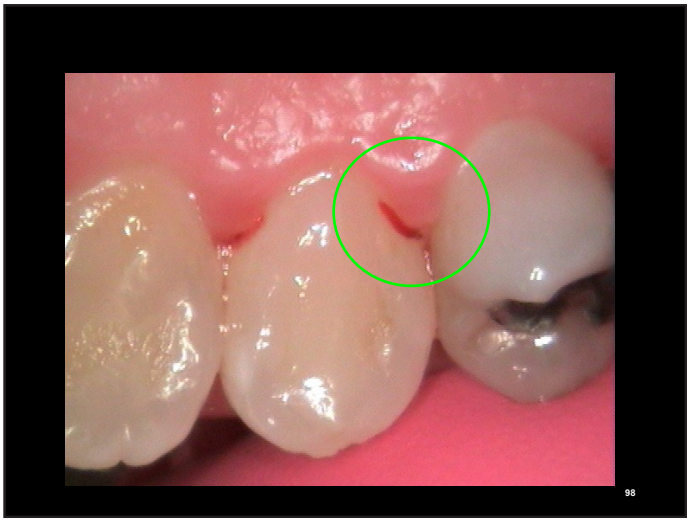
Received 7 June 2016
Revised 1 November 2016
Accepted 5 November 2016
ABSTRACT
Periodontal disease (PD) is generated by microorganisms. These microbes can enter the general circulation causing a bacteraemia. The result can be adverse systemic effects, which could promote conditions such as cardiovascular disease. Level A evidence supports that PD is independently associated with arterial disease. PD is a common chronic condition affecting the majority of Americans 30 years of age and older. Atherosclerosis remains the largest cause of death and disability. Studies indicate that the adverse cardiovascular effects from PD are due to a few putative or high-risk bacteria: Aggregatibacter actinomycetemcomitans, Porphyromonas gingivalis, Tannerella forsythia, Treponema denticola or Fusobacterium nucleatum. There are three accepted essential elements in the pathogenesis of atherosclerosis: lipoprotein serum concentration, endothelial permeability and binding of lipoproteins in the arterial intima. There is scientific evidence that PD caused by the high-risk pathogens can influence the pathogenesis triad in an adverse manner. With this appreciation, it is reasonable to state PD, due to high-risk pathogens, is a contributory cause of atherosclerosis. Distinguishing this type of PD as causal provides a significant opportunity to reduce
The most common were Pg and Aa. Sixty-four per cent of those atheromas had two or more pathogens. Only one of the atheroma from a patient without PD demonstrated any oral pathogens.[3] In 2011, 42 carotid endarterectomy specimens were analysed for oral pathogen DNA. Every atheroma had at least one pathogen, and many had multiple pathogens. Again, the most common bacteria were Pg and Aa.[4] Oral pathogens create bacteraemia, and those bacteria, especially the high-risk microbes, are frequently associated with atherosclerotic lesions.
The American Heart Association (AHA) stated after an extensive review of the literature that PD was independently associated with arteriosclerotic vascular disease (ASVD). This relationship was demonstrated with level A evidence. They discussed in their statement several plausible mechanisms by which PD could be associated with arterial disease. One explanation involves systemic inflammation, which can occur with periodontitis. This has been documented by increased levels of biomarkers such as high-sensitivity C-reactive protein, tumour necrosis factor-α (TNF-α) and interleukin 6. PD has been associated with the stimulation of the
96


Periodontitis: Host Response to Bacterial Challenge
Genetics
Bacteria
Host Immune & Inflammatory Response
Connective Tissue and Bone Destruction
Environmental and Acquired Factors
DIABETES
97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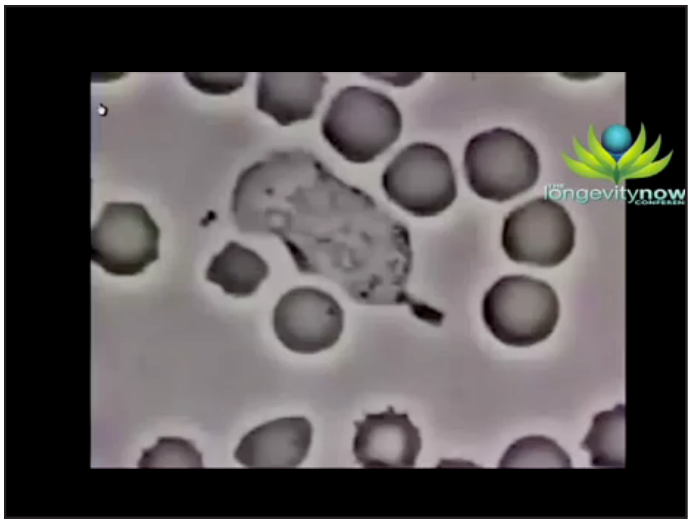


TheTraveling Microbiome

They can survive and even multiply inside of other cells

These bugs travel

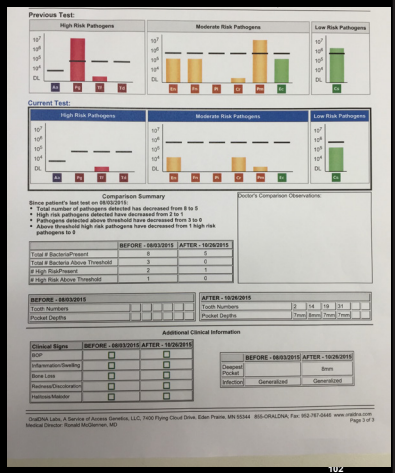
They travel through the blood to infect other organs

"They have tentacles like an octopus can weave in between the endothelial cells where there are only 10-16 layers."

Periodontal pathogens, periodontitis & systemic risks …

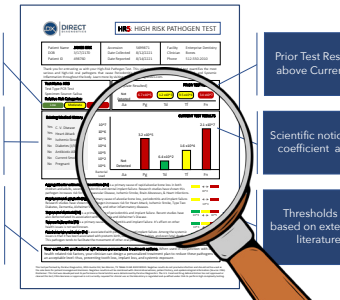
Very Strong	Strong	Moderate	Moderate
Actinobacillus actinomycetem-comitans Porphyromonas gingivalis Tannerella forsythensis	Prevotella intermedia Eubacterium nodatum Treponema denticola	Campylobacter rectus Peptostretococc micros Fusobacterium nucleatum Eikenella corrodens	Eikenella Corrodens Capnocytophaca Species: (gingivalis, ochracea, sputagena)

Modified from Haffajee and Socransky and Slots and Chen. This list is not all-inclusive



HR5 TEST RESULT

- Color-coded for easy-to-understand risk levels
- Patient medical history relevant to Oral Systemic Health risk factors
- Detailed information about each pathogen and systemic health risks
- Prior Test Results displayed above Current Test Results
- Scientific notion with precise coefficient and exponent
- Thresholds determined based on extensive scientific literature citations



directdiagnostics.com

103

THESE FIVE: Red Complex + *Fn*

These five bacteria, now known as the "New **Red Complex**", have been shown across multiple studies to be the most virulent, destructive, systemically impactful, and impactful to manage.

Why these 5?

Fragkioudakis, et al.,
Journal of Medical Microbiology 2021;
70:001247: DOI 10. 1099/jmm.0.001247

"Known Putative Pathogens (e.g., Red complex) regulate the pathogenicity of the entire subgingival community."

"Red Complex containing biofilm down-regulates the biological processes of blood coagulation and haemostasias…"

"Absence of Red Complex … led to enhanced health related colonization."

Folia Medica 2014; 56(3):
152-160 Copyright
© 2014 Medical University, Plovdiv
doi: 10.2478/folmed-2014-0022

Red Complex should be considered as major etiologic agents.

The increased amount of these periodontal pathogens…Causes a cascade of defense mechanisms with the production of cytokines and MMPs causing inflammation and destruction.

Case Study Reviews

Clinical studies and Individual patient studies performed by Dr. Tom Nabors demonstrate that when the HR5 bacteria are treated effectively, levels of other potentially harmful bacteria are reduced and become health-associated.

Testing for five high risk pathogens is sufficient for the majority of patients

ics.com

PATHOGENS

Bacterial Pathogens	Pre-eclampsia Gestational Hypertension	Chorloamniotis Intra-amniotic Infection	Neonatal Sepsis	Pre-term Birth Low Birth Weight
Aggregatibacter actinomycetemcomitans [Aa]	X			X
Porphyromonas gingivalis [Pg]	X			X
Treponema denticola [Td]		X		X
Tannerella forsythia [Tf]	X			X
Fusobacterium nucleatum [Fn]	X	X	X	X
Fn animalis	X	X	X	X
Prevotella intermedia [Pi]	X			X
Campylobacter rectus [Cr]				X
Eikenella corrodens [Ec]		X	X	X
Capnocytophaga sputigena [Cs]		X	X	X

See directdiagnostics.com for research bibliography

gnostics.com Screen. Test.

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Impact of Salivary Diagnostics in Practice

Doctor & Practice Owner
- Increase Patient Acceptance
- Strong economics for practice
- High-margin treatments
- Patient loyalty
- Emerging standard of care

Dental Hygienist
- Job satisfaction and quality of life
- Stop guessing and start personalizing treatment
- No more waiting and watching disease progression
- Build true patient loyalty

Patient
- Understand and see clear evidence of early detection (preclinical disease)
- Take charge of your oral and systemic health
- Live healthier

directdiagnostics.com Screen. Test. Clear.™

106

Included in your periodontal therapy package:
- Periodontal examination and a complete clinical diagnosis
- Evaluation of all probable causes
- Saliva testing for identification of specific pathogens
- Saliva testing for identification of specific pathogens for your spouse/partner (if desired)
- Saliva testing for genetic predisposition to periodontal disease and cardiovascular disease (if suspected)
- Saliva testing for 9 possible fungal infections (if suspected)
- A1C finger stick blood testing (if you have two or more risk factors for Type 2 Diabetes)
- Risk evaluation for sleep disorders such as UARS and Obstructive Sleep Apnea
- Health coaching for lifestyle changes necessary for a positive outcome
- Dispensing of all necessary instruments for daily self-care (power brush, water pic and adjunctive instruments)
- Dispensing of necessary antimicrobial rinse(s)
- Fluoride Varnish and CTX gel
- Skill-building series of visits (as many as necessary *prior* to full mouth disinfection)
- High quality probiotics (as adjunctive therapy for antibiotic prescription)
- Consultation letter(s) and coordination with your other health care professionals
- Full mouth disinfection (including scaling and root planing)
- Collaboration between your hygienist and Dr. Susan/Dr. Tracey at each visit
- Saliva testing for specific pathogens, 6 weeks after all bleeding-on-probing is alleviated

Our intention is to work with you all the way to periodontal stability. Because bone doesn't grow back around your teeth, periodontal maintenance will be necessary for ongoing stability and the recommended frequency will be established on an individual basis. Our hope is to help you achieve an optimal state of healing and treat your periodontal disease once and for the rest of your life.

Total Health Dentistry
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Holt, MI 48842
(517) 694-0353
www.Total-Health-Dentistry.com

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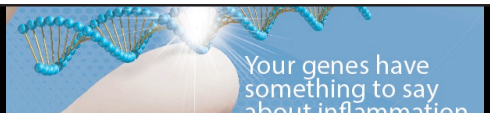
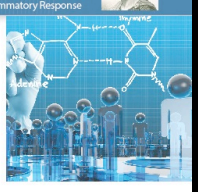


Celsus One™

Salivary DNA tests to Evaluate Gene Markers Related to Inflammatory Response

We test 8 gene markers associated with inflammation, a critical factor in periodontal, diabetes and cardiovascular disease severity:
- Interleukin 1 composite genotype
- Interleukin 6
- Interleukin 17A
- Beta-defensin 1
- CD 14
- Tumor necrosis factor alpha
- Toll-like receptor 4 composite genotype
- Matrix metalloproteinase 3



Reported risk is based on peer-reviewed research data and highly accurate methodology:
- Multiple genetic markers provide powerful insight into the genetic component of disease
- Salivary samples are evaluated using target-enriched next-generation sequencing

These tests help you personalize therapy by:
- Establishing which patients are at risk before clinical signs and symptoms appear
- Determining which patients may require more aggressive treatment and optimizing timing of recare appointments

ORALDNA LABS

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Eliminate ultra-processed foods (carbs), fermented foods eliminate sugar

Add-in whole, high-fiber foods

Eliminate/reduce alcohol intake

Reduce stress

Look for auto-immune disorders

Improve sleep quality and quantity

De-medicate, safely where possible

Supplement

Contains:

Sodium Caprylate is included to disrupt the metabolism of Candida

potent botanicals, such as berberine HCl, oregano, rosemary, cinnamon and ginger, and Pau d'Arco

Purpose: sooth the GI tract, provide potent antioxidant support, and boost microbial balance.

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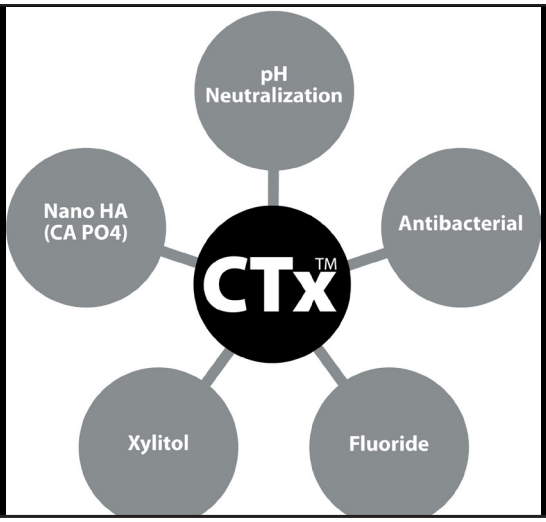

CARIFREE

Q: Do we need Antibiotics and/or Antimicrobial Rinses?

Receive a sample box and schedule a webinar to learn more!

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Skill Building Visits

3

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Probiotics

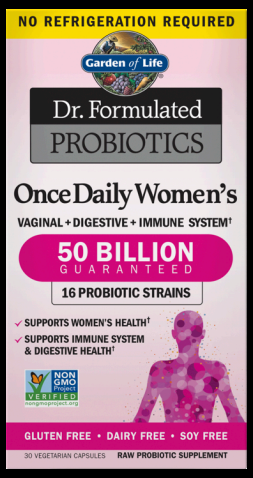
16 strains of bacteria

100 billion CFUs BID

High quality

+/- 2 hour window

125



126

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S.R.P.

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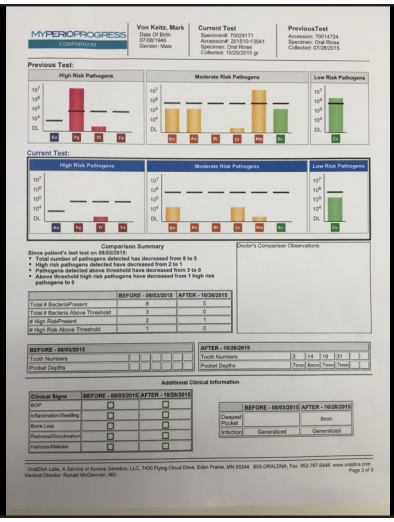

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WHY Direct Diagnostics?

- The **most sensitive, accurate, and affordable** test on the market.
- Our test is **backed by science and third-party verification.**
- We provide **training and resources** to build your confidence to test, treat, and clear your patients effectively.

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Screen. Test.

132

Getting off the Peri-Go-Round

133

Question:

What elements would we have to consider to ***truly*** create periodontal stability once and for all?

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Periodontal Disease Risk Factors

Oral Risk Factors

- Inflammation
  - mild mod severe
- Pocket depths (generalized)
  - mild mod severe
- Furcation involvement
  - mild mod severe
- Mobility
  - mild mod severe
- Root caries
- Gingival overgrowth/hyperplasia
- Salivary hypofunction
  - mild mod severe
- Suspicion of Candida
- Homecare skills/habit development
  - inadequate adequate
- Previous Perio Therapy

Systemic Risk Factors

- Suspicion of food sensitivities
- Suspicion of chemical sensitivities
- Metabolic disease
  - obesity/insulin resistance
  - pre-diabetes/diabetes
  - acid reflux
- A1C
- Physical difficulty/ poor manual dexterity
- Genetics
  - young age
  - parents or immediate family members that have lost teeth from gum disease
  - rapid or severe bone loss
- Tobacco or Cannabis use
- Polypharmacy
- Inflammatory Diet
- History of CVD
  - Hypertension
  - Hyperlipidemia
  - Previous Cardiac Event
- Suspicion of OSA or untreated OSA
- Depression
- Heightened Stress Factors

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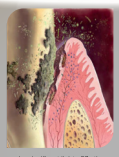
PERIODONTAL DISEASE

The Importance of Discovery & Treatment

137

YOUR PERIODONTAL DISEASE:
We Take It Seriously!

If you're over 30 years old, you're more likely to have some periodontal disease than not. It's that prevalent! And it's relatively painless, which means you're handicapped by a lack of feedback that might stimulate your desire to get some help.



Periodontal disease can be devastating in the mouth, causing bleeding gums, *permanent* bone loss, drifting teeth, foul breath, loose teeth and significant infection. It can also be devastating to the body, as the dangerous pathogens cruise through the blood stream to act as a *root cause* of heart attack and stroke, and a *significant link* to 57 other ailments including dementia, immune suppression, chronic systemic inflammation, and erectile dysfunction.

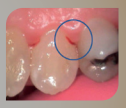
If you've ever been diagnosed and/or treated for gum disease, you've likely had a traditional form of treatment which includes getting your teeth scraped to remove calcified plaque and accepting a recommendation to improve your brushing and flossing. This mechanical scraping process is called scaling and root planing (SRP).

Unfortunately, SRP usually isn't enough to eradicate the infection, as we tend to see continued bleeding when we probe the deeper pockets of your bone loss over time. Bleeding gums are not healthy gums! And we refer to this ongoing effort to stabilize the disease as the "peri-go-round."

Our hope is to treat this once and for all. As with all infectious diseases, we must first identify the specific bug population at work and at what dose (the size of the bug population). By swishing with sterile salt water and spitting into a cup, we can have a microbiology laboratory identify which (of the 11 most dangerous) pathogens are present and their concentrations. We can then identify which antibiotic(s) are most effective against this particular crop of bugs.

Next, we must evaluate the "host immune response." This means we must look at the whole body, including lifestyle factors such as sleep and diet, to help each infected patient shift toward a state of optimal healing. **We must address such critical, evidence-based factors as:**

- Insulin Resistance or Hyperglycemia (Pre-Diabetes or Diabetes)
- Dry mouth (often from medications)
- Acid Reflux
- Inflammatory diet
- Obstructive Sleep Apnea risk factors
- Tobacco/cannabis smoking
- Obesity
- Nutrient deficiencies
- Underlying fungal infections
- Chemical/food sensitivities
- Depression
- Underlying immunocompromising conditions
- Multiple medications (prescription and OTC)



Many of these factors are challenging to change but can be the missing piece for periodontal disease suppression.

Finally, there's your part. Effective daily self-care is about one third of the necessary treatment. Before we start the *full mouth disinfection* process, we will engage you in effective **skill-building** visits, where we will temporarily stain the plaque at your gumline and help you navigate every surface, in every pocket, with the best instruments (power brush, water jet, pointed brushes, triangular tooth pics, floss, etc.) and skills for *effective daily plaque removal*.

Digging for root cause and addressing these before the full mouth disinfection—scaling and root planing in the presence of the right antibiotics and chemo-therapeutic rinse(s)—takes TIME. We will explore all these factors before scraping your teeth, and Dr. Susan or Dr. Tracey will consult with you and your hygienist regularly throughout your periodontal therapy.

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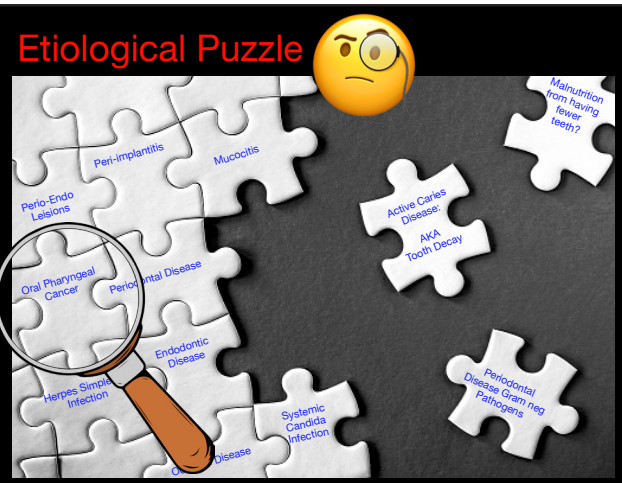
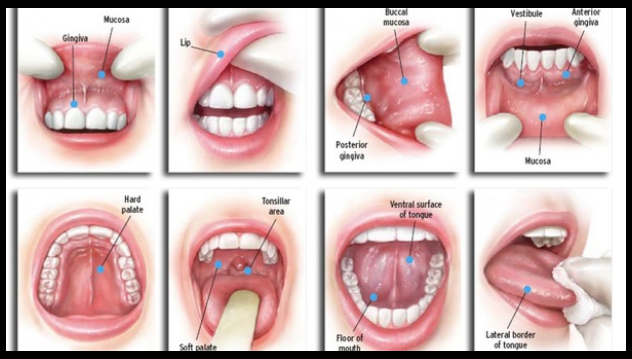
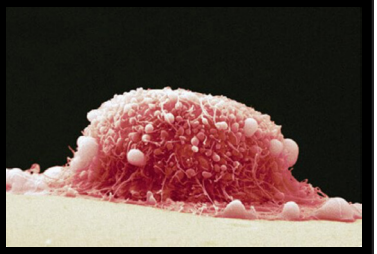
Etiological Puzzle



This....is NOT enough!

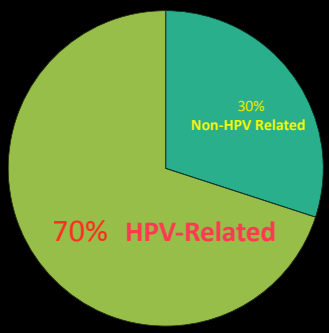


This is excellent....but not enough!



HPV and Oral Pharyngeal Cancer

HPV-OPC

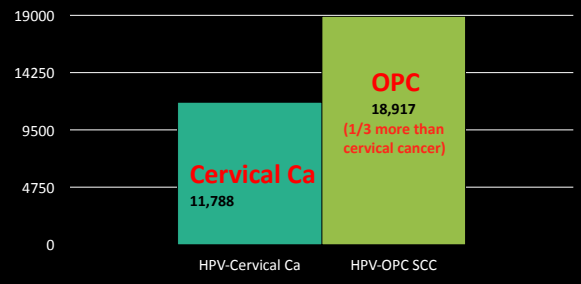


146

- Epstein-Barr Virus - Burkitt's Lymphoma, Hodgkins Lymphoma
- Hepatitis B and Liver Carcinoma
- Hepatitis C and Liver Carcinoma
- Merkel Cell Polyomavirus-Merkel Cell Carcinoma
- Herpes Simplex Virus and
- HIV and Kapposi's Sarcoma
- Human T-Cell Lymphotrophic Virus-T Cell Lukemia/lymphoma
- Human Papaloma Virus- Several cancers including OPC

HPV is considered the most common sexually transmitted infection in the United States.

2105 US Data: Comparison of HPV-Cancers



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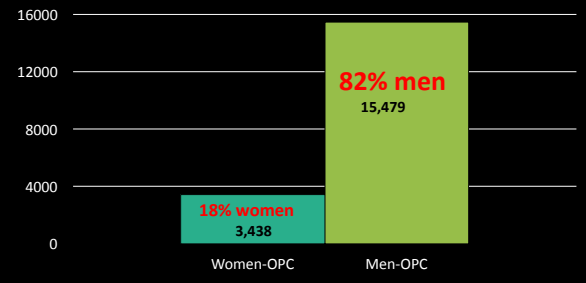
US HPV-OPC Gender Comparison



150

Sexual Behavior?

"White men have the highest number of lifetime oral sex partners and report first performing oral sex at a younger age compared with other racial/ethnic groups."

Trends in Human Papillomavirus–Associated Cancers — United States, 2015
August 24, 2018 / 67(33);918–924

151

50% of new HPV infections occur in 15- to 24-year olds

152

HPV Vaccination

The Gardisil vaccine was for HPV 16, 18, 6 and 11

The newest (October 2018) vaccine, Gardasil 9, includes:
HPV 6, 11, 16, 18, 31, 33, 45, 52 and 48

153

FDA Expands Gardasil to Cover Adults to Age 45

Oct. 8, 2018 – The FDA has approved a supplemental application for Gardasil 9, Merck's HPV vaccine for men and women ages 27-45.

"Today's approval represents an important opportunity to help prevent HPV-related diseases and cancers in a broader age range," Peter Marks, MD, PhD, director of the FDA's Center for Biologics Evaluation and Research, says in a news release.

"The Centers for Disease Control and Prevention has stated that HPV vaccination prior to becoming infected with the HPV types covered by the vaccine has the potential to prevent more than 90% of these cancers, or 31,200 cases every year, from ever developing," Marks says.

About 14 million Americans become infected with HPV every year, the

154

"The 9-valent HPV vaccine targets oncogenic types attributed to 73% of HPV-associated cancers"

Trends in Human Papillomavirus–Associated Cancers — United States, 1999–2015
August 24, 2018 / 67(33);918–924

155

Vaccine tied to drop in HPV cases still not reaching half of U.S. kids

Lisa Rapaport

(Reuters Health) - Although a vaccine for the cancer-causing human papillomavirus (HPV) has led to a dramatic decrease in infections, a new study suggests that half of U.S. teens are still not fully vaccinated against this virus.

156

The Advisory Committee on Immunization Practices

Recommends routine vaccination with 2 doses at age 11 to 12 with catch up vaccination at 13 to 26 years. If the first does occurs after age 15 years, a series of three doses is recommended

157

Saliva is our Future for Fighting HPV-Cancer

158

YOUR SPIT
COULD SAVE YOUR LIFE

159

The OraRisk® HPV SalivaTest

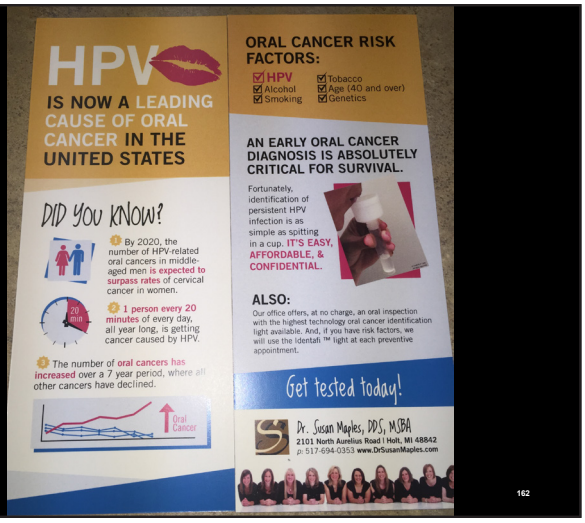
Tests for 51 of the 200 identified types of HPV

If positive further tests for which one(s) are present

25 have been associated with oral cancer so even though 16, and 18 are the highest risk if the patient has *any of the types* persist beyond 12-18 months we consider them high risk for HPV-related cancer

Can you CLEAR an HPV Infection before it becomes cancerous?

161



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SELF EVALUATION

Four Major Diseases Impacting Oral Health: Parts 1 & 2

1. T/F - Caries disease, including early childhood caries disease is considered to be on the decline in the United States

2. On average, Americans consume how many teaspoon equivalents of sugar every day:

a. 3-6
b. 10-18
c. 22-40

3. T/F - Strep Mutans is transmissible through saliva and the most significant window of infectivity is thought to be between 6 months and 3 ½ years of age.

4. Caries Disease is considered to be:

a. Transmissible through saliva
b. Not affected by diet
c. 100% preventable
d. treatable only through caries removal and fillings
e. A and C
f. All of the above

5. All of the following contribute to Caries Disease except:

a. Transmissibility of Strep Mutans
b. Acid reflux
c. Hypertension
d. Intake of sugar and processed carbohydrates
e. Dry mouth from multiple medications and/or metabolic disease such as diabetes

6. Enamel dissolves at a pH of 5.5 which represents:

a. About 5 times more acidic than saliva (pH of 7)
b. About 25 times more acidic than saliva (pH of 7)
c. About 80 times more acidic than saliva (pH of 7)
d. None of the above

7. T/F - Irrespective of the sugar in sugar sweetened beverages, the acidity of the liquid itself has no bearing on Caries Disease

8. Occlusal Disease is the term for wear and tear on the dentition including:

a. Fractured restorations
b. Fractured cusps
c. Deep cracks in teeth
d. Wear defects on enamel and dentin
e. Fractured prosthetics
f. All of the above

9. T/F - Occlusal Disease (wear and fracture) is exacerbated by a low pH in the mouth.

10. All of the following has been shown to increase bruxism and/or wear on teeth EXCEPT:

a. Acid reflux (also known as airway reflux)
b. Unmanageable stress
c. Sleep Related Breathing Disorders including OSA and UARS
d. Lack of adequate oral hygiene

11. T/F - Periodontal Disease causes Chronic Systemic Inflammation

12. Saliva testing can be used today for

a. Periodontal pathogen (bacteria) identification
b. Genetic predisposition to heart disease
c. Detection of an overgrowth of 9 Candida (yeast) strains
d. 51 strains of Human Papilloma Virus
e. none of the above
f. all of the above

SELF EVALUATION

Four Major Diseases Impacting Oral Health: Parts 1 & 2 cont.

13. Identifying Periodontal Pathogens is a critical element in effective treatment planning element for:

a. A patient who as severe disease, but not if a patient just has a few “active” bleeding pockets.
b. Treatment planning for ALL patients who have “active” disease.
c. Mostly for patients who have “active” disease and are under 30 years old

14. T/F - Identifying what contributing strains of bacteria are above threshold in active periodontal disease dictates the specific antibiotic regimen that would be therapeutic during periodontal therapy.

15. The most prevalent location for oral/pharyngeal cancer today is:

a. Floor of the mouth
b. Buccal mucosa
c. Posterior pharynx (throat)
d. Lateral border of the tongue
e. Attached gingiva

16. The following behaviors are thought to increase your risk of developing head/neck cancer EXCEPT:

a. Smoking cigars
b. Chewing tobacco
c. Heavy alcohol binges
d. Unprotected oral sex
e. Getting cavities filled with amalgam
f. Working in the sun without sunblock on your lips
g. Habitually eating foods that give you acid reflux

17. Which is true about HPV?

a. Some non-cancerous strains of HVP are responsible for warts
b. There are 200+ strains, 51 identified in the mouth, 26 associated with oral pharyngeal cancer
c. Every single person has some type of HPV on or in their body
d. Host immunity is responsible for how your body manifests the viral infection
e. All of the above

18. T/F - According to the US-CDC, HPV infection is increasing by 6 million cases a year which represents a 30% increase yearly.

19. By a thirty second swish saliva test, we can very accurately identify HPV strains but it’s the persistent infection that puts people at risk. After a positive test, at what point should we retest and, if still positive, consider the patient high risk:

a. 3-6 months
b. 6-9 months
c. 9-12 months
d. 12-18 months

20. The HPV vaccination Gardisil 9 is:

a. Beneficial for both girls and boys
b. Is now recommended and insurance covered up to age 45 for men and women
c. Important to start early since the average age of first oral sex occurs between 10-13 years old
d. All of the above

Answer Key: 1. F, 2. C, 3. T, 4. E, 5. C, 6. B, 7. F, 8. F, 9. T, 10. D, 11. T, 12. F, 13. B, 14. T, 15. C, 16. E, 17. E, 18. T, 19. D, 20. D

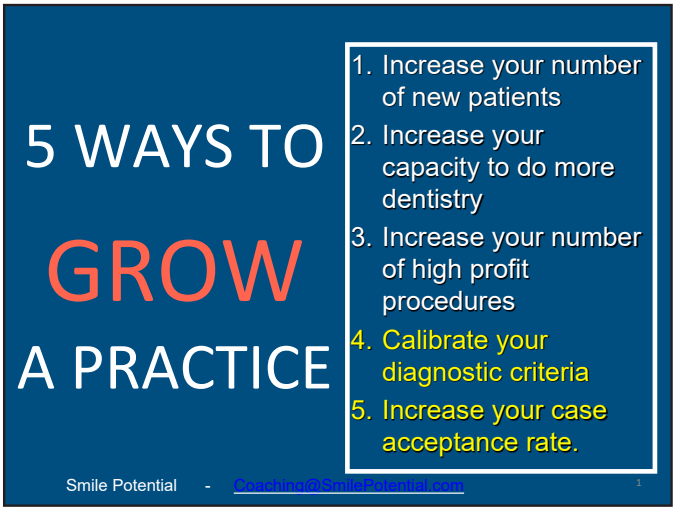
Steven M. Katz, DMD, MAGD

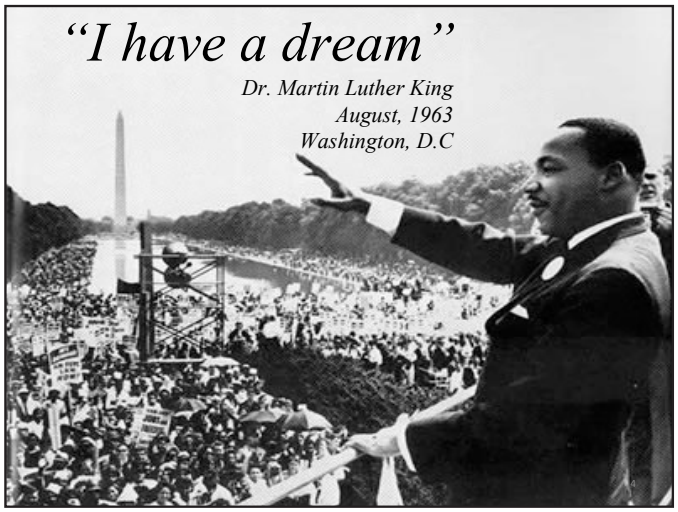
Steven M. Katz, DMD, MAGD, of Jericho, New York, had a thriving private practice and then experienced a series of setbacks, including two years of disability. A student of practice management techniques and a recipient of a degree in Business and Finance, he implemented a number of goals and strategies which enabled him to triple the revenue of his practice in just a few years. Dr. Katz founded Smile Potential Dental Practice Coaching to help his professional colleagues optimize their practices' culture and systems. He is a Master of the Academy of Dentistry, a Fellow of the International College of Dentists, and an Attending at North Shore University Hospital. Dr. Katz was also team dentist for the New York Jets for 10 years, a dental consultant to Fox News, a recipient of multiple speaking awards, and is the author of *They Didn't Teach Us THAT in Dental School*.

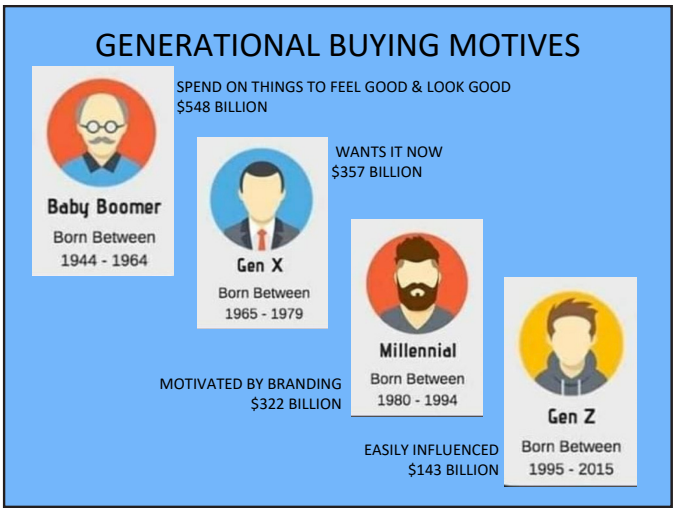
You may contact Dr. Katz with your questions and comments at (516) 524-7573, or by email at DrKatz@smilepotential.com.

Smile Potential Practice Growth Coaching
Steven M. Katz, DMD, MAGD, FICD
https://smilepotential.com
coaching@smilepotential.com
516-599-0214

Increasing Dental Treatment Acceptance

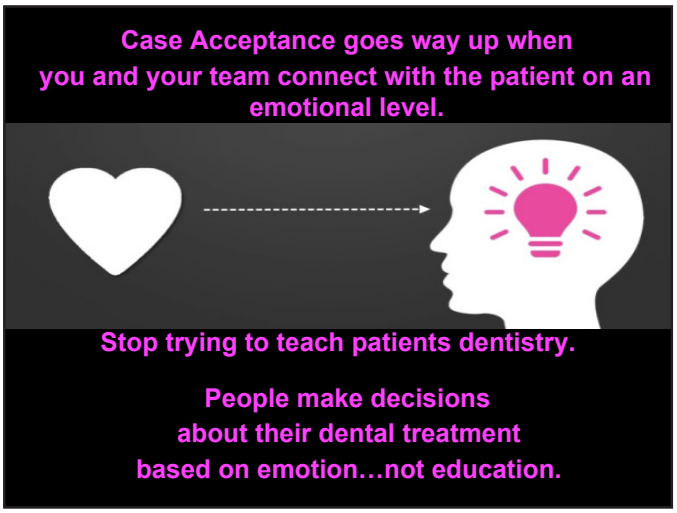


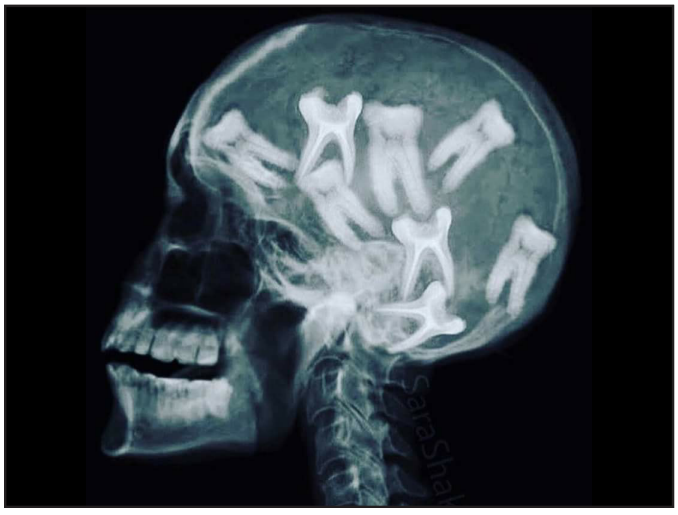


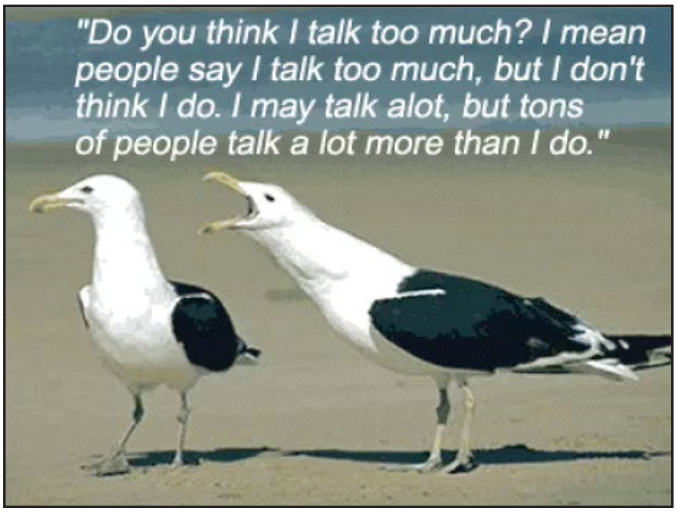

GENERATIONAL BUYING MOTIVES
SPEND ON THINGS TO FEEL GOOD & LOOK GOOD
$548 BILLION
Baby Boomer
Born Between
1944 - 1964
WANTS IT NOW
$357 BILLION
Gen X
Born Between
1965 - 1979
MOTIVATED BY BRANDING
$322 BILLION
Millennial
Born Between
1980 - 1994
EASILY INFLUENCED
$143 BILLION
Gen Z
Born Between
1995 - 2015

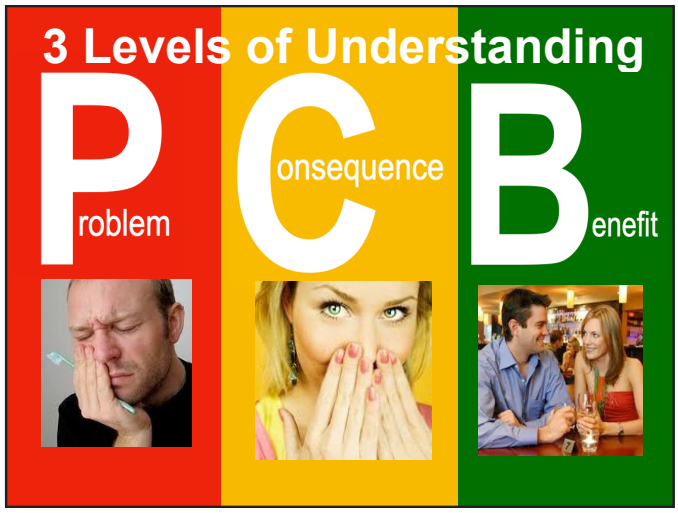

Case Acceptance Is a Team Success
Don't you hate when patients say:
"Doctor, I'll think about it."
"I'll do the fillings, but I'm going to wait on the crowns."


The MOST THOROUGH
& Comprehensive Exam…EVER…
Blood pressure
Oral Cancer Screening
Full charting
Perio Charting
TMJ exam
Airway exam
Photos
Scanning
BUILDS VALUE

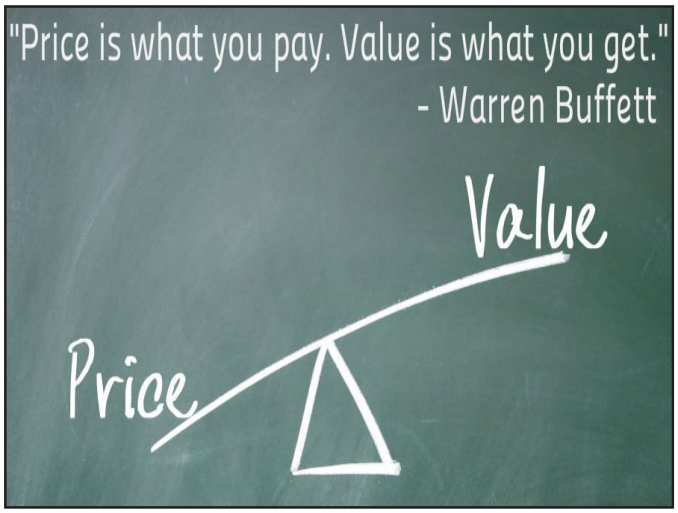

Case Acceptance goes way up when
you and your team connect with the patient on an emotional level.
Stop trying to teach patients dentistry.
People make decisions
about their dental treatment
based on emotion…not education.




"Do you think I talk too much? I mean people say I talk too much, but I don't think I do. I may talk alot, but tons of people talk a lot more than I do."

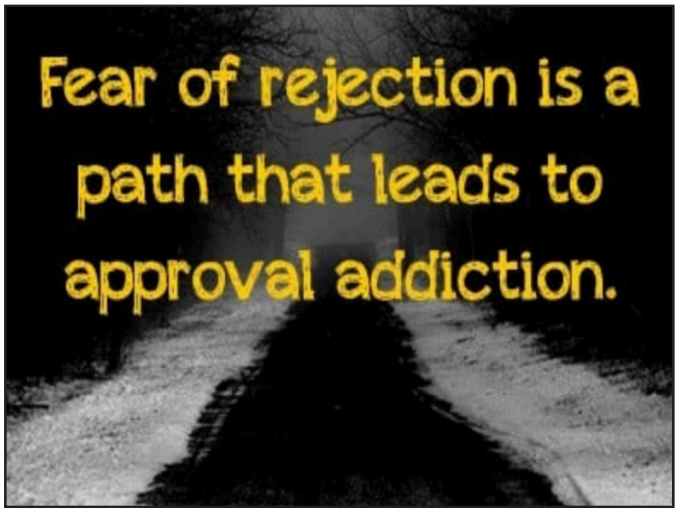


When we talk about benefits, our patients care less about what we're doing and more about the benefits they are receiving.
They WANT it more.



Path to Treatment Acceptance

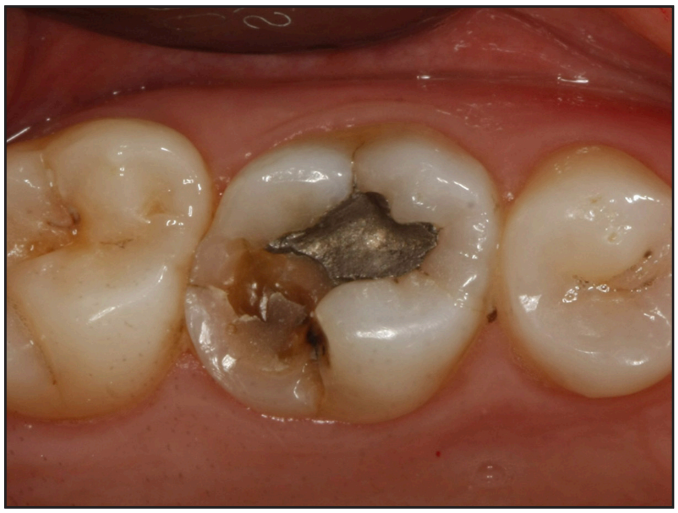
1	2	3
Should I?	Can I?	Will I?
Hygienist	Cost	Options
Dentist	Time	Financing
Admin	Family	Payment



The Permission Statement

19

20

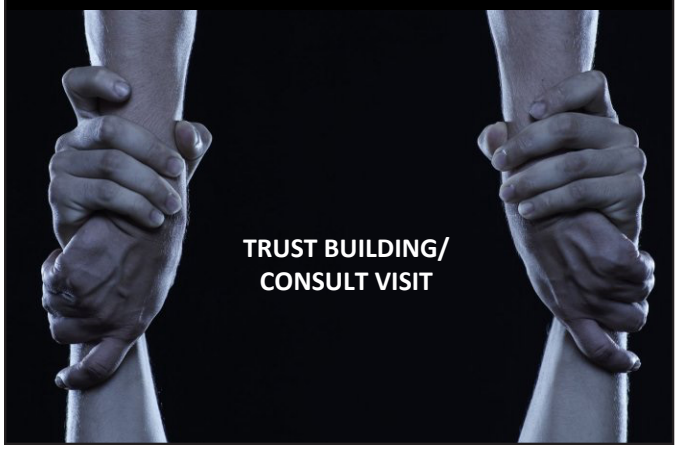


Smile Potential's Practice Building Scripts & Treatment Acceptance Strategies

Use QR code…
or send email to:
coaching@smilepotential.com

Include name and phone number.

Successful Financial Agreements



Treatment Presentation

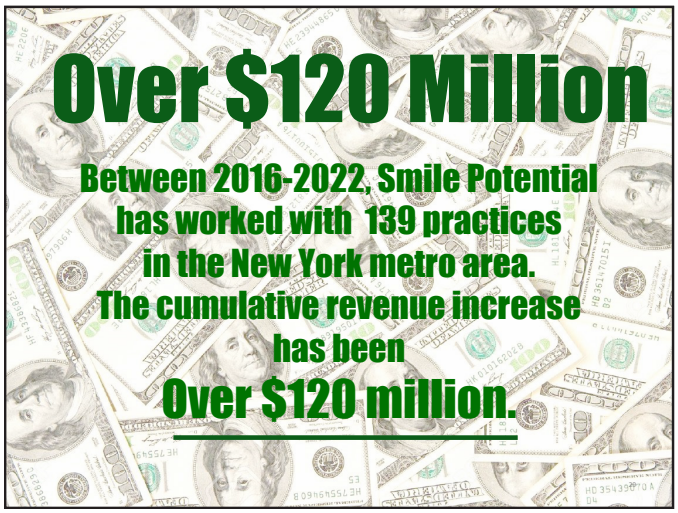
- Private Non-Clinical Consultation Room
- Treatment Coordinator
- Significant other
- No interruptions
- Non-technical
- Presentation folder
- Present comprehensive care
- Focus on Benefits, Not on treatment


Don't just "wing it"
PRACTICE MAKES PERFECT
"When you fail to plan…
…you plan to fail."
- Benjamin Franklin

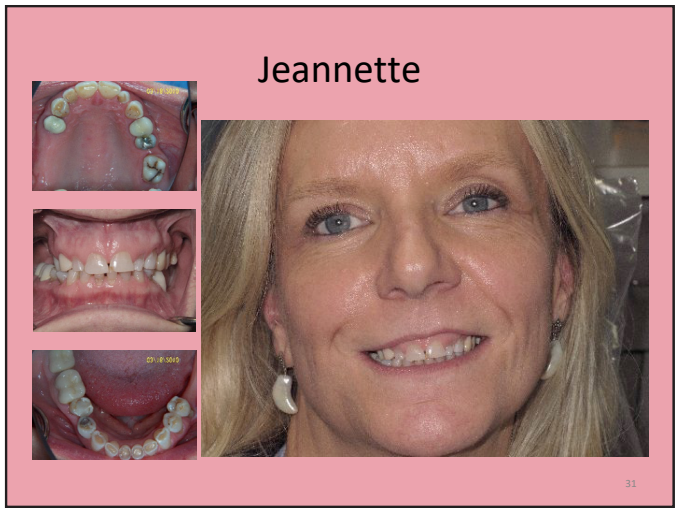

Objections are Opportunities
1. Cost
2. Fear
3. Time
4. Sense of Urgency
5. Trust
The questions are not always what they seem.


PATIENTS HAVE
TWO WAYS TO PAY:
PAY NOW OR PAY NOW


Our patients' needs have changed.
Society has changed.
Our profession has changed.
WE MUST BE WILLING TO CHANGE!


Over $120 Million
Between 2016-2022, Smile Potential has worked with 139 practices in the New York metro area.
The cumulative revenue increase has been
Over $120 million.


DENTISTS DO AMAZING THINGS


Jeannette
31


Jeannette
32


WE HAVE
THE POWER
TO CHANGE
LIVES !!!
33


SMILE POTENTIAL
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coaching@smilepotential.com
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If you would like any additional information about anything discussed in this program, or copies of any of the slides or resources mentioned…
Use QR code…
or send email to:
coaching@smilepotential.com
Include name and phone number.

SELF EVALUATION

Increasing Dental Treatment Acceptance

1. Which two (2) strategies yield the most immediate results in growing a practice.

- **a.** Increasing your number of new patients
- **b.** Increasing your capacity to do more dentistry
- **c.** Increasing high profit procedures performed
- **d.** Calibrating your diagnostic criteria
- **e.** Increasing your case acceptance rate
- **f.** D & E

2. T/F - In the current business environment, it is a great time to be a dentists

3. T/F - Case acceptance is totally dependent on the doctor

4. As perceived value goes up, perceived price:

- **a.** Goes up
- **b.** Stays the same
- **c.** Goes down
- **d.** Fluctuates

5. The Permission Statement is a tool to help overcome:

- **a.** Approval addiction
- **b.** Depression
- **c.** Anxiety
- **d.** Drug addiction

6. Triple-hear is comprised of communication:

- **a.** Patient to hygienist, patient to doctor, patient to clinical assistant
- **b.** Hygienist to patient, Hygienist to doctor, Doctor to patient
- **c.** Administrator to hygienist, Hygienist to doctor, Doctor to administrator
- **d.** Hygienist to Doctor, Doctor to lab, Doctor to patient

7. The only objection to treatment that should be dealt with by the administrator is:

- **a.** Cost
- **b.** Fear
- **c.** Time
- **d.** Sense of urgency
- **e.** Trust

8. T/F - As dental professionals, we have the power to change lives.

Answer Key: 1. F, 2. T, 3. F, 4. C, 5. C, 6. B, 7. A, 8. T

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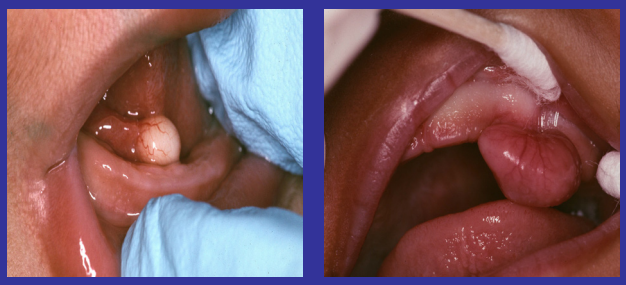
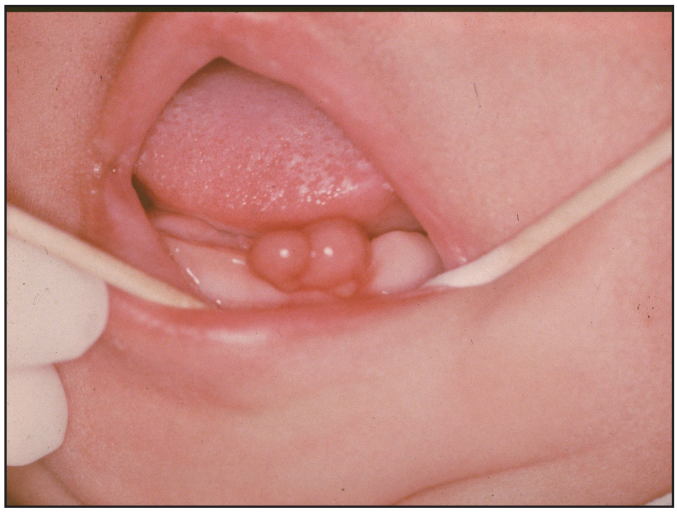
Associate Professor, Donald and Barbara Zucker School of Medicine at Hofstra Northwell
Director, Clinical Oral Pathology

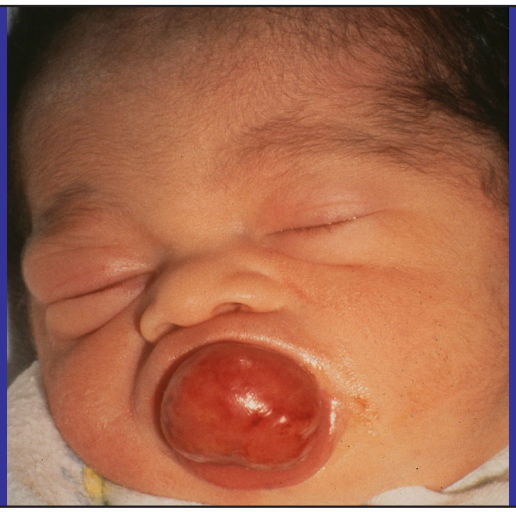
Pediatric Oral Pathology

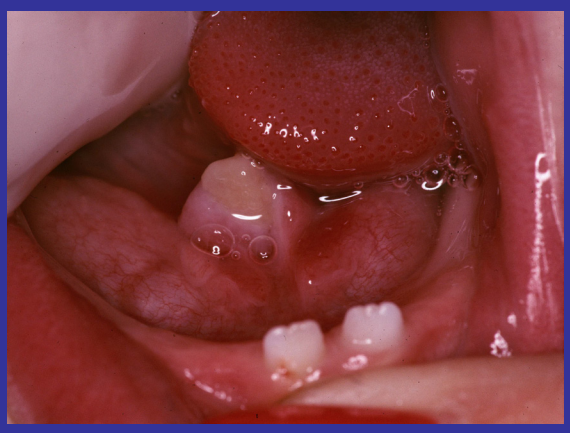
LESIONS OF THE NEWBORN

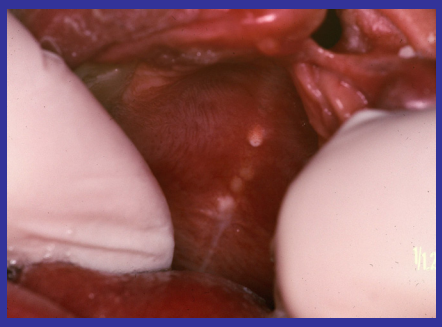
- CONGENITAL EPULIS
- RIGA-FEDE
- CYST OF THE NEWBORN
- NATAL TEETH







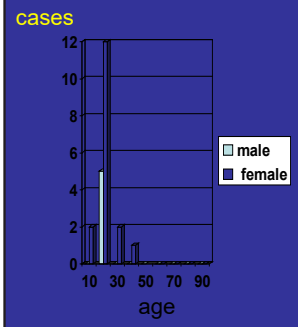


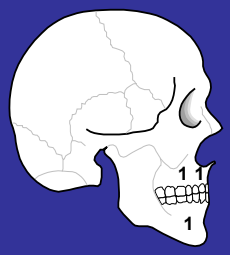


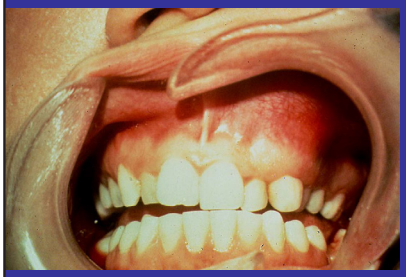
NEOPLASIA

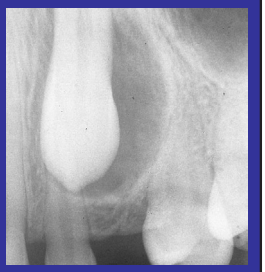
- ODONTOGENIC
- NON-ODONTOGENIC

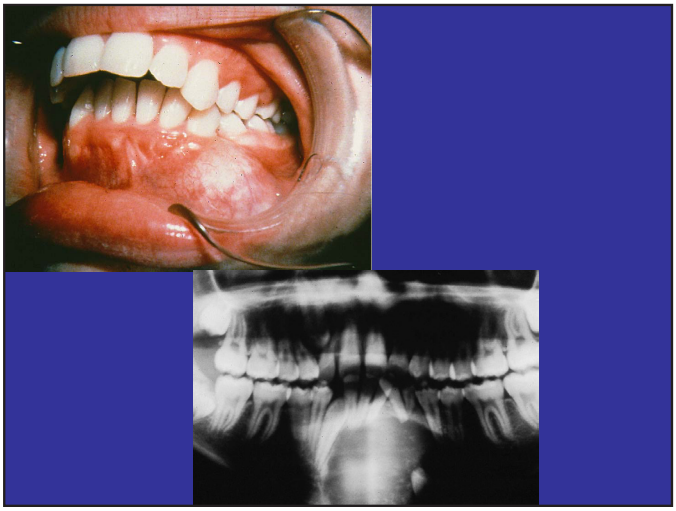
ADENOMATOID ODONTOGENIC TUMOR



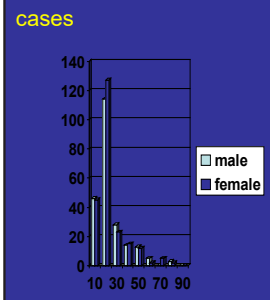


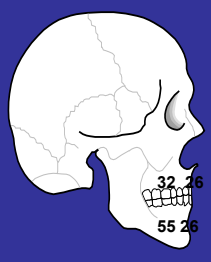


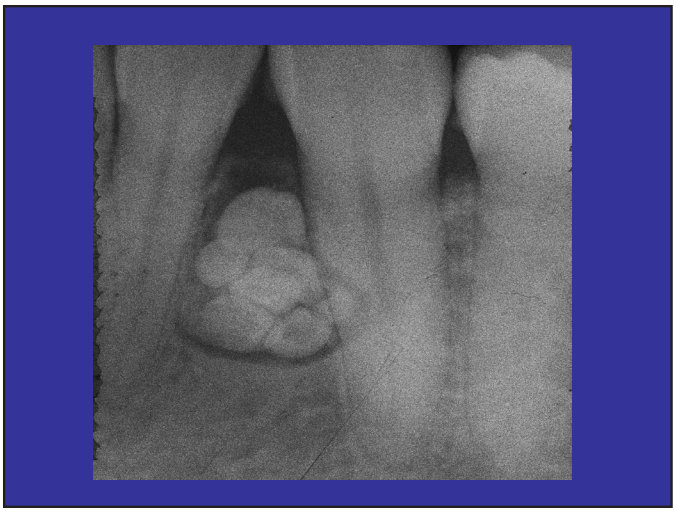


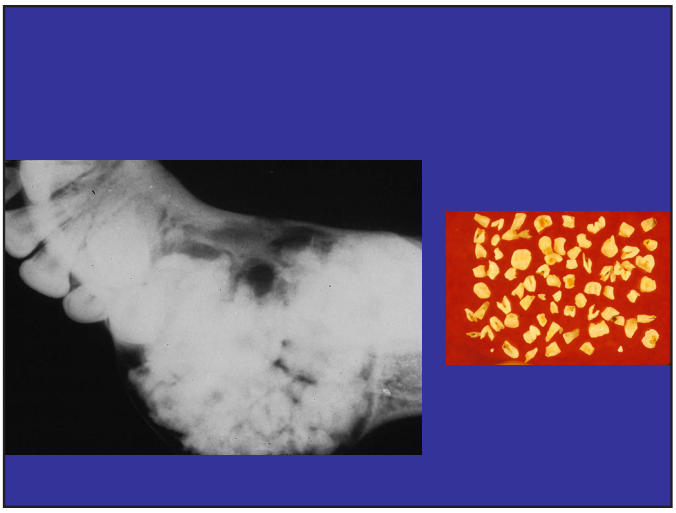


Odontomas

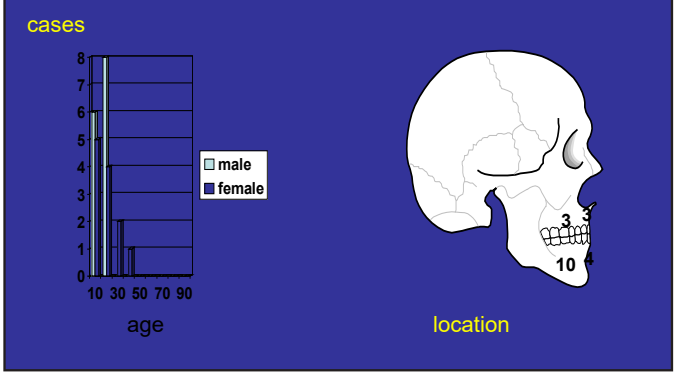


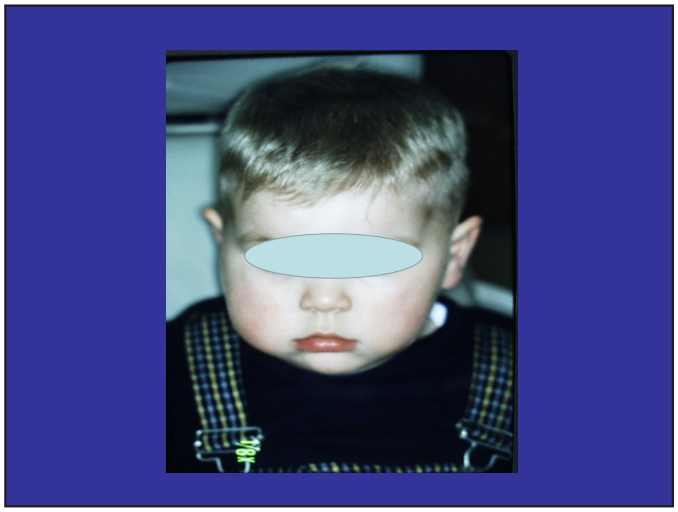


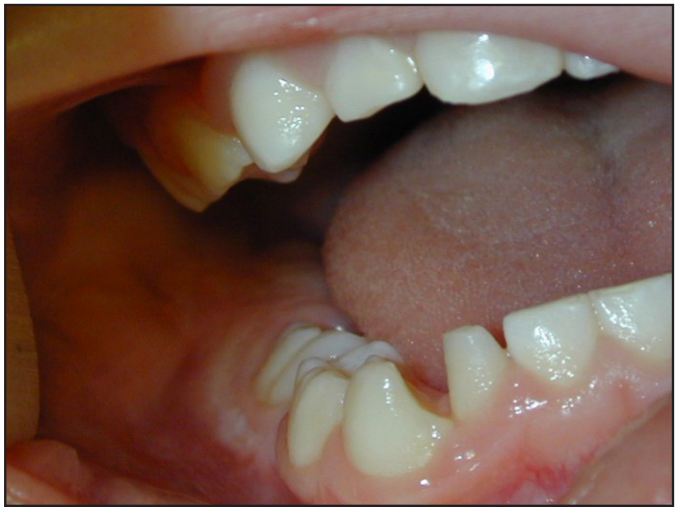


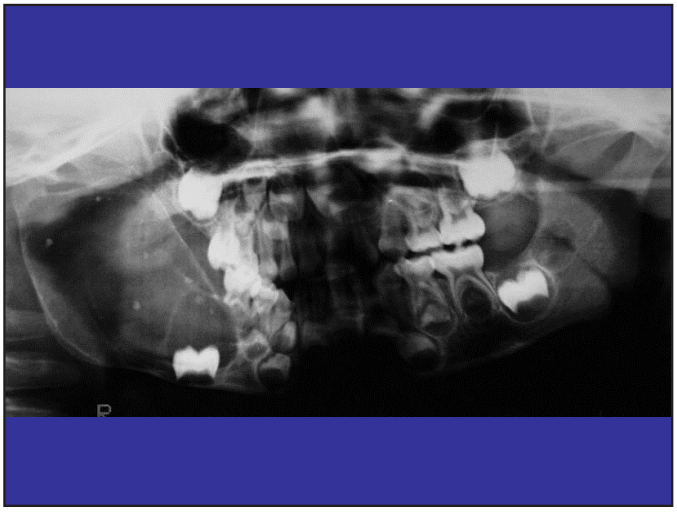


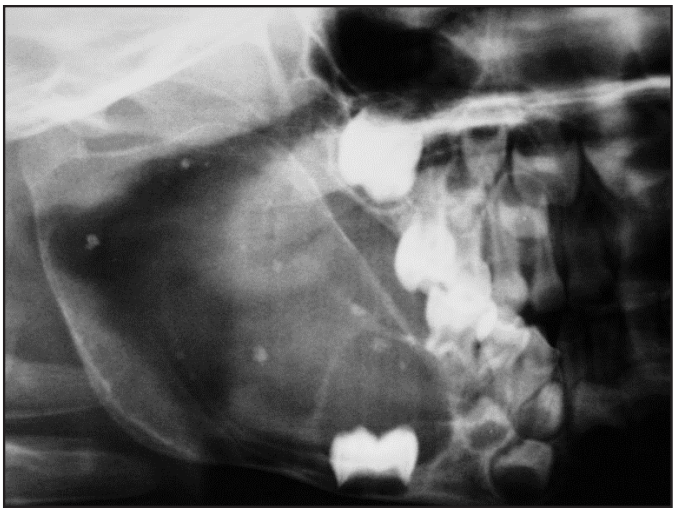
Ameloblastic Fibroma/ Fibro-Odontoma

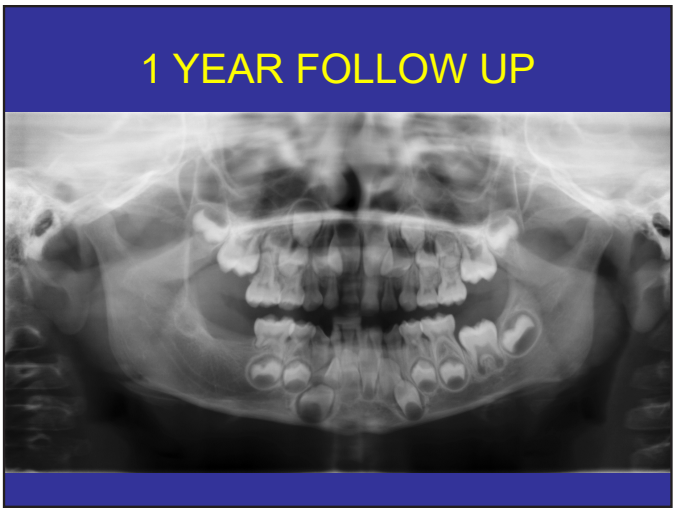


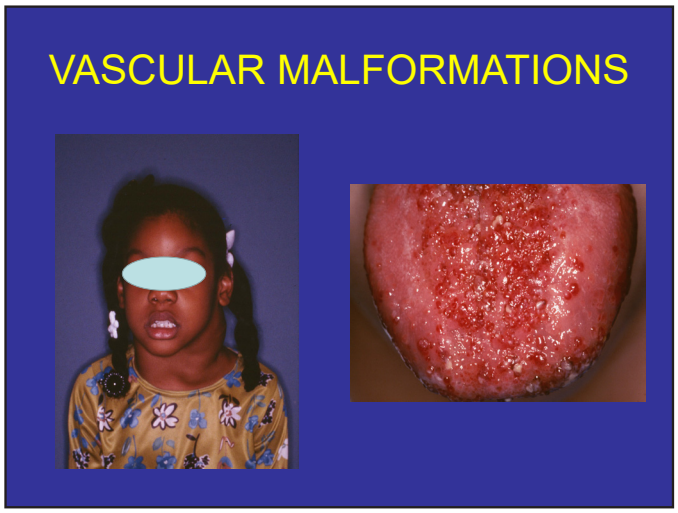


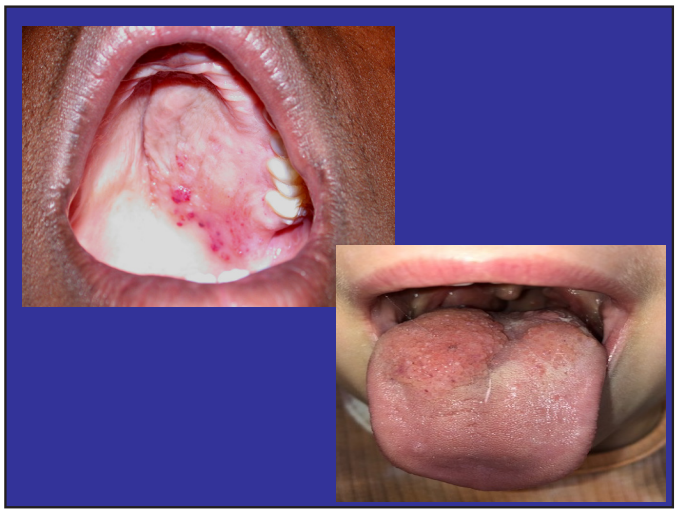


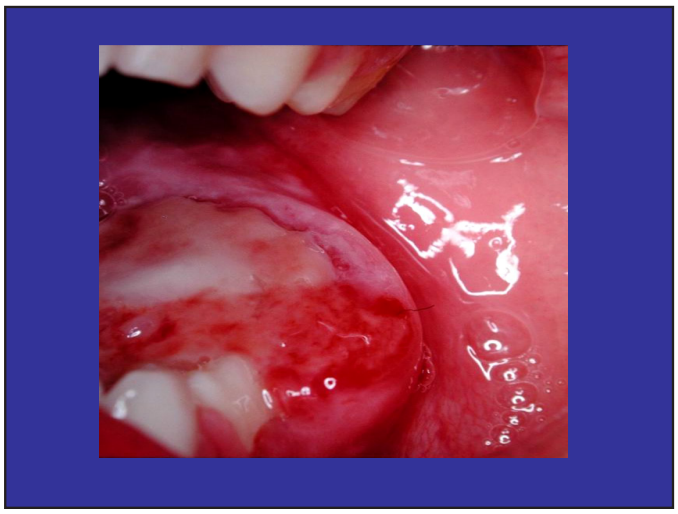


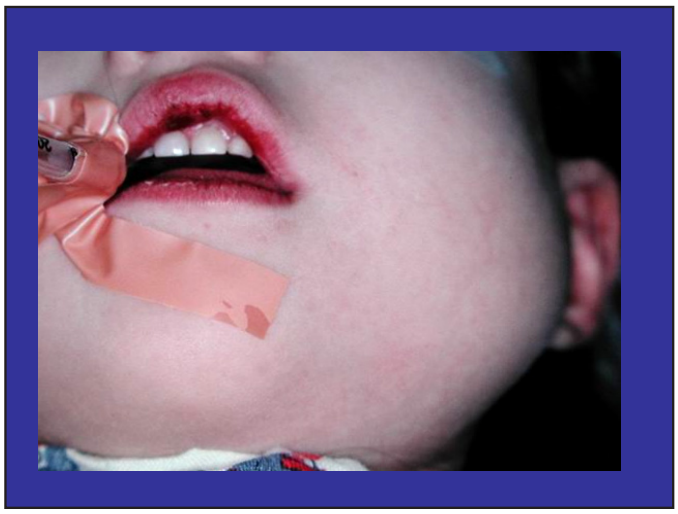


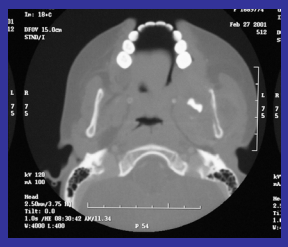

1 YEAR FOLLOW UP

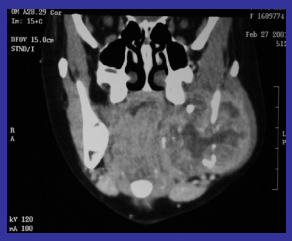

VASCULAR MALFORMATIONS











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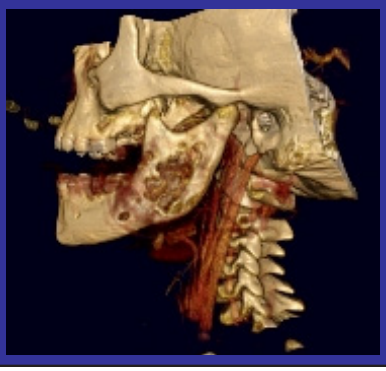
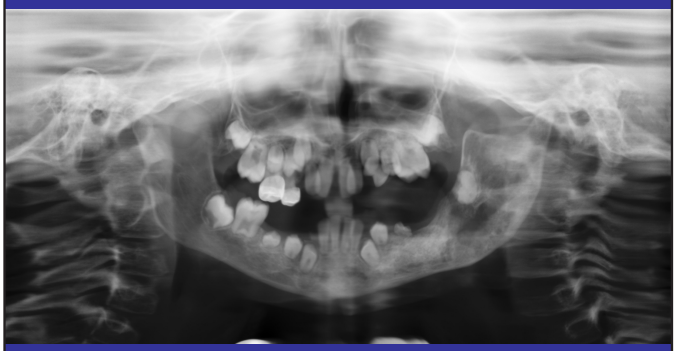
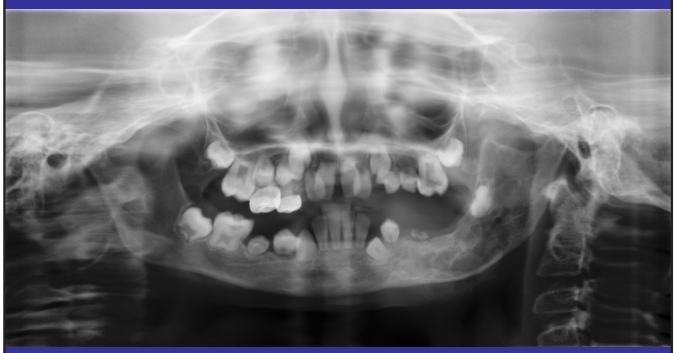
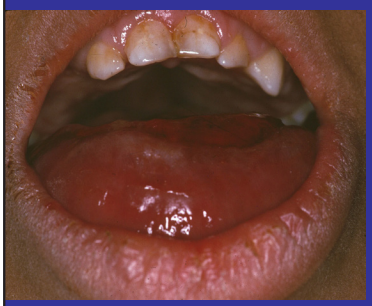


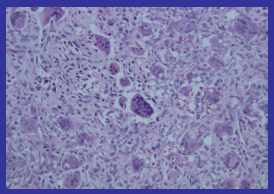
6 MONTH FOLLOW UP



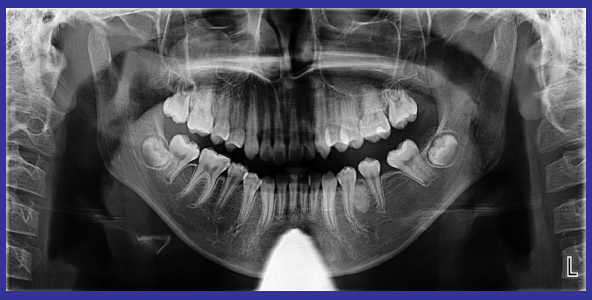
1 YEAR FOLLOW UP



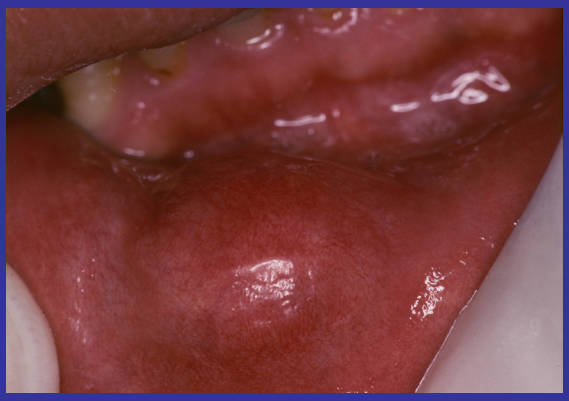


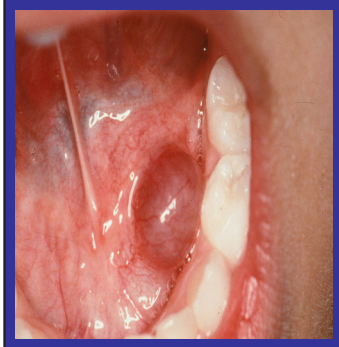


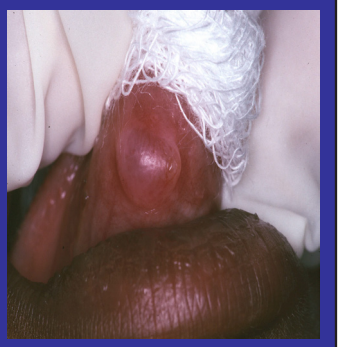
Focal osteosclerosis

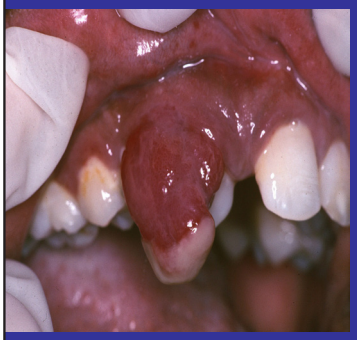


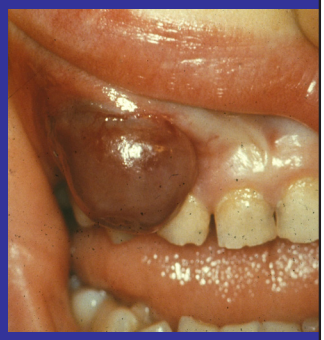
SOFT TISSUE LESIONS



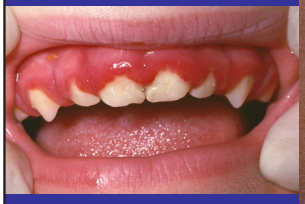


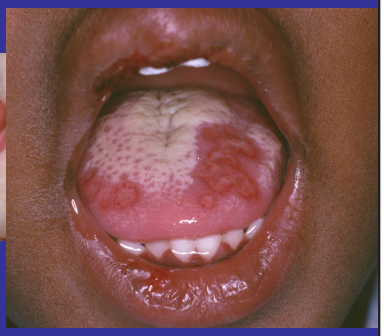


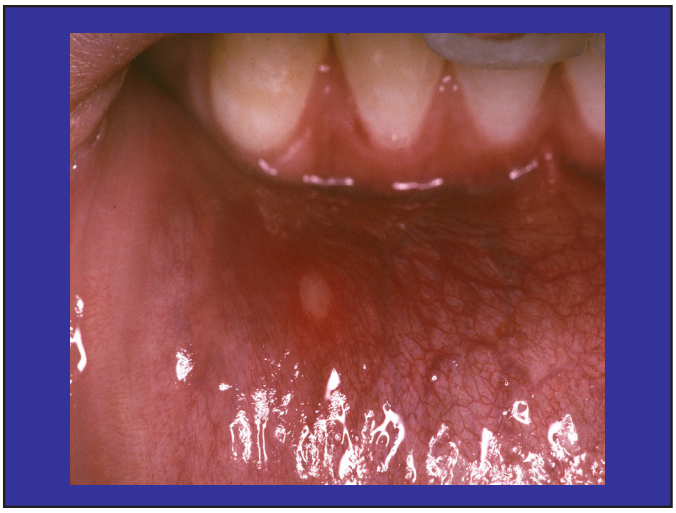


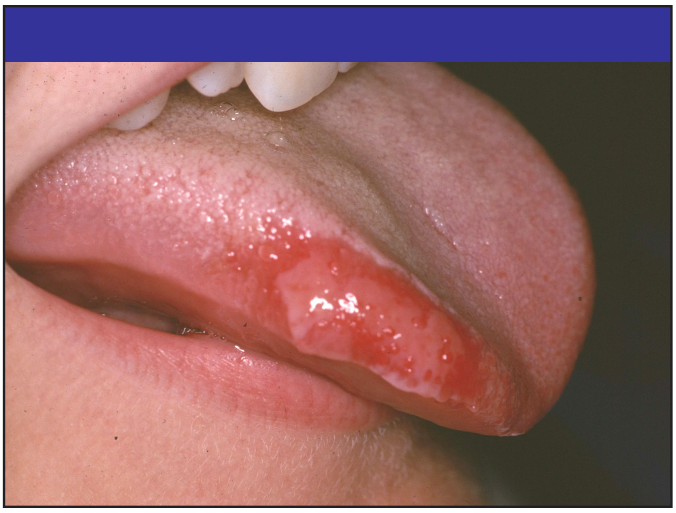


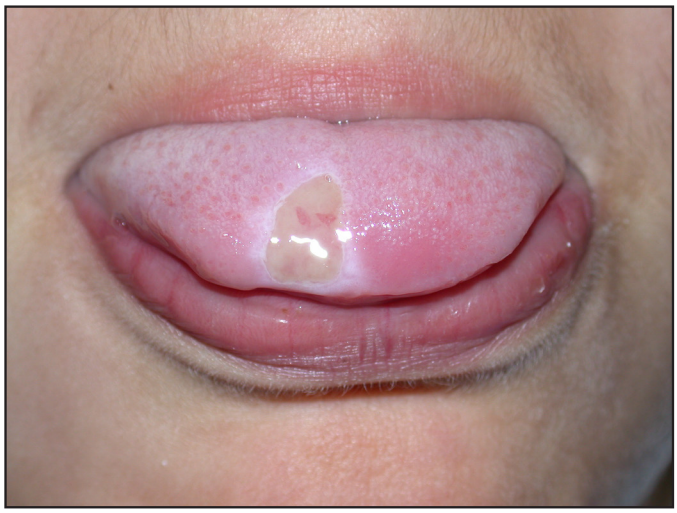
MUCOSAL DISEASE



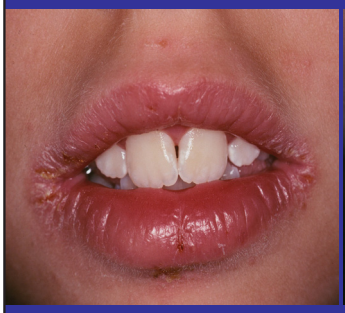


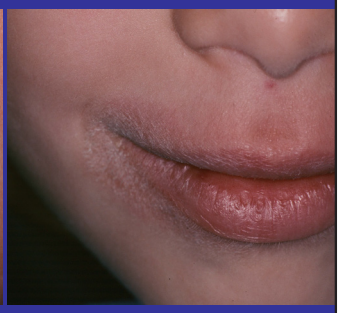




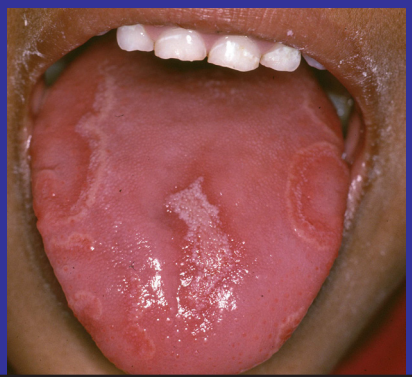


CHEILITIS

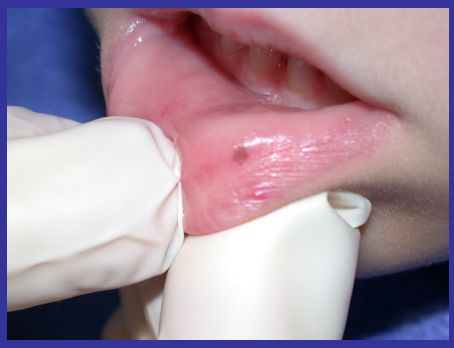




BENIGN MIGRATORY GLOSSITIS



LABIAL MELANOTIC MACULE



SELF EVALUATION

Pediatric Oral Pathology

True/False

1. The congenital epulis of the newborn always requires excision.

2. Extraction of the involved tooth in the management of the adenomatoid odontogenic tumor is required.

3. The most common location for a mucocele is the lower lip.

4. Antiviral therapy is always necessary when managing a patient with primary herpetic gingivostomatitis.

5. Benign migratory glossitis is an infectious process.

Answer Key: 1. F, 2. F, 3. T, 4. F, 5. F

David B. Mandell, JD, MBA

David B. Mandell, JD, MBA, of Ft. Lauderdale, Florida, is a practicing attorney in The Law Offices of David B. Mandell, PC and a principal of the wealth management firm OJM Group, LLC. He specializes in risk management, asset protection, and financial planning and has authored a number of books for doctors including, *Wealth Planning for the Modern Physician: Residency to Retirement*. Mr. Mandell also created the Category 1 CME monograph, *Risk Management for the Practicing Physician*. His articles have appeared in over 100 publications, including over 30 medical specialty journals, and he has addressed many of the nation's leading medical conferences.

Mr. Mandell holds a bachelor's degree from Harvard University from which he graduated with honors, a law degree from the UCLA School of Law where he was awarded the "American Jurisprudence Award" for achievement in legal ethics and earned his MBA from UCLA'S Anderson School of Management.

You may contact Mr. Mandell with any questions or comments at (877) 656–4362 or by email at mandell@ojmgroup.com.

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Protecting Professional and Personal Assets

David B. Mandell, JD, MBA

TODAY'S PRESENTATION

1. Background on physician financial stress
2. Asset protection fundamentals
3. Growing source of liability – qualified plans
4. Shielding physicians' & dentists' personal assets
5. Recent cases

PHYSICIANS STRESSED ABOUT LIABILITY

- 87 percent of respondents said they are moderately-to-severely stressed/burned out on an average day.*
- Concern about liability and lawsuits are a motivating force behind the skyrocketing costs associated with "defensive medicine"**
- 2016 PubMed study: "Exploring Physicians' Dissatisfaction and Work-Related Stress: Development of the PhyDis Scale"

*Of 2,000 physicians as reports by Bouchard, Stephanie, "Impact of Physician Stress Underestimated," *HealthCare Finance News*, December 2, 2011

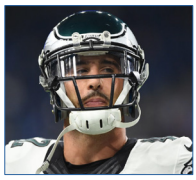
**Peter Ubel, "Do Malpractice Fears Cause Physicians To Order Unnecessary Tests?" Forbes.com, October 22, 2013

IN THE NEWS

CNN Sports

Former Philadelphia Eagles captain Chris Maragos Awarded $43.5 million in medical malpractice case

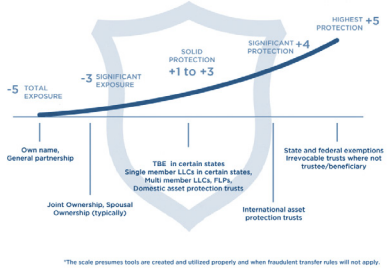
- February 15, 2023



TYPES OF LIABILITY FACING PHYSICIANS & DENTISTS

- Medical/dental malpractice
- Employer liability
  - Sexual harassment ("hostile work environment"); Wrongful termination (protected classes); Violation of fiduciary duty (qualified plans)
- Billing issues
  - Over-billing, improper billing, fraud, violation of anti-kickback rules, Stark rules, etc.
- HIPAA
- Premises liability
- Personal liability

ASSET PROTECTION "SLIDING SCALE"



*The scale presumes tools are created and utilized properly and when fraudulent transfer rules will not apply.

BEST ASSET PROTECTION NOT AP

- Why wealth protection MUST be tied to wealth creation: timing
- Like tax planning: economic substance
- Top (+5) tools are primarily not AP tools
- AP must be implemented in a multidisciplinary approach

PRACTICE/ANCILLARIES PROTECTION

- Insurances
- Choice of entity
- LLC lease-backs
- Qualified retirement plans
- Non-qualified plans
- Advanced tools

INSURANCES AS FRONT-LINE PROTECTORS

- Types of policies
  - Medical or dental malpractice
  - General Liability
  - Cyber
  - Landlord
  - Other
- Be aware of coverage limitations, deductibles
- Review and get second opinions

PROTECTING EQUIPMENT & REAL ESTATE

MAXIMIZE PROTECTIVE BENEFIT PLANS

- **Shields #1 asset – cash flow**
- Qualified retirement plans (QRPs): state exemption laws vary
  - Most states also protect QRPs to an unlimited value
  - Some states: value limitations
  - Some states: timing claw-backs
- Non-qualified plans – depends on funding mechanism
  - COLI – about 20 states provide (+5) exemption
  - Other states: can use trusts or LLCs

ARE YOU EXPOSED?

- Parties involved in QRP administration
  - Recordkeeper
  - Third Party Administrator
  - Investment advisor
- "Bundled" services often lead to conflicts, kick-backs, expensive fund lineups
- Many small practice plans have not been reviewed
- As plan sponsor/trustee, you have fiduciary liability to employees
  - You can be sued for underperformance; high expense funds
    - U. of Chicago, MIT
    - MassMutual, Ameriprise, Nationwide settlements. Goldman Sachs ongoing
  - **Solution: have your plan audited independently with benchmarks**

CASE STUDY: SOLO SURGEON OVERPAYING AND EXPOSED

- Employees: 1 physician, 4 employees, including spouse
- Fees: 1.50% Investment Advisory
  - 2.41% across mutual fund expenses, TPA/Recordkeeping, and Investment Advisory
- This was a pooled investment account, meaning all participant investments are managed in the same manner. This can cause liability for the plan since not all participants will be comfortable taking the same level of risk.

Solution

- Plan design changed to allow each participant to direct his/her individual investments, including target-date retirement options.
- Per industry benchmarking, the advisory fee was dropped to 0.60% for the plan. Total fees dropped from 2.41% to 1.63%, which saved the plan $4,000 annually.

TITLING ASSETS: DOES IT PROTECT?

- Spousal
- Basics: Tenancy in common, joint tenancy
- Tenancy by the Entirety (TBE)
- Community Property

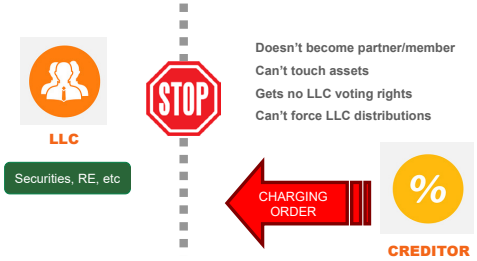
START WITH EXEMPT ASSETS (+5)

- (+5) Federal or state exempt asset
- No gifting, compliance, accounting fees or special taxes
- Protection cannot be matched by any other planning
- Federal bankruptcy exemptions for QRPs and IRAs
- States vary widely
  - Homestead
  - QRPs, IRAs
  - Life insurance and annuities

LLCs (+2): IDEAL FOR MOST ASSETS BEYOND EXEMPTIONS

- Inside Creditors
- Outside Creditors Isolates their lawsuit damage only to LLC property
  - Creditors can only get "charging order" against the LLC interest (+1 to +3) depending on use, compliance
  - Should tie into your estate plan
- "Building blocks" of asset protection
- *Control and Access*

WHAT A "CHARGING ORDER" MEANS



KEYS TO PROTECTION: LLCs

- Proper operating agreement
- Compliance with annual formalities
- Non-asset protection purpose: estate planning/gifting
- Jurisdiction: use the best state, when you have options
- Many LLCs are lacking in 1 of the 4 elements above: vulnerable
- Key: experienced attorney who has annual monitoring/gifting plan

USING TRUSTS TO SHIELD ASSETS

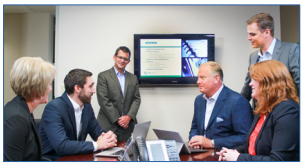
- Revocable trusts
  - "Family," "living," "loving trusts"
  - Valuable for probate avoidance, in event of incapacity
  - No asset protection while you are alive
- Irrevocable trusts
  - Many types, including ILITs, GRATs, CRTs and DAPTs
  - Because they are irrevocable, strong asset protection
  - **DAPT is most innovative, newest**
    - 20 states
    - "Hybrid" version for other states
    - Different than LLCs

NEW CASES RELATED TO LLCS

- Reminder from last year's course: Excela Technologies
  - Delaware court allowed "reverse piercing" case vs. an LLC
- Two Ohio LLC cases
  - Wick v. Ash : Both trial and appellate court dismissed the "reverse piercing" claim
  - Berns Custom Homes v. Johnson : Court refuses to appoint receiver for LLC – charging order is the exclusive remedy for plaintiffs.
- IRS LLC Case
  - TBS Properties LLC v. United States: IRS attacks real estate-owning LLC for unpaid taxes owed by corporation lessee. Court allows case to move forward.
  - Formalities matter!

ABOUT OJM GROUP

- Unique, fee-based wealth management firm
- 1,000 physician clients in 48 states
- Multidisciplinary; three divisions
- Corporate and personal planning
- Goal: Reducing physician financial stress



HOW WE WORK WITH PHYSICIANS

- **Investing**
  - RIA
  - Fiduciary, independent custodian
  - Tax-focused
- **Insurance and Benefits**
  - Life, disability, long term care insurance
  - Through partner firm, P&C coverages
  - Qualified and non-qualified plans
- **Consulting**

PERSONAL WEALTH PLANNING

DIAGNOSTIC vs. TREATMENT

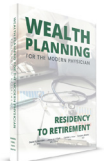
ADVICE & EXPERTISE FOR A FLAT FEE

BUILDING A RELATIONSHIP

OJMGROUP

NEXT STEPS TO LEARN MORE

- **Contact the presenter**
  - David B. Mandell, JD, MBA
  - 877.656.4362
  - mandell@ojmgroup.com
- **Free resources**
  - Text **AEIOJM** to 844-418-1212
  - Scan the QR Code
  - Visit ojmbookstore.com and enter **AEIOJM** at checkout.



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SELF EVALUATION

Protecting Professional and Personal Assets

1. According to the Healthcare Finance News survey referenced in the talk, the percentage of physicians surveyed who felt moderately-to-severely stressed was:

a. 17%
b. 37%
c. 47%
d. 87%

2. T/F - An orthopedic surgeon and practice were recently found liable for over $43 million in a malpractice claim.

3. Which of the following tools are generally used to shield practice real estate?

a. Limited liability companies (LLCs)
b. Community property
c. Spousal ownership
d. State or federally exempt assets

4. Which is a tool to shield cash flow at a practice:

a. Limited liability companies (LLCs)
b. Qualified retirement plans (QRPs)
c. Irrevocable trusts
d. Revocable trusts

5. T/F - Revocable trusts do not provide asset protection to you as the grantor while you are alive.

Answer Key: 1. D, 2. T, 3. A, 4. B, 5. T

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Eric Ploumis, DMD, JD, of New York, New York, is an attorney, orthodontist, Adjunct Clinical Associate Professor in Graduate Orthodontics at New York University College of Dentistry, and clinical attending faculty at Wyckoff Heights Hospital Pediatric Residency Program. His legal practice as of-counsel with Rivkin Radler, LLP focuses on the business and transactional issues related to the practice of dentistry including practice transitions, partnership and employment agreements, office leases and the defense of allegations of professional misconduct. Dr. Ploumis also maintains a practice in orthodontics in New York City, has contributed to many dental journals and is a frequent national speaker on dental-legal topics.

You may contact Dr. Ploumis with your questions and comments by email at EPloumis@DentalPracticeLawyers.com.

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Patient Dismissal: Legal, Practical and Ethical Issues

Why am I speaking to you today?

- To answer some of your questions and dispel some of your misconceptions about how to dismiss a patient.
- To empower you to take control of your office.

1

Objectives

We will review the legal, practical and ethical issues required to implement an effective patient-dismissal protocol in your office.

At the conclusion of the lecture, you should understand what steps to take to dismiss a patient from your office in a legal, practical, and ethical manner.

2

Knowing How to Say Goodbye

- Part I: Dismissing the Successfully Treated Patient
- Part II: Dismissing the Active Patient
- Part III: Ethical Issues in Patient Dismissal

3

Part I: Dismissing the Successfully-Treated Patient

4

Why Dismiss a Completed Patient?

- free up chair time
- reduce record-retention burden
- commence the statute of limitations
- reduce long-term risk exposure

5

Four Part Protocol that Employs:

A. a clear, concise contract for treatment
B. office procedure manual
C. knowledge of the law
D. documentation and correspondence

6

A. Contract for Treatment

- What does treatment cost?
- What is covered by the fee?
- What is not covered by the fee?
- How long will treatment take?
- When does treatment end?
- How many post-treatment (recall) visits are included?
- How long will you "guarantee" your work

7

Patient Contract: What is Covered

The fee for services covers the following: _____ .

For recall or observation visits following treatment a nominal office visit charge will apply.

8

Length of Treatment

- If a patient's treatment doesn't have an endpoint, neither does your liability.
- You must make it clear to the patient how long treatment lasts and when the patient is considered finished with treatment.

9

B. Clinical Procedure Manual

- Create an office policy manual that addresses active and follow-up issues
- Ensure that all staff (including doctors) understand the manual
- Present a consistent message
- Establish evidence of a habitual protocol

10

C. Know the Law

- statutes of limitations for malpractice
- exceptions to the statutes
  - age of majority (18 in most states)
  - continuous treatment
  - foreign object in body (eg: t.a.d., broken file)
- occurrence or discovery jurisdiction
- record-retention requirements

11

Contract Law: Statutes of Limitations

- Statute of limitations for written contract in Illinois is 10 years, five years for oral contracts
- Statute of limitations for written or oral contracts in New York and Hawaii is six years.
- Statute of limitations for written or oral contracts in Pennsylvania is four years.
- Prescriptive Period for written or oral contracts in Louisiana is ten years.

12

Medical/dental Malpractice: Statues of Limitations

- Illinois: two years from the date of *discovery* of the injury, max four years from *occurrence*
- New York: two and a half years from the date of the *occurrence* of the injury
- Hawaii: two years from the date of *discovery* of the injury, max six years from *occurrence* of the injury
- Pennsylvania: two years from the date of *discovery* of the injury, max seven years from *occurrence* of the injury
- Louisiana (prescriptive period): one year from the date of the *discovery*, max three years from *occurrence*

13

Exception: Infancy (minors)

- Infant (minor) = under the age of 18
- IL minors have 8 years from the date of injury, max age 22
- NY minors have until 20.5 with a max of 10 years
- HI minors under age 10 have 6 years from date of the injury or until the minor's tenth birthday, whichever is longer
- PA minors have seven years from the date of the injury or after their twentieth birthday, whichever is later
- Louisiana: No toll for infancy

14

D. Documentation/Correspondence

- patient handouts
- chart entries
- notification to parent or patient that treatment is completed
- follow-up dismissal letter

15

What about patients who just won't leave?

- Have him/her fill out a new patient information and health history sheet.
- Bill the patient for each visit
- Start a new chart within the chart
- Document each visit as a *follow-up* visit

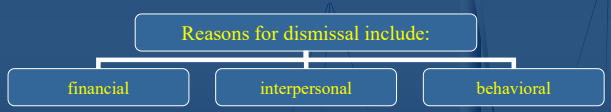
16

Dismissing the Successfully Treated Patient: Summary

- Free up chair time.
- Reduce record-retention burden.
- Commence the statute of limitations.
- Reduce long-term risk exposure.

17

Part II: Dismissing the Active (Problem) Patient



18

Who Is the Problem Patient?

-Doesn't pay
-Doesn't cooperate
-Doesn't behave

19

Benefits of Dismissing a Problem Patient

- better doctor, staff and office morale
- reduced stress
- improved bottom line
- enhanced care for "normal" patients
- improved access for other patients
- reduced record-keeping burden
- commencement of the statute of limitations

20

Contract Law: legal foundation for patient dismissal

- What is a contract?
  - a bargained-for exchange
  - a promise to do something in exchange for something
  - a set of expressed and implied duties

21

A Contract Includes Express and Implied Duties

- express duties: written or spoken
  - covered in informed consent and fee schedule
- implied duties: not written or spoken
  - understood by convention and law

22

Doctor's Express Duties

- Provide dental care for an agreed-upon fee

23

Patient's Express Duties

- Pay the agreed-upon fee

24

Doctor's Implied Duties

- Maintaining a current license
- Being competent to perform procedure
- Properly supervising office staff
- Being available for emergency care
- Taking and maintaining proper records
- Conforming with infection control
- Not abandoning patient

25

Patient's Implied Duties

- keep appointments
- follow instructions
- reveal changes in health status
- behave acceptably

26

Breaching the Doctor/Patient Contract

- failure to perform either the expressed or implied duties is grounds for dismissal of the patient
- You can dismiss a patient for "any reason but the wrong reason"

27

Reasons to Dismiss a Patient Include:

- breach of express terms: failure to pay
- breach of implied terms
  - failure to keep appointments
  - failure to follow instructions (including hygiene and home care)
  - failure to conform to acceptable behavior
  - breakdown of doctor/patient relationship

28

Tort (malpractice) Issues

A patient who:

- doesn't pay
- doesn't cooperate
- doesn't behave

. . . is more likely to sue you for malpractice. The sooner you terminate your relationship with that patient, the better off you will be.

29

Administrative Code and Dental Practice Act Issues

A patient who:

- doesn't pay
- doesn't cooperate
- doesn't behave

. . . is more likely to file a complaint with the state board. The sooner you terminate your relationship with that patient, the better off you will be.

30

Statute of Limitations Issues

- The statute of limitations put a time limit on when a patient can bring a suit
- The sooner you "start the clock" the safer you will be
- Once you dismiss a patient, the statute of limitations starts running (remember the exceptions: infancy, continuous treatment)

31

Dismissing the Patient: Sending a Dismissal Letter

Your letter must state:

- reason for discontinuing treatment: failure to pay, behave, cooperate
- importance of seeking alternative care and risks involved in not doing so
- offer to treat patient on an emergency basis
- availability of records

32

Date

Patient Name
Address 1
Address 2

Dear <Patient Name>:

You have not kept up with your financial obligations to our office. As a consequence, we are informing you that we are withdrawing from further professional attendance to your dental needs. The doctor/patient relationship is hereby terminated. Since your dental condition requires further treatment, we urge you to seek the care and treatment of another dentist without delay.

If you desire, we shall be available on an emergency basis for 30 days from your receipt of this letter. This should give you ample time to select another dentist. Your dental records can be transferred if we have a written request from you.

We regret having to take this action, but the situation has left us no other option.

Sincerely,

_____
{Doctor's name and signature}

33

Why Your Are Dismissing Patient

- You have not kept up with your financial obligation to our office.
- As a consequence, we must inform you that we are withdrawing from further professional attendance to your dental needs.

34

Importance of Seeking Alternative Care

- Since your dental condition requires further treatment, we urge you to seek the care and treatment of another dentist without delay.
- Failure to do so may result in severe damage to your oral health.

35

Isn't this abandoning the patient?

NY Rules of the Board of Regents, Part 29 Unprofessional Conduct Section 29.2(a)(1)

Unprofessional conduct shall include: "abandoning or neglecting a patient or client under and in need of immediate professional care, without making reasonable arrangements for the continuation of such care."

36

Emergency Care

- If you desire, we shall be available to attend to your dental needs for 30 days on an emergency basis.

37

Records Available

- Your dental records can be transferred if we have a written request from you.
- There is a charge to duplicate these records

38

Dismissal Letter (child)

You have not kept up with your financial obligations to our office. As a consequence, we must inform you that we are withdrawing from further professional attendance to Johnny's dental needs. Since his dental condition requires further treatment, we urge you to place him under the care and treatment of another dentist without delay. Failure to do so may result in severe damage to Johnny's oral health.

39

Dismissal Letter (cont.)

If you desire, we shall be available to attend to Johnny's dental needs for 30 days on an emergency basis. This should give you ample time to select another dentist. Johnny's dental records can be transferred if we have a written request from you. There is a charge to duplicate and transfer his records.

40

Dismissal Letter (cont.)

We regret having to take this action, but the situation has left us no other option.

Sincerely,
Doctor's Name

41

Dismissal Letter

- Send certified, return-receipt requested
- Send a separate copy in a plain-white envelope

42

Patient Reentry into Practice

- Once you dismiss, you should not see the patient again except on an emergency basis
- If you do choose to reinstitute treatment, treat the patient as though they were a new start

43

Dismissal Letter: Failure to cooperate, failure to behave

- failure to keep appointments
- failure to follow instructions (including hygiene and elastic wear)
- failure to conform to acceptable behavior
- breakdown of doctor/patient relationship

44

Dismissal Letter

After much consideration, I feel it is best that I discontinue further professional attendance to your dental needs. Successful treatment depends upon a positive doctor-patient relationship.

You no longer have the requisite confidence in our office to maintain this relationship. [Or other appropriate reason here]

Since your dental condition requires further treatment, I urge you to seek the care and treatment of another dentist without delay.

45

Dismissal Letter: cont.

I shall be available to attend to your dental needs for 30 days on an emergency basis. This should give you ample time to select another dentist. Your records can be transferred if we have a written request from you.

46

Dismissal Letter: cont.

In an effort to expedite the transfer of care I will refund a portion of the money you have paid.

I regret having to take this action but feel it is in our mutual interests.

<Dentist Name>

cc: referring dentist

47

No Refund Without a Release

- Get a signed release before refunding money.
- Consult your malpractice carrier before refunding money.
- Make sure you state this is a refund, not a settlement.

48

A release should contain:

The names of both the releasor (the patient) and the releasee (the doctor). If the patient is a minor, he or she does not posses the legal standing to sign a valid release. One or both parents or a legal guardian must sign the release. If you practice under a corporate or trade name, be sure to include these names after yours as releasees.

49

A release should contain:

A specific dollar amount you intend to refund to the patient. Do not just say you will refund one-half of the treatment fee or other inexact language.

50

A release should contain:

- A statement that by returning the fee, you admit to no liability.
- If you do not include this clause, the patient may assume that you are refunding money to them because you did something wrong.
- Refunding money is not and admission of wrongdoing.

51

A release should contain:

- A clause that states the patient, by accepting a refund, waives the right to any future actions against you, your associates, partners, employees, corporation, and heirs.
- Caveat: this does not preclude an action by the state dental board

52

Patient Release: termination of the doctor/patient relationship

Make sure the patient knows that by accepting your money, he or she is no longer a patient. Unless you specifically terminate this relationship, the patient may continue to think you are his or her dentist. This may also prolong the statute of limitations for other causes of action the patient may have against you.

53

A release should contain the following:

Confidentiality agreement. The release should stipulate that the terms of the release are confidential and are not to be revealed to any outside parties or shared on social media.

54

A release should contain the following:

- signature of the realeasor, releasee, and at least one witness.
- A minor cannot sign the release, so make sure a parent or legal guardian signs the release. Be sure it is dated.
- notarize if possible

55

Release of All Claims

I, (patient name) am discontinuing treatment with Dr. Smith. Dr. Smith has refunded $[1,000.00] to me. Return of this fee does not constitute any admission of liability on behalf of Dr. Smith.

By accepting this refund, I release Dr. Smith, his agents, associates, partners, and employees from any and all claims and causes of action, and other compensation now or in the future.

I acknowledge that by signing this release, I am terminating the doctor/patient relationship. The terms of this release are to be kept confidential and will not be disclosed to anyone or posted on any form of social media without the written authorization of the doctor or an order from a court of competent jurisdiction.

56

Dismissal Letter

- Send certified, return-receipt requested
- Send a separate copy in a plain-white envelope.
- Enclose the release (but not the check).
- Once patient sends signed release back, send the check promptly

57

Patient Reentry into Practice

- Once you dismiss, you should not see the patient again except on an emergency basis
- If you do choose to reinstitute treatment, treat the patient as though they were a new start

58

Part III: Ethical Considerations in Patient Dismissal

- allocation of resources
- obligation to society (choose your charity)
- quality of care
- access to care
- patient satisfaction
- doctor and staff satisfaction
- doctor and staff empowerment
- doctor/patient relationship

59

Requisite Disclaimer

THIS INFORMATION IS NOT INTENDED AS A SUBSTITUTE FOR LEGAL ADVICE. YOU SHOULD FAMILIARIZE YOURSELF WITH THE LAWS OF YOUR LOCAL JURISDICTION AND SEEK LEGAL ADVICE FROM A LOCAL ATTORNEY WHO SPECIALIZES IN COLLECTION ISSUES.

60

SELF EVALUATION

Patient Dismissal: Legal, Practical and Ethical Issues

1. The “statute of limitations” is a time limit on how long a patient has to sue a doctor for malpractice.

2. An important reason to formally notify a patient of the completion of treatment is to commence the statute of limitations running.

3. Reasons to dismiss a problem patient include:

a. Failure to pay your fee
b. Interpersonal breakdown
c. Failure of the patient to cooperate
d. All of the above

4. In most circumstances, the failure of a patient to comply with either express or implied duties gives the doctor the legal right to dismiss a patient.

5. When dismissing a problem patient, if you are refunding part of the fee it is always a good idea to get a Release of All Claims from the patient.

Answer Key: 1. T, 2. T, 3. D, 4. T, 5. T

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Holt, Michigan, 48842
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Major Sources of Chronic Systemic Inflammation

We SEE what we expect to SEE
(Not necessarily what is really there)

3

Hands-On LEARNING LAB

SelfScreen.net
Discover your oral ⟋ systemic health risks!

Blabber Mouth!
77 Secrets
Only Your Mouth Can Tell You To Live a Healthier, Happier, Sexier Life
Susan Smallegan Maples, DDS, MSBA & Diana Kightlinger DeCouteau, MA

BRAVE PARENT
Raising Healthy, Happy Kids in Today's World
Dr. Susan Smallegan Maples DDS, MSBA

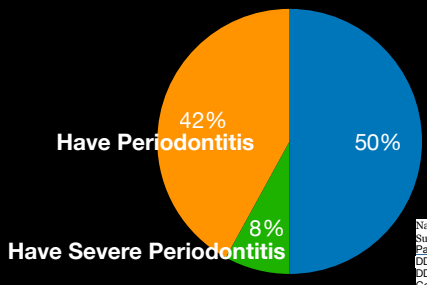
TOTAL HEALTH ACADEMY

5

Is inflammation good or bad?

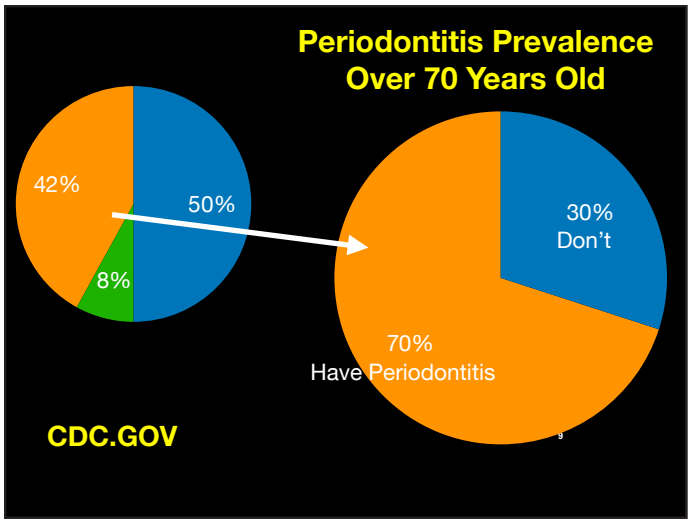
6

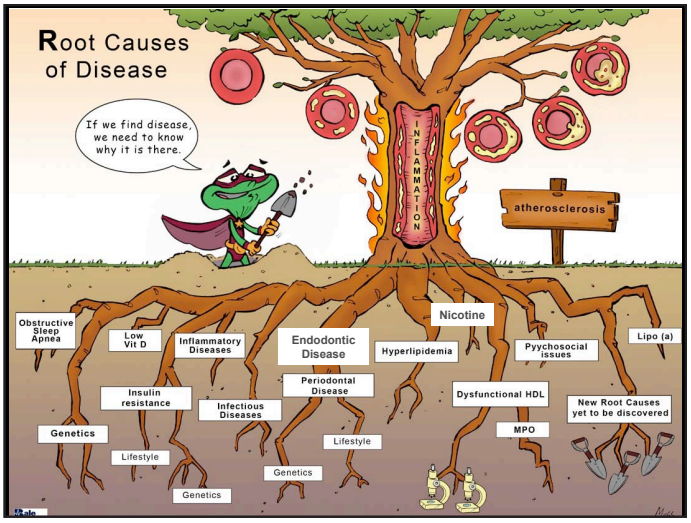
U.S. Adults Over 30 Years Old with Periodontitis

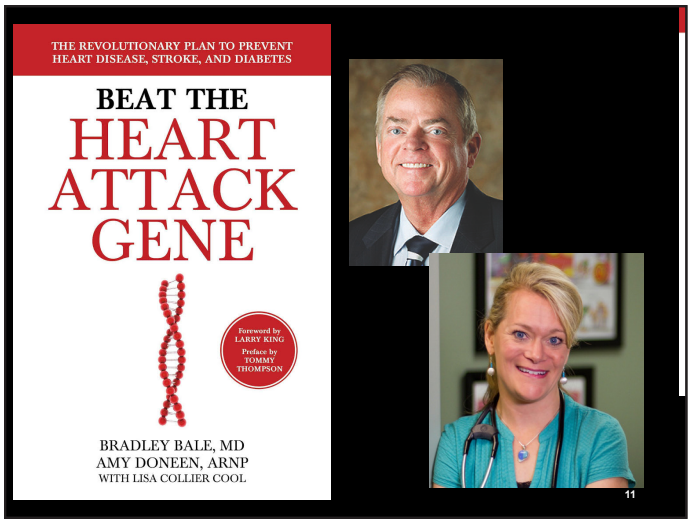


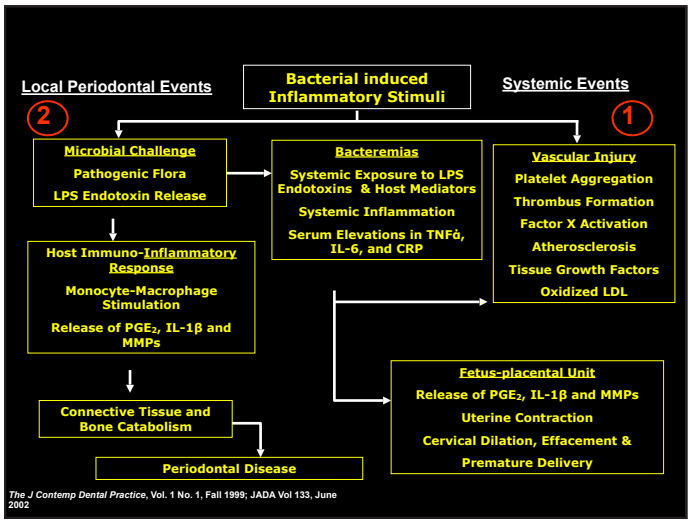
National Health and Nutrition Examination Survey 2009-2014 Paul I. Eke, PhD, Gina O. Thornton-Evans, DDS, Liang Wei, MS, Wenche S. Borgnakke, DDS, PhD, Bruce A. Dye, DDS, MPH, Robert J. Genco, DDS, PhD

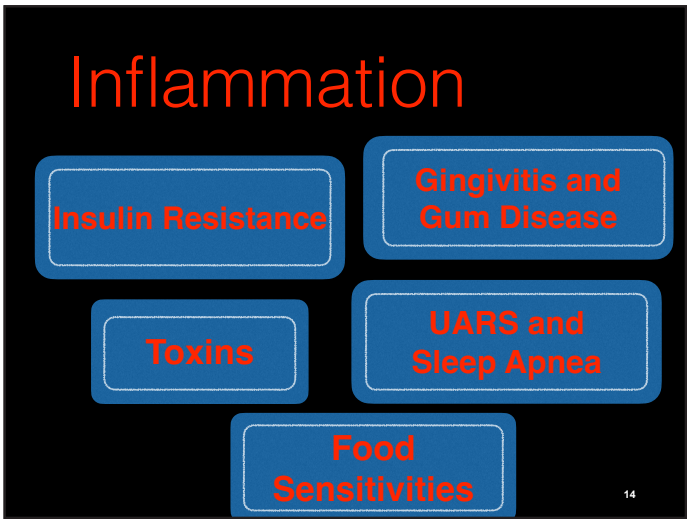
8

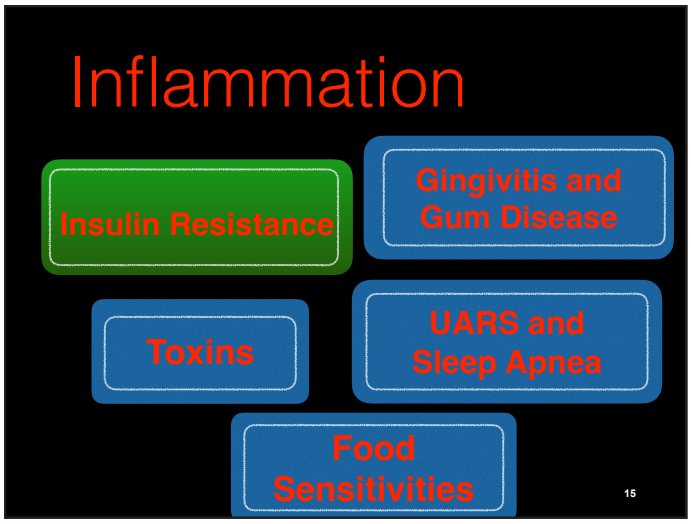

Periodontitis Prevalence
Over 70 Years Old
42%
50%
8%
30%
Don't
70%
Have Periodontitis
CDC.GOV

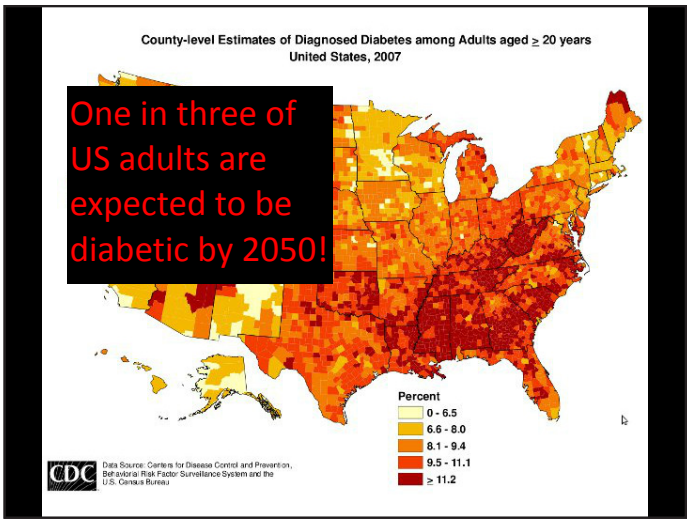

Root Causes
of Disease
If we find disease, we need to know why it is there.
INFLAMMATION
atherosclerosis
Obstructive Sleep Apnea
Low Vit D
Inflammatory Diseases
Endodontic Disease
Hyperlipidemia
Nicotine
Pychosocial issues
Lipo (a)
Insulin resistance
Infectious Diseases
Periodontal Disease
Dysfunctional HDL
New Root Causes yet to be discovered
Genetics
Lifestyle
Genetics
Lifestyle
Genetics
MPO

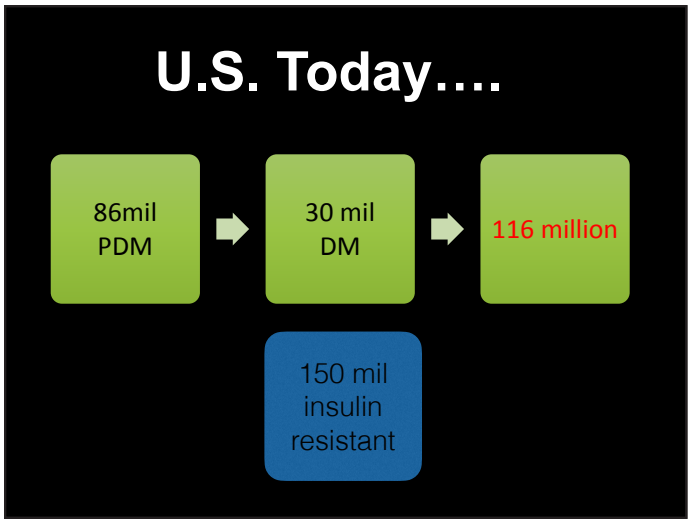

THE REVOLUTIONARY PLAN TO PREVENT HEART DISEASE, STROKE, AND DIABETES
BEAT THE
HEART ATTACK GENE
Foreword by LARRY KING
Preface by TOMMY THOMPSON
BRADLEY BALE, MD
AMY DONEEN, ARNP
WITH LISA COLLIER COOL
11

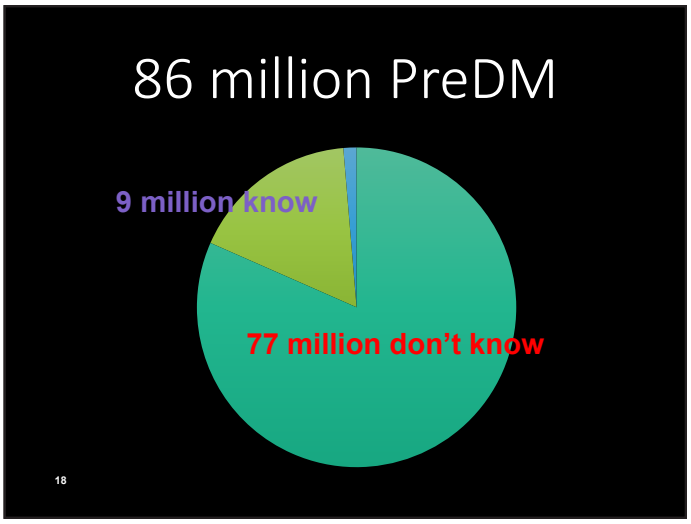

Local Periodontal Events
Bacterial induced Inflammatory Stimuli
Systemic Events
2
1
Microbial Challenge
Pathogenic Flora
LPS Endotoxin Release
Bacteremias
Systemic Exposure to LPS Endotoxins & Host Mediators
Systemic Inflammation
Serum Elevations in TNFá, IL-6, and CRP
Vascular Injury
Platelet Aggregation
Thrombus Formation
Factor X Activation
Atherosclerosis
Tissue Growth Factors
Oxidized LDL
Host Immuno-Inflammatory Response
Monocyte-Macrophage Stimulation
Release of PGE2, IL-1β and MMPs
Fetus-placental Unit
Release of PGE2, IL-1β and MMPs
Uterine Contraction
Cervical Dilation, Effacement & Premature Delivery
Connective Tissue and Bone Catabolism
Periodontal Disease
The J Contemp Dental Practice, Vol. 1 No. 1, Fall 1999; JADA Vol 133, June 2002

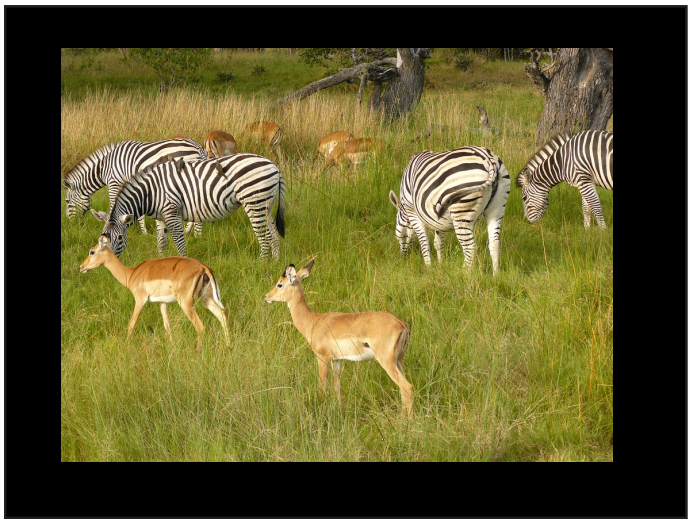

Inflammation
Insulin Resistance
Gingivitis and Gum Disease
Toxins
UARS and Sleep Apnea
Food Sensitivities
14


Inflammation
Insulin Resistance
Gingivitis and Gum Disease
Toxins
UARS and Sleep Apnea
Food Sensitivities
15


County-level Estimates of Diagnosed Diabetes among Adults aged ≥ 20 years
United States, 2007
One in three of US adults are expected to be diabetic by 2050!
Percent
0 - 6.5
6.6 - 8.0
8.1 - 9.4
9.5 - 11.1
≥ 11.2
CDC
Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System and the U.S. Census Bureau


U.S. Today….
86mil PDM
30 mil DM
116 million
150 mil insulin resistant


86 million PreDM
9 million know
77 million don't know
18




SICK CARE
Vs.
HEALTH CARE
WHICH WILL YOU CHOOSE?

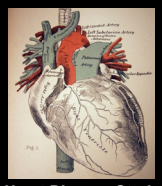
Inflammation

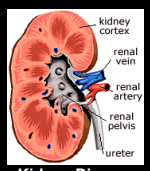
- Insulin Resistance
- Gingivitis and Gum Disease
- Toxins
- UARS and Sleep Apnea
- Food Sensitivities

21

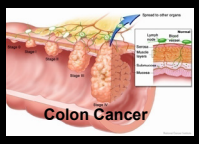
Periodontal Disease is Linked to:


Osteoporosis

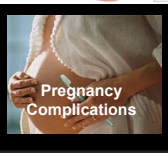

Heart Disease-Stroke

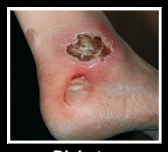


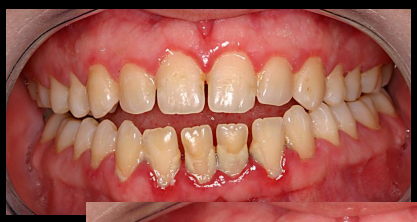
Kidney Disease

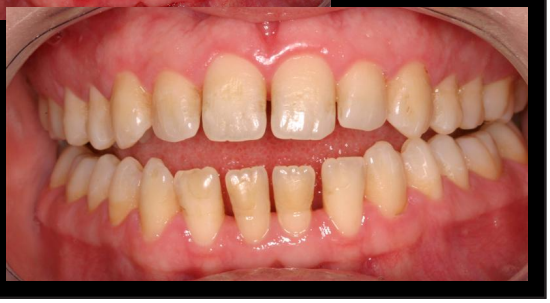

Colon Cancer


Alzheimer's


Pregnancy Complications


Diabetes





Question:

What elements would we have to consider to ***truly*** create periodontal stability once and for all?

24

Periodontal Disease Risk Factors

Oral Risk Factors

- Inflammation
  - mild mod severe
- Pocket depths (generalized)
  - mild mod severe
- Furcation involvement
  - mild mod severe
- Mobility
  - mild mod severe
- Root caries
- Gingival overgrowth/hyperplasia
- Salivary hypofunction
  - mild mod severe
- Suspicion of Candida
- Homecare skills/habit development
  - inadequate adequate
- Previous Perio Therapy

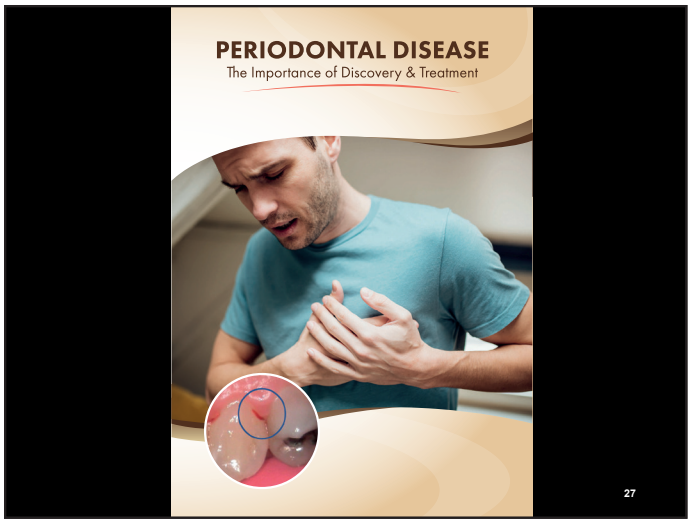
Systemic Risk Factors

- Suspicion of food sensitivities
- Suspicion of chemical sensitivities
- Metabolic disease
  - obesity/insulin resistance
  - pre-diabetes/diabetes
  - acid reflux
- A1C
- Physical difficulty/ poor manual dexterity
- Genetics
  - young age
  - parents or immediate family members that have lost teeth from gum disease
  - rapid or severe bone loss
- Tobacco or Cannabis use
- Polypharmacy
- Inflammatory Diet
- History of CVD
  - Hypertension
  - Hyperlipidemia
  - Previous Cardiac Event
- Suspicion of OSA or untreated OSA
- Depression
- Heightened Stress Factors

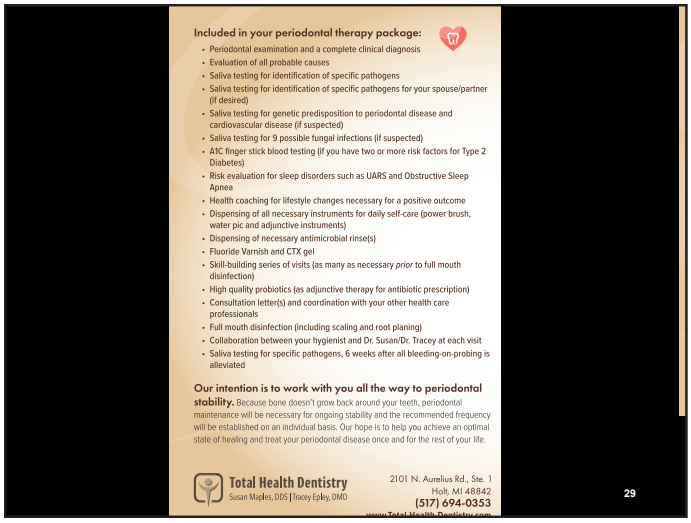
25

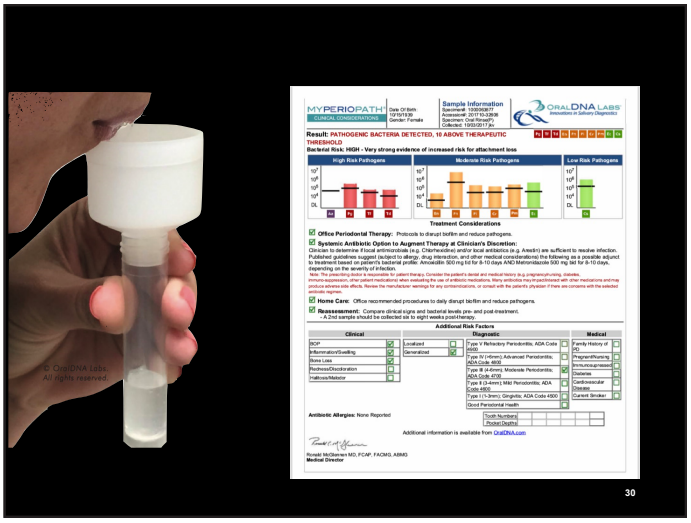
What's possible if money no longer matters?

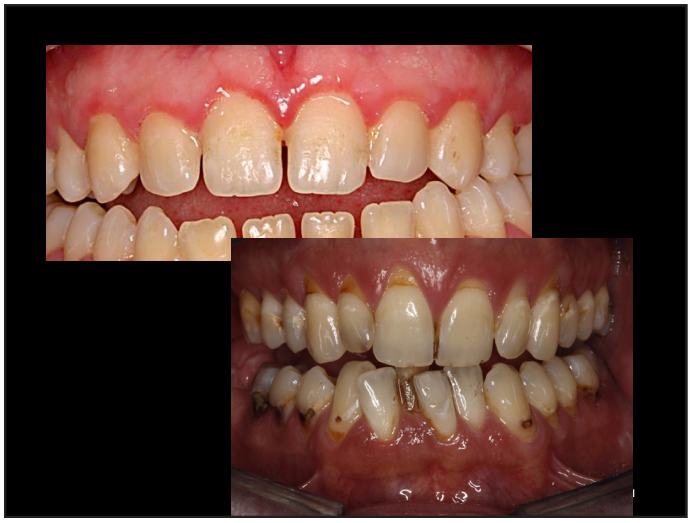
26

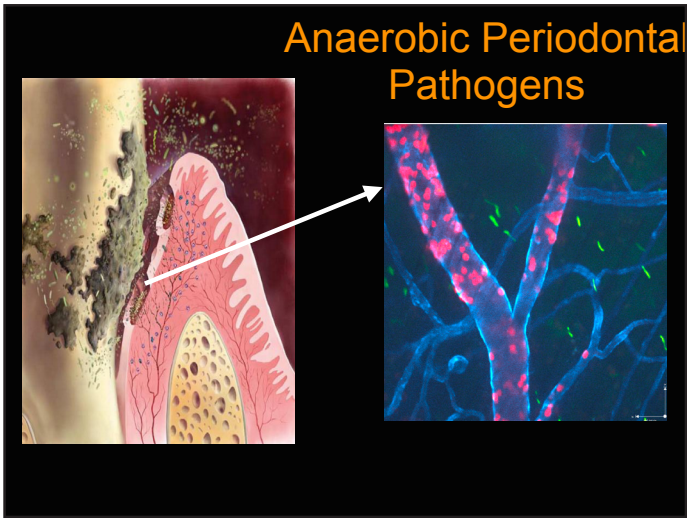

PERIODONTAL DISEASE
The Importance of Discovery & Treatment
27


YOUR PERIODONTAL DISEASE:
We Take It Seriously!
If you're over 30 years old, you're more likely to have some periodontal disease than not.
Finally, there's your part.
28

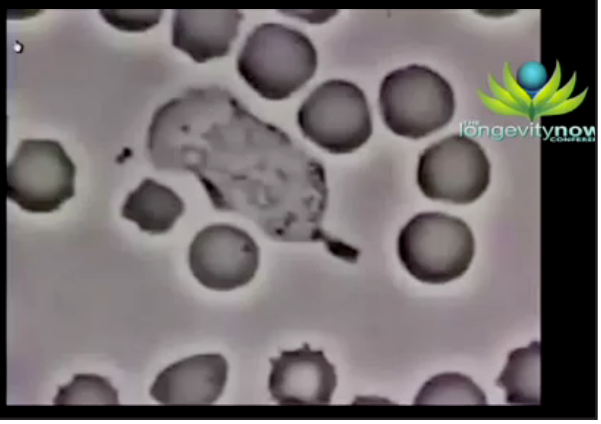

Included in your periodontal therapy package:
Our intention is to work with you all the way to periodontal stability.
Total Health Dentistry
Susan Maples, DDS | Tracey Epley, DMD
2101 N. Aurelius Rd., Ste. 1
Holt, MI 48842
(517) 694-0353
29

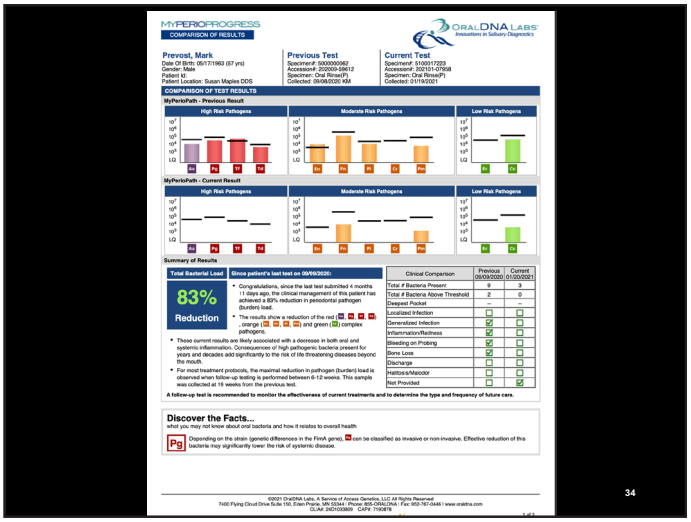

MYPERIOPATH
ORALDNA LABS
Result: PATHOGENIC BACTERIA DETECTED, 10 ABOVE THERAPEUTIC THRESHOLD
Treatment Considerations
30




Anaerobic Periodontal Pathogens

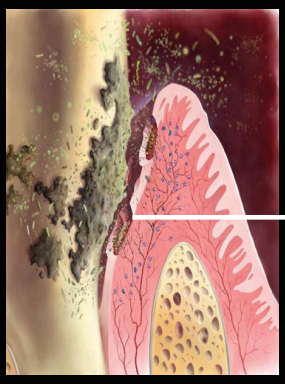
YouTube Search
"White Blood Cell in Pursuit of Bacteria"

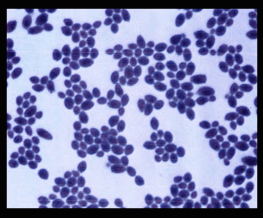


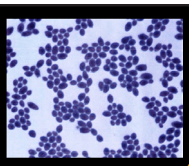


Candida

Facultative anaerobic
Candida species





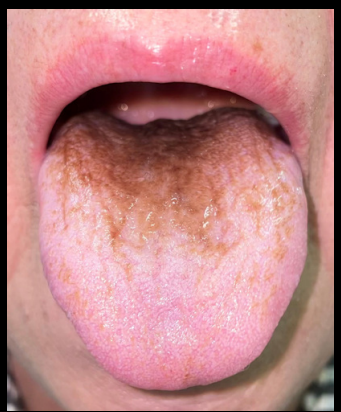


Candida

Candida species are the **4th** most common cause of nosocomial bloodstream infections

- Of the more than 150 Candida spp., a single species (C. albicans) accounts for 50 to 75% of isolates in humans
- In the United States, Canada, and Latin America, 54% of episodes were attributed to C. albicans , 16% to C. glabrata , 15% to C. parapsilosis, 8% to C. tropicalis, 2% to C. krusei, and 5% to other Candida spp.
- Compared with C. albicans, little is known about the pathogenesis of C. glabrata.

Comparative abilities of Candida glabrata and Candida albicans to colonize and translocate from the intestinal tract of antibiotic-treated mice
Michelle J. Henry-Stanley, Robb M. Garni, Mary Alice Johnson, Catherine M. Bendel & Dr Carol L. Wells
Microbial Ecology in Health and Disease. 2005; 17: 129–137



WHY?

- Antibiotics
- Hypo-salivary fx
- Steroids
- Antimicrobial rinses
- Dentures
- Gut dysbiosis
- Immunocompromised
- Polypharmacy
- Lack of diversity in diet
- Ultra-processed food diet high in sugar

- C.albicans
- C.glabrata
- C.krusei
- C.parapsilosis,
- C.tropicalis
- C.rugos
- C.guilliermondii/ C.zeylanoides
- C.kefyr
- C.lusitaniae

39

Nystatin

Diflucan

Antimicrob Agents Chemother. 2015 Nov; 59(11): 6975–6982. PMCID: PMC4604417
Published online 2015 Oct 13. Prepublished online 2015 Aug 31. doi: 10.1128/AAC.01005-15 PMID: 26324281

Rapid Development of *Candida krusei* Echinocandin Resistance during Caspofungin Therapy

A. Forastiero,[a,*] V. Garcia-Gil,[a,*] O. Rivero-Menendez,[a] R. Garcia-Rubio,[a] M. C. Monteiro,[a] A. Alastruey-Izquierdo,[a] R. Jordan,[c] I. Agorio,[b] and E. Mellado[a]

Author information ▸ Article notes ▸ Copyright and License information Disclaimer

Associated Data

Supplementary Materials

ABSTRACT Go to:

In invasive candidiasis, there has been an epidemiological shift from *Candida albicans* to non-*albicans* species infections, including infections with *C. glabrata*, *C. parapsilosis*, *C. tropicalis*, and *C. krusei*. Although the prevalence of *C. krusei* remains low among yeast infections, its intrinsic resistance to fluconazole raises epidemiological and therapeutic concerns. Echinocandins have *in vitro* activity against

In invasive candidiasis, there has been an epidemiological shift from *Candida albicans* to non-*albicans* species infections, including infections with *C. glabrata*, *C. parapsilosis*, *C. tropicalis*, and *C. krusei*.

Eliminate ultra-processed foods (carbs), fermented foods eliminate sugar

Add-in whole, high-fiber foods

Eliminate/reduce alcohol intake

Reduce stress

Look for auto-immune disorders

Improve sleep quality and quantity

De-medicate, safely where possible

Supplement

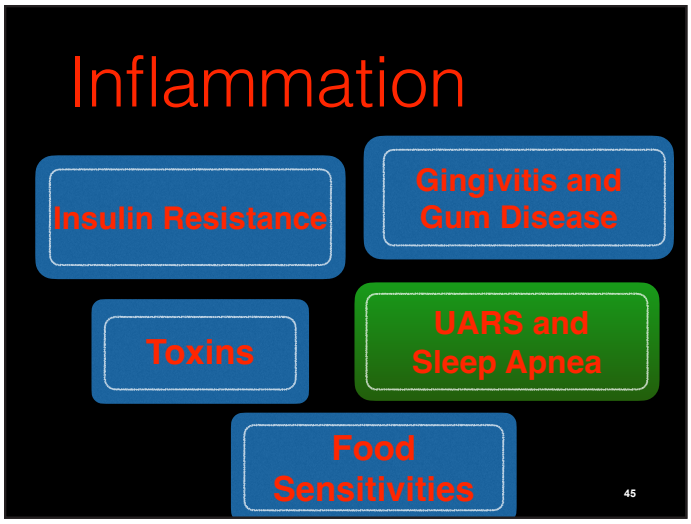
Contains:

Sodium Caprylate is included to disrupt the metabolism of Candida

potent botanicals, such as berberine HCl, oregano, rosemary, cinnamon and ginger, and Pau d'Arco

Purpose: sooth the GI tract, provide potent antioxidant support, and boost microbial balance.

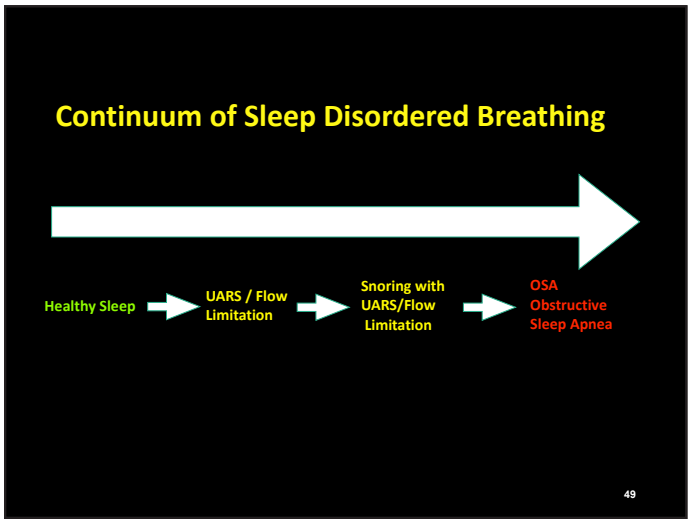
44

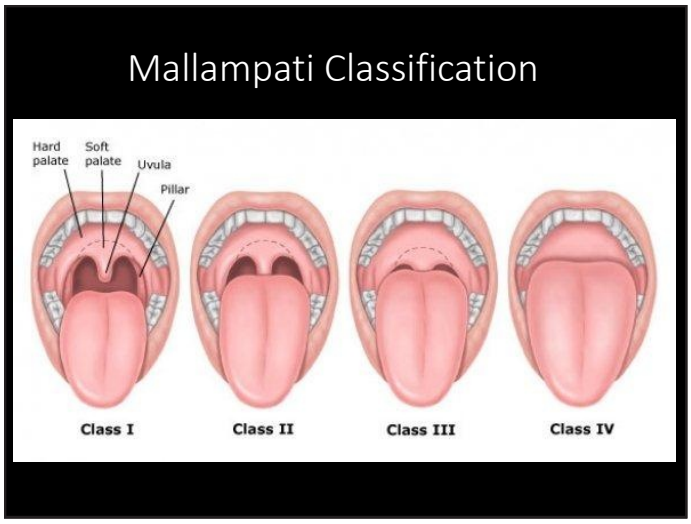


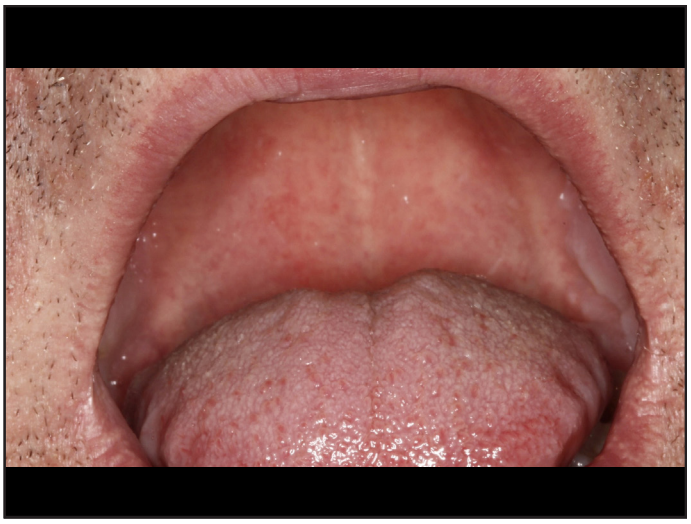
Signs and Symptoms

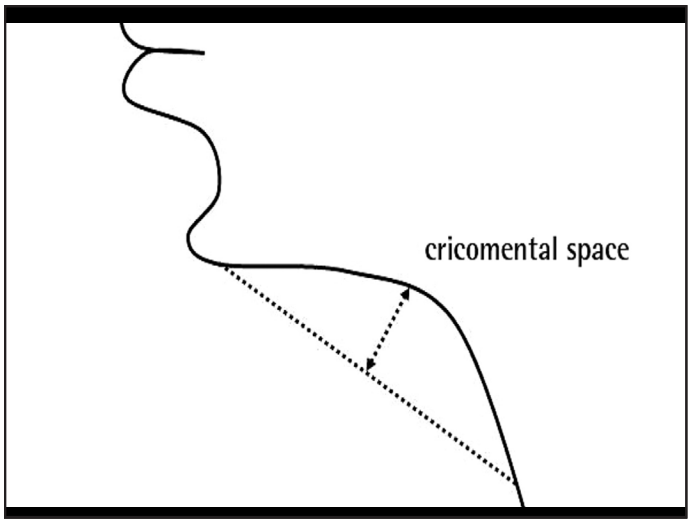
- Snoring
- Daytime sleepiness
- Bruxism
- Overweight
- Weight gain/Difficulty losing weight
- Memory loss
- Impaired concentration
- Erectile dysfunction

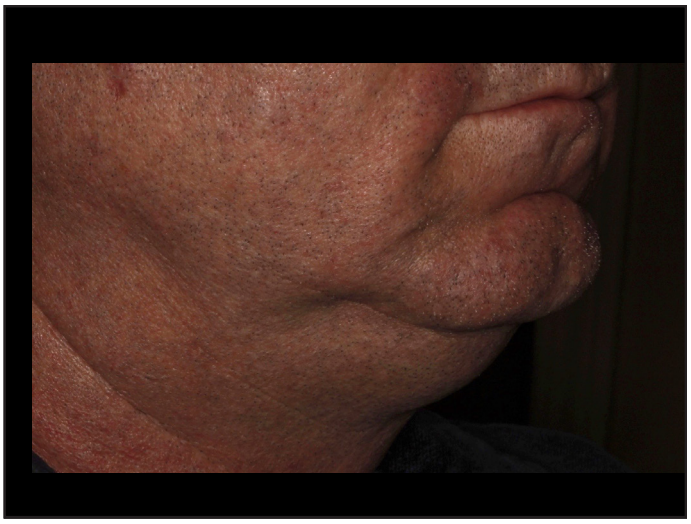
48

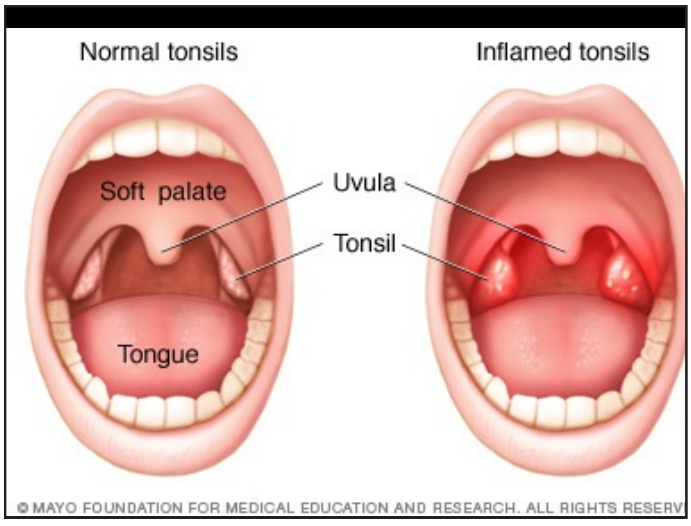



Mallampati Classification
Hard palate
Soft palate
Uvula
Pillar
Class I
Class II
Class III
Class IV




cricomental space




Normal tonsils
Inflamed tonsils
Soft palate
Uvula
Tonsil
Tongue
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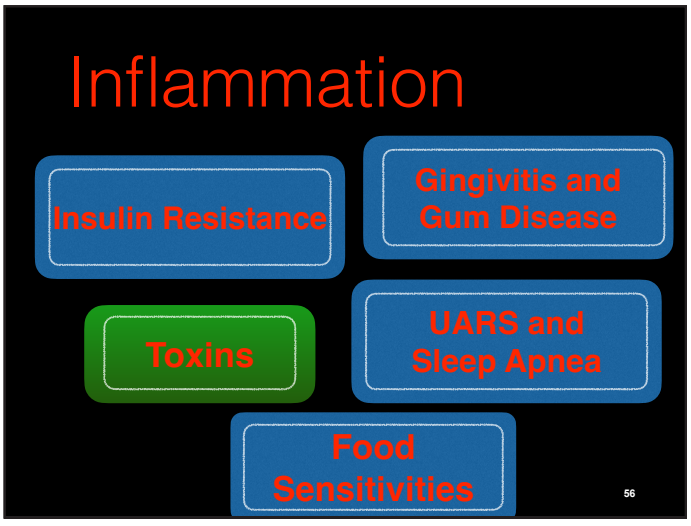
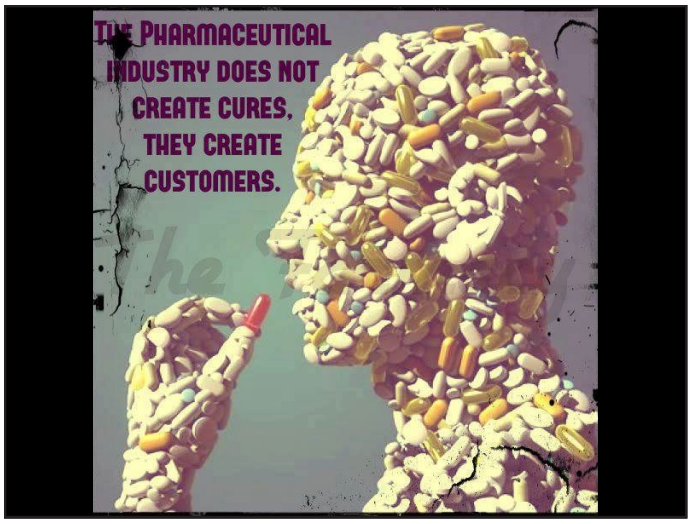

Inflammation
Insulin Resistance
Gingivitis and Gum Disease
Toxins
UARS and Sleep Apnea
Food Sensitivities
56

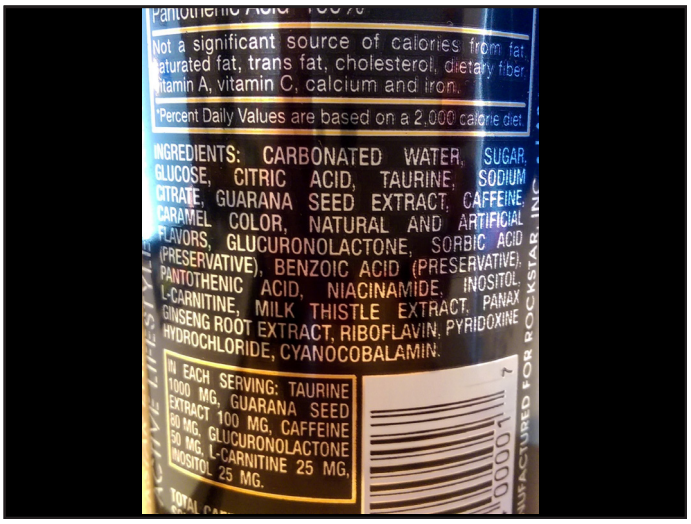

THE PHARMACEUTICAL INDUSTRY DOES NOT CREATE CURES, THEY CREATE CUSTOMERS.


Newsweek
TOXIC
FOOD
Newsweek
TOXIC
FOOD
Newsweek
TOXIC
FOOD
58


Cholesterol Less than 300g 375g
Sodium 2,400mg 2,300mg
Total Carbohydrate 25g 30g
Dietary Fiber
Calories per gram:
Fat 9 • Carbohydrate 4 • Protein 4
Ingredients: Whole Corn, Vegetable Oil (Contains One or More of the Following: Corn, Soybean, and/or Sunflower Oil), Salt, Cheddar Cheese (Milk, Cheese Cultures, Salt, Enzymes), Maltodextrin, Wheat Flour, Whey, Monosodium Glutamate, Buttermilk Solids, Romano Cheese From Cow's Milk (Part-Skim Cow's Milk, Cheese Cultures, Salt, Enzymes), Whey Protein Concentrate, Onion Powder, Partially Hydrogenated Soybean and Cottonseed Oil, Corn Flour, Disodium Phosphate, Lactose, Natural and Artificial Flavor, Dextrose, Tomato Powder, Spices, Lactic Acid, Artificial Color (Including Yellow 6, Yellow 5, Red 40), Citric Acid, Sugar, Garlic Powder, Red and Green Bell Pepper Powder, Sodium Caseinate, Disodium Inosinate, Disodium Guanylate, Nonfat Milk Solids, Whey Protein Isolate, and Corn Syrup Solids.
CONTAINS MILK AND WHEAT INGREDIENTS.
FRITO-LAY, INC.
PLANO, TX 75024-4099
Frito-Lay


Doritos
Nacho Cheese
GARDEN of EATIN'
WHITE CHIPS
ALL NATURAL CANTINA CHIPS
ORGANIC
60

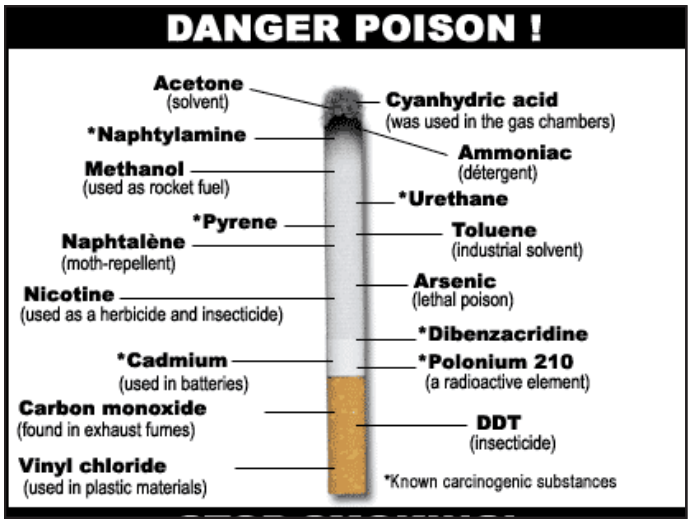

• Calories 260
• Total sugars 62 g
• pH 3.00
• Caffeine 240 mg
TAURINE • GUARANA
ROCKSTAR
ENERGY DRINK
ORIGINAL
Nutrition Facts

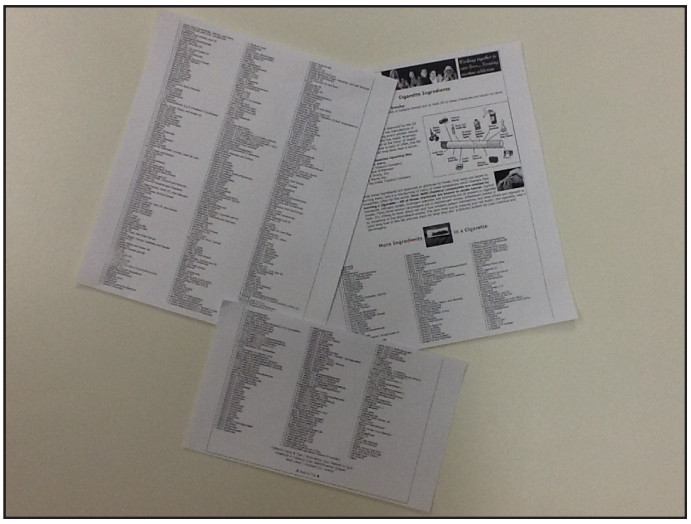

Not a significant source of calories from fat, saturated fat, trans fat, cholesterol, dietary fiber, vitamin A, vitamin C, calcium and iron.
*Percent Daily Values are based on a 2,000 calorie diet
INGREDIENTS: CARBONATED WATER, SUGAR, GLUCOSE, CITRIC ACID, TAURINE, SODIUM CITRATE, GUARANA SEED EXTRACT, CAFFEINE, CARAMEL COLOR, NATURAL AND ARTIFICIAL FLAVORS, GLUCURONOLACTONE, SORBIC ACID (PRESERVATIVE), BENZOIC ACID (PRESERVATIVE), PANTOTHENIC ACID, NIACINAMIDE, INOSITOL, L-CARNITINE, MILK THISTLE EXTRACT, PANAX GINSENG ROOT EXTRACT, RIBOFLAVIN, PYRIDOXINE HYDROCHLORIDE, CYANOCOBALAMIN.
IN EACH SERVING: TAURINE 1000 MG, GUARANA SEED EXTRACT 100 MG, CAFFEINE 80 MG, GLUCURONOLACTONE 50 MG, L-CARNITINE 25 MG, INOSITOL 25 MG.


Mountain Dew

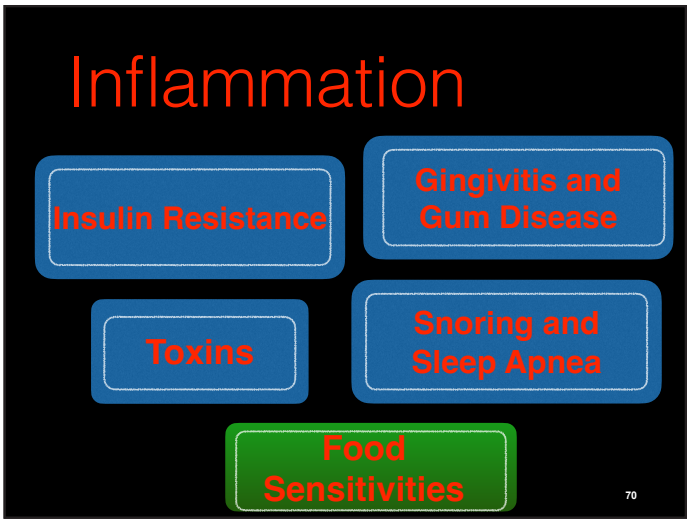

FIFTEEN
JOIN THE CHALLENGE
EAT CLEAN
The rules are simple. For fifteen days, avoid any processed or packaged foods that include more than five ingredients. THAT'S IT! So, how do you do it? Simply, eat real whole foods. P.S. If you're already eating clean & you want a bonus challenge, avoid boxes, bags, bottles or cans; and any food that has a commercial! Come on! Sign a commitment card and take the challenge with us!
Remember, we're all in this together! LET'S DO IT!
FOR IN 15


65

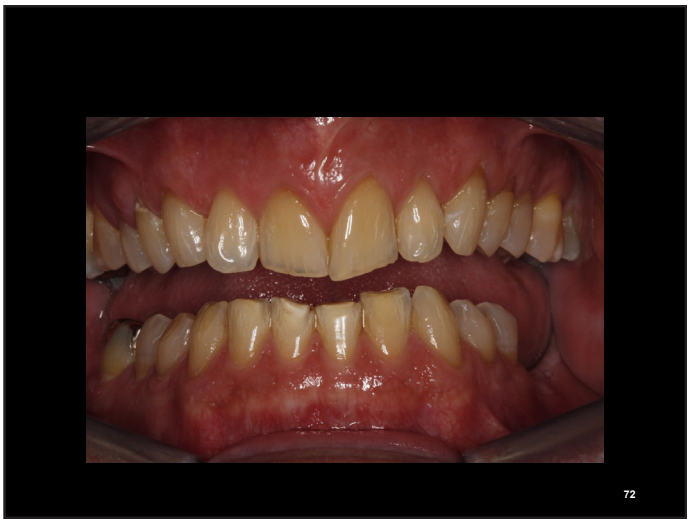

DANGER POISON !
Acetone (solvent)
*Naphtylamine
Methanol (used as rocket fuel)
*Pyrene
Naphtalène (moth-repellent)
Nicotine (used as a herbicide and insecticide)
*Cadmium (used in batteries)
Carbon monoxide (found in exhaust fumes)
Vinyl chloride (used in plastic materials)
Cyanhydric acid (was used in the gas chambers)
Ammoniac (détergent)
*Urethane
Toluene (industrial solvent)
Arsenic (lethal poison)
*Dibenzacridine
*Polonium 210 (a radioactive element)
DDT (insecticide)
*Known carcinogenic substances

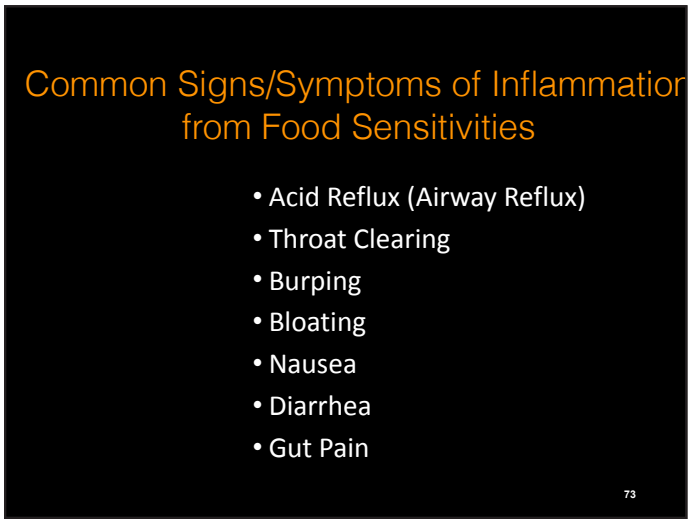



TUTTI FRUTTI
69


Inflammation
Insulin Resistance
Gingivitis and Gum Disease
Toxins
Snoring and Sleep Apnea
Food Sensitivities
70


Helping Identify Food Sensitivities


72


Common Signs/Symptoms of Inflammation from Food Sensitivities
• Acid Reflux (Airway Reflux)
• Throat Clearing
• Burping
• Bloating
• Nausea
• Diarrhea
• Gut Pain
73


Airway Reflux?
74

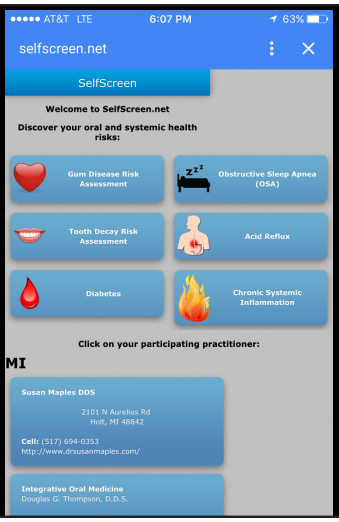
Sensitivity /Bio-Individuality

- Alcohol, particularly red wine
- Coffee, tea and carbonated drinks
- Gluten
- Black pepper, garlic, raw onion
- Spicy foods and peppermint
- Dairy products (Caseins, Lactose)
- Tomatoes
- Chocolate
- Other night shade vegetables
- Tree nuts and peanuts
- Eggs

75

60% US adults report some reflux

20-30% …at least weekly



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SELF EVALUATION

Major Sources of Chronic Systemic Inflammation

1. Cardiovascular Disease (CVD) has been linked to

a. Obesity
b. Diabetes
c. Chronic Systemic Inflammation
d. Periodontal Disease
e. A and B
f. All of the above

2. T/F - Heart attack and Stroke both involve a blood clot in an artery.

3. Chronic Systemic Inflammation can be caused by:

a. Vitamin D Deficiency
b. Insulin Resistance
c. Food Sensitivities
d. Periodontal Disease
e. Autoimmune Deficiencies
f. All of the above

4. Inflammation is the body's way of healing but chronic inflammation creates a cascade of byproducts that damages:

a. The heart muscle
b. The pancreas
c. The neurons in the brain
d. The endothelium (inner lining) of all the arteries
e. None of the above

5. T/F - It is strictly speculation that some of the blood clots responsible for heart attack and stroke are caused by the migration of specific strains of mouth bacteria that migrated through the blood stream.

6. T/F -Chronic Inflammation increases the chances for mouth bacteria to penetrate the blood vessel wall.

7. In this case of Diabetes and Periodontal Disease, Bi-Directional means:

a. Bacteria from the mouth can travel to the pancreas and from there throughout the vascular system.
b. Periodontal disease increases the risk of developing diabetes and vise versa
c. Uncontrolled diabetes worsens periodontal disease progression and active periodontal disease worsens hyperglycemia.
d. None of the above

8. T/F -Type 2 diabetes is somewhat rare and is usually diagnosed early as a result of quickly developing symptoms.

9. An oral sign of uncontrolled (or undiagnosed diabetes) is:

a. Gingival inflammation
b. Early onset bone loss
c. Rapid bone loss
d. Candida overgrowth
e. Foul Breath
f. All of the above

10. HbA1c is a measure of how many months average circulating blood sugar?

a. 1
b. 2-3
c. 5-6
d. None of the above

11. The American Diabetes Association Guidelines for A1C testing include:

a. All patients over 45 years old
b. If normal, every three years following
c. Under 45, all patients with an abnormally high BMI plus at least one other diabetes risk factor
d. All of the above

12. T/F - We currently don't have access to fast and highly accurate point-of-care measuring devises for HbA1C

Answer Key: 1. F, 2. T, 3. F, 4. D, 5. F, 6. T, 7. C, 8. F, 9. F, 10. B, 11. D, 12. F

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Healthcare Practice Financial Literacy – Parts 1 & 2

Carole C. Foos, CPA

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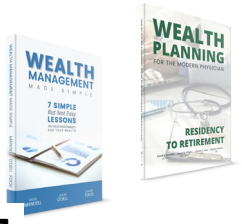
  - Click the link in the reply text
- Visit ojmbookstore.com and enter **AEIOJM** at checkout
- Scan the QR Code



LEARNING OBJECTIVE:

GAIN A BETTER UNDERSTANDING OF BUILDING WEALTH UTILIZING:

- TAX PLANNING
- ASSET PROTECTION
- INVESTMENT PLANNING
- AVOIDING FINANCIAL PITFALLS

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ASSET PROTECTION

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TYPES OF LIABILITY FACING PHYSICIANS & DENTISTS

- Medical/dental malpractice
- Employer liability
  - Sexual harassment ("hostile work environment"); Wrongful termination (protected classes); Violation of fiduciary duty (qualified plans)
- Billing issues
  - Over-billing, improper billing, fraud, violation of anti-kickback rules, Stark rules, etc.
- HIPAA
- Premises liability
- Personal liability

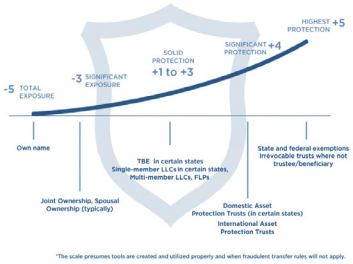
ASSET PROTECTION FITNESS

Your ability to earn an income may be your greatest asset. Make sure you are well protected against other risks.

- **Protection objectives: Discouragement, Settlement, Protection**
- Insurances:
  - P&C: practice: all coverages, renewed focus on business interruption? Cyber?
  - Disability: your greatest asset is often the ability to work
  - Life insurance: death benefit for family, cash value insurances have investment floors
  - **Whole life policies will credit dividends of 5-6%, Equity-indexed will have floor of 0%**
- Asset protection:
  - Review by an expert
  - Proper ownership structure
  - Proper language in operating agreements
- Estate planning: for yourselves and parents

BEST ASSET PROTECTION NOT AP

- Why wealth protection MUST be tied to wealth creation: timing
  - Fraudulent transfer law
  - Transfer for less then fair value that leaves one unable to pay debt
- Insurance is a key component
  - Commercial/personal, captives, RRGs
- AP must be implemented in a multidisciplinary approach
  - Legal, Financial, Insurance
- Legal planning - like tax planning: economic substance
- Top (+5) tools are primarily not AP tools



*The scale presumes tools are created and utilized properly and when fraudulent transfer rules will not apply.

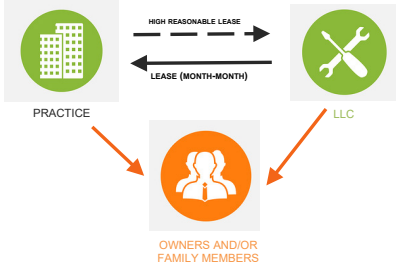
INSURANCES AS FRONT-LINE PROTECTORS

- Types of policies
  - Medical or dental malpractice
  - General Liability
  - Cyber
  - Landlord
  - Other
- Be aware of coverage limitations, deductibles
- Review and get second opinions

CHOICE OF ENTITY FOR NON-PRACTICE BUSINESSES

	Corporation	LLC
Inside Protection	Yes. General corporate law principles.	Yes. General corporate law principles.
Outside Protection	**None, unless licensure for professional corporations.**	Charging order protections available. (+2)

PROTECTING EQUIPMENT & REAL ESTATE



MAXIMIZE PROTECTIVE BENEFIT PLANS

- **Shields #1 asset – cash flow**
- Qualified retirement plans (QRPs): state exemption laws vary
  - Most states also protect QRPs to an unlimited value
  - Some states: value limitations
  - Some states: timing claw-backs
- Non-qualified plans – depends on funding mechanism
  - COLI – about 20 states provide (+5) exemption
  - Other states: can use trusts or LLCs

TITLING ASSETS: DOES IT PROTECT?

- Spousal
- Basics: Tenancy in common, joint tenancy
- Tenancy by the Entirety (TBE)
- Community Property

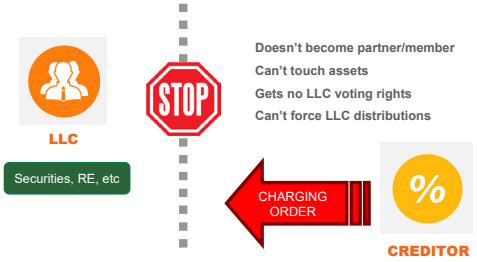
START WITH EXEMPT ASSETS (+5)

- (+5) Federal or state exempt asset
- No gifting, compliance, accounting fees or special taxes
- Protection cannot be matched by any other planning
- Federal bankruptcy exemptions for QRPs and IRAs
- States vary widely
  - Homestead
  - QRPs, IRAs
  - Life insurance and annuities

LLCs (+2): IDEAL FOR MOST ASSETS BEYOND EXEMPTIONS

- Inside Creditors
- Outside Creditors Isolates their lawsuit damage only to LLC property
  - Creditors can only get "charging order" against the LLC interest (+1 to +3) depending on use, compliance
  - Should tie into your estate plan
- "Building blocks" of asset protection
- *Control and Access*

WHAT A "CHARGING ORDER" MEANS



KEYS TO PROTECTION: LLCs

- Proper operating agreement
- Compliance with annual formalities
- Non-asset protection purpose: estate planning/gifting
- Jurisdiction: use the best state, when you have options
- Many LLCs are lacking in 1 of the 4 elements above: vulnerable
- Key: experienced attorney who has annual monitoring/gifting plan

PROTECTING THE HOME

- Homestead protection is best
- Tenancy by the entirety (TBE) in those states that protect TBE well
- Next best option:
  - Usually debt shield

WEALTH PLANNING

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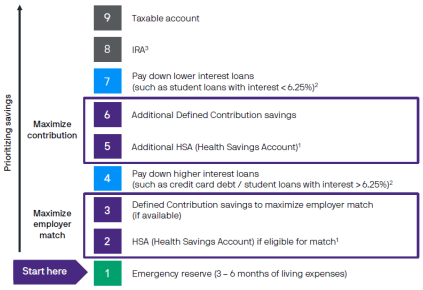
FOCUS ON WEALTH ACCUMULATION

"It's not how much money you make, but how much money you keep, how hard it works for you, and how many generations you keep it for."

Robert Kiyosaki

SAVINGS HIERARCHY



RETIREMENT SAVINGS CHECKPOINT

Current age	Current household income: $30,000	$40,000	$50,000	$60,000	$70,000	$80,000	$90,000
	Checkpoint (x current household income)						
25	See "Annual savings needed" on slide 16"	0.1	0.1	0.3	0.5	0.6	0.8
30		0.2	0.5	0.7	1.0	1.1	1.3
35		0.6	0.9	1.1	1.5	1.7	1.9
40		0.3	1.1	1.4	1.7	2.2	2.4	2.6
45		0.7	1.6	2.1	2.4	3.0	3.2	3.5
50		1.1	2.3	2.8	3.2	3.9	4.1	4.5
55		1.7	3.0	3.6	4.1	4.8	5.2	5.6
60		2.2	3.7	4.4	4.9	5.8	6.1	6.7
65		2.5	4.1	4.9	5.5	6.5	6.9	7.5

Current age	Current household income: $100,000	$125,000	$150,000	$175,000	$200,000	$250,000	$300,000
	Checkpoint (x current household income)						
25	0.1	0.3	0.5	0.7	0.8	1.0	1.2
30	0.6	1.0	1.2	1.5	1.6	1.9	2.1
35	1.5	1.9	2.2	2.5	2.7	2.9	3.2
40	2.5	3.0	3.3	3.7	3.9	4.2	4.6
45	3.6	4.3	4.7	5.1	5.4	5.8	6.2
50	5.0	5.8	6.3	6.7	7.1	7.6	8.0
55	6.5	7.5	8.0	8.5	8.9	9.5	10.0
60	8.0	9.1	9.7	10.3	10.8	11.4	12.0
65	9.3	10.5	11.1	11.8	12.3	13.0	13.7

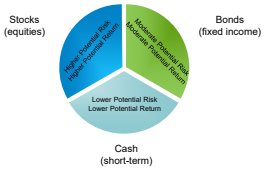
This analysis assumes you would like to maintain an equivalent lifestyle in retirement. Household income is assumed to be gross income (before taxes and savings).

How to use:

- Go to the intersection of your current age and your closest current household income.
- Multiply your current household income by the checkpoint shown. This is the amount you should have saved today, assuming you continue contributions of 5% going forward.
- **Example: For a 40-year-old with a household income of $50,000: $50,000 x 1.4 = $70,000**

THE PRINCIPLES OF ASSET ALLOCATION

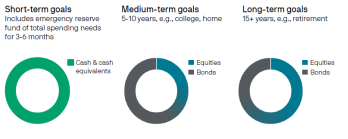
Asset allocation = combining different investment types



*** Up to 91.5% of variations in returns can be attributed to asset allocation**

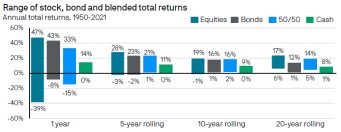
* Source: "Determinants of Portfolio Performance," Brinson, Hood and Beebower, *Financial Analysts Journal*, July-August 1986, and "Determinants of Performance II: An Update," Brinson, Singer and Beebower, *Financial Analysts Journal*, May-June 1991. This represents a landmark study which has not been refuted and which stands today as a valid, widely accepted theory.

GOALS BASED WEALTH MANAGEMENT



Divide and conquer

Aligning your investment strategy by goal can help you take different levels of risk based on varying time horizons and make sure you are saving enough to accomplish all of your goals – not just the ones that occur first.



Source (top chart): J.P. Morgan Asset Management.
Source (bottom chart): Bloomberg, FactSet, Federal Reserve, Robert Shiller, Strategas/Ibbotson, J.P. Morgan Asset Management.
Returns shown are based on calendar year returns from 1950 to 2021. Stocks represent the S&P 500 Shiller Composite and Bonds represent Strategas/Ibbotson for periods from 1950 to 2010 and the Bloomberg Aggregate thereafter. Cash represents the U.S. 90-Day Treasury Bill Total Return.
Portfolio allocations are hypothetical and are for illustrative purposes only. They were created to illustrate different risk/return profiles and are not meant to represent actual asset allocation.

7 QUESTIONS TO ASK YOUR ADVISOR / PROSPECTIVE ADVISOR

1. Does your advisor owe you a fiduciary duty as a client, or are they held only to a "suitability" standard?
2. Can your advisor provide a detailed explanation of all the ways in which they are compensated?
3. Does your advisor's firm make money in other ways on your individual investments?
4. Does your advisor use an outside custodian?
5. Does your advisor utilize proprietary securities?
6. Does the advisor's firm engage in investment banking activities?
7. How does the advisor communicate with you and how often?

FIDUCIARY VS SUITABILITY

- A fiduciary advisor has a ***fiduciary*** duty to his or her clients, which means that he or she has a fundamental obligation to provide suitable investment advice and ***always act in the clients' best interests.***
- A broker ***does not need to act in the best interests of the underlying customer.*** Instead, their actions must only be ***suitable*** for the client.
- A key distinction in terms of loyalty is also important, in that ***a broker's duty is to the broker-dealer he or she works for***, not necessarily the client served.
- **#1 mistake made by physician investors: not using a fiduciary when getting professional investment advice.**

HOW TO RECOGNIZE THE TYPE OF FIRM YOU WORK WITH

ADVISOR
Fiduciary
Advice Driven
Transparency
Registered Investment Advisor
3rd Party Custody
No Proprietary Products

VS

BROKER
Suitability
Transaction Based
Disclosure
Investment or Financial Advisor
In-house Custody
Proprietary Products

FIDUCIARY VS SUITABILITY: STOCK FUND PURCHASE EXAMPLE

- Client A contacts his broker and expresses an interest in investing $50,000 in U.S. growth stocks. The broker invests the client assets in Fund XYZ, which charges a sales load of 5.75 percent with operating expenses of 0.68 percent annually. The client will immediately pay a one-time fee of $2875 on the trade on top of the recurring fund–management fee. In this case, the suitability standard has been met.
- Client B contacts his Registered Investment Advisor, a fiduciary firm, with the same request. The investment advisor purchases an ETF with a gross expense ratio of 0.18 percent and pays a commission of $8.95 on the trade. This client pays his RIA a management fee of 1 percent of the assets, which equates to $500 per year on $50,000. The advisor has met the fiduciary standard.
- **In our very realistic example, the front-loaded fees paid by client A are significant enough that it would require a commitment of approximately nine years to this fund family before that commission is equal to the sum of advisory fees paid by client B.**

SEQUENCE OF RETURNS RISK

SEQUENCE OF RETURNS RISK

Hypothetical example

	PORTFOLIO A		PORTFOLIO B	
Year	Return	Balance	Return	Balance
0		$100,000		$100,000
1	–15%	$80,750	22%	$115,900
2	–4%	$72,720	8%	$119,772
3	–10%	$60,948	30%	$149,204
4	8%	$60,424	7%	$154,298
5	12%	$62,075	18%	$176,171
6	10%	$62,782	9%	$186,577
7	–7%	$53,737	28%	$232,418
8	4%	$50,687	14%	$255,257
9	–12%	$40,204	–9%	$231,374
10	13%	$39,781	16%	$262,594
11	7%	$37,216	–6%	$242,138
12	–10%	$28,994	17%	$277,452
13	15%	$28,553	19%	$324,217
14	17%	$27,557	–10%	$287,296
15	–6%	$21,204	7%	$302,056
16	16%	$18,796	13%	$335,674
17	–9%	$12,165	–12%	$290,993
18	14%	$8,612	4%	$297,433
19	28%	$4,624	–7%	$271,962
20	9%	$0	10%	$293,658
21	18%	$0	12%	$323,297
22	7%	$0	8%	$343,761
23	30%	$0	–10%	$304,885
24	8%	$0	–4%	$287,890
25	22%	$0	–15%	$240,456
Arithmetic Mean	6.8%		6.8%	
Standard Deviation	12.8%		12.8%	
Compound Growth Rate	6%		6%	

TECHNIQUES TO REDUCE YOUR INVESTMENT TAX BILL

- Take advantage of account registration
  - Active funds & bonds in deferred accounts, ETFs in taxable
- Own municipal bonds in taxable accounts
  - Tax free rates vs. ordinary income, understand breakeven points
- Be aware of holding periods
  - 23.8% vs 40.8% LT vs. ST Cap gains
- Offset gains by realizing losses
  - Diversify across asset classes to create planning opportunity
  - Real example: $3 mil client, 194k gains, 50k realized, offset 30k with swap, savings $7,140
- Think twice about gifting cash
  - Gifting appreciated stock can make your contribution worth 20% more
- Understand your fund's tax cost ratio
  - Annualized return reduced by tax on income / distributions

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TAX PLANNING

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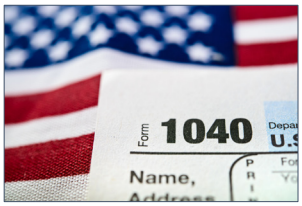
PLANNING FOR THE FUTURE OF UNKNOWN TAX RATES

- Understanding your retirement plan and how it will be taxed
  - Taking advantage of employer contributions
  - Qualified vs. non-qualified plans
  - Tax rates in earning years vs. in retirement years
- Savings outside of your retirement plan
  - Importance of tax efficient investing
  - Dividend and capital gains rates
- Building wealth through tax diversification
  - The three buckets
- Protecting your estate for your heirs
  - Ever changing estate tax exemption



TAX DIVERSIFICATION

ORDINARY INCOME	CAPITAL GAINS	TAX FREE
37.0% FEDERAL + 6.6% STATE + 3.8% ACA	20% FEDERAL + 6.6% STATE + 3.8% ACA	
(47.4% TAX)	(30.4% TAX)	(0% TAX)
WITHDRAWAL: $100,000	WITHDRAWAL: $100,000	WITHDRAWAL: $100,000
LESS TAX: $47,400	LESS TAX: $30,400	LESS TAX: $0
NET AFTER TAX: $52,600	NET AFTER TAX: $69,600	NET AFTER TAX: $100,000

TAX DIVERSIFICATION

- Many physicians have high concentration of retirement assets in qualified plans
  - Traditional plans offer deductible contributions and tax deferred growth
  - Distributions from these plans will be taxed at ordinary income tax rates in effect at time of distribution
- Physicians often have low concentration of assets that will be taxed at capital gains rates or that will be tax free
- Hedging against future tax rate changes is desirable
- Back door Roth has been one way to hedge

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ANOTHER WAY TO FILL THE TAX-FREE BUCKET

Utilize permanent life insurance policy to supplement retirement income:

- Premiums are paid with after tax dollars
- Premiums cover the cost of death benefit as well as building cash value in the policy
- Cash value can be invested in various types of investments, depending on the policy
  - Investment options often contain a floor which provides downside protection
  - They also contain a cap
- Owner can borrow against the cash value, generally tax free
- Policy design, interest rate on borrowing and insured's health are key

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RETIREMENT PLANS

- QRP contributions are tax deductible (401(k)s, profit sharing plans, DB plans, SEP IRAs)
- Contributions grow tax deferred but are taxed at ordinary income tax rates as distributed
- **SO… if a different type of plan or design allows for greater deductions, or more efficient for owners or lower cost, look into adopting now for 2023**
- *Beyond the deduction for the QRP contribution, for some owners in practices taxed as pass through entities, there can be a 2nd level of deduction created under 199A if the QRP contribution lowered the owner's personal taxable income below thresholds for SSTBs.*

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QRP'S: DEFINED CONTRIBUTION PLANS AND SEP IRA'S

- IRS defines the contribution amount
- 401(k)s, 403(b), and 457 plans
  - $22,500 employee deferral amount
  - $30,000 with catch up
- PS: Defined contribution maximum $66,000
- Flexibility on funding
  - No penalties for underfunding or termination
- **Proper plan design is key**

CASH BALANCE PLANS

- Tax Reform has provided additional opportunities – bringing taxable income down below threshold so 20% QBI deduction is not phased out for professionals
- ***Tax Benefits*** - Contributions to the Plan are Tax Deductible and investment return is tax deferred.
- ***Higher*** tax-deductible ***contributions*** than 401(k) alone – use in combination
- Creditor Protection
- Increase retirement benefits for employees *(paid for by tax benefits to owners)*
- Can include death benefits funded with life insurance in addition to retirement benefits (also a way to fund tax free retirement income)
- Can include 401(h) for tax free Retiree Medical expenses

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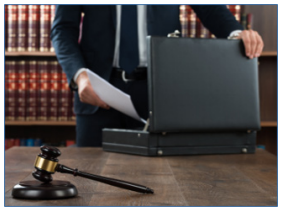
NON-QUALIFIED PLANS

- Non-qualified plans – asset protection depends on plan/state
- Significant other benefits:
  - Present tax deductions – maybe but generally not
  - Long term tax growth deferred and can be designed so that distributions are tax free
  - Discrimination is permitted
  - Reward / retain key employees
  - Save more for retirement to meet goals



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ROTH PLANS

- Contributions of after-tax dollars
  - Taxed at your current rate
- Tax free growth
  - Assuming funds stay in at least 5 years from time Roth started
- Distributions tax free
  - No required minimum distributions
- Over income limit for Roth IRA contribution but not for Roth 401(k)
  - Salary deferral to Roth / profit sharing or match to traditional or Roth
  - No income limit for Roth conversions currently

40

CORPORATE STRUCTURE

- Sole Proprietorship / Single Member LLC
- Multiple Member LLC
  - Partnership
  - C Corporation
  - S Corporation
- Partnership
  - General Partnership
  - Limited Partnership
- Corporation
  - C Corporation
  - S Corporation
- Consider multiple entity structure for tax planning and asset protection

CORPORATE STRUCTURE

- Correct choice of entity
  - May be able to change
- Asset Protection considerations
- Utilize the entity choice correctly with the right compensation structure and profit distribution structure
  - Partnership – income vs guaranteed payment
  - S corporation – don't be taxed like a C Corp
    - BBB Act could change this
  - C corp – double tax conundrum
  - Sole proprietorship – Medicare tax on all net income
  - Health insurance for partners and S Corp shareholders
- QBI deduction – managing the threshold

SECTION 199A QBI

There will be a 20% deduction against **QUALIFIED BUSINESS INCOME (QBI)** of pass-through entities *(S corps, partnerships, LLC's, sole proprietorships, trusts, estates)*

- Effective 2018 through 12/31/2025
- Deduction amount will be the lesser of:
  - 20% of the taxpayer's qualified business income; or
  - 20% of taxable income less net capital gains
- For **business owners below the applicable threshold *amount*** *($182,100 single / $364,200 joint)* there are no further limitations
  - Owners of any non-corporate business in any industry qualify if under the threshold
  - No W-2 limitation if under the threshold
  - Partial deduction if TI below $232,100 / $464,200
- Effectively reduces tax rate on QBI from 37% to 29.6%
- **Can you get yourself below the threshold with QRP deduction or additional changes???**
  - Increase retirement contributions
  - Transfer ownership
  - Corporate structure changes

FINANCIAL PITFALLS

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TAX PITFALLS

- Lack of diversification
- Failure to take advantage of corporate structure
- Inability to maximize and diversify retirement plans
- Lack of planning during earning years

ASSET PROTECTION PITFALLS

- Poor insurance coverage
- Not utilizing +5 assets
- Poor titling of assets
- Lack of strong operating agreements

WEALTH PLANNING PITFALLS

- Failure to use goals-based planning
- Too much risk in portfolio as withdrawals begin
- High tax drag on investments
- Failure to properly allocate assets and match your risk tolerance
- Failure to understand how advisor is paid

PERSONAL WEALTH PLANNING

DIAGNOSTIC vs. TREATMENT

ADVICE & EXPERTISE FOR A FLAT FEE

BUILDING A RELATIONSHIP

OJMGROUP

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  - 877.656.4362
  - carole@ojmgroup.com
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SELF EVALUATION

Healthcare Practice Financial Literacy – Parts 1 & 2

1. T/F - A qualified retirement plan offers the highest level of asset protection (+5).

2. T/F - Titling all my valuable assets in my spouse's name protects me if my spouse is involved in a car accident.

3. An LLC offers excellent asset protection since charging orders for creditors allow them to

a. Get LLC voting rights
b. Limit their lawsuit damages to LLC property only
c. Force LLC distributions
d. Become a partner / member

4. T/F - The first step to starting a savings plan is a 3-6 month emergency reserve of living expenses.

5. T/F - An advisor who has a fiduciary duty to his clients must always do what is in the client's best interest.

6. Having the same average annual return in 2 separate portfolios of retirees withdrawing assets where one runs out of money and the other does not is called

a. Indexing
b. Harvesting capital losses
c. Sequence of Returns Risk
d. Suitability standard

7. One way to reduce your investment tax bill is to

a. Hold assets at least 12 months prior to selling
b. Own municipal bonds in taxable accounts
c. Gift appreciated stock instead of cash to charity
d. All of the above

8. T/F - Tax diversification means having assets in each of 3 income buckets: ordinary income, capital gains and tax-free.

9. Utilizing permanent life insurance as a way to supplement retirement income helps to fill which bucket?

a. Ordinary income
b. Capital gain
c. Tax free
d. None of the above

10. The maximum that an employee under age 50 can defer from his or her salary into a 401k plan in 2023 is:

a. $19,500
b. $22,500
c. $30,000
d. $66,000

11. T/F - The asset protection features of a non-qualified retirement plan is the same in every state.

12. T/F - The earnings growth on a Roth 401k account or a Roth IRA account is tax free as long as the account has been open for at least 3 years prior to taking withdrawals.

13. Which of the following corporate structures has the potential for double taxation?

a. Partnership
b. Sole proprietorship
c. S corporation
d. C corporation

14. T/F - Cash balance plans generally offer higher tax-deductible contributions than 401k plans alone.

Answer Key: 1. T, 2. F, 3. B, 4. T, 5. T, 6. C, 7. D, 8. T, 9. C, 10. B, 11. F, 12. F, 13. D, 14. T

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Understanding, Negotiating and Enforcing Contracts

Why am I Speaking to You Today?

- To explore legal issues in a transition from both the buyer's and seller's perspective
- To answer some of your questions about the legal issues of a practice transition

1

Objective

This presentation is designed to give both buyers and sellers a brief overview of some of the legal issues to consider when transitioning into or out of a dental practice.

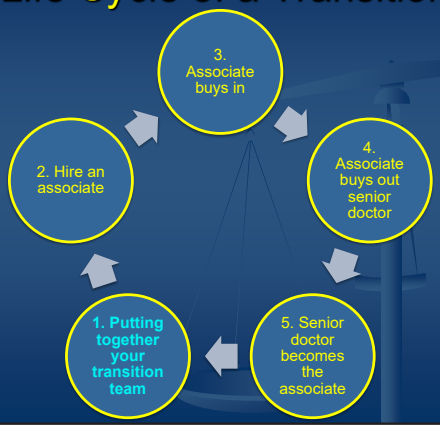
2

Objective

We will review the legal documents your transition might require.

3

Life Cycle of a Transition



4

Do you really need an associate?

- Excessive patient load
- Desire to reduce workload
- Transition imminent

5

Why you don't need an associate

- Professional companionship
- Expectation of growth
- Desire to keep all procedures "in house"
- Locked-in buyer
- Better utilization of overhead

6

Associates, you have two functions in the office:

- Make your employer's life easier
- Make money for your employer

7

Seller's Transition Team	Buyer's Transition Team
Accountant	Accountant
Attorney	Attorney
Financial Planner	Finance Source
Practice Broker	Practice Broker
Transition Consultant	Transition Consultant
Spouse	Insurance Broker
	Spouse

8

Attorney's Role

- Evaluates: legal issues, employment issues, legal structure of practice, documents
- advisor
- negotiator
- document drafter
- document reviewer

9

Legal Considerations

Things to consider and have in place when contemplating a transition . . .

10

Seller's Entity Status

- "C" or "S" corporation?
- If a "C" corp, consider switching to "S" status prior to transition.
- "C" corp makes a transition more difficult due to tax consequences for both parties

11

Seller's Employment by Corporation

- If you are a C corp and have an employment contract with your corporation, "resign" from corporation at least a year prior to sale.
- This will help ensure the goodwill value is personal to you and not a corporate asset.

12

Buyer's Entity Status

In conjunction with your accountant, choose the appropriate entity:

- Sole Proprietor
- Professional Corporation (s-corp election)
- Professional Limited Liability Company

13

Lease Issues: Buyer and Seller

- Pay careful attention to your lease years in advance. Negotiate hard.
- Put your lease where you can find it.
- READ THE LEASE
- You must have at least five to seven years left on your lease when you are ready to sell. Buyer cannot get financing without a lease of this duration.

14

Lease Issues

- Never assume the landlord will cooperate even if he is your patient, friend or brother
- Make absolutely sure you can assign and sublet to your buyer. Key words in lease are "such consent shall not be unreasonably withheld, conditioned or delayed."
- Practice purchase agreement must have a lease contingency

15

Lease Issues

- Seller: do not assign your lease unless you close
- Buyer: do not close unless the lease is assigned to you.
- Buyer: if office is owned by seller, get an exclusive even if you vacate the space

16

Lease Zingers

- right of landlord to recapture space
- large assignment commission to landlord
- unobtainable standards for assignment
- "time is of the essence" clauses
- costly holdover rates
- failure to get an exclusive for dental office
- failure of landlord to release seller

17

Lease to Own

- fair market value rent
- fair market value purchase price
- right of first refusal vs. option to purchase

Seller: Restrictive Covenants

- Make sure all associates have employment contracts with restrictive covenants
- Never hire an associate with the idea you will prepare a contract later
- Lack of restrictive covenant will hurt practice marketability

19

Buyer: Restrictive Covenants

- Restrictive covenants are enforceable: don't sign one if you don't intend to adhere to it.
- Be careful about a "bait and switch" restrictive covenant.
- You will be asked to sign a restrictive covenant: look for creative solutions to difficult issues.

20

Financial Policy, Accounts Receivable

- Tighten up your financial policies at least a year in advance.
- Make an effort to collect your accounts receivable at least six months in advance. This may be money left on the table after the transition.
- Buyer does not want to collect your a/r. Once you sell, you will not be in a strong position to collect them yourself.

21

Practice Liens and Loans

- Review and begin to pay off any outstanding debt on practice.
- Do not enter into any long-term leases or contracts. The buyer may not want to assume these, and you may have to absorb them.
  - examples include: yellow page ad, digital x-ray/cbct, postage meter, water cooler, laundry service, sharps pick-up, alarm system, software maintenance.

22

Practice Statistics: Charts and Computer Entries

- Be diligent about entering computer stats
- Inaccurate stats present an incomplete picture of the practice.
- Improve your charting. Take progress records.
- Buyer will do a chart audit. Do not be offended or defensive. Neat charts improve value and buyer confidence.

23

Pre-Sale Patient Management and Care

- Start treatment on any patient who is ready to begin.
- Increase your initial fee and make sure patients adhere to your fee schedule.
- Avoid excessive prepayments and excessive use of third-party financing.
- Avoid a last minute "fire sale" on treatment. Buyer's can spot that and will look unfavorably on it.

24

Tax Returns/Financial Data

- Clean up your books.
- Slow down on the personal deductions to show more income.
- Report cash in the unlikely event you haven't been.
- Have tax returns and P&L ready for buyer.
- Work with your accountant to have all the financial data ready for buyer.

25

Post-Transition Employment

- Does seller want to work for buyer?
- Does buyer want to employ seller?
- If yes, how much and in what capacity? As an independent contractor or an employee?
- Will Seller close P.C. or have P.C. work for buyer?
- Seller: how you treat buyer will be how buyer will treat you.

26

Personal and Financial Issues/ Seller

- Can I afford to retire?
- Am I burned out?
- Do I have something else I would rather be doing?
- Is my spouse on-board with the sale? (For better or worse, but not for lunch.)

27

Personal and Financial Issues/ Buyer

Know seller's answers to the previous questions and ask yourself:

- Can I afford this practice?
- Do I need to work somewhere else?
- Am I ready to run a practice?
- Is my spouse as excited as I am?

28

Tax Issues in a Transition

There are three parties to every transition:

- Seller
- Buyer
- IRS

29

Tax Issues in a Transition

- goodwill
- accounts receivable, contracts receivable
- restrictive covenants
- fixed (tangible) assets
- supplies and instruments
- leasehold improvements
- stock transfer

30

Goodwill

- best for seller
  - buyer: straight-line 15-year amortization
  - seller:
    - capital gain for unincorporated, S-corp, LLC
    - double tax if C corp
      - 35% corp tax plus personal income tax rate

31

Restrictive Covenants

- allocation unfavorable to both parties
  - buyer: straight-line 15-year amortization
  - seller: ordinary income

(If restrictive covenants are merged into goodwill, capital gains treatment is possible.)

32

Fixed (Tangible) Assets

- dental and office equipment, furniture, fixtures
- good for buyer
  - buyer: depreciates annually according to schedule, 5 – 7 years
    - Section 179 (ask your accountant)
    - buyer may pay sales tax on value of assets
  - seller: ordinary income

33

Supplies and Instruments

- great for buyer
  - buyer:
    - immediately deductible
    - no sales tax
  - seller: ordinary income

34

Leasehold Improvements

- so-so for buyer
- up to 39 years to depreciate
  (cost segregation analysis may speed this up)

35

Allocation of Purchase Price

- Make sure you can support the allocations in your agreements
- Get your accountant involved

Stock Sale

- Great for seller, terrible for buyer.
- Buyer: no deduction, becomes "basis"
- Buyer: inherits all of corporation's liabilities
- Seller: capital gain above basis

37

Fractional (Stock) Buy-In

- Limited value assigned to stock in a fractional buy-in to reduce unfavorable tax outcome to purchaser (depreciated value of assets)
- Income shift, buyer to seller
  - offset (increase) in purchase price
- Personal goodwill of seller
- May be the only way to buy in to a group practice

38

Psychological Issues

- Seller's Concerns
- Buyer's Concerns

39

Seller

- Your practice is probably not worth 1x gross despite how great you feel it is
- You probably aren't worth $2,000/day despite how great you think you are
- Don't stay too long, sell while your practice still has real value
- Even though you just "hung out a shingle" and did well, it is a different environment today.
- Are you sure you can live on what you have left?

40

Buyer

- Seller's practice is worth more than 25% of gross despite how antiquated you feel the physical plant is
- Somehow, seller managed to make a great living with that dowdy old office
- You probably aren't worth $2,000/day despite how great you think you are
- It will take you a year or two to realize you don't know everything
- Are you sure you can live on what you have left?

41

Inter-family Transitions

- every parent's dream
- fraught with emotion
- dependent upon having a large practice
- challenging with divorced families
- complex tax issues

You are ready to move ahead.

What documents will you need?

Formal Document Drafting

- asset, stock , or interest purchase agreement
- new lease or lease assignment and assumption
- employment agreement for seller
- consulting agreement for seller
- deferred compensation agreement for seller
- stock purchase agreement
- stock pledge agreement
- goodwill assignment agreement
- restrictive covenants
- partnership agreements/ partnership dissolution agreements
- promissory note
- bill of sale
- security agreement
- escrow agreement
- lien search/title search

44

Formal Document Drafting

- letter of intent
- parties negotiate issues
- formal documents are drawn up, usually by seller's attorney
- documents can be drawn up by broker, consultant or buyer's attorney
- other attorney reviews and comments

45

Disclaimer

This information is not intended at a substitute for legal advice. You should familiarize yourself with the laws of your local jurisdiction and seek legal advice from a local attorney who specializes in such matters.

48

SELF EVALUATION

Understanding, Negotiating and Enforcing Contracts

1. The “right” reasons an office needs an associate include:

a. Excessive patient load
b. The desire for the senior doctor to reduce his/her workload
c. A transition is imminent
d. All of the above

2. An employee receives what type of tax document at the end of the fiscal year:

a. 1099
b. W-2
c. K-1
d. None of the above

3. If your jurisdiction permits restrictive covenants in associate agreements, they must be:

a. Less than five miles
b. Less than one year
c. No broader than necessary to protect the employer’s legitimate business interests
d. Whatever the parties negotiate

4. T/F - In an “employment at will” jurisdiction, either party may terminate a associate’s employment agreement at any time for any reason.

5. The terms of a negotiated employment agreement supersede any federal, state, or local laws as long as the parties agree to it.

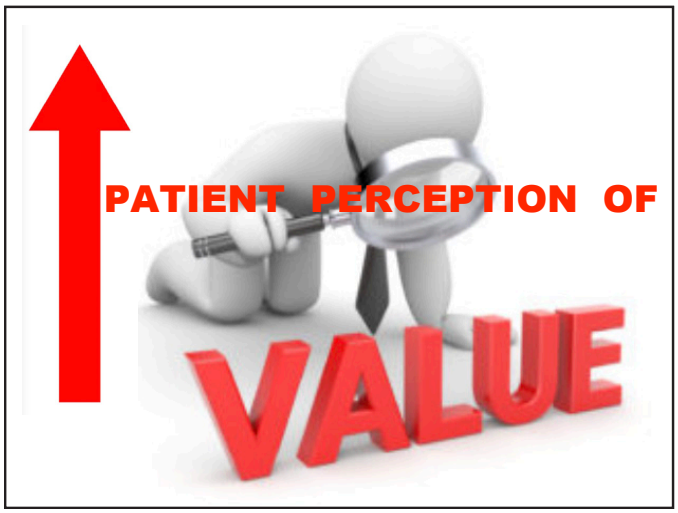
Answer Key: 1. D, 2. B, 3. C, 4. T, 5. F

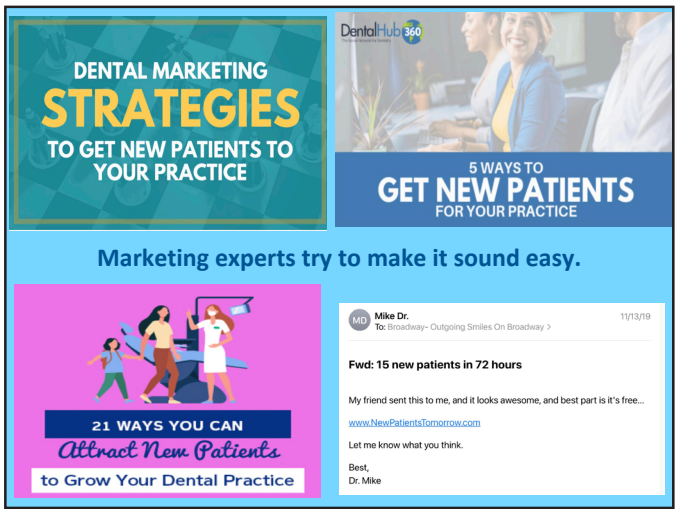
Smile Potential Practice Growth Coaching
Steven M. Katz, DMD, MAGD, FICD
https://smilepotential.com
coaching@smilepotential.com
516-599-0214

Understanding and Implementing Effective Dental Practice Systems

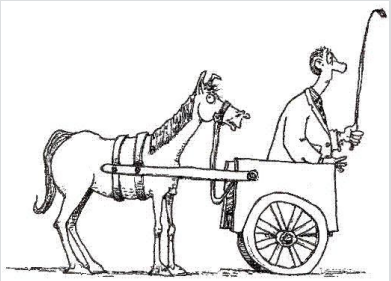

LOTTERY
JACKPOT WINNER
EDWARDS FUNK 14
42,529,765.37
POWER
BALL
NEW YORK
LOTTERY
MEGA
MILLIONS


Systems Must Be Written
enter
return
Job Descriptions
10


PATIENT PERCEPTION OF
VALUE


DENTAL MARKETING
STRATEGIES
TO GET NEW PATIENTS TO
YOUR PRACTICE
DentalHub 360
5 WAYS TO
GET NEW PATIENTS
FOR YOUR PRACTICE
Marketing experts try to make it sound easy.
21 WAYS YOU CAN
Attract New Patients
to Grow Your Dental Practice
Mike Dr.
11/13/19
Fwd: 15 new patients in 72 hours
My friend sent this to me, and it looks awesome, and best part is it's free...
www.NewPatientsTomorrow.com
Let me know what you think.
Best,
Dr. Mike

"I Just Need More Fee-for-Service Patients!"



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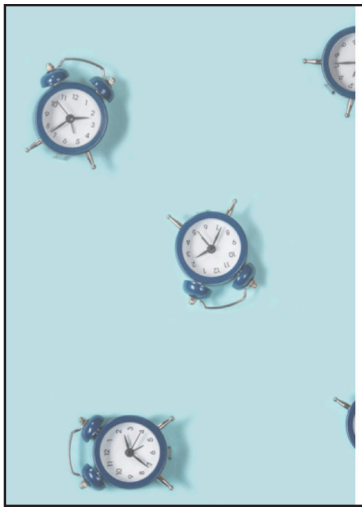
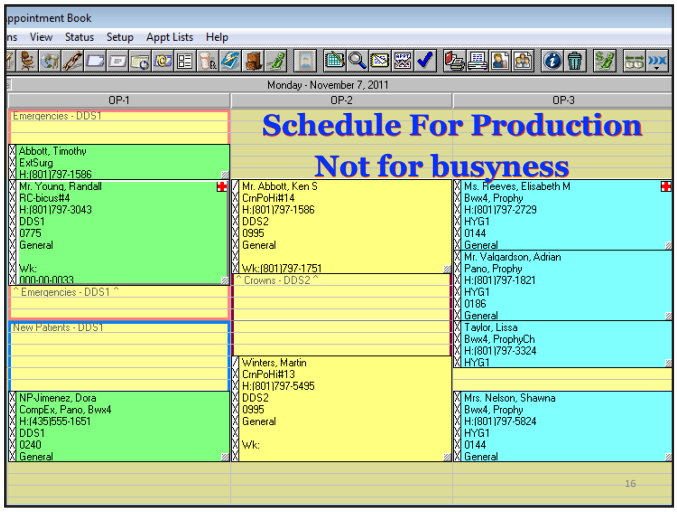


SOOT
Start Out On Time

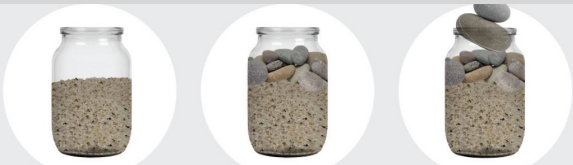
SOT
Stay On Time

GOOT
Get Out On Time

Administrative Profitability



BLOCK SCHEDULING

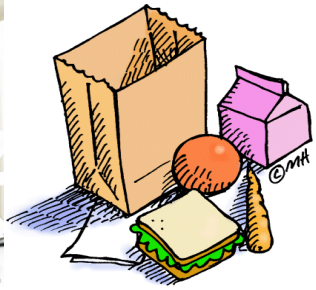


SAND=No Production
PEBBLES=Low/Mid Production
ROCKS=High Production

Master the Art of The New Patient Phone Call

18

Answer Phones During Lunch



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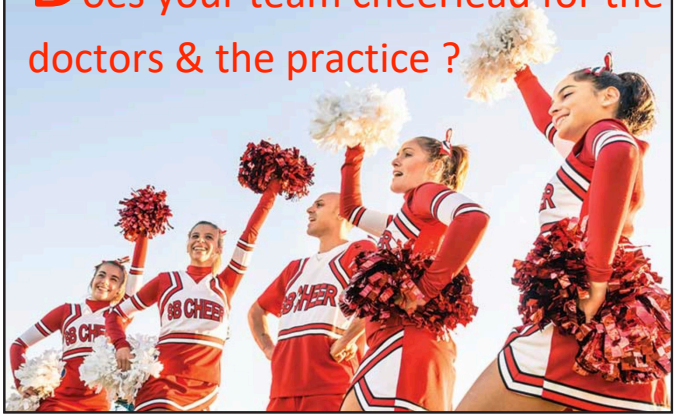
Welcoming your "guests

The "10-foot rule"

Does your team cheerlead for the doctors & the practice ?

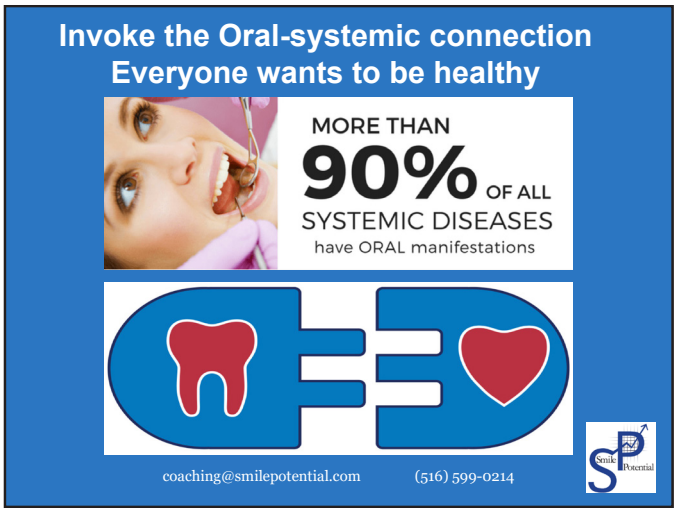


The MOST THOROUGH & Comprehensive Exam…EVER…

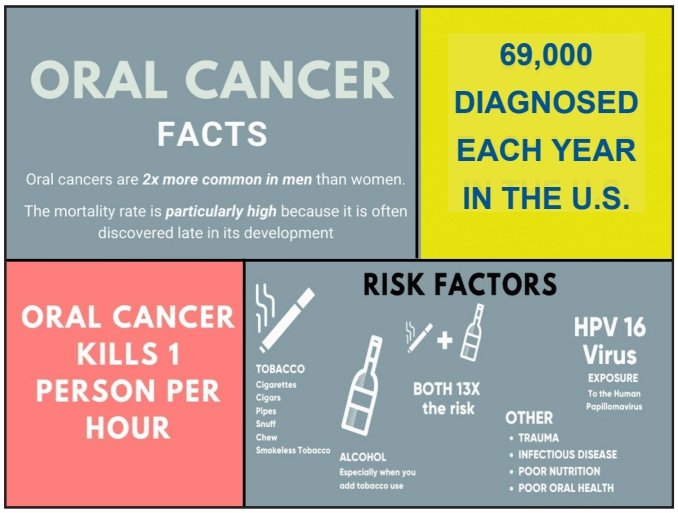
- Blood pressure
- Oral Cancer Screening
- Full charting
- Perio Charting
- TMJ exam
- Airway exam
- Photos
- Scanning

BUILDS VALUE

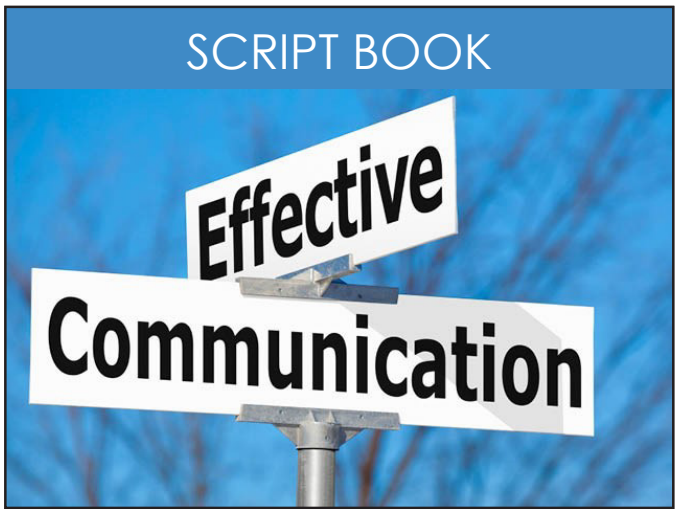

DIFFERENTIATE
Smile Potential


Invoke the Oral-systemic connection
Everyone wants to be healthy
MORE THAN
90% OF ALL
SYSTEMIC DISEASES
have ORAL manifestations
coaching@smilepotential.com
(516) 599-0214

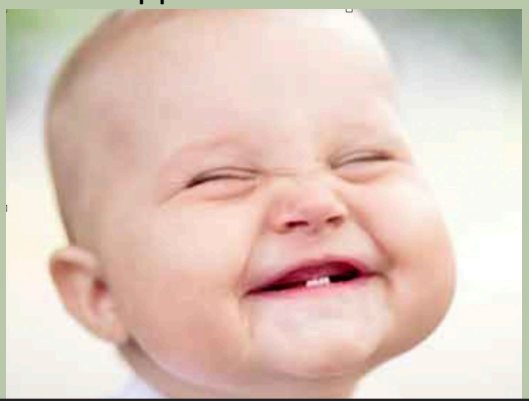

Take patients' Blood Pressures…
Routinely
Screen for Diabetes


ORAL CANCER
FACTS
Oral cancers are 2x more common in men than women.
The mortality rate is particularly high because it is often discovered late in its development
69,000
DIAGNOSED
EACH YEAR
IN THE U.S.
ORAL CANCER
KILLS 1
PERSON PER
HOUR
RISK FACTORS
TOBACCO
Cigarettes
Cigars
Pipes
Snuff
Chew
Smokeless Tobacco
ALCOHOL
Especially when you add tobacco use
BOTH 13X the risk
HPV 16 Virus
EXPOSURE
To the Human Papillomavirus
OTHER
• TRAUMA
• INFECTIOUS DISEASE
• POOR NUTRITION
• POOR ORAL HEALTH


The key to success is
COMMUNICATION


SCRIPT BOOK
Effective
Communication

"When should I bring my child in for their first dental appointment?"



If you would like any additional information about anything discussed in this program, or copies of any of the slides or resources mentioned…

Use QR code…

or send email to:
coaching@smilepotential.com

Include name and phone number.

SELF EVALUATION

Understanding and Implementing Effective Dental Practice Systems

1. T/F - Systems run the practice and people run the systems.

2. Documented systems:

- **a.** Create greater confusion
- **b.** Are not recommended for dental practices
- **c.** Create a framework of accountability

3. T/F - Marketing should be done prior to getting systems in place.

4. SOOT-SOT-GOOT is

- **a.** The name of a fraternity drinking song
- **b.** A quarterback's audibles at the line of scrimmage
- **c.** The number one marketing secret in dentistry
- **d.** A code for dismissing a patient from the practice

5. In block scheduling, you want to fill the schedule in this sequence:

- **a.** Sand, Pebbles, Rocks
- **b.** Rocks, Pebbles, Sand
- **c.** Pebbles, Sand, Rocks
- **d.** Rocks, Sand, Pebbles

6. Strategies that help to differentiate a practice include:

- **a.** Embracing the Oral-systemic connection
- **b.** Doing a thorough oral cancer screening
- **c.** Improving communication
- **d.** All of the above

7. Scripting:

- **a.** Destroys individuality
- **b.** Makes the team sound like robots
- **c.** Delivers a consistency in message
- **d.** Raises patients' confidence
- **e.** C & D

Answer Key: 1. T, 2. C, 3. F, 4. C, 5. B, 6. D, 7. E

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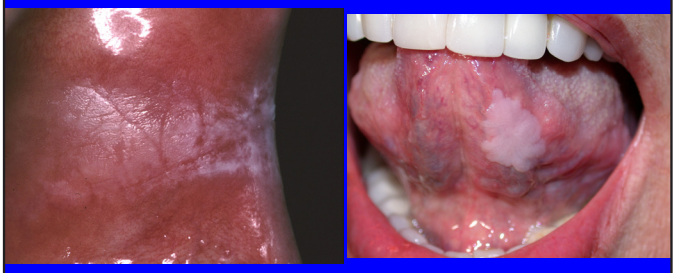
Associate Professor, Donald and Barbara Zucker School of Medicine at Hofstra Northwell
Director, Clinical Oral Pathology

Identifying and Treating Pre-Cancerous and Cancerous Oral Lesions

Detection

- Thorough history
  - Tobacco and alcohol
- Clinical examination
- Biopsy

LEUKOPLAKIA



LEUKOPLAKIA

- LEUKOPLAKIA - WHITE PATCH
- WHO
  - A WHITE PATCH OR PLAQUE THAT CANNOT BE RUBBED OFF OR CHARACTERIZED CLINICALLY OR PATHOLOGICALLY AS ANY OTHER DISEASE
- STRICTLY A CLINICAL TERM - NO CORRELATION TO MICROSCOPIC FEATURES

LEUKOPLAKIA

LOCATION

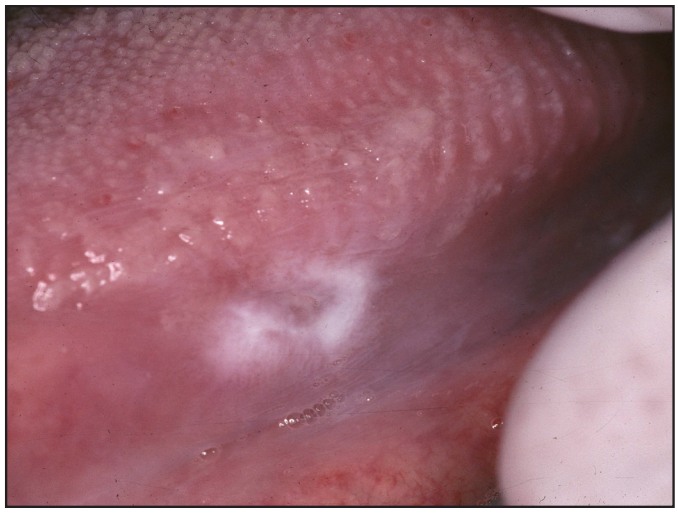
• Mandibular mucosa/sulcus	25.2%
• Buccal mucosa	21.9%
• Maxillary mucosa/sulcus	10.7%
• Palate	10.7%
• Lip	10.3%
• Floor of mouth	8.6%
• Tongue	6.8%
• Retromolar pad area	5.9%

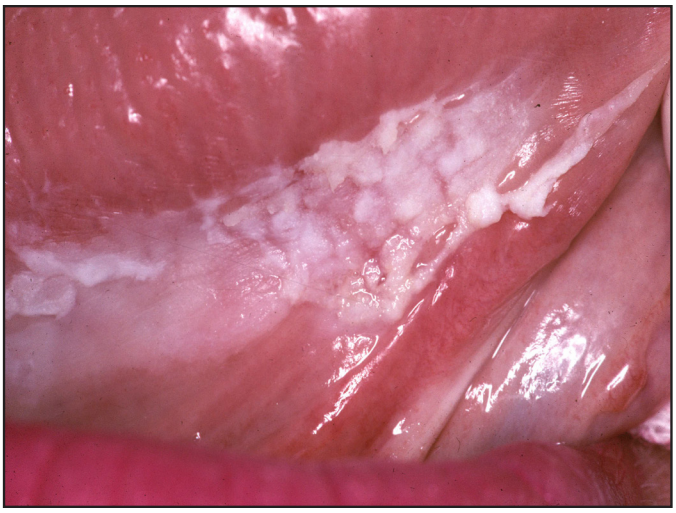
LEUKOPLAKIA

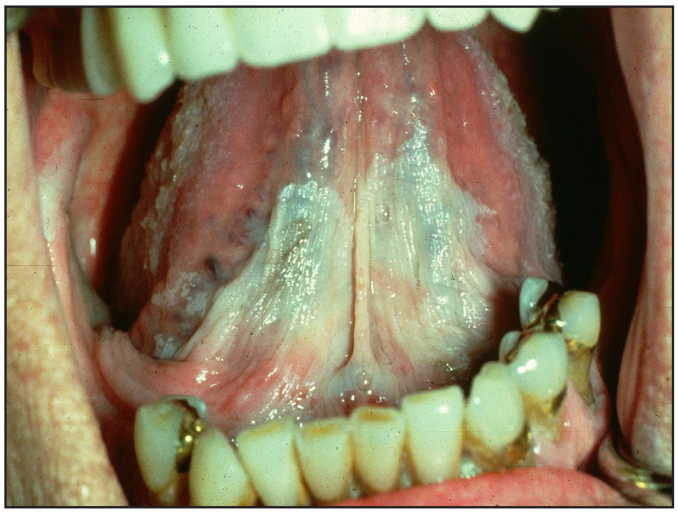
SITE	DYSPLASIA OR CARCINOMA (%)
FLOOR OF MOUTH	43
TONGUE	24
LOWER LIP	24
PALATE	19
BUCCAL MUCOSA	17
VESTIBULAR MUCOSA	15
RETROMOLAR PAD	12

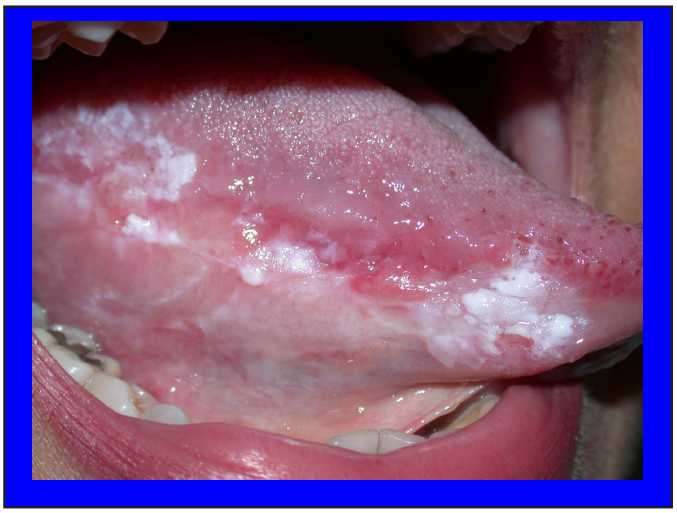
LEUKOPLAKIA

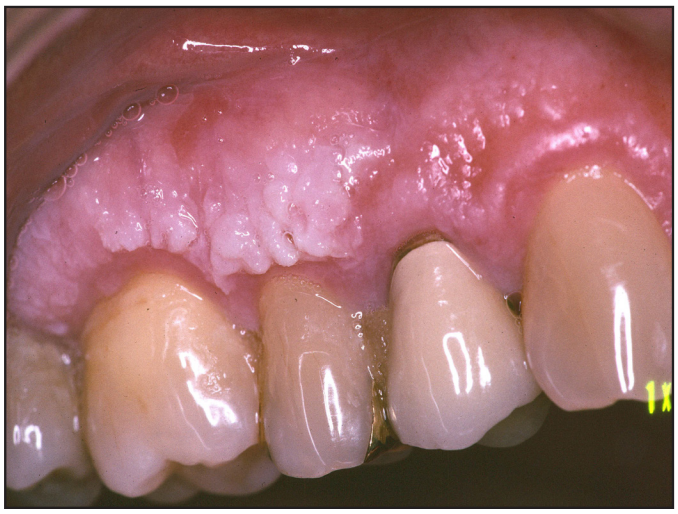
- Histologic Diagnosis
  - Squamous Cell Carcinoma 7.6%
  - Carcinoma in-situ
  - Severe Dysplasia
  - Mild to Moderate Dysplasia 12.2%
  - Hyperkeratosis/ No Dysplasia 80.1%





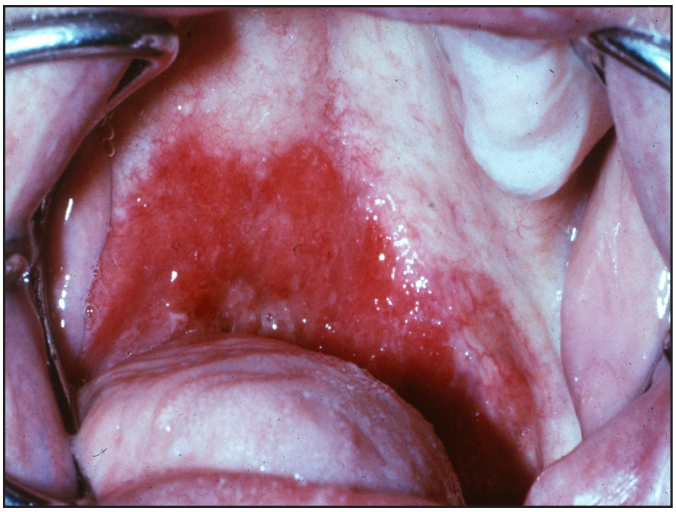


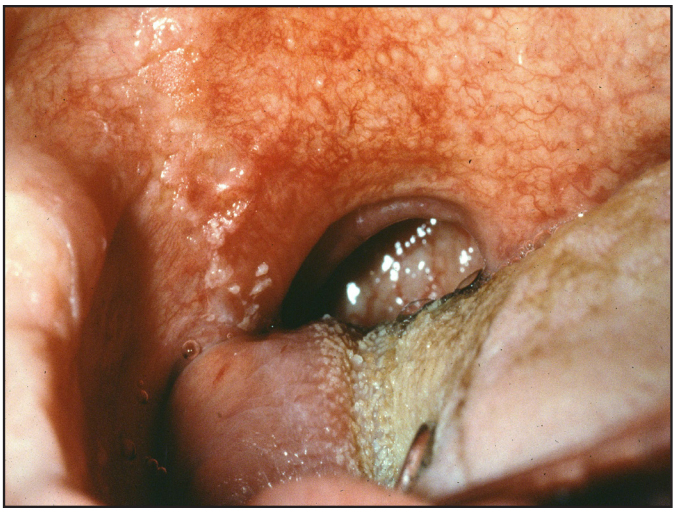


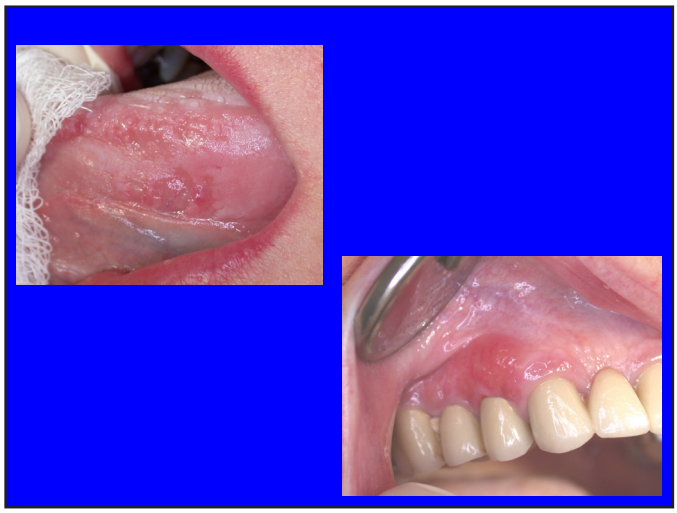


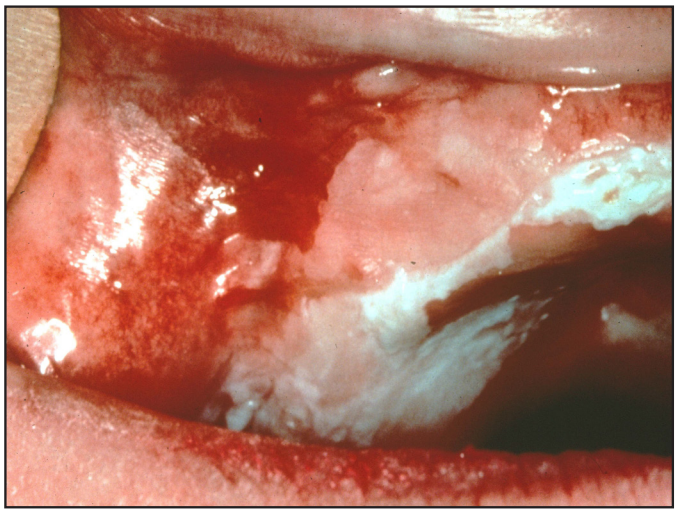
ERYTHROPLAKIA

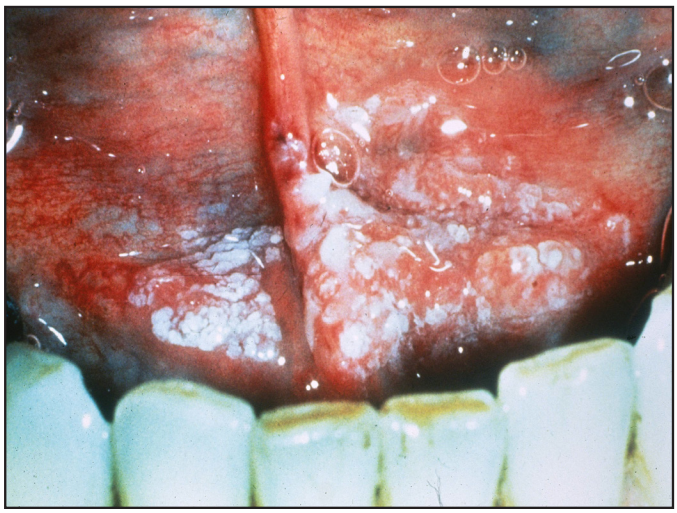
- A RED PATCH THAT CANNOT BE CLINICALLY OR PATHOLOGICALLY DIAGNOSED AS ANOTHER CONDITION
- PROPOSED ETIOLOGY SIMILAR TO SQUAMOUS CELL CARCINOMA
- CAN BE ASSOCIATED WITH LEUKOPLAKIA











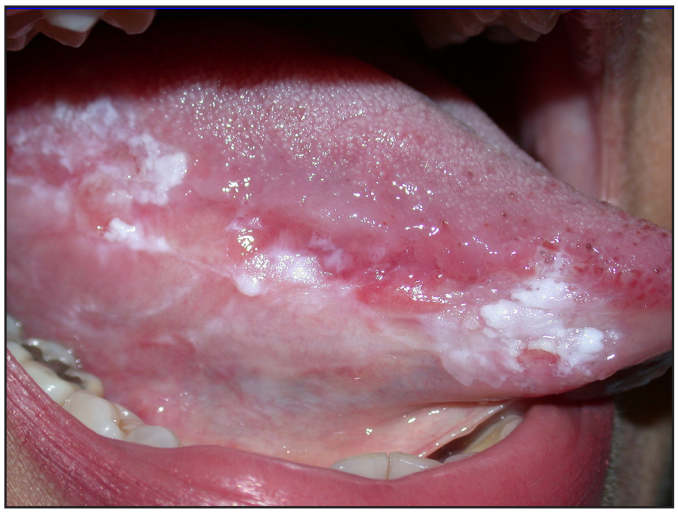
ERYTHROPLAKIA

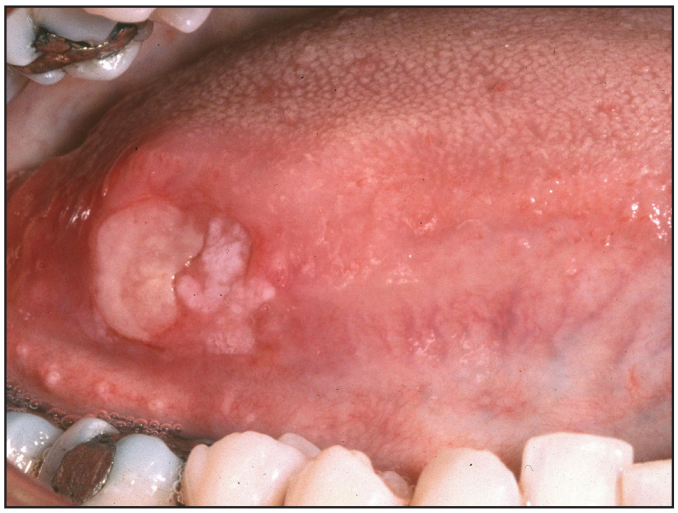
- DIFFERENTIAL DIAGNOSIS
  - MUCOSITIS
  - ERYTHEMATOUS CANDIDIASIS
  - VASCULAR LESIONS
- TREATMENT AND PROGNOSIS
  - BIOPSY !!! - ESPECIALLY ON FLOOR OF MOUTH AND TONGUE
  - RECURRENCE COMMON
  - LONG TERM FOLLOW - UP NECESSARY
  - DEFINITIVE TREATMENT DEPENDS ON HISTOPATHOLOGIC DIAGNOSIS

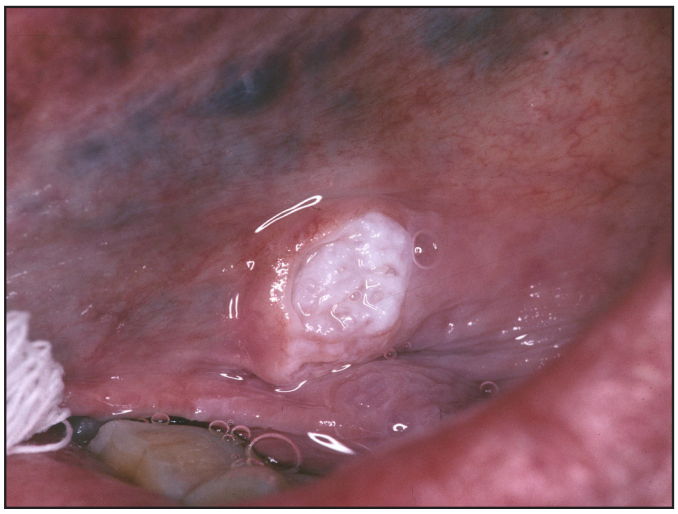
SQUAMOUS CELL CARCINOMA

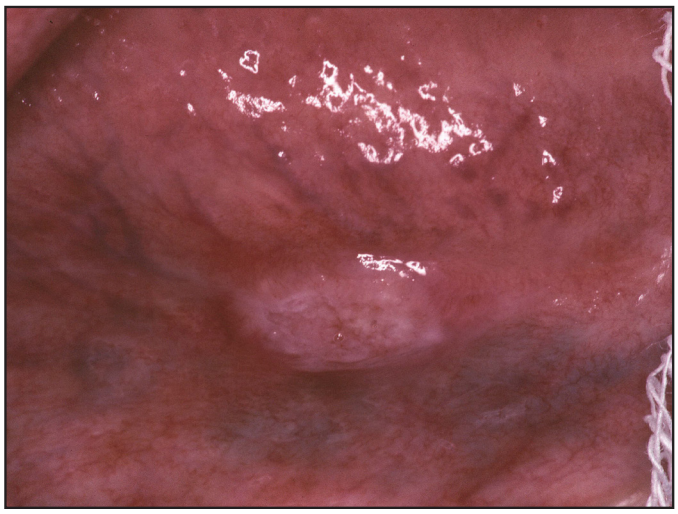
SQUAMOUS CELL CARCINOMA

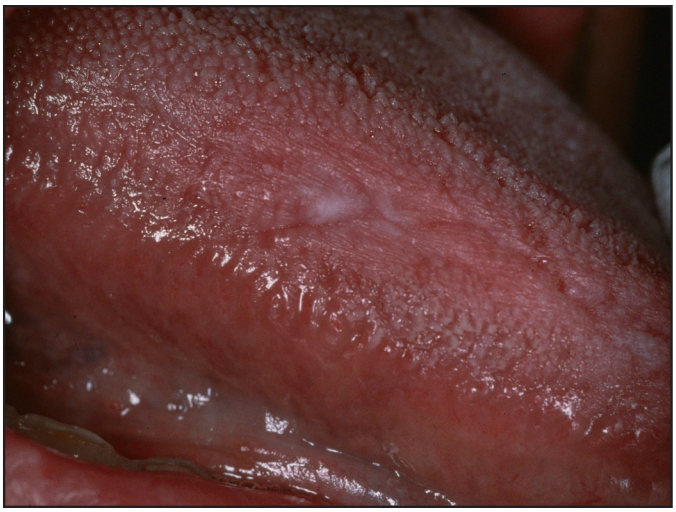
- CLINICAL FEATURES
  - MINIMAL PAIN OR DISCOMFORT
  - DELAY IN SEEKING CARE
  - SEVERAL MONTHS UNTIL DIAGNOSIS
    - EXOPHYTIC - IRREGULAR SURFACE USUALLY INDURATED
    - ENDOPHYTIC - ULCERATED, DEPRESSED ROLLED BORDER - INFILTRATION UNDER MUCOSA
    - LEUKOPLAKIC
    - ERYTHROPLAKIC - SPECKLED

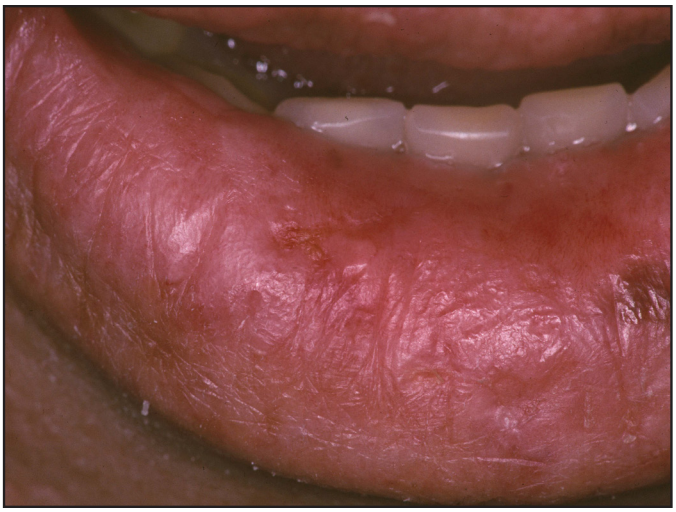


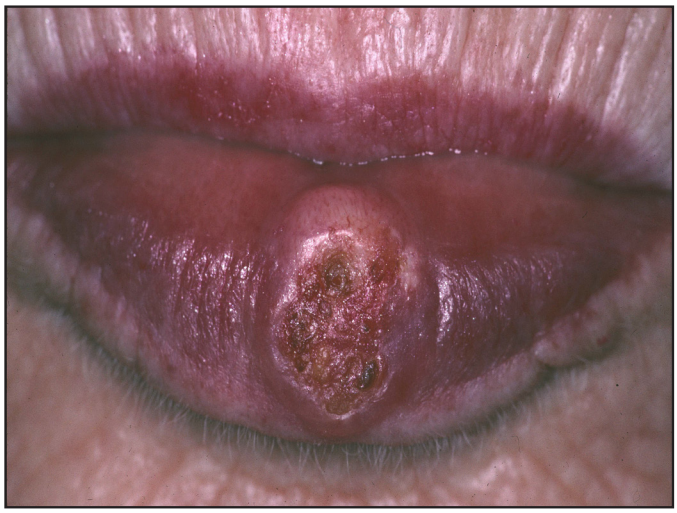


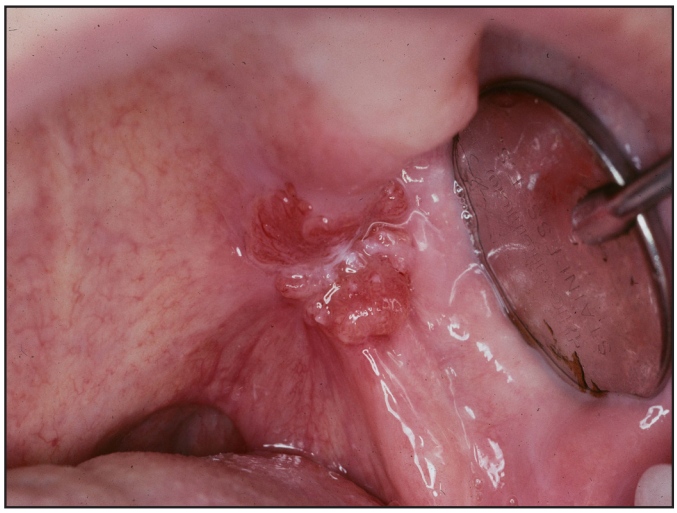


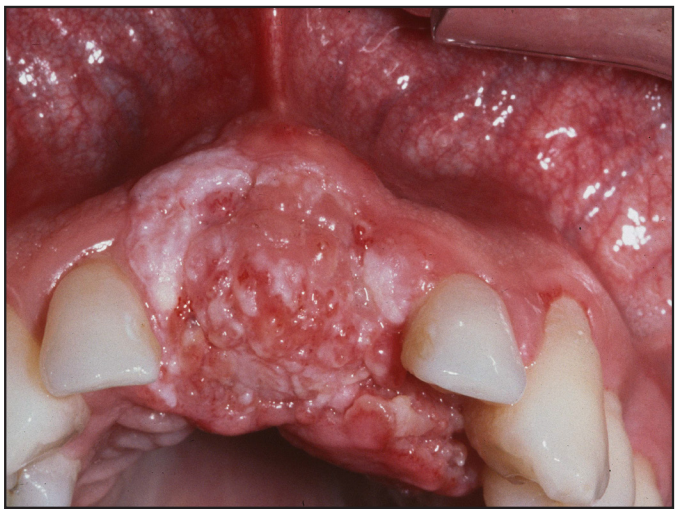


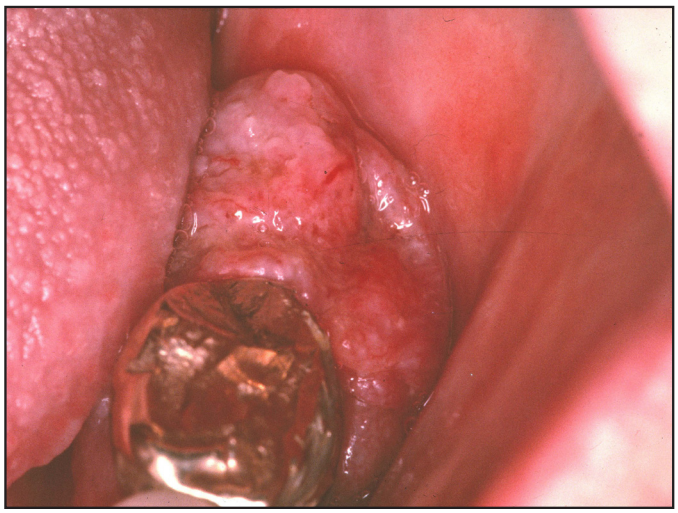


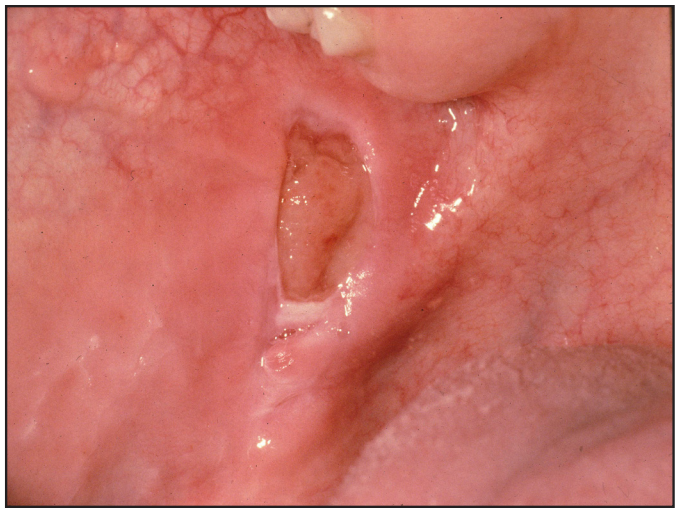


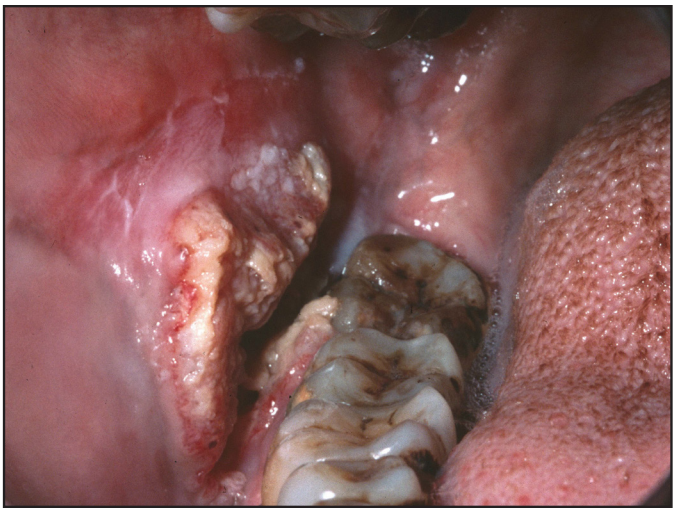


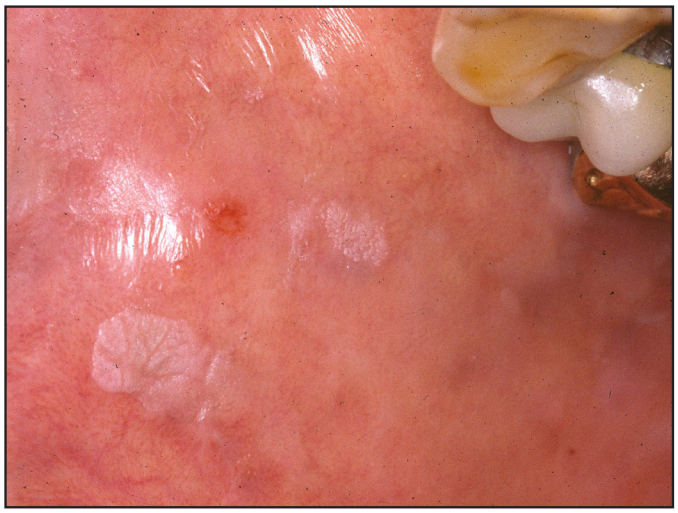






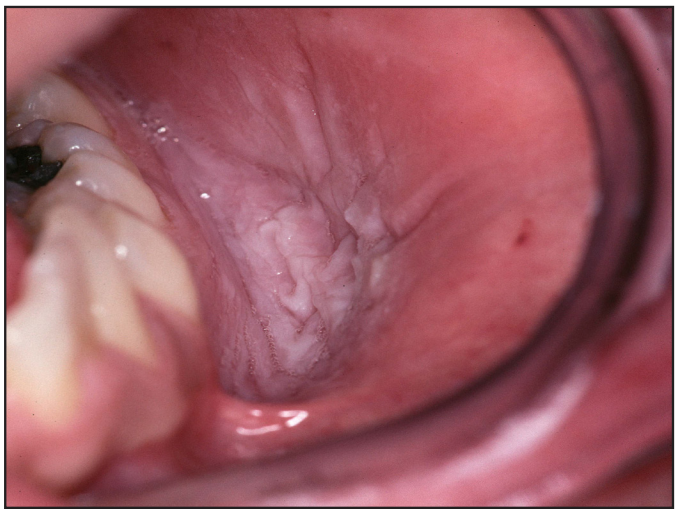


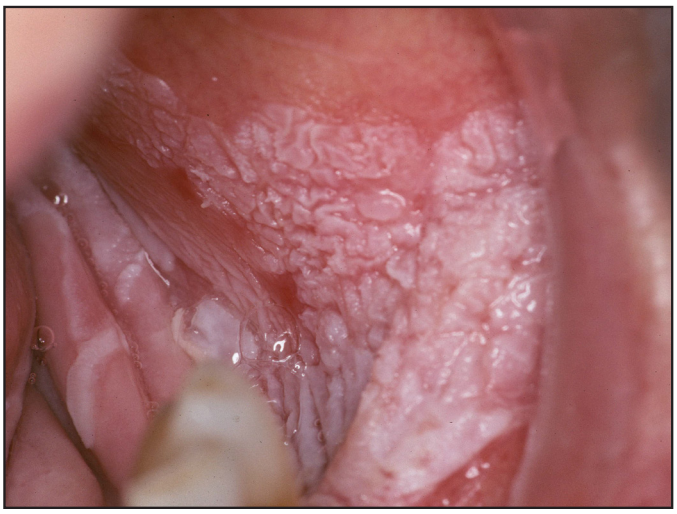


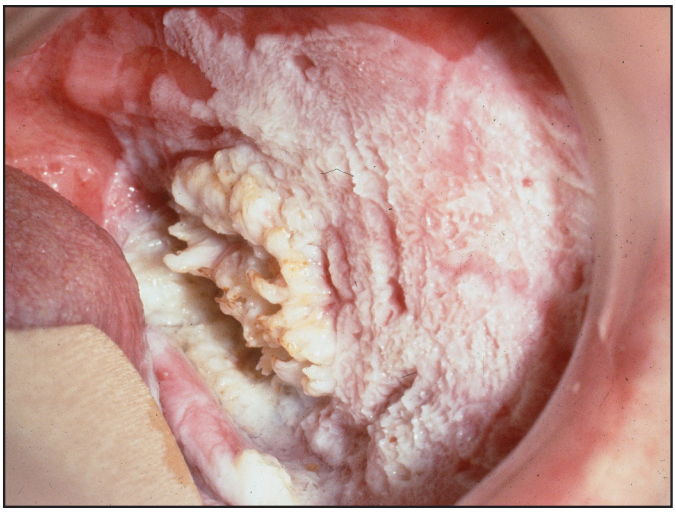


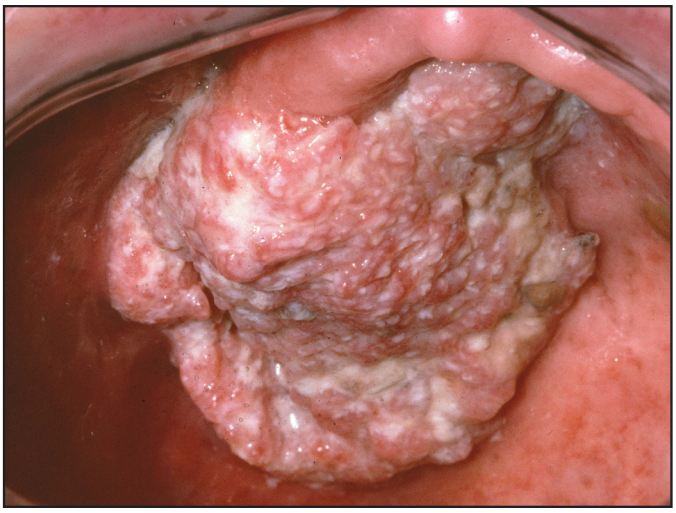
VERRUCOUS CARCINOMA

- LOW GRADE VARIANT OF ORAL SQUAMOUS CELL CARCINOMA
- MAY BE DIAGNOSED IN OTHER SITES
- 1 - 10 % OF ORAL CARCINOMAS
- MOST DIAGNOSED IN SMOKELESS TOBACCO USERS
- 20 % IN NONUSERS
- MANDIBULAR VESTIBULE, BUCCAL MUCOSA, HARD PALATE









SELF EVALUATION

Identifying and Treating Pre-Cancerous and Cancerous Oral Lesions

1. Which of the following is false regarding Verrucous Carcinoma?

a. related to smokeless tobacco use
b. low grade variant of squamous cell carcinoma
c. metastasis common
d. common in buccal vestibule

2. Which of the following are considered high risk sites for oral cancer?

a. Floor of of the mouth
b. Ventral tongue
c. Lateral border of the tongue
d. All of the above

3. T/F - A leukoplakia is defined as a clinical term for a white patch.

4. T/F - Biopsy is of a red patch (erythroplakia) is indicated for a lesion that does not resolve within two weeks.

5. T/F - Most leukoplakias are malignant.

Answer Key: 1. C, 2. D, 3. T, 4. T, 5. F

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Thomas A. Viola, RPh, CCP, CDE, CPMP, of New York, New York, has over 30 years' experience as a pharmacist, educator, speaker, and author. He has particular expertise in the most prevalent oral and systemic diseases, the most frequently prescribed drugs used in their treatment and considerations and strategies for effective patient care planning. Dr. Viola is on faculty at over 10 dental professional degree programs, having received several teacher of the year awards. He is well known internationally for his contributions as an author, and for his work as an editor, of several pharmacology, pain management and local anesthesia professional journals and textbooks. Dr. Viola has presented over one thousand continuing education courses to medical and dental professionals here and abroad since 2021.

You may contact Dr. Viola with your questions and comments by email at tom@tomviola.com. You may also visit his website, www.tomviola.com, and follow him on Facebook and Instagram at "pharmacologydeclassified".

TOM VIOLA
PHARMACOLOGY DECLASSIFIED

The Medically Complex Dental Patient

Thomas A. Viola, RPh, CCP, CDE, CPMP

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 2

Cardiovascular Agents

 3

Antihyperlipidemic Agents

 4

Antihyperlipidemic Agents

- Types
  - Lipitor (atorvastatin)
  - Crestor (rosuvastatin)
- Mechanism of Action
  - Inhibits HMG-CoA reductase, reduces cholesterol synthesis, decreases LDL's and increases HDL's
- Therapeutic Indication
  - Treatment of high cholesterol
  - Reduction of risk of MI, angina

 5

Antihyperlipidemic Agents

- Adverse Effects
  - Headache
  - Myalgia, allergy
  - GI upset
  - Anterograde amnesia
  - Flatulence
- Precautions
  - Active liver disease
  - Pregnancy
- Dental Considerations
  - Drug interactions with erythromycin, fluconazole, grapefruit juice, pomegranate juice
    - Possible severe myopathy or rhabdomyolysis

 6

Red Rice Yeast *(Monascus purpureus)*

Treatment of hyperlipidemia.
Also used to treat indigestion and diarrhea.

Mechanism of Action
- Contains lovastatin, an HMG-CoA inhibitor

Adverse Effects
- GI upset
- Myalgia
- Rhabdomyolysis

Dental Considerations
- Additive hepatotoxicity
- Many drug interactions

 7

Garlic *(Allium sativum)*

Treatment of hypertension, hyperlipidemia, and CAD.

Mechanism of Action
- Antioxidant and antiplatelet action
- Inhibits HMG-CoA

Adverse Effects
- Offensive breath and body odor
- GI upset, flatulence

Dental Considerations
- Additive bleeding
- Additive hypoglycemia
- Additive hypotension

 8

Antihypertensive Agents

 9

Classification of Hypertension

Blood pressure categories

Category	Systolic (mmHg)		Diastolic (mmHg)
Normal	Less than 120	and	Less than 80
Elevated	120-129	and	Less than 80
Hypertension stage 1	130-139	or	80-89
Hypertension stage 2	140+	or	90+
Hypertension crisis	180+	and/or	120+

Source: American Heart Association (AHA) and American College of Cardiology (ACC), 2020 AHA Annual Meeting, Anaheim, CA

 10

Treatment of Hypertension

- Non-pharmacologic treatment of hypertension
  - Reduce weight
  - Limit alcohol consumption
  - Increase aerobic physical activity
  - Restrict sodium intake
  - Stop smoking

 11

Calcium Channel Antagonists

- Types
  - Norvasc (amlodipine)
  - Adalat (nifedipine)
- Mechanism of Action
  - Prevent calcium from entering cells of the heart and blood vessel walls, relax and widen blood vessels and reduce blood pressure
- Therapeutic Indication
  - Treatment of hypertension, arrhythmia

 12

Calcium Channel Antagonists

- Adverse Effects
  - Dizziness
  - Orthostasis
  - Constipation
  - Dysgeusia
- Precautions
  - Consider short appointments and stress-reduction techniques
- Dental Considerations
  - Increased risk of gingival hyperplasia
  - No interaction with NSAIDs

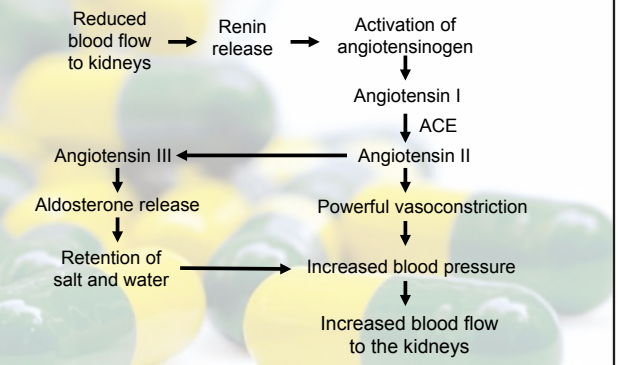
 13

Angiotensin Antagonists

- Types
  - Angiotensin Receptor Blockers
    - Diovan (valsartan)
  - ACE Inhibitors
    - Altace (ramipril)
    - Prinivil (lisinopril)
- Mechanism of Action
  - Inhibit action of angiotensin II
- Therapeutic Indication
  - Treatment of hypertension, heart failure

 14

Renin-Angiotensin-Aldosterone System (RAAS)



Angiotensin Antagonists

- Adverse Effects
  - Dizziness
  - Orthostasis
  - Cough (ACEIs)
  - Joint pain
- Precautions
  - Hepatic impairment
  - Renal artery stenosis
- Dental Considerations
  - Use sedatives and general anesthesia with caution (possible hypotensive episode)
  - Consider short appointments and stress-reduction techniques

 16

Antiplatelet Agents

 17

Plavix (clopidogrel)

- Pharmacologic Classification
  - Platelet aggregation inhibitor
- Mechanism of Action
  - Inhibits binding of ADP to platelet receptors, inhibits formation of thrombi
- Therapeutic Indication
  - Treatment of MI, stroke, PVD
  - Treatment of acute coronary syndrome
  - Prevention of thrombosis post-stent placement

 18

Plavix (clopidogrel)

- Adverse Effects
  - Skin rash
  - Epistaxis, bruising
  - GI upset
  - Stomatitis, dysgeusia
- Precautions
  - Active liver disease
  - Active bleeding
- Dental Considerations
  - Avoid discontinuation for dental procedures due to increased risk of thromboembolism
  - Use NSAIA's with caution
  - Consider local hemostasis measures

 19

Anticoagulant Agents

 20

Vitamin K Antagonists

- Types
  - Coumadin (warfarin)
- Mechanism of Action
  - Inhibits the synthesis of Vitamin K-dependent clotting factors
- Therapeutic Indication
  - Prevention and treatment of venous thrombosis, pulmonary embolism, thromboembolism due to
    - Atrial fibrillation
    - Prosthesis
    - Recent MI

 21

Vitamin K Antagonists

- Patient care considerations
  - Increased risk of bleeding
    - Assessed by INR
      - INR (international normalized ratio)
        - Value of 1 is "normal"
        - Value of <3.5 is needed for dental treatment
      - INR test should be done immediately before oral treatment

 22

Vitamin K Antagonists

- Dental considerations
  - Anticoagulant effect may be reversed with administration of Vitamin K or whole blood
  - Increased risk of bleeding may be exacerbated by other drugs used in dentistry
    - NSAID's
    - Antibiotics
  - No contraindication for dental treatment!

 23

Non-Vitamin K Antagonist Anticoagulants

- Types
  - Xarelto (rivaroxaban)
  - Eliquis (apixaban)
  - Savaysa (edoxaban)
    - Inhibit factor Xa
- Uses
  - Prevention and treatment of venous thrombosis, pulmonary embolism, thromboembolism due to atrial fibrillation

 24

Non-Vitamin K Antagonist Anticoagulants

- Patient care considerations
  - Reversal agent for Xarelto and Eliquis: Andexxa
  - No reversal agent for Savaysa
    - No INR testing for monitoring
  - Increased risk of bleeding may be exacerbated by other drugs used in dentistry
    - NSAID's
    - Antibiotics
  - No contraindication for dental treatment!

 25

Gastrointestinal Agents

 26

Proton Pump Inhibitors

- Types
  - Nexium (esomeprazole)
  - Prilosec (omeprazole)
- Mechanism of Action
  - Inhibits enzyme on the surface of parietal cells, reduces gastric acid synthesis
- Therapeutic Indication
  - Treatment of gastroesophageal reflux disease

 27

Proton Pump Inhibitors

- Adverse Effects
  - Headache
  - GI upset
  - Xerostomia
  - Halitosis
- Precautions
  - Active liver disease
  - Allergy
- Dental Considerations
  - Reduced absorption of calcium, other minerals
  - Reduced absorption of drugs requiring low pH
  - Use NSAIA's with caution
  - Consider semi-supine chair position

 28

Histamine-2 Receptor Antagonists

- Types
  - Tagamet (cimetidine)
  - Pepcid (famotidine)
  - Zantac (ranitidine)
- Mechanism of action
  - Block H2 gastric acid production
- Therapeutic Indication
  - Treatment of peptic ulcer disease
  - Treatment of gastroesophageal reflux disease

 29

Histamine-2 Receptor Antagonists

- Adverse Effects
  - Headache
  - GI upset
  - Halitosis
  - Xerostomia
  - Flatulence
- Precautions
  - Dizziness
- Dental Considerations
  - Reduced absorption of calcium, other minerals
  - Reduced absorption of drugs requiring low pH
  - Use NSAIA's with caution
  - Consider semi-supine chair position

 30

Respiratory Agents

 31

Singulair (montelukast)

- Pharmacologic Classification
  - Leukotriene receptor antagonist
- Mechanism of Action
  - Inhibits binding of leukotrienes to receptors, decreases bronchoconstriction and edema
- Therapeutic Indication
  - Prophylaxis and treatment of chronic bronchial asthma

 32

Singulair (montelukast)

- Adverse Effects
  - Headache
  - Skin rash
  - GI upset
  - Viral infection
- Precautions
  - Not for use in acute asthma or exercise-induced asthma
- Dental Considerations
  - Keep short-acting bronchodilators readily available
  - Use NSAID's with caution
  - Use vasoconstrictors (sulfites) with caution
  - Consider semi-supine chair position

 33

ProAir HFA (albuterol)

- Pharmacologic Classification
  - Short-acting Beta-2 adrenergic agonist
- Mechanism of Action
  - Stimulates Beta-2 receptors, relaxes bronchial smooth muscle, producing bronchodilation
- Therapeutic Indication
  - Prevention and relief of bronchospasm and exercise-induced bronchospasm

 34

ProAir HFA (albuterol)

- Adverse Effects
  - Headache
  - Tachycardia
  - Pharyngitis
  - Xerostomia
- Precautions
  - Hyperthyroidism
  - Severe cardiac disease
- Dental Considerations
  - Keep short-acting bronchodilators readily available
  - Use NSAID's with caution
  - Use vasoconstrictors (sulfites) with caution
  - Consider semi-supine chair position

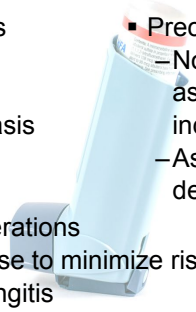
 35

Combination Products

- Types
  - Advair (fluticasone/salmeterol)
  - Symbicort (budesonide/formoterol)
- Mechanism of Action
  - Corticosteroid reduces inflammation and Beta-2 agonist produces bronchodilation
- Therapeutic Indication
  - Prophylaxis and treatment of chronic asthma
  - Treatment of COPD

 36

Combination Products



- Adverse Effects
  - Headache
  - Tachycardia
  - Oral candidiasis
  - Xerostomia
- Precautions
  - Not for use in acute asthma or exercise-induced asthma
  - Asthma-related death
- Dental Considerations
  - Rinse after use to minimize risk of candidiasis and fungal pharyngitis
  - Use NSAID's with caution
  - Use vasoconstrictors (sulfites) with caution

 37

CNS Agents

 38

Antidepressant Agents

 39

SSRI's

- Types
  - Lexapro (escitalopram)
  - Celexa (citalopram)
- Mechanism of Action
  - Selective serotonin reuptake inhibitor (SSRI), increases serotonin activity at receptors
- Therapeutic Indication
  - Treatment of major depressive disorder
  - Treatment of generalized anxiety disorder

 40

SSRI's

- Adverse Effects
  - Headache
  - Xerostomia
  - GI upset
  - Bruxism
- Precautions
  - Increased bleeding
  - Serotonin syndrome
  - Seizure disorder
  - Suicidal thoughts
- Dental Considerations
  - Increased risk of bleeding events, especially with concurrent use of NSAID's, aspirin, warfarin
  - Use epinephrine with caution, monitor blood pressure and pulse

 41

SNRIs

- Types
  - Cymbalta (duloxetine)
  - Effexor (venlafaxine)
- Mechanism of Action
  - Inhibits serotonin and norepinephrine reuptake, increases their activity at their receptors
- Therapeutic Indication
  - Treatment of major depressive disorder
  - Treatment of diabetic neuropathy
  - Treatment of fibromyalgia and chronic pain

 42

SNRIs

- Adverse Effects
  - Headache
  - Xerostomia
  - GI upset
  - Bruxism
- Precautions
  - Increased bleeding
  - Hepatotoxicity
  - Serotonin syndrome
  - Suicidal thoughts
- Dental Considerations
  - Increased risk of bleeding events, especially with concurrent use of NSAIA's, aspirin, warfarin
  - Use epinephrine with caution, monitor blood pressure and pulse

 43

St. John's Wort *(Hypericum perforatum)*

Treatment of depression, PMS, and OCD.
Also used to treat Hepatitis C and nicotine addiction.

Mechanism of Action
- Contains hypericin, inhibits reuptake of serotonin and dopamine and increases norepinephrine in CNS

Adverse Effects
- Photosensitivity
- Xerostomia

Dental Considerations
- Possible serotonin syndrome with tramadol
- Additive bleeding
- Many drug interactions especially with HIV medications

 44

Endocrine Agents

 45

Agents for T2DM

 46

Agents for T2DM

- Biguanides
  - Types
    - Glucophage (metformin)
  - Mechanism of action
    - Decrease the amount of glucose produced by the liver
    - Improve insulin sensitivity and increase glucose uptake

 47

Agents for T2DM

- Biguanides
  - Advantages of metformin
    - Result in weight loss and mild improvement of all aspects of the lipid profile
    - Associated with a generally low level of adverse effects (mostly GI)
    - Availability of generic version leads to a generally low cost of therapy

 48

Agents for T2DM

- Biguanides
  - Disadvantages of metformin
    - Risk of hypoglycemia in predisposed patients
    - May cause lactic acidosis
    - Contraindicated in:
      - Renal impairment
      - Hepatic dysfunction
      - Heart failure

 49

Agents for T2DM

- Incretin mimetics
  - Types
    - Byetta (exenatide)
    - Victoza (liraglutide)
    - Trulicity (dulaglutide)
    - Ozempic (semaglutide)
  - Mechanism of action
    - Enhance insulin secretion
    - Decrease glucagon secretion
  - Patient care considerations
    - Possible increased risk of pancreatitis
    - Possible risk of thyroid c-cell tumor (Victoza)

 50

Agents for T2DM

- DPP-4 Inhibitors
  - Types
    - Januvia (sitagliptin)
    - Onglyza (saxagliptin)
    - Tradjenta (linagliptin)
  - Mechanism of Action
    - Inhibit DPP-4 enzyme
    - Increase incretin hormones

 51

Agents for T2DM

- Adverse Effects
  - Peripheral edema
  - Headache
  - Hypoglycemia
  - Nausea, vomiting
  - Sinusitis
- Patient care considerations
  - Possible increased risk of pancreatitis
  - Morning appointments to minimize stress-induced hypoglycemia

 52

Lantus (insulin glargine)

- Pharmacologic Classification
  - Long-acting insulin
- Mechanism of Action
  - Facilitates passage of glucose into skeletal and adipose tissue, regulates serum glucose levels
- Therapeutic Indication
  - Treatment of Type I diabetes
  - Treatment of Type II diabetes

 53

Lantus (insulin glargine)

- Adverse Effects
  - Fatigue
  - Muscle weakness
  - Skin rash
  - Mouth numbness
- Precautions
  - Hypoglycemia
  - Hypokalemia
- Dental Considerations
  - Additive hypoglycemia with NSAIA's, salicylates
  - Corticosteroids and epinephrine may increase serum glucose levels
  - Monitor for hypoglycemia, ketoacidosis

 54

SELF EVALUATION

The Medically Complex Dental Patient

1. All of the following medications are used in the treatment of diabetes mellitus except:
- a. Byetta (exenatide)
- b. Victoza (liraglutide)
- c. Januvia (sitagliptin)
- d. Onglyza (saxagliptin)
- e. Bentyl (dicyclomine)

2. T/F - Calcium channel blockers may be used for the treatment of hypertension and arrythmia.

3. Which of the following drugs works to reduce the effect of angiotensin II?
- a. Diovan (valsartan)
- b. Benicar (olmesartan)
- c. Altace (ramipril)
- d. Prinivil (lisinopril)
- e. All of the above

4. Adverse effects of SSRI's include which of the following?
- a. Headache
- b. Xerostomia
- c. GI upset
- d. Bruxism
- e. All of the above

5. Which of the following dietary supplements is thought to cause bleeding?
- a. Garlic
- b. Ginseng
- c. Ginger
- d. Gingko biloba
- e. All of the above

Answer Key: 1. E, 2. T, 3. E, 4. E, 5. E

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Cone Beam Computed Tomography: Understanding Legal and Risk Management Issues

Overall Presentation Objectives:

- Understand the nexus of emerging technology and evolving law
- Evaluate the risk-management issues that accompany utilizing technology in your office
- Implement protocols to reduce liability exposure
- Provide you with a conceptual framework to evaluate the suitability of new technology for your office
- Address some of the ethical issues new technology presents

Specific Presentation Objectives:

- Evaluate the risk-management issues that accompany owning, taking and evaluating a CBCT
- Implement protocols to reduce CBCT-related liability
- Review informed consent and informed refusal issues in utilizing CBCT

Technology vs. Jurisprudence

- auto, Uber  
- telephone 
- facsimile 
- computer 
- e-mail @
- Google, Facebook Google 
- AI 
- genomic and reproductive issues
- Dolly 1996  Louise Brown (1978) 

Technology vs. Jurisprudence: Dentistry

- cone beam radiography (CBCT) 2001
- implants
- sleep apnea
- botox
- electronic medical records
- teledentistry
- salivary diagnostics and genomics
- covid testing

Background Information to help us better understand CBCT technology and risk:

- Definition of the Standard of Care
- Elements of Professional Negligence

Standard of Care

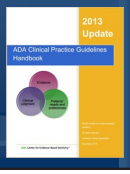
The level at which the average, prudent provider in a given community would practice. It is how similarly qualified practitioners would have managed the patient's care under the same or similar circumstances.

Standard of Care

The standard of care is not determined by any law, textbook, journal, speaker, professor, or dental society. It is determined during a malpractice trial by the triers of fact—the judge and jury. It often comes down to a battle of qualified experts.

ADA Clinical Practice Guidelines

1.1 . . . Evidence-based clinical practice guidelines are intended to provide guidance and should be integrated with a practitioner's professional judgment and a patient's needs and preferences. **They are not standards of care, requirements, or regulations.** They represent the best judgment of a team of experienced clinicians, researchers and methodologists interpreting the scientific evidence on a particular topic.



Standard of Care as it relates to malpractice

The dental malpractice plaintiff must establish the appropriate standard of care and demonstrate that the standard of care has been breached.

Proving a Malpractice Case

In order to demonstrate a breach of the standard of care the plaintiff must prove these four essential elements:

- Duty (doctor/patient relationship)
- Breach
- Causation
- Damages

Questions we will answer:

- When should you take a CBCT?
- Should you read your own CBCT?
- Should you take CBCT for outside dentists?
- Is there any disclaimer that can reduce your liability?
- What type of informed consent is appropriate?

Taking the Tomograph

When should you take a CBCT?

Has a CBCT become the standard of care?

Q. When should you take a CBCT?

- When the average, prudent dentist would take a CBCT.
- When the benefits outweigh the risks.
- When there is a favorable cost/benefit ratio.

Q. Has a CBCT become the standard of care in dentistry?

A. Would the average, prudent dentist have taken a CBCT under same or similar circumstances.

Interpreting the CBCT

- Should you read your own CBCT?
- Is having a radiologist read a CBCT the standard of care?

Answer

- Does the average, prudent dentist in your community have a radiologist interpret a CBCT?
- Would a similarly qualified dentist send the CBCT to a radiologist under the same or similar circumstances?

AAO Insurance's position

"CBCT scans can show information beyond that which we, as orthodontists, are trained to interpret. However, legally you may be presumed to know all that is shown. Involving a radiologist relative to the reading of CBCT scans is therefore advisable."

Know When to Refer your Patients

As specialists, we are presumed to recognize the need to involve other medical and dental disciplines when appropriate. General dentists, other dental specialists or physicians may be necessary for the proper treatment of the patient. CBCT scans are an example of how recent technological advances have made it even more important to recognize when it is necessary to involve other specialists. These scans may reveal information beyond that which we are trained to interpret. However, legally you may be presumed to know all that is shown. Referral of reading CBCT scans to a qualified radiologist is therefore advisable.

AAE & AAOMR joint position

- There is no informed consent process that allows the clinician to interpret only a specific area of an image volume.
- Clinicians can be liable for a missed diagnosis, even if it is outside their area of practice.
- Any questions regarding image interpretation should promptly be referred to a dental radiologist.

Oral and Maxillofacial Radiology

Oral and maxillofacial radiology is the specialty of dentistry and discipline of radiology concerned with the production and interpretation of images and data produced by all modalities of radiant energy that are used for the diagnosis and management of diseases, disorders and conditions of the oral and maxillofacial region.

- Is it okay for dentist to read their own CBCT images?
- If not, will there ever come a time where the average dentist can read a CBCT image?

Oral and Maxillofacial Radiology
Executive Position Paper

- "Standard of Care: Dentists using CBCT should be held to the same standards as board certified radiologists."
- "There may be a misconception on the part of some practitioners that the user has no responsibility for radiologic findings beyond those needed for a specific task (e.g., implant treatment planning). This assumption is erroneous."

Who Is Reading Your Scan?

- Is it a boarded medical/dental radiologist?
- Are they licensed in your state?
- Are they even licensed?
- Will they indemnify you?
- Have they maintained the necessary malpractice insurance?
- How do you know?

Should you take a CBCT for outside dentists?

It may help justify the cost of the machine; it may even get you some referrals, but . . .

Should you take CBCT for outside dentists?

- There is potential liability that comes with serving as an imaging center.
- You may not be covered by your malpractice policy. You need a separate errors and omissions policy.
- You may run afoul of "Stark" or anti-kickback laws.

Electronic Records: HIPAA issues

- Are your records securely stored?
- File transfer protocol for e-mailing patient-related data
- Are you using a secure transmission?
- HIPAA (Health Insurance Portability and Accountability Act
- HITECH (Health Information Technology for Economic and Clinical Health)

HIPAA

- AOL, Yahoo, Dropbox: not HIPAA compliant
- Google can be if you have a paid account and sign a Business Associate Agreement
- Box can be if you sign a BAA

Electronic Medical Records Issue

- Do you have a way to encrypt and share your files with other health care providers?
  - FTP (file transfer protocol)
  - DICOM: (digital imaging and communication in medicine) is the ADA standard
  - EMHR: electronic medical health records

Is there any disclaimer that can reduce your liability?

- Professionals cannot "disclaim" their way out of the standard of care.
- Courts have not recognized disclaimers as an effective shield against an allegation of malpractice.

What type of Informed Consent is appropriate for a CBCT?

Consent is appropriate when a reasonably prudent person in the patient's position would have undergone and accepted the procedure if he/she had been fully informed of the risks, benefits and costs.

The Cost of Care vs the Standard of Care

AJODO LITIGATION AND LEGISLATION
Volume 144, Issue 6 L. Jerrold

The Cost of Care vs the Standard of Care

When does the cost of care impact the standard of care?

Informed Consent

- Radiation concerns
- Diagnostic concerns
- Treatment concerns

Informed Consent: Radiation Concerns

- Are you informing the patient of the increased radiation a CBCT provides?
- Is your cbct "ALARA" (as low as reasonably achievable)?
- What do you do about an older machine that is not ALARA?

California Dose Reporting Law

- California radiologists are required to incorporate radiation dose levels in their reports.
- Radiologists must include in their reports the dose length product or the CT dose index if the machine is able to calculate it.

Informed Consent: Diagnostic Concerns

- Are you offering the patient the option to have the CBCT read by a radiologist?
- Are you reading the scan yourself?
- Are you sure you aren't missing any pathology?
- Are you attempting to "disclaim" responsibility for reading a scan?

Informed Consent: Treatment Concerns

- Once you pick up pathology, are you presenting all treatment options?
- Are you documenting all of your findings and suggestions?
- Are you providing Informed Refusal?
- Is the patient able to consent?

Informed Refusal

- Patients must be informed of what might happen if they do *not* follow your advice
- Document this as you would informed consent

Conclusions:

- CBCT is a new technology that has outpaced the ability of the law to guide us.
- Some of us will be the ones who make new law.

Conclusions:

- Images should be read by someone "qualified" to interpret them.
- If you feel qualified, that could be you.
- If you have any doubt, send the scans to a radiologist.

Conclusions:

- You don't need to know how to interpret the entire scan, but . . .
- You do need to know how to recognize something unusual.

Conclusions:

- You have a duty to refer if you don't understand something on the scan.
- You have a duty to inform the patient of what might happen if they don't seek an outside opinion.

DISCLAIMER:

THIS INFORMATION IS NOT INTENDED AS A SUBSTITUTE FOR LEGAL ADVICE. YOU SHOULD FAMILIARIZE YOURSELF WITH THE LAWS OF YOUR LOCAL JURISDICTION AND SEEK LEGAL ADVICE FROM A LOCAL ATTORNEY WHO SPECIALIZES IN SUCH MATTER.

ERIC J. PLOUMIS

SELF EVALUATION

Cone Beam Computed Tomography: Understanding Legal and Risk Management Issues

True/False

1. The standard of care for interpreting cone beam images is set by the American Association of Oral and Maxillofacial Radiologists.

2. Offering your professional opinion on a cone beam image, even if you took the image as a courtesy for a colleague, can result in the formation of a doctor-patient relationship resulting in professional negligence.

3. A well-drafted disclaimer that you will do your best to interpret an CBCT can serve as a shield to malpractice liability.

4. A doctor is obligated to provide a patient with informed consent and informed refusal.

5. If you take a cone beam you must be fully qualified to interpret the image yourself.

6. If you take a cone beam and decide to interpret the image yourself you must perform to the level of a dental radiology specialist.

7. You have a duty to refer if your ability to diagnose and treatment plan from a CBCT does not meet the standard of care.

Answer Key: 1. F, 2. T, 3. F, 4. T, 5. F, 6. T, 7. T

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Safe Sedation in the Dental Office

Anesthesia in a Dental office

- Sedation techniques may be indicated to treat patient anxiety associated with dental procedures
- Treatment, to enable treatment for patients who have cognitive impairment or motor dysfunction

Anesthesia in a Dental office

- For patients 12 years of age and under, practitioners should also refer to the American Academy of Pediatric Dentistry's *Guidelines for Monitoring and Management of Pediatric*
- Consult your local Board of Dentistry Guidelines

Definitions

- **ACLS –** Advanced Cardiac Life Support
- **AED –** Automated External Defibrillator
- **Analgesia –** the diminution or elimination of pain.
- **Bag valve mask –** a hand-held device used to provide positive-pressure ventilation to a patient who is not breathing
- **BLS –** Basic Life Support for Health Care Providers
- **BMI –** Body Mass Index
- **Continual –** repeated regularly and frequently in a steady succession.
- **Continuous –** prolonged without any interruption at any time.

Definitions

- **Deep sedation –** a drug-induced depression of consciousness during which patients **cannot be easily aroused but** respond purposefully following repeated or painful stimulation. **Spontaneous ventilation** may be **inadequate,** and patients may require intervention to maintain a patent airway. Cardiovascular function is usually maintained.
- **Enteral –** a technique of drug administration in which the agent is absorbed through the gastrointestinal (GI) tract or mucosa; • oral • sublingual (transmucosal)
- **General anesthesia –** a drug-induced loss of consciousness during which patients are **not arousable,** even by painful stimulation. **Ventilatory function** is commonly **impaired,** and patients commonly require assistance to maintain a patent airway. **Cardiovascular function** may be impaired.

Definitions

- **Immediately available** – on-site in the facility and available for immediate use.
- **Local anesthesia –** the elimination of sensation, especially pain, in one part of the body by the topical application or regional injection of an analgesic drug.
- **Maximum Recommended Dose (MRD) –** maximum FDA-recommended dose of a drug, as printed on FDA-approved labelling for unmonitored home use.
- **Minimal sedation –** a minimally depressed level of consciousness produced by a pharmacological method, ability to independently and continuously maintain an airway and respond normally to tactile stimulation and verbal command. Cognitive function and co-ordination may be modestly impaired
- **Mock drill –** a dedicated clinical session, which takes place within the facility, in which sedation team members practice the management of medical and/or anesthetic emergencies
- **Moderate sedation –** a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. A **patent airway**, and spontaneous ventilation is adequate. Cardiovascular function is rarely compromised. **Further, a patient whose only response is reflex withdrawal from a painful stimulus is not considered to be in a state of moderate sedation but, rather, deep sedation.**

Definition

- Levels of Anesthesia / Sedation/ Continuum

	Minimal Sedation (Anxiolysis)	Moderate Sedation/Analgesia (Conscious Sedation)	Deep Sedation/Analgesia	General Anesthesia
Responsiveness	Normal response to verbal stimulation	Purposeful* response to verbal or tactile stimulation	Purposeful* response after repeated or painful stimulation	Unarousable, even with painful stimulus
Airway	Unaffected	No intervention required	Intervention may be required	Intervention often required
Spontaneous ventilation	Unaffected	Adequate	May be inadequate	Frequently inadequate
Cardiovascular function	Unaffected	Usually maintained	Usually maintained	May be impaired

Basics of safety anesthesia

- Patient evaluation and preparation
- Continual monitoring of ventilatory function with capnography/ c02 replaces monitoring by observation and pulse oximetry.
- The presence of an individual in the procedure room with the knowledge/skills to recognize and treat airway complication.
- Sedatives and analgesics are not intended for general anesthesia (BNZ Opioids).
- Sedatives and analgesia intended for general anesthesia (propofol, ketamine).
- Recovery care
- Creation and implementation of quality improvement processes.

Preoperative Evaluation

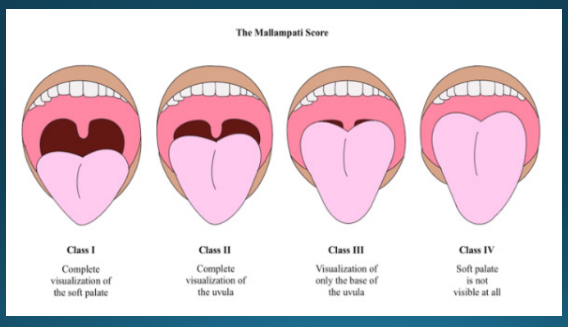
- ◦ Abnormalities in major organ systems (*e.g.*, Cardiac, renal, pulmonary, neurologic, sleep apnea, metabolic, endocrine)
- ◦◦ Adverse experience with sedation/analgesia, as well as regional /general anesthesia
- ◦◦ History of a difficult airway
- ◦◦ Current medications, potential drug interactions, drug allergies, and nutraceuticals
- ◦◦ History of tobacco, alcohol or substance use or abuse
- ◦◦ Frequent or repeated exposure to sedation/analgesic agents

Preoperative Evaluation

- Conduct physical examination of the patient.
- Make sure that your skills are up to task-keep procedure<2 hrs.
- Evaluation of the airway.
- Review available laboratory test result/ order test concerning patient's medical condition, physical examination.
- Have Medical Clearance from M.D./DO.
- Evaluate results of these tests before sedation is initiated.
- Perform the preprocedure evaluation well enough in advance (*e.g.*, several days to weeks) to allow for optimal patient preparation.
- Reevaluate the patient immediately before the procedure.

Preoperative Evaluation

ASA PS Classification	Definition	Adult Examples, Including, but not Limited to:	Pediatric Examples, Including but not Limited to:	Obstetric Examples, Including but not Limited to:
ASA I	A normal healthy patient	Healthy, non-smoking, no or minimal alcohol use	Healthy (no acute or chronic disease), normal BMI percentile for age	
ASA II	A patient with mild systemic disease	Mild diseases only without substantive functional limitations. Current smoker, social alcohol drinker, pregnancy, obesity (30<BMI<40), well-controlled DM/HTN, mild lung disease	Asymptomatic congenital cardiac disease, well controlled dysrhythmias, asthma without exacerbation, well controlled epilepsy, non-insulin dependent diabetes mellitus, abnormal BMI percentile for age, mild/moderate OSA, oncologic state in remission, autism with mild limitations	Normal pregnancy*, well controlled gestational HTN, controlled preeclampsia without severe features, diet-controlled gestational DM
ASA III	A patient with severe systemic disease	Substantive functional limitations. One or more moderate to severe diseases. Poorly controlled DM or HTN, COPD, morbid obesity (BMI ≥40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, ESRD undergoing regularly scheduled dialysis, history (>3 months) of MI, CVA, TIA, or CAD/stents.	Uncorrected stable congenital cardiac abnormality, asthma with exacerbation, poorly controlled epilepsy, insulin dependent diabetes mellitus, morbid obesity, malnutrition, severe OSA, oncologic state, renal failure, muscular dystrophy, cystic fibrosis, history of organ transplantation, brain/spinal cord malformation, symptomatic hydrocephalus, premature infant PCA <60 weeks, autism with severe limitations, metabolic disease, difficult airway, long term parenteral nutrition. Full term infants >6 weeks of age.	Preeclampsia with severe features, gestational DM with complications or high insulin requirements, a thrombophilic disease requiring anticoagulation.
ASA IV	A patient with severe systemic disease that is a constant threat to life	Recent (<3 months) MI, CVA, TIA or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, shock, sepsis, DIC, ARD or ESRD not undergoing regularly scheduled dialysis	Symptomatic congenital cardiac abnormality, congestive heart failure, active sequelae of prematurity, acute hypoxic-ischemic encephalopathy, shock, sepsis, disseminated intravascular coagulation, automatic implantable cardioverter-defibrillator, ventilator dependence, endocrinopathy, severe trauma, severe respiratory distress, advanced oncologic state.	Preeclampsia with severe features complicated by HELLP or other adverse event, peripartum cardiomyopathy with EF <40, uncorrected/decompensated heart disease, acquired or congenital.
ASA V	A moribund patient who is not expected to survive without the operation	Ruptured abdominal/thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction	Massive trauma, intracranial hemorrhage with mass effect, patient requiring ECMO, respiratory failure or arrest, malignant hypertension, decompensated congestive heart failure, hepatic encephalopathy, ischemic bowel or multiple organ/system dysfunction.	Uterine rupture.
ASA VI	A declared brain-dead patient whose organs are being removed for donor purposes			



Pre-Operative Evaluation

Airway factors	Score		
	0	1	2
Mallampati classification	Class I	Class II	Class III to IV
Thyromental distance, cm	>6.5	6.0 to 6.5	<6.0
Head and neck movement, degrees	>90	90	<90
Body mass index, kg/m^2	<25	≥25	NA
Buck teeth	No	Mild	Severe
Inter-incisor gap, cm	>5.0	4.0 to 5.0	<4.0

*Easy airway strata: ADA score ≤6; difficult airway strata: ADA score >6; NA- Not applicable.

Prevention of Airway disasters

Evaluate Airway

Watch Level of Sedation

Can I Ventilate /Oxygenate this patient?

What is the plan to get out of trouble?

Obstructive Sleep Apnea (STOP)

- **Snoring ?**
  Do you **Snore Loudly** (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)?
- **Tired ?**
  Do you often feel **Tired, Fatigued, or Sleepy** during the daytime (such as falling asleep during driving or talking to someone)?
- **Observed ?**
  Has anyone **Observed** you **Stop Breathing** or **Choking/Gasping** during your sleep ?
- **Pressure ?**
  Do you have or are being treated for **High Blood Pressure** ?

Obstructive Sleep Apnea (BANG)

- **Body Mass Index more than 35 kg/m²?**
- **Age older than 50 ?**
- **Neck size large ? (Measured around Adams apple)**
  Is your shirt collar 16 inches / 40cm or larger?
- **Gender = Male ?**

Obstructive Sleep Apnea

- OSA - Low Risk : Yes to 0 - 2 questions
  OSA - Intermediate Risk : Yes to 3 - 4 questions
  OSA - High Risk : Yes to 5 - 8 questions

- Treatment-Resistant Hypertension, Congestive Heart Failure Ischemic Heart Disease, Atrial Fibrillation, Dysrhythmias
- Type II Diabetes Mellitus Metabolic Syndrome Hypothyroidism Morbid Obesity

Minimal Sedation

- Inhalational administration of nitrous oxide and oxygen; or
- Oral/sublingual administration of a single sedative drug, within Maximum recommend dose (MRD), with or without nitrous oxide and oxygen.

Minimal Sedation

- 1. The dentist **must** ensure that the assistant is adequately trained to perform their duties
- 2. The dentist administers the sedation
- 3. The dentist is responsible to ensure the patient is monitored
- 4. The dentist is responsible for recognizing and treating adverse event utilizing the appropriate emergency equipment, medications and protocols.

Minimal Sedation/Pre-Operative

- 1. The patient, parent, escort, guardian or caregiver **must** be advised regarding the procedure and proposed sedation **must** be obtained
- 2. Dietary restrictions **must** be considered
- 3. Pre-operative verbal and written instructions **must** be given to the patient, parent, escort, guardian or caregiver
- 4. Baseline vital signs **must** be obtained
- 5. A focused physical evaluation **must** be performed.

Minimal Sedation/ Intraoperative

- 1. Oxygenation Color evaluated. Measurement of oxygen saturation by pulse oximetry is **required** for patients
- 2. Ventilation
  - The dentist and/or appropriately trained staff member **must** continually confirm chest excursions **must** continually monitor respirations.

3. Circulation

- • Blood pressure and heart rate should be evaluated

Minimal Sedation/ Postoperative

- The dentist **must** determine and document that the level of consciousness, oxygenation, ventilation and circulation are satisfactory prior to discharge.
- Post-operative verbal and written instructions **must** be given to the patient, parent, escort, guardian or caregiver

Moderate Sedation

- Responsiveness purposeful movement to stimulus verbal or tactile
- Airway no intervention required
- Spontaneous ventilation- adequate
- Cardiovascular function-Maintained

Moderate Sedation

- Enteral moderate sedation is usually accomplished by oral administration of **multiple sedative drugs**, with or without nitrous oxide and oxygen. While considered parenteral administration, the administration of a sedative agent of a multi-drug oral regime.
- This can be Oral Sedation with multiple medications (Benzodiazepines and opioids)
- This can be intravenous
- Must be able to RESCUE from a deeper level of sedation

Moderate Sedation

- 1. Assisting in determining the patient's level of consciousness
- 2. Assisting in monitoring ventilation and maintaining a patent airway
- 3. Assisting in protecting the airway by keeping it free of secretions, blood and debris

Moderate Sedation

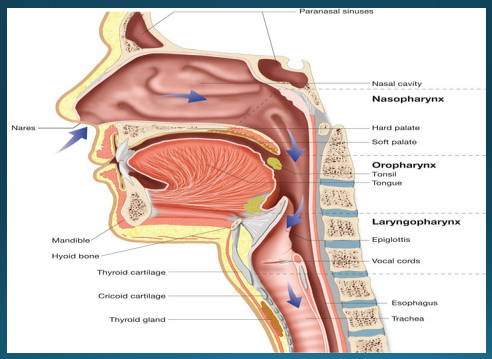
- 1. An adequate supply of intravenous equipment and supplies, including needles, intravenous catheters, syringes, tape, intravenous fluid and intravenous administration sets
- 2. Equipment necessary to provide advanced airway management
- 3. At least one battery-powered physiologic monitor
- 4. At least one battery-powered emergency suction machine
- 5. Documentation of vital signs, medications, consciousness

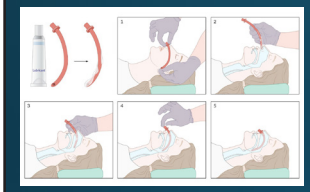
Moderate Sedation

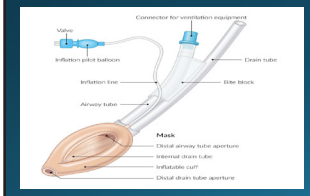
- 1. Oxygenation • Color of mucosa • Oxygen saturation must be monitored by pulse oximetry
- 2. Ventilation • The confirm chest excursions, monitoring end-tidal CO_2 or verbal communication with the patient
- 3. Circulation • Heart rate must be continuously monitored via pulse oximetry; • Blood pressure must be continually monitored (at a minimum of 15-minute); • Patients with significant cardiovascular disease must be continuously monitored with ECG
- 4. Consciousness • Level of consciousness (e.g., responsiveness to verbal commands, either alone or accompanied by light tactile stimulation) must be continually assessed and documented

Slipping away

Awake /alert Sedated , easy to arouse, Sedated **moderate**, Deep Sedation ,Loss of airway, EMERGENCY







Offering Sedation in the Office Practice

- Check your local governing state board on Rule and Regulations
- Be Prepared(policy/ procedure, Mock drill, equipment/rescue)
- Pick the right patient (<2hrs case, ASA status, anxiety status)
- Train yourself and staff of recognize complication
- Have adequate room in your operatory
- Start slow , get comfortable
- Consider getting outside help for sedation

SELF EVALUATION

Safe Sedation in the Dental Office

1. T/F - Within the classification of ASA physical status, an ASA status of three means that the patient has mild disease without functional limitation; example, current smoker, social drinker, BMI is less than 40.

2. One measurement(s) of a difficult intubation would be the:

    a. incisor gap
    b. buck teeth
    c. body mass index
    d. head and neck movement
    e. thyroid mental distance
    f. mallanpati classification
    g. all of the above

3. T/F - Before providing anesthesia to a patient either minimal sedation or conscious sedation the dentist must obtain clearance from the medical provider.

4. T/F - In obstructive sleep apnea acronym STOP, the P in the acronym stands for Prostate issues.

5. T/F - In patients with sleep apnea the reason the sedation dentist should be concerned is that they have a higher risk of congestive heart failure, coronary artery disease, atrial fibrillation, diabetes and metabolic syndrome.

6. T/F - When sedating a pediatric patient, the same level of training for an adult applies.

7. T/F - When sedating your patient with multiple medications or intravenous medications the first sign of hypoxia are blue lips and gums that are easily visualized by the dentist.

Answer Key: 1. F, 2. G, 3. F, 4. F, 5. T, 6. F, 7. F

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Negotiating Your Office Lease and Buildout Agreement

Objectives

- To explore the legal and practical issues related to leasing and purchasing real estate for your dental office.
- To help you to understand what goes into a lease and buildout agreement for your office space.

1

Buying or Renting

- There are advantages and disadvantages to each
- Most young doctors start off renting
- As your practice matures and your financial situation improves, buying may be advantageous

2

Buying

- Building, condo, coop
- Pre-existing dental office
- Renovating an existing building
- Ground-up construction

3

Advantages of Buying

- You get what you want
- You control what you get
- Some tax advantages
  - depreciation (as slow as 39 years)
    - cost segregation for more rapid depreciation
  - mortgage interest deduction
- You set your rent
- Possible appreciation of the building
- Ability to sublet
- Easier to transition your practice

4

Disadvantages of Buying

- Large initial cash outlay
- Greater investment risk
- You are in the real estate business
- You are the property manager
- Management and maintenance issues
- Property may lose value
- You may outgrow your space

5

Advantages of Renting

- You do what you do best: dentistry
- Smaller initial cash outlay
- Frees up cash for other uses
- Flexibility to move if your practice outgrows the space
- Rent is deductible as paid

6

Disadvantages of Renting

- You have a landlord
- Your costs always go up
- You don't control your real-estate destiny
- You build no equity in your space
- Your lease may not be renewed

7

So what is best for you, buying or leasing?

- Leasing is better for the recent graduate who is just starting to build a practice.
- Leasing is better for someone who doesn't want to be bothered managing a property or who isn't handy

8

So what is best for you, buying or leasing?

- Buying is better once you have a financial cushion and are looking for the next investment.
- Buying is better when your practice has grown to the point where you know how much space you really need to thrive.

9

Using a Broker to Find Space

- Even if you contact the broker and the broker "represents" you, if you aren't paying the broker's commission, the broker isn't working for you.
- Your relationship with the broker is a one-time thing; the landlord gives the broker repeat business

10

Who Should Negotiate Your Lease?

- A dental lease is unlike many other leases.
- The extensive buildout costs create a different set of issues.
- Use a professional lease negotiator.
- Use an attorney skilled at negotiating and preparing leases.
- Make sure your advisor knows local issues.

11

What does a lease document look like?

- pre-printed Blumberg form (legal paper)
  - legal size paper (14")
- rider (regular size paper)
- every page and every word is important
- The only thing a judge will look at in the event of a dispute is what is written in the lease. Don't rely on oral agreements.

12

Negotiating Your First Lease

- base rent, annual increases
  - preset increase vs. cpi
- common charges (CAM) and operating costs
  - consider an annual cap
- utilities (water, sewer, electric, gas, steam)
- building security
- taxes, usually "increase over base year"
- pro-rata refund in a tax certiorari hearing
- triple-net lease: taxes, insurance, rent, all costs
- permitted uses/valid certificate of occupancy

13

Negotiating your Lease

- term and termination
- renewal options: 10 + 5, 5 + 5
- right to sublet or assign
- renovations and repairs
- HVAC repair, maintenance, replacement
- exclusivity clause (only dentist/specialist in building)
- no hazardous substances on premises

14

What you want to see in your lease

- landlord's consent, w.s.n.b.u.w.c.d. (which shall not be unreasonably withheld, conditioned, or delayed
- limited personal guaranty (good-guy clause)
- right of first refusal/option to purchase
- right to review landlord's costs if you are paying c.a.m. charges

15

What you want to see in your lease

- period of free rent during buildout
- landlord concessions towards buildout
- termination in the event of death or disability of tenant
- right to assign to an entity owned by tenant (51% or greater)

16

What You Never Want to See in Your Lease

- landlord's right to recapture
- relocation clause
- commission to landlord upon the sale of your practice
- termination clause upon sale of building
- landlord's ability to withhold consent in its sole discretion
- personal guaranty

17

What You Never Want to See in Your Lease

- costly holdover fees
- "time is of the essence" clauses (especially with regard to options)
- very short periods to cure a breach
- tenant pays landlord's costs in the event of a dispute (should be reciprocal)
- need to return space to original condition

18

Lease Issues

- Pay careful attention to your lease. Negotiate hard.
- Put your lease where you can find it.
- READ THE LEASE
- Seller must have at least five to seven years left on your lease when you are ready to buy. Buyer cannot get financing without a lease of this duration.
- Put the option/renewal date in your I-phone at least two years in advance. Have the date pop up every month, not just one time.

19

Lease Issues

- The landlord may be a great guy, but he may sell the building to someone who is not.
- Never assume the landlord will cooperate even if he is your patient, friend or brother.
- Make absolutely sure you can assign and sublet to your buyer. Key words in lease are "such consent shall not be unreasonably withheld, conditioned or delayed."
- Copy your canceled security-deposit check and staple it to your lease.

20

Lease Issues in a Practice Sale

- Seller: do not assign your lease unless and until you close
- Buyer: do not close unless the lease is assigned to you

21

Buildout Issues: before you even start . . .

- Make sure your lease gives you and your contractor reasonable access to the premises.
- Can you use your own contractors?
- Is it a union site?
- Get your permits lined up well in advance
- Find out if there are any restrictions on the premises. Is it landmarked? Are you in a special zoning area?
- Does the building even have a certificate of occupancy and does the C of O permit a dental office?

22

Negotiating with the Contractor

- Ask for references. Call them. See their work.
- Get several bids including one from the landlord.
- Use a designer knowledgeable about dental offices. You need very technical drawings for the contractor to properly bid.
- Don't work on just a handshake. You need a solid contract with the builder.

23

Contractor Agreement

- Be as precise as possible, everything in writing.
- Stipulate a timetable. Have a penalty for delays and over-runs.
- Expect delays and cost overruns.
- Every change order will cost you.
- Always hold back enough money to keep the contractor focused and motivated.
- No final payment until C of O granted.
- The lowest bid is often not the least expensive.
- Time is money even more than money is.

25

Buying Your Building

- Get a demographic study of the area
- Get the building inspected by a knowledgeable inspector. You should receive a written report.
- Check local zoning. Just because there has always been an office there doesn't mean you can have one.
- Arrange for financing well in advance. Get quotes from several lending sources.
- Buy more space than you need. Moving is expensive.

26

Buying Your Building

- If possible, think big and buy extra space.
- Fill that space with complimentary health care specialists for cross referrals.
- Be careful about renting to tenants who don't compliment your vision.

27

Disclaimer

This information is not intended at a substitute for legal advice. You should familiarize yourself with the laws of your local jurisdiction and seek legal advice from a local attorney who specializes in such matters.

28

SELF EVALUATION

Negotiating Your Office Lease and Buildout Agreement

1. One advantage of buying your own office space is that you are building equity.

2. The term “CAM charges” in a lease stands for:

a. Control, Air Rights, Market Forces
b. Common Amplitude Moderation
c. Common Area Maintenance Charges
d. Consideration, Agreement, Comity

3. In a Triple Net Lease, the landlord pays all occupancy costs such a taxes, utilities, and insurance.

4. A Limited Personal Guaranty is also known as a Good Guy Clause.

5. When signing a new lease for office space you should ask the landlord for:

a. A period of “free rent”
b. A “buildout allowance”
c. Only a
d. Both a & b

Answer Key: 1. T, 2. C, 3. T, 4. T, 5. D

Smile Potential Practice Growth Coaching
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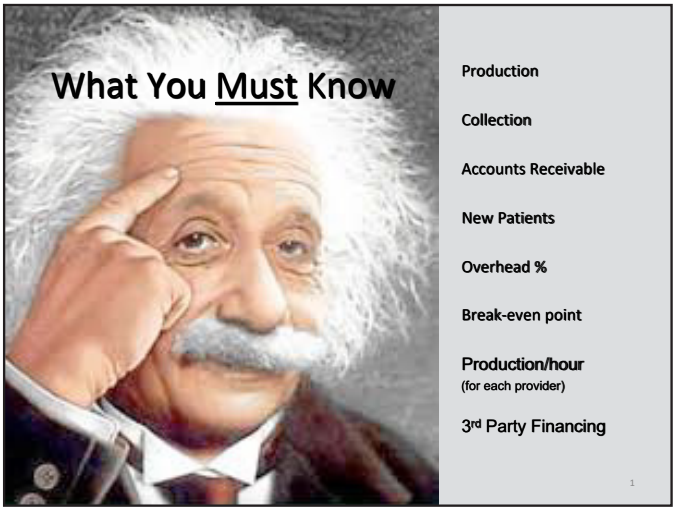
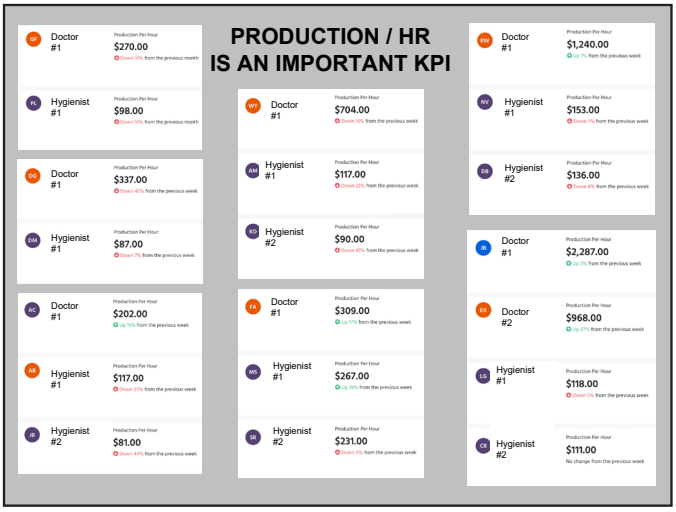
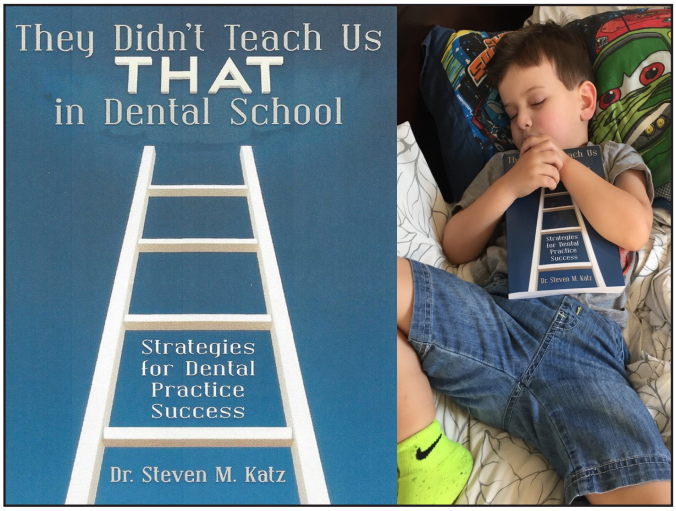
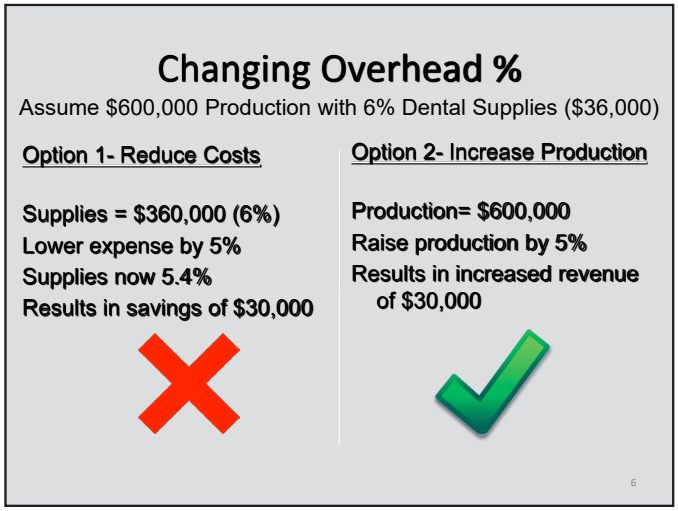
https://smilepotential.com
coaching@smilepotential.com
516-599-0214

Leveraging Analytics for Practice Success









BLUEPRINT FOR $300,000 GROWTH
Production Per Hour

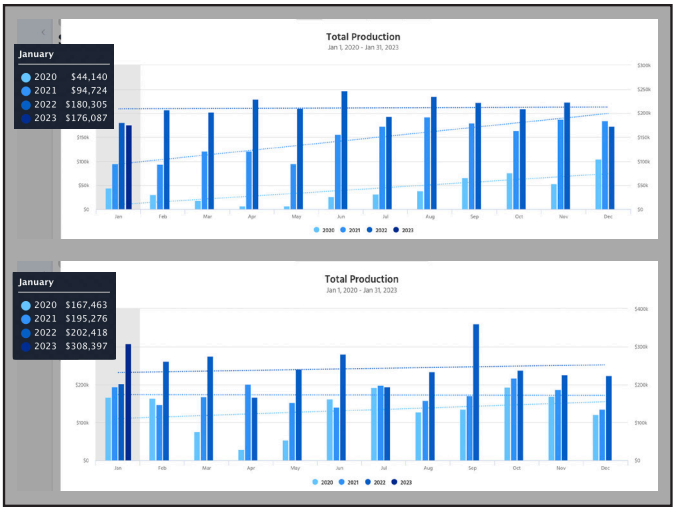
32 Hours/week — 48 weeks/year
Dentist $500/hr — Hygienist $150/hr
$ 1,000,000

1 additional resin/day ($200) results in $25/hour increase
Additional $40,000

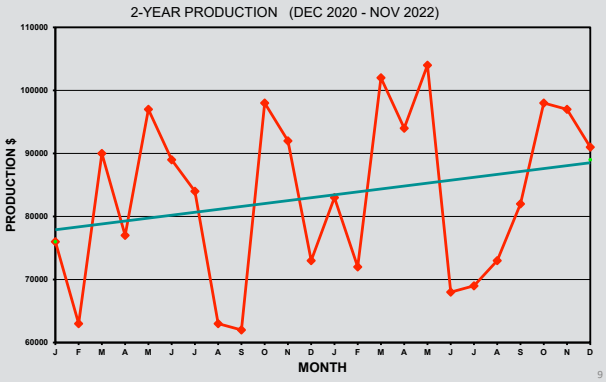
1 Additional Root Pl/day ($160)
Results in $20/hour increase
Additional $30,000

1 additional crown/day ($1,000) results in $125/hour increase
Additional $200,000

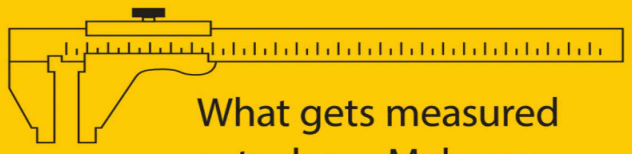
1 additional sealant/day ($40)
Results in $5/hour increase
Additional $8,000



Metrics – Measuring Trends



Embrace analytics !



What gets measured gets done. Make sure you are measuring the right things!

ACTIONABLE DATA

DENTALINTEL

PRODUCTIVITY FORMULA

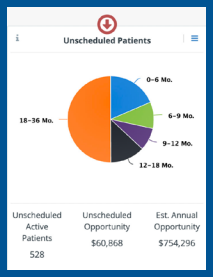
VISITS X **PRODUCTION PER VISIT** = **TOTAL PRODUCTION**

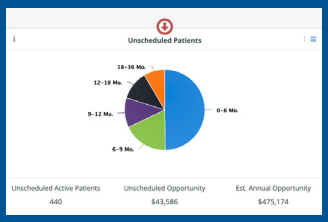
1. New patients
2. Re-appointment
3. Re-activation
4. Recapture
5. Reduce broken appointments

1. Increase Fees
2. Reduce PPO Dependency
3. Expand Tx Procedures
4. Diagnose Needed Tx
5. Increase Case Acceptance

X
COLLECTION %
MINUS
OVERHEAD
EQUALS
PROFITS

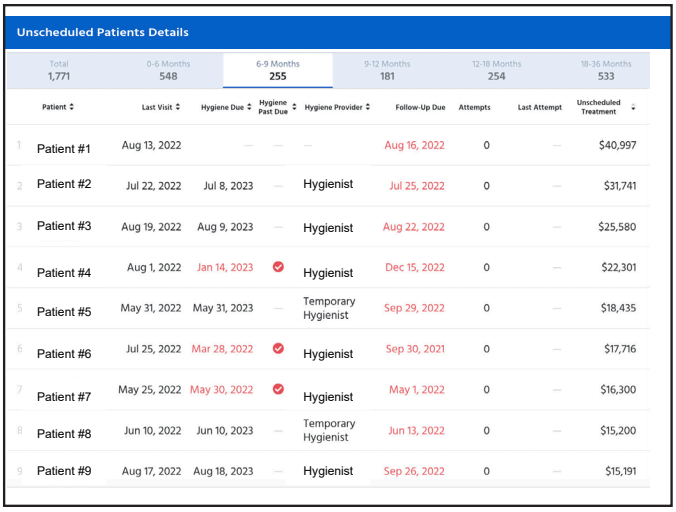
Improved systems…

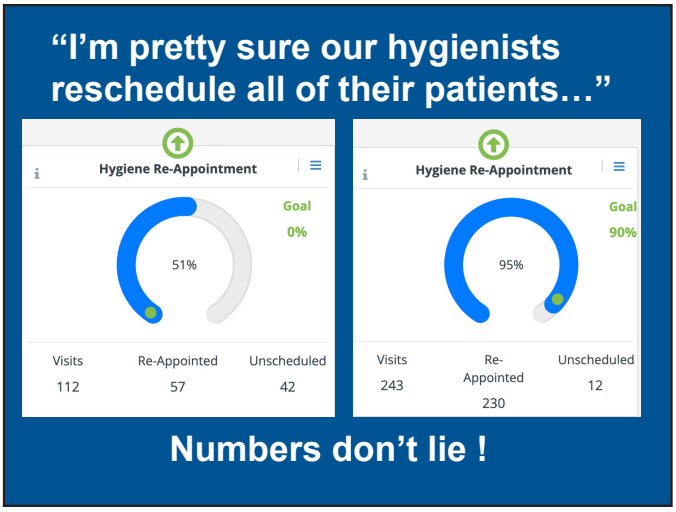


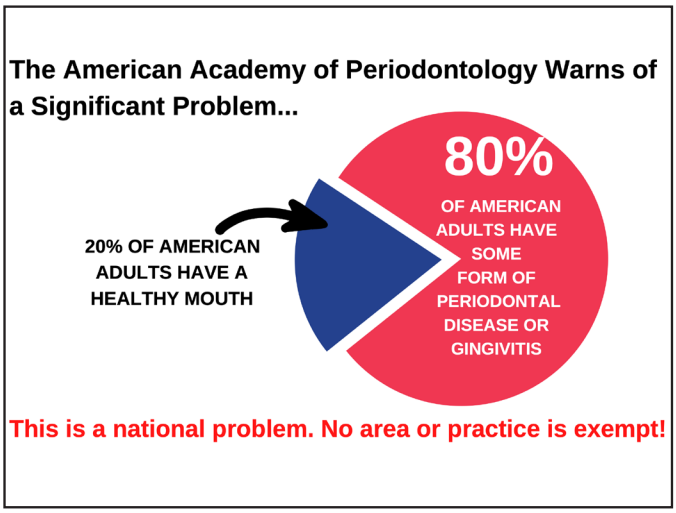


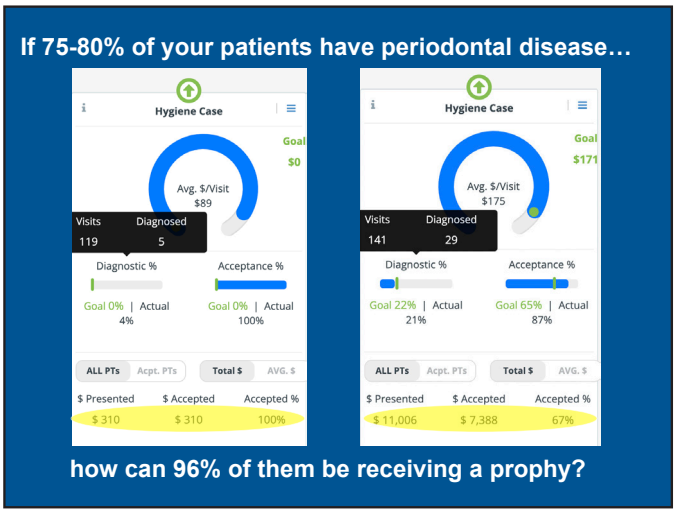
prevent patients from being lost through the cracks.

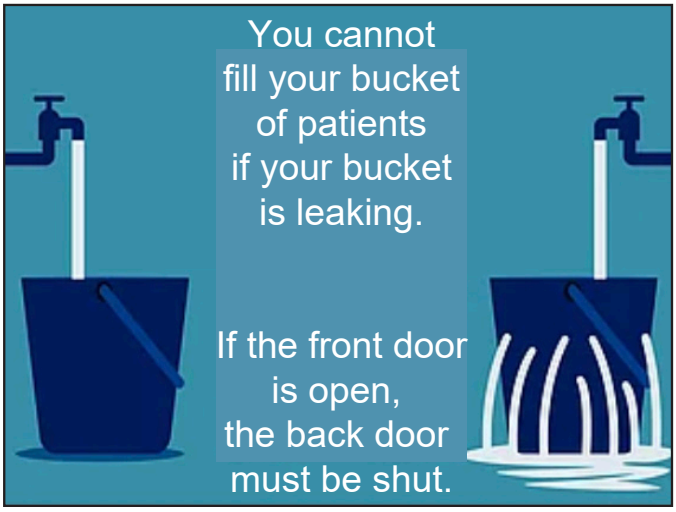
DENTALINTELLIGENCE

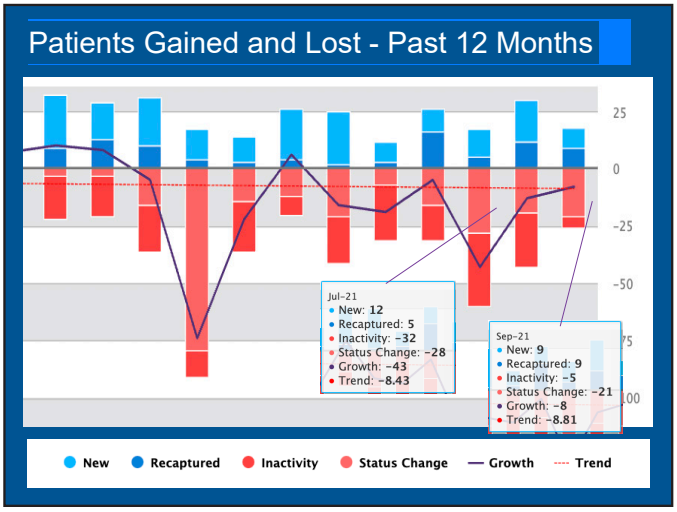

Unscheduled Patients Details
Total 1,771
0-6 Months 548
6-9 Months 255
9-12 Months 181
12-18 Months 254
18-36 Months 533
Patient
Last Visit
Hygiene Due
Hygiene Past Due
Hygiene Provider
Follow-Up Due
Attempts
Last Attempt
Unscheduled Treatment
1 Patient #1 Aug 13, 2022 — — — Aug 16, 2022 0 — $40,997
2 Patient #2 Jul 22, 2022 Jul 8, 2023 — Hygienist Jul 25, 2022 0 — $31,741
3 Patient #3 Aug 19, 2022 Aug 9, 2023 — Hygienist Aug 22, 2022 0 — $25,580
4 Patient #4 Aug 1, 2022 Jan 14, 2023 Hygienist Dec 15, 2022 0 — $22,301
5 Patient #5 May 31, 2022 May 31, 2023 — Temporary Hygienist Sep 29, 2022 0 — $18,435
6 Patient #6 Jul 25, 2022 Mar 28, 2022 Hygienist Sep 30, 2021 0 — $17,716
7 Patient #7 May 25, 2022 May 30, 2022 Hygienist May 1, 2022 0 — $16,300
8 Patient #8 Jun 10, 2022 Jun 10, 2023 — Temporary Hygienist Jun 13, 2022 0 — $15,200
9 Patient #9 Aug 17, 2022 Aug 18, 2023 — Hygienist Sep 26, 2022 0 — $15,191

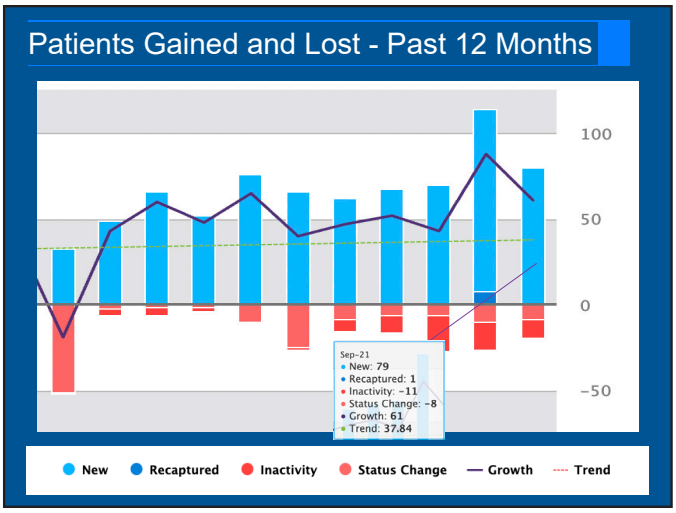

"I'm pretty sure our hygienists reschedule all of their patients…"
Hygiene Re-Appointment
Goal 0%
51%
Visits 112
Re-Appointed 57
Unscheduled 42
Hygiene Re-Appointment
Goal 90%
95%
Visits 243
Re-Appointed 230
Unscheduled 12
Numbers don't lie !

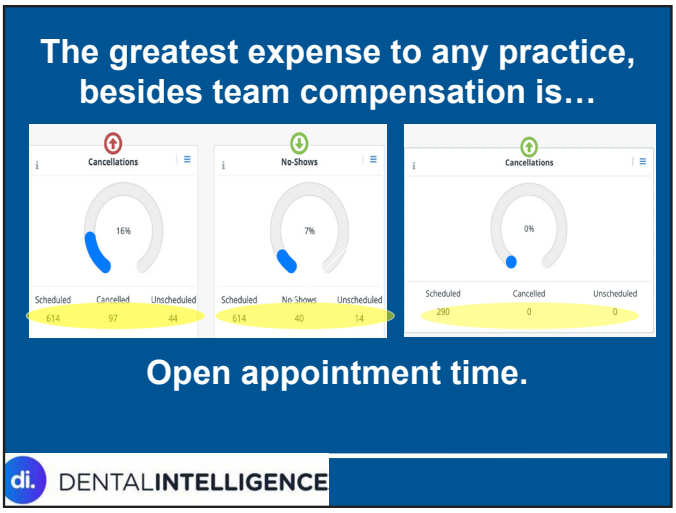

The American Academy of Periodontology Warns of a Significant Problem...
20% OF AMERICAN ADULTS HAVE A HEALTHY MOUTH
80%
OF AMERICAN ADULTS HAVE SOME FORM OF PERIODONTAL DISEASE OR GINGIVITIS
This is a national problem. No area or practice is exempt!

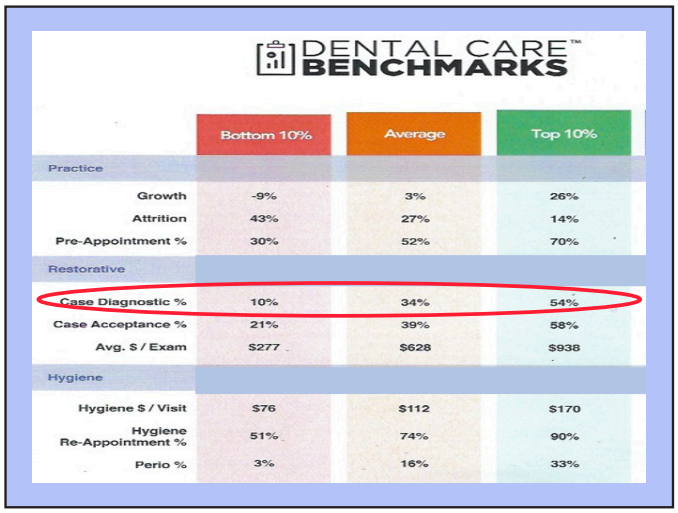

If 75-80% of your patients have periodontal disease…
Hygiene Case
Goal $0
Avg. $/Visit $89
Visits 119
Diagnosed 5
Diagnostic %
Goal 0% | Actual 4%
Acceptance %
Goal 0% | Actual 100%
$ Presented $ 310
$ Accepted $ 310
Accepted % 100%
Hygiene Case
Goal $171
Avg. $/Visit $175
Visits 141
Diagnosed 29
Diagnostic %
Goal 22% | Actual 21%
Acceptance %
Goal 65% | Actual 87%
$ Presented $ 11,006
$ Accepted $ 7,388
Accepted % 67%
how can 96% of them be receiving a prophy?

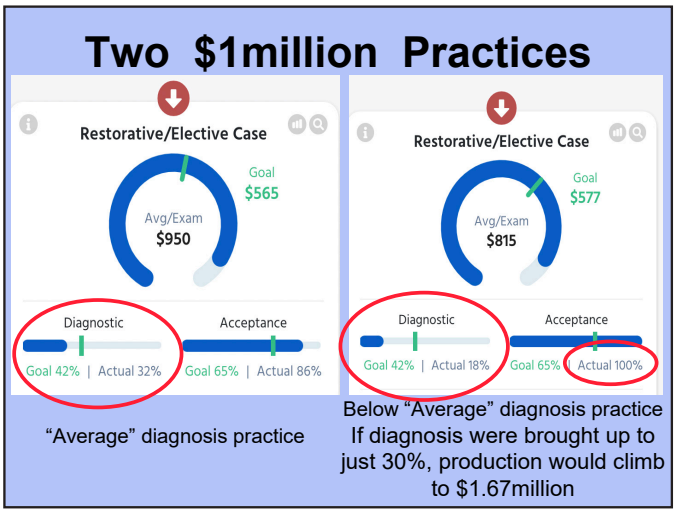

You cannot fill your bucket of patients if your bucket is leaking.
If the front door is open, the back door must be shut.


Patients Gained and Lost - Past 12 Months
25
0
-25
-50
Jul-21
New: 12
Recaptured: 5
Inactivity: -32
Status Change: -28
Growth: -43
Trend: -8.43
Sep-21
New: 9
Recaptured: 9
Inactivity: -5
Status Change: -21
Growth: -8
Trend: -8.81
New
Recaptured
Inactivity
Status Change
Growth
Trend

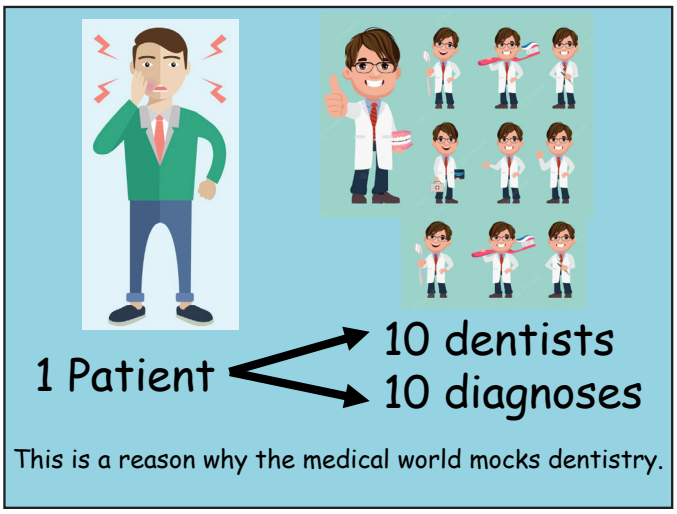

Patients Gained and Lost - Past 12 Months
100
50
0
-50
Sep-21
New: 79
Recaptured: 1
Inactivity: -11
Status Change: -8
Growth: 61
Trend: 37.84
New
Recaptured
Inactivity
Status Change
Growth
Trend

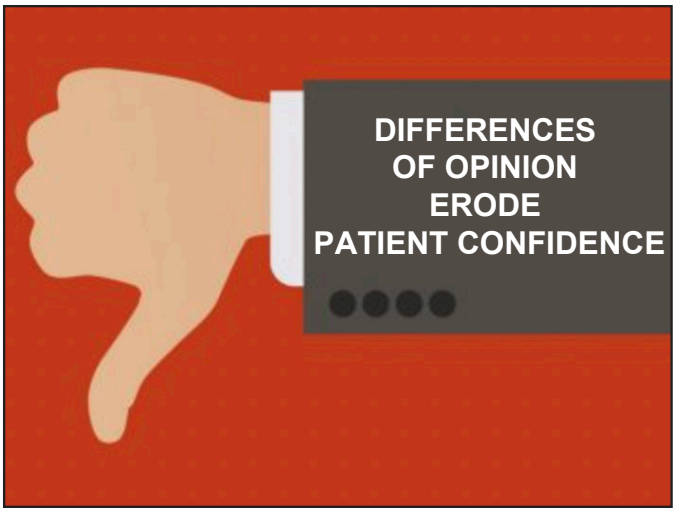

The greatest expense to any practice, besides team compensation is…
Cancellations
16%
Scheduled
Cancelled
Unscheduled
614
97
44
No-Shows
7%
Scheduled
No-Shows
Unscheduled
614
40
14
Cancellations
0%
Scheduled
Cancelled
Unscheduled
290
0
0
Open appointment time.
DENTALINTELLIGENCE


DENTAL CARE BENCHMARKS
Bottom 10%
Average
Top 10%
Practice
Growth -9% 3% 26%
Attrition 43% 27% 14%
Pre-Appointment % 30% 52% 70%
Restorative
Case Diagnostic % 10% 34% 54%
Case Acceptance % 21% 39% 58%
Avg. $ / Exam $277 $628 $938
Hygiene
Hygiene $ / Visit $76 $112 $170
Hygiene Re-Appointment % 51% 74% 90%
Perio % 3% 16% 33%


Two $1million Practices
Restorative/Elective Case
Goal $565
Avg/Exam $950
Diagnostic
Acceptance
Goal 42% | Actual 32%
Goal 65% | Actual 86%
Restorative/Elective Case
Goal $577
Avg/Exam $815
Diagnostic
Acceptance
Goal 42% | Actual 18%
Goal 65%
Actual 100%
"Average" diagnosis practice
Below "Average" diagnosis practice
If diagnosis were brought up to just 30%, production would climb to $1.67million


6!
9!
Do we have universal diagnostic criteria?
…and treatment?

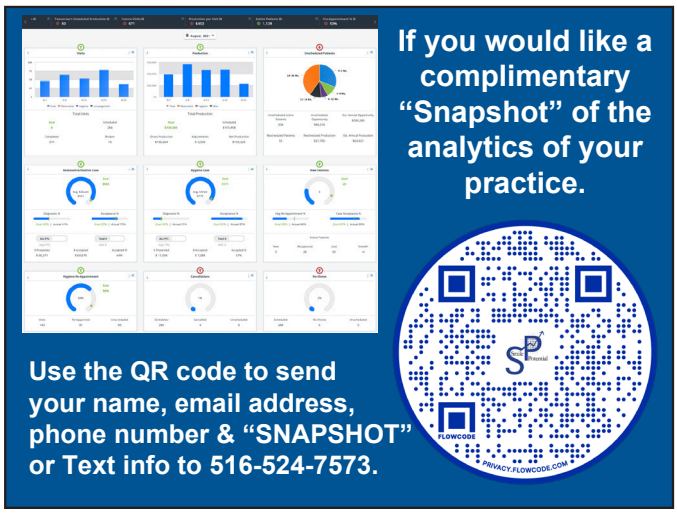

1 Patient
10 dentists
10 diagnoses
This is a reason why the medical world mocks dentistry.


DIFFERENCES
OF OPINION
ERODE
PATIENT CONFIDENCE


CONSERVATIVE ?
AGGRESSIVE ?

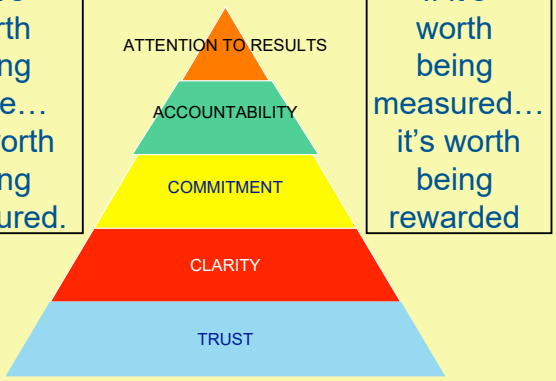

PROTECTIVE !!!


Standardization of Care...
Complete Clarity
Diagnostic Criteria Photos


If you would like a complimentary "Snapshot" of the analytics of your practice.
Use the QR code to send your name, email address, phone number & "SNAPSHOT" or Text info to 516-524-7573.


Our patients' needs have changed.
Society has changed.
Our profession has changed.
WE MUST BE WILLING TO CHANGE!

If it's worth being done… it's worth being measured.



If it's worth being measured… it's worth being rewarded

Lencioni's Team Development Pyramid

Surround Yourself With Advisors

SMILE POTENTIAL DENTAL PRACTICE COACHING

coaching@smilepotential.com 516-599-0214

Over $120 Million

Between 2016-2022, Smile Potential has worked with 139 practices in the New York metro area. The cumulative revenue increase has been Over $120 million.

If you would like any additional information about anything discussed in this program, or copies of any of the slides or resources mentioned…

Use QR code…

or send email to:
coaching@smilepotential.com

Include name and phone number.

SELF EVALUATION

Leveraging Analytics for Practice Success

1. Metrics that every dentist should be aware of include all except:

- **a.** Production and Collection
- **b.** Production per hour for providers
- **c.** Break-even point and overhead percentage
- **d.** Changes in Insurance coding

2. Success in a challenging economic environment should include the following strategy:

- **a.** Control expenses
- **b.** Treatment plan less aggressively
- **c.** Eliminate external marketing
- **d.** Changes in Insurance coding

3. In order to increase productivity in a one-doctor, one-hygienist office by $300,000 you can:

- **a.** Significantly increase hours worked
- **b.** Look for daily opportunities to do one more crown, one or two more resins and one or two more periodontal procedures
- **c.** Drop all insurance plans
- **d.** Introduce a specialist to the practice

4. Analytics which demonstrate deficiencies in systems include:

- **a.** An abundance of unscheduled patients
- **b.** Low percentages of periodontal procedures
- **c.** Low hygiene reappointment
- **d.** All of the above

5. The average diagnostic percentage in general practices is:

- **a.** 14%
- **b.** 24%
- **c.** 34%
- **d.** 44%

6. It is important to make sure that patients return to the practice before they hit the threshold for becoming inactive, which is :

- **a.** 12 months
- **b.** 18 months
- **c.** 24 months
- **d.** 30 months

7. It is very advisable to surround yourself with advisors including:

- **a.** Colleagues and mentors
- **b.** Dental CPAs, accountants and IT experts
- **c.** Local business owners and your dental team
- **d.** Dental sales reps and lab technicians
- **e.** Practice coaches
- **f.** All of the above

Answer Key: 1. D, 2. D, 3. B, 4. D, 5. C, 6. B, 7. F

Thomas P. Cox, ARM

Thomas P. Cox, ARM, of Richmond, Virginia, is president of Bluewater Solutions, LLC, a boutique risk and insurance management company focusing primarily on health care and related risks. He has over 30 years of experience working almost exclusively with health care professionals. Mr. Cox has held executive positions with a large medical center, a major medical malpractice insurance company, and multiple insurance agencies before starting Bluewater Solutions in 2009. Bluewater Solutions offers all manner of risk and insurance management, consulting, and litigation stress coaching. Mr. Cox has a B.S. in Health Education, has done graduate work in Public Health, and earned his Associate in Risk Management designation from the Insurance Institute of America.

You may contact Mr. Cox at tpcox@bluewatersolutions.net or at 804-221-4369.

WINNING FOCUS, INC.
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Thomas Cox, COO, Litigation Stress Coach
2312 Summerwood Drive, Henrico, VA 23233
804-221-4369
tpcox@bluewatersolutions.net
www.winfordoc.com

Reducing Practice Risk through Effective Communication

Objectives

3

At the end of this presentation the attendee will be able to:

1. List three or more forces affecting healthcare delivery today.
2. List three or more challenges to effective patient communication.
3. List three positive steps that can reduce the impact of litigation stress.

Objectives

Integrated issues:

- Who you are is what you do
  - Personally and professionally
- Information Technology
- Wall Street
- How can you lose what you have earned?

Wall Street and Health Care

- **Wall Street's Buying Up U.S. Health Care — Including In North Carolina** *Charlotte Observer*
- **Physicians, Hospitals Meet Their New Competitor: Insurer-Owned Clinics**
- **Consolidation of Health Care Driving Up Prices in Work Comp**

Wall Street and Health Care

BusinessweekFeature

- **How Private Equity Is Ruining American Health Care**

What happens when Wall Street takes over health care?

Private equity firms —which invest money for wealthy people, pension funds and endowments —are buying up medical practices and hospitals all over the U.S., expecting a big return on their money.

Technology

- Social media
  - Twitter, Mastodon, Facebook, WebMD, Sharecare, Trackyourdoctor, Beenverified, HealthGrades, etc.
- Electronic Records
  - Reimbursement tool, tracks what is done and not done, malpractice tool?
- Artificial Intelligence
  - ChatGP, BioGPT

Artificial Intelligence: ChatGPT

- ChatGPT is a large language model chatbot developed by OpenAI based on GPT-3.5
- Large language models perform the task of predicting the next word in a series of words. Large Language Models (LLMs) are trained with massive amounts of data to accurately predict what word comes next in a sentence.
- It was discovered that increasing the amount of data increased the ability of the language models to do more.
- Newest iterations can generate paragraphs from single sentence.
- ChatGPT passed a Medical School exam, but…
- GPT-4

How does ChatGPT work?

- **Step 1: Set a goal**

  Determine an "objective function" or what it is you want the program to do, i.e., win chess games or predict the three-dimensional shapes of proteins using only amino acid sequences. Most LLM have one goal: given a line of text, predict what comes next.
- **Step 2: Collect lots of data**

  This usually means scraping billions of pages from the internet, such as blog posts, tweets, Wikipedia articles and news stories, or medical and dental journals. In general, the more data we have, and the more diverse the sources, the better our model will be.
- **Question: at what point does this become copyright infringement?**

How does ChatGPT work?

- **Step 2 (continued)**
- Before we can feed the data into our model, we need to break it down into units called **tokens**, which can be words, phrases or even individual characters. Transforming text into bite-size chunks helps a model analyze it more easily.
- **Question: at what point does this become copyright infringement?**

How does ChatGPT work?

Step 3: Build a neural network

Once our data is tokenized, we need to assemble the A.I.'s "brain" — a type of system known as a **neural network**. This is a complex web of interconnected nodes (or "neurons") that process and store information. A relatively new type of neural network is the **transformer model**. This can analyze multiple pieces of text at the same time, making it faster and more efficient. (Transformer models are the key to systems like ChatGPT — whose full acronym stands for "Generative Pretrained Transformer").

Step 4: Train your neural network

Next, the model will analyze the data, token by token, identifying patterns and relationships. It might notice "Dear" is often followed by a name. By identifying these patterns, the A.I. learns how to construct messages that make sense. The system also develops a sense of context.

How does ChatGPT work?

Step 5: Fine-tune your model

Once our large language model is trained, it needs to be calibrated for a specific job. A chatbot used by a hospital might need to understand medical terms, for example. To fine-tune our Chatbot, we could ask it to generate a bunch of emails and articles, hire people to rate them on accuracy and then feed the ratings back into the model until it improves. This is a rough approximation of the approach that was used with ChatGPT, which is known as **reinforcement learning with human feedback**.

Step 6: Launch, carefully

Once our LLM has been trained and fine-tuned, it's ready to use. But no matter how good it seems, you're still going to want to keep tabs on your new assistant. As companies like Microsoft and Meta have learned the hard way, A.I. systems can be erratic and unpredictable, or even turn creepy and dangerous.

GPT-4

- March 16, 2023
- OpenAI announced the next-generation version of the artificial intelligence technology that underpins its viral chatbot tool, ChatGPT. The more powerful GPT-4 promises to blow previous iterations out of the water, potentially changing the way we use the internet to work, play and create. But it could also add to challenging questions around how AI tools can upend professions, enable students to cheat, and shift our relationship with technology.

BioGPT

- Source: *Futurism*
- Populated same as ChatGPT
- Microsoft's medicine/biology version of ChatGPT
- The answer you get depends on how you ask the question

BioGPT

- Microsoft's artificial intelligence system BioGPT, designed to answer questions about medicine and biology, produced inaccurate and possibly dangerous answers, including mystifying answers about **ghosts in hospitals** as well as **false information about vaccines**. BioGPT also **invented citations and fabricated studies to support its claims**, and Roxana Daneshjou, a clinical scholar at the Stanford University School of Medicine, says not only do people in medicine want to start using AI without fully understanding all the limitations, but the tools could also be used maliciously to "generate research papers that perpetuate misinformation and actually get published."

So….

To conclude the introduction:

- Integrated issues
- Increasing loss of control (*but more to come*)
- Wall Street
- Artificial Intelligence

Office Practice Risk Management

Premise

- Office practice policies and procedures for dentists and physicians have changed over the last 20 years, and the rate of change has accelerated due to automation and consolidation.
- **Patients** have changed over the last 20 years due to easy access to internet information.

Risk Management

- Risk Reduction
- Risk Control
- Risk Financing
- Enterprise Risk Management

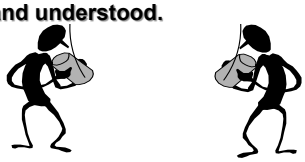
Physicians spending more time with computers than patients

STEVEN REZNICK, MD ; *PHYSICIAN*
MARCH 6, 2023

- My local community hospital has recently signed on to be a member of a **large regional not-for-profit hospital system**. In the past, I would access the hospital website and enter my user ID and password to log in. Now I must first enter the health system database using several levels of authentication, which proves it is me and not some mercenary trying to introduce a virus or kidnap the system. If I enter my information correctly, a prompt is sent to an app on my mobile phone. I must access that app, and then, if I enter everything correctly, a new sign-in window appears from my local hospital.

Communication in the Health Care Setting

- Communication:
  A process by which information is exchanged between individuals through a common system of symbols, signs, or behavior.
- To communicate means to share.
- **Good communication means what has been said is what has been heard and understood.**



Communication in the Health Care Setting

Some challenges:

- 90% of communication is nonverbal
- 47% of the adult elderly are either functionally illiterate or minimally literate
- Less than 10% of medical treatment decisions involve a fully informed patient
- Providers believe that 89% of patients understand the side effects of medication they are taking, while only 57% of patients claim to understand

Communication in the Health Care Setting

- **Impediments to successful communication in the healthcare setting:**

1. Literacy of patients
2. Health literacy of patients
3. Complexity of the health care delivery system.
4. Fragmentation of health care delivery system.
5. Business aspects of health care delivery system.
6. Keeping up with science and ignoring the human dynamic.

Communication in the Health Care Setting

- Impediments to successful communication in the medical office:

7. To which we have added:

Communication in the Health Care Setting

Traditional thought:

- Malpractice experience is determined by factors associated with the provider, case-load, and unpredictable circumstances, in addition to a litigious population and bad luck.
- "*There are three kinds of lies: lies, damn lies, and statistics*." -Benjamin Disraeli

Communication in the Health Care Setting

"*Patient Complaints and the Malpractice Risk*"
(The Journal of the American Medical Association, June 12, 2002)

"*Research has forced reconsideration of these traditional explanations of claims experience. Risk seems **not** to be predicted by patient characteristics, illness complexity, or even physicians' technical skills.*

Communication in the Health Care Setting

"*Patient Complaints and the Malpractice Risk*"
(The Journal of the American Medical Association, June 12, 2002)

"*Instead, risk appears related to patients' dissatisfaction with their physician's ability to establish rapport, provide access, administer care and treatment consistent with expectations, and communicate effectively*."

Communication in the Health Care Setting

Multiple studies were cited by the author of the article. This research studied the communication behaviors of physicians with multiple medical claims against them, as opposed to those of physicians with **no claims** against them. Audio tapes of 10 routine visits were examined for each group of physicians.

Communication in the Health Care Setting

Physicians with **no** claims against them:

- Used more statements of orientation (*educating patients about what to expect)*
- Laughed more, used more humor
- Tended to use more facilitation (*soliciting opinions, encouraging patients to talk, checking for understanding*).
- Validated patient's emotions

Communication in the Health Care Setting

Physicians with no claims against them:

- Those physicians without claims also, on average, spent an additional 3.3 minutes longer with each patient than those physicians with claims.

Communication in the Health Care Setting

Conclusion:

- *Patient dissatisfaction is critical.*
- *The combination of a bad outcome and patient dissatisfaction is a recipe for litigation.*
- *When faced with a bad outcome, patients and families are more likely to sue a health care provider if they feel they were not caring and compassionate.*
- *Highest claim frequency remains failure to diagnose or late diagnosis.*

Communication in the Health Care Setting

Literacy and Health Care

In 1992 The U.S Department of Education conducted a National Adult Literacy Survey (NALS) to measure the general literacy skills of 26,000 randomly selected adults

1. Functionally illiterate 20%
2. Marginally illiterate 27%
3. Marginally literate
4. Functionally literate
5. High level literacy <5%

Communication in the Health Care Setting

Literacy and Health Care

The NASL study also showed an *increase* in literacy problems with **aging**, due to:

- Declines in reading skills
- Vision
- Health
- Other communication skills

Communication in the Health Care Setting

Literacy and Health Care

The low literacy level in the elderly is only **one** contributing factor to their low ***health literacy***, however.

- 80% of adults over 65 have at least one chronic health condition.
- 50% of those have at least two chronic conditions.
- Elderly with chronic conditions see, on average, eight (8) different physicians annually.

Communication in the Health Care Setting

Literacy and Health Care

Low health literacy, however, is not limited to the elderly, nor is it limited to those with low literacy. According to an Institute of Medicine (IOM) report *Health Literacy: A Prescription to End Confusion:* "*Health literacy …includes a variety of components beyond reading and writing, including numeracy, listening, speaking, and cultural and conceptual knowledge*."

Communication in the Health Care Setting

Literacy and Health Care

The IOM report identified distinct causes of low health literacy, some or all or which may be present in any given patient:

1. Limited reading ability
2. Lack of background knowledge in health sciences or biology
3. Lack of familiarity with medical language or medical materials or documents
4. Cultural differences in approaches to health and health care.

Communication in the Health Care Setting

Reducing all of this to one basic concept:

Good communication means what has been said is what has been heard and understood.

The more you can do to ensure that what you say is what the patient hears and understands, the better off everybody will be.

So, what has changed?

Communication in the Health Care Setting

Literacy and Health Care

1. Electronic health records
2. Fewer "normal" patients

Communication in the Medical Office

Literacy and Health Care

Electronic Health Records

- Here to stay
- Reimbursement tool
- More time on computer, less time with, and attention paid to, patient
- Be aware of this (less laying on of hands)

Communication in the Medical Office

Literacy and Health Care

Fewer Normal Patients

The human body contains 206 bones, 32 teeth (more or less) 600 muscles, 39 trillion microbes, and dozens, maybe over 100, **man-made chemicals.**

Fewer "normal" patients

- *Center for Genomics and Personalized Medicine*, Stanford University
- Michael Snyder, Ph.D., Geneticist
- Over nine years of data
- Six different trials
- Two million gigabytes of his own health data stored

Fewer "normal" patients

- Why are our genes not sequenced at our annual wellness checkup?
- Estimated: 10% of cardiovascular disease, cancer, diabetes, neurodegenerative disease progression and development is driven by genes.
- Most of our maladies appear to be brought on by things we inflict on ourselves, such as lifestyle and environmental factors (exposure to air and water pollution, toxic waste, and chemicals) that turn on the gene.

Fewer "normal" patients

- 2021 study from University of California-San Francisco: 109 different industrial and consumer chemicals in study subject's blood.
- More than 50 never found in studies before.
- 42 were mystery chemicals of unknown origin.
- Over one generation or two, human beings have become petri dishes, part of an unplanned experiment in which chemicals and substances that have never existed in nature are interacting in ways science is just beginning to understand.

Fewer "normal" patients

"I had a doctor tell me, '*When I started my practice, all my patients were normal, but it has slowly shifted to all abnormal cases. Now it is weird to have a normal case.*'" Tracy Woodruff, Ph.D., UCSF

- Increasing cancer rates in people under 50 years of age
- Decreased quality of sperm
- Increased fertility problems
- Estimated more than 12 millions deaths each year due to toxic exposures

Fewer "normal" patients

Exposome

("Exposomics")

The concept that nearly all exposures, *starting in utero*, will have an impact on us.

- Forever chemicals
- Refineries
- Synthetic flavors
- Synthetic smells

Fewer "normal" patients

- Over 80,000 potentially toxic chemicals currently in use in the U.S.
- Dr. Snyder's "exposometer" captures everything he is exposed to in a day.
- To date, it has measured over 3,000 chemicals that he has been exposed to
- 158 identified
- 67 most likely dangerous

Fewer "normal" patients

Exposometer

- Approximately 33% are pesticides
- 21% from pharmaceuticals and personal care products
- 11% from plastic
- 10% known carcinogens

Fewer "normal" patients

Cause and Effect?

- Certain chemicals from plastics were associated with inflammatory markers and changes in the population of his gut biome.
- Some pesticides correlated with inflammatory effects involving his kidney and liver functions.

Fewer "normal" patients

Your exposome time capsule?

Baby teeth

Fewer "normal" patients

Manish Arora, Ph.D., Icahn School of Medicine at Mount Sinai

- Trained dentist
- Whatever is in your blood stream gets deposited in your teeth
- Baby teeth from Flint, MI, showed when the exposure to lead-contaminated water occurred…
- …**but** only about 50% were reported to be unwell.
- "Genetics loads the gun, and your environment pulls the trigger." Francis Collins, M.D., Ph.D., former NIH Director

How is this all connected?

"*The Body Keeps the Score*"

Bessel van der Kolk, M.D.

Professor of Psychiatry, Boston University School of Medicine

Published 2014

229 Weeks on New York Times Best-Seller List (Non-Fiction)

27 Weeks at #1

464 pages

The book explains what ***traumatic stress*** is, how it affects our minds and bodies, how it can change our lives for the worse, and the wide-ranging effects experienced not only by traumatized people, but also those around them.

The Body Keeps the Score

Trauma is incredibly common in our society today.

Traumas result from experiences of extreme stress or pain that leave an individual feeling helpless, or too overwhelmed, to cope with adversity.

Lack of control or a belief in lack of control.

The Body Keeps the Score

Flashbacks cause people to relive the mental and physical experience of trauma when they're reminded of it. Your mind might be aware that a traumatic event is over, but established science has shown that the processes your body uses to defend itself can result in patterns being formed. This prevents you from completely moving on.

Never "present"

The Body Keeps the Score

Childhood trauma has negative impacts, not just in a person's youth but well into adulthood, too. While normal memories fade and change, traumatic memories are vivid, unchanging and easily triggered. When they are re-lived, the body responds to what the mind is experiencing.

The Body Keeps the Score

Treat the symptoms, first.

The goal is not to work to stop keeping score, but to become aware that the body is keeping score and how it is doing so.

Treat the symptoms

The Body Keeps the Score

Treat the Physical Symptoms

Talk therapy: top down
- Talk it out to understand it

Somatic therapy: bottom up
- Recognize, understand, release

Mind-Body Balance
- Learn to "feel your body"

The Body Keeps the Score

What is your body trying to tell you?

Neuromuscular Relaxation

Communication in the Medical Office

Literacy and Health Care

Examples of challenges:

- 85% did not understand the direction “Take with food.”
- 61% did not understand the direction “Take with plenty of water.”
- 81% did not understand the direction “Do not take with dairy products.”

Communication in the Medical Office

Dealing with low health literacy patients

Cultural Considerations

Consider the Hispanic patient with hypertension who presented to the ER complaining of dizziness and low blood pressure, even though he was taking the two medications his doctor had given him two days ago. The directions were “Take once daily.”

Communication in the Medical Office

Literacy and Health Care

Examples of challenges:

- 80% of what doctors tell patients is forgotten as soon as they leave the office
- 50% of what is recalled by patients is incorrect
- 44% cannot accurately describe the nature of an upcoming surgical procedure
- 18% to 45% of patients are unable to recall the major risks of a treatment

Communication in the Medical Office

Clues to identifying low health-literacy patients

- Incomplete or inaccurate patient registration forms.
- Frequently missed appointments.
- Noncompliance with treatment regimens.
- Lack of follow through with lab tests, radiological tests, or referrals to specialists.
- Saying things such as “I forgot my glasses” when asked to read or write something.

Communication in the Medical Office

Clues to identifying low health literacy patients

- Saying things such as “I will take this home to discuss with my children/spouse.”
- Inability to name medication he/she is taking.
- Inability to explain what a medication is for.
- Inability to explain the dosage or how to take a medication.
- Identification of medications by looking at or describing the size, shape and color, rather than the names.

Communication in the Medical Office

Dealing with low health literacy patients

- Introduce yourself
- Slow down
- Use simple language
- Show or draw pictures or diagrams
- Give information in bite-sized pieces

Communication in the Medical Office

Dealing with low health literacy patients

- Use the "teach-back" technique to check comprehension
- Help patients avoid feeling ashamed
- Suggest bringing a friend or relative to office visits
- Enlist staff assistance

Communication in the Medical Office

Dealing with low health literacy patients:
Enlist staff assistance

Office staff can assist with filling out forms or reading information in a polite, discreet, cheerful and confidential manner. Staff also need to be aware of the shame and embarrassment many patients feel and should be sensitized to avoid embarrassing anyone.

Communication in the Medical Office

Dealing with low health literacy patients
Printed Materials

- Typeface: bland, not *quirky* (Garamond)
- Type Size: 12 point is recommended minimum
- Type weight and contrast: medium or semi-bold letters on a light background, not bold on white
- Capital letters: use both cases
- Design and layout: simple, clear, consistent, wide margins, not too much clutter, use pictures to illuminate the text, not muddy the water

Communication in the Medical Office

Dealing with "Problem" Patients:
Listening pitfalls

1. Assuming you know how the speaker feels.
2. Anticipating what the speaker is going to say.
3. Thinking about what you are going to say while the speaker is still talking.
4. Wishing the speaker would just get to the point.

Communication in the Medical Office

Dealing with "Problem" Patients:
Listening pitfalls

5. Getting defensive over criticism.
6. Determining to follow your own agenda.
7. Getting over-emotional.
8. Allowing your mind to wander.

Communication in the Medical Office

Dealing with "Problem" Patients:
Developing better listening skills

1. Control distractions
2. Concentrate on what the speaker is saying mentally and physically (make eye contact, lean forward, relax).
3. Be patient, don't interrupt.
4. Don't daydream.

Communication in the Medical Office

Dealing with "Problem" Patients:

Developing better listening skills

5. Avoid finishing sentences for the speaker unless the speaker is struggling, in which case it is best to suggest a word to help.
6. Agree when you can.
7. Paraphrase to check accuracy.

Communication in the Medical Office

Dealing with "Problem" Patients:

Key technique to master

1. Let the patient talk and listen to what is said.
2. When the patient is done, wait five seconds before saying anything. If the patient starts talking again, listen.
3. When the patient is done, re-state what you think the patient's primary concern is in your own words.
4. Once you and the patient agree on the main problem, determine a course of action. Solve problem, don't "win."

Communication in the Medical Office

Dealing with "Problem" Patients:

The long wait

- Studies have shown that patient satisfaction is tied to wait time.
- Apologize and explain, don't ignore.
- Give a realistic time, not a vague promise such as "*The doctor will see you soon.*" Instead state, "*I am sorry you have had to wait. You are the next patient and I expect Dr. Iamalwayslate to be with you in about 10 minutes. If it will be longer, I will let you know."*

Communication in the Medical Office

Dealing with "Problem" Patients:

Short-circuit the long wait

- Place a sign on the reception desk that lets patients know the office policy on waiting, such as:

  "*We know your time is valuable and we do our best to not keep you waiting. We will let you know if your doctor will not be able to see you within 15 minutes of you signing in. If you cannot wait, please talk with the receptionist to re-schedule your appointment. We are sorry if we inconvenienced you.*"

Communication in the Medical Office

Dealing with "Problem" Patients:

The long wait

- Don't show patients to an exam room until shortly before they will be seen, unless you have a very comfortable exam room.
- Explain why the doctor is running late, if possible.
- Thank patients who wait.
- Keep the waiting area a nice place to be (current magazines, clean, attractive, TV)

Communication in the Medical Office

Apologies

1. *Tactical* (Trying to soften someone up)
2. *Explanation* ("I am sorry, but…")
3. *Formalistic* (Socially expected)
4. *Authentic* (Feel and express genuine sympathy and regret, and take responsibility for actions, frequently leading to a change in feelings and restoration of trust)

Communication in the Medical Office

What are some things doctors can do to enhance communication?

- Ask permission before entering the exam or treatment room
- Introduce yourself (even if it is a returning patient)
- BEFORE inducing conscious sedation or anesthesia explain the procedure and how long it should take (document)
- If diagnostic tests are indicated, explain why, what will be done, and estimate how long until results are available (document)

Communication in the Medical Office

What are some things doctors can do to enhance communication?

- Before finishing the encounter, ask if the patient or family has any questions that have not been answered (document)
- If follow up will be required, explain an approximate time frame and what the expectation are for that session (document)
- Thank the patient and family for allowing you to be a part of the health care team

Communication in the Medical Office

What are some things doctors can do to enhance communication?

Delivering bad news

- Consider the emotional state of the patient and family
- Patient tends to not want to hear what is being said, while the doctor prefers to not want to say anything direct.
- In one Yale study, 100% of physicians stated they had given a prognosis, while 69% of patients stated they had received a prognosis.

Communication in the Medical Office

What are some things doctors can do to enhance communication?

Delivering bad news?

"SPIKES"

- SET UP the interview
- Assess the PATIENT'S perception
- Obtain an INVITATION to proceed
- Give the patient KNOWLEDGE and diagnostic information (the bad news)
- Respond with EMPATHY to the patient's EMOTIONS
- SUMMARIZE and STRATEGIZE

Communication in the Medical Office

Conclusion

- Most communication training is received very early on in residency, long before it is needed
- To effectively communicate means to be human
- To effectively communicate means that the message being delivered is the message being sent
- Communication skills CAN be improved, CAN be practiced and, as with any risk management activity, must be REPEATED to remain effective
- The key to more successful communication for many physicians resides in developing better listening skills.

Communication in the Medical Office

Conclusion

The computerization of offices continues and there are fewer "normal" patients, work to not let the computer become one more distraction between you and the patient and, maybe, start considering Zebras more often.

SELF EVALUATION

Reducing Practice Risk through Effective Communication

1. A challenge with the use of BioGPT Artificial Intelligence is:

a. It invents citations.
b. It references non-existent studies.
c. It can provide false information on vaccines.
d. All of the above.

2. Communication with patients can be impeded by:

a. The literacy of the patient.
b. The health literacy of the patient.
c. Provider focus on the Electronic Health Record.
d. All of the above.

3. T/F - In a 1992 study of 26,000 randomly selected Americans, the U.S. Department of Education determined that 47% of the participants were either functionally or marginally illiterate.

4. The perception of healthcare professionals that they are seeing fewer “normal” patients is likely related to:

a. Patients being unfamiliar with medical terminology.
b. Patients lacking background knowledge in health sciences or biology.
c. Patients having, on average, over 100 toxic, man-made chemicals in their bodies.
d. Providers missing non-verbal communication from patients.

5. Communication between healthcare professionals and patients:

a. Can be improved with practice.
b. Can be improved with better listening skills on the part of healthcare professionals.
c. Is better when providers re-state in their own words what the patient said.
d. All of the above.

Answer Key: 1. D, 2. D, 3. T, 4. C, 5. D